STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREEK LIVING LLC	2270 OAKLAND ROAD FOREST CITY, NC 28043

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D 000	Initial Comments The Adult Care Licensure Section and the Rutherford County Department of Social Services completed an annual and follow-up surveys and a complaint investigation on 12/28/22 to 12/30/22 and 01/03/23 with an exit conference via telephone on 01/04/23.	D 000		
D 030	10A NCAC 13F .0302 (b) Design And Construction 10A NCAC 13F .0302 Design And Construction (b) Each facility shall be planned, constructed, equipped and maintained to provide the services offered in the facility. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the building was maintained to provide services for a licensed capacity of 44 residents related to a non-resident occupying a resident room as personal living space. The findings are: Review of the facility's current license revealed a capacity of 44 residents. Review of the facility's census for 12/28/22 revealed the current census was 18 residents. Interview with a resident on 12/28/22 at 9:46am revealed: -One of the staff was living in the facility in a vacant resident room. -The staff gave her medications, so the resident assumed she was a Medication Aide (MA). -The resident was unsure how long the MA had	D 030		

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D 030	Continued From page 1 been living at the facility. Interview with a MA on 01/03/23 at 9:28am revealed: -She lived at the facility. -This was her only place of residency. Telephone Interview with the Administrator on 01/04/23 at 10:14am revealed: -A MA lived at the facility. -He did not think this was an issue that the MA lived at the facility because he had open rooms. -He was not aware he needed to contact DHSR if a non-resident was living at the facility.	D 030		
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 3 of 5 sampled staff (Staff D and E and the Operations Manager) completed a criminal background check prior to working in the facility. The findings are: 1. Review of the Operations Manager's personnel record revealed: -She was hired on 01/20/20 as the Operations Manager. -There was no signed consent for a criminal	D 139		

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background check in her personnel record.
-There was no documentation a criminal background check was completed prior to 01/20/20.

Interview with the Operations Manager on 01/03/22 at 11:50am revealed:
-She had a criminal background completed prior to hire but did not get the results or have a copy of the completed background check in her personnel record.
-She did not sign a consent since she was the one obtaining the background check.
-She did not obtain the results of her own background check.

Refer to interview with the Administrator-in-Charge (AIC) on 12/30/22 at 2:00pm.

Refer to interview with the Operations Manager on 01/03/22 at 11:50am.

Refer to interview with the Administrator on 01/03/22 at 11:52am.

2. Review of Staff D's personnel record revealed:
-Staff D was hired on 06/28/21 as a personal care aide (PCA).
-There was no documentation a criminal background check was completed before 06/28/21.
-There was no signed consent for a criminal background check in her personnel record.

Interview with Staff D on 12/30/22 at 9:30am revealed:
-She worked at the facility as a PCA.
-She could not remember if she signed a consent for a background check before she was hired.

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D 139	Continued From page 3 -There was no signed consent for a criminal background check in Staff D's personnel record. -She did not know if the criminal background check was completed prior to her starting work. Refer to interview with the AIC on 12/30/22 at 2:00pm. Refer to interview with the Operations Manager on 01/03/22 at 11:50am. Refer to interview with the Administrator on 01/03/22 at 11:52am. 3. Review of Staff E's personnel record revealed: -Staff E was hired on 05/25/22 as a housekeeper. -There was no documentation a criminal background check was completed before 05/25/22. -There was no signed consent for a criminal background check in his personnel record. Interview with Staff E on 12/30/22 at 9:45am revealed: -He worked at the facility as a housekeeper. -He could not remember if he signed a consent for a background check before she was hired. -He did not know if the criminal background check was completed before he started work. Refer to interview with the Administrator-in-Charge (AIC) on 12/30/22 at 2:00pm. Refer to interview with the Operations Manager on 01/03/22 at 11:50am. Refer to interview with the Administrator on 01/03/22 at 11:52am.	D 139		

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D 139	Continued From page 4 Interview with the AIC on 12/30/22 at 2:00pm revealed: -The Operations Manager was responsible for completing the background checks on all staff as well as herself prior to working in the facility. -She completed an audit a few months ago and notified the Operations Manager, Staff D and Staff E did not have criminal background checks completed and a signed consent in their personnel record. -If the criminal background check was not in the staff record, then it was not completed. -A criminal background was completed on Staff D and E on 12/30/22. Interview with the Operations Manager on 01/03/22 at 11:50am revealed: -She was responsible for completion of the criminal background check on each staff and herself prior to starting work. -She did not know Staff D and Staff E did not have a criminal background check prior to starting work at the facility. Interview with the Administrator on 01/03/23 at 11:52am revealed: -The Operations Manager was responsible for completion of the criminal background check on each staff prior to the staff starting work. -There was not an audit completed any other staff. -He did not know Staff D and Staff E did not have a criminal background check prior to starting work at the facility.	D 139		
D 150	10A NCAC 13F .0501 (a & b) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training	D 150		

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D 150	Continued From page 5 And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services.	D 150		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff D) who provided personal care to residents had documentation of successful completion of an 80-hour personal care training and competency evaluation program.

The findings are:

Review of Staff D's, personal care aide (PCA), personnel record revealed:
-Staff D's hire date was 06/08/21.
-There was no documentation Staff D completed an 80-hour personal care and competency training.

Interview with the Administrator-in-Charge (AIC) on 12/30/22 at 2:00pm revealed:
-She was responsible for maintaining all the records related to staff qualifications and notification to the facility contracted Registered Nurse (RN) to schedule the training.
-Staff D was hired as a PCA on 06/28/21.
-Staff D did not completed the 80-hour personal care and competency training because she did not follow up on making sure the training was completed.
-She knew the PCA's were required to complete the 80-hour personal care and competency training within 6 months of hire.

Interview with Staff D on 01/03/23 at 8:45am revealed:
-She was trained by another PCA when she was hired 06/28/21.
-She also received a check off from the facility's contracted RN within 3 months after being hired.

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D 150	Continued From page 7 -The check off consisted of bed baths, showers, changing a resident's brief and other personal care duties. Attempted telephone interview with the facility's contracted RN on 01/03/23 at 9:45am was unsuccessful. Interview with the Administrator on 01/03/23 at 11:52am revealed: -He was not aware Staff D did not complete the 80-hour personal care and competency training. -The AIC was responsible for making sure the PCAs received the 80-hour personal care and competency training within 6 months. -The AIC was responsible for completing audits of staff personnel records to check for mandatory training completion.	D 150		
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 A2 VIOLATION

Based on observations and interviews,the Administrator failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to management of the facility.

The findings are:

Interview with Resident #3 on 12/28/22 at 9:28am revealed:
-There were several occasions in the past few months when the personal care aide (PCA) administered medications to him.
-There was a medication aide (MA) who prepared his medications, but the PCA administered his medications.
-He was concerned the facility may not have enough qualified staff to administer medications.

Interview with a MA on 12/29/22 at 10:30am revealed she was aware only MAs were qualified to administer medications to residents.

Interview with Resident #6 on 12/29/22 at 2:50pm revealed:
-He tried to speak to the Administrator about unauthorized/untrained staff administering medications, but the Administrator was never in the facility.

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-He informed the Administrator-in-Charge (AIC) that unauthorized and untrained staff continued to administer his medication.
-There was no change after he informed the AIC and he continued to receive medication from the unauthorized and untrained staff.

Interview with another MA on 12/30/22 at 3:45pm revealed:
-She prepared and gave medications to one PCA for administration to residents on 4 or 5 occasions.
-The PCA administered the 8:00pm medications to Resident #4 most recently on 12/28/22.
-She did not observe the PCA administer the medications to Resident #4 on 12/28/22.
-She documented she administered the medications to Resident #4 on 12/28/22.

Interview with AIC on 12/29/22 at 8:30am, 12/30/22 at 9:30am and telephone interview on 01/03/23 at 10:00am revealed:
-She was notified by a MA of a physical altercation between Resident #1 and Resident #7 on 10/24/22.
-Resident #1 was physically agressive toward Resident #7.
-She notified the Administrator who came to the facility.
-Administrator notified the Department of Social Services who advised the Administrator to complete Involuntary Commitment paperwork.
-Local law enforcement transported Resident #1 to the local hospital for evaluation.
-Resident #1 returned to the facility on 10/25/22 at 2:30am.
-Notice of Discharge was discussed with the Administrator but Administrator declined to give Resident #1 Notice of Discharge paperwork.
-She was unaware of any PCA's administering

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medications to residents.
-There had been physical altercations that were started by Resident #1 and included 3 other residents on 08/16/22, 09/29/22, and 10/24/22.
-Resident #1 had been sent to the hospital for evaluation after the altercation with the third resident (Resident #7) on 10/24/22.
-Resident #1 was discharged from the hospital and came back to the facility within 24 hours.
-No discharge notification had been issued to Resident #1.
-She was working at the facility as the AIC, Resident Care Coordinator, Activity Director, Transportation Coordinator and would sometimes cook when needed.
-She was licensed as an Administrator.
-Staff usually contacted her with any resident or facility concerns.
-The Administrator came in "a few days a week" before or after his full-time job.
-She tried to keep up with all her job responsibilities as best as she could.

Interview with the Administrator on 01/03/23 at 11:54am revealed:
-MAs were trained to administer medications to residents.
-PCA's were not qualified to administer medications to residents.
-No PCA should ever administer a resident's medications.
-He was not aware there was unqualified staff administering medication to the residents.
-He did not know anything about the electronic Medication Administration Records.
-The AIC and a MA were responsible for medications, the medication cart and anything related to the pharmacy.
-He was notified of the 10/24/22 physical altercation between Resident #1 and Resident #7

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by the AIC.
-He went to the facility, called the Department of Social Services and completed Involuntary Commitment paperwork for Resident #1.
-Local Law Enforcement transported Resident #1 to the local hospital for evaluation.
-He was not familiar with the facility's discharge policy.
-He did not issue a Notice of Discharge to Resident #1.
-He allowed Resident #1 to return to the facility after he was released from the hospital.
-He did not know he could refuse to accept Resident # 1 back from the hospital.
-He was concerned the Department of Social Services would accuse him of abandonment.

Telephone interview with the Administrator on 01/04/23 at 10:14am revealed:
-He was not able to devote 100 percent of his time to the facility.
-Staffing had been an immense challenge over the past year.

_____

The Administrator failed to ensure overall management and operations of the facility which compromised the care and safety of all residents to include medications being administered by untrained staff, physical abuse of one resident toward other residents, and failure to discharge a resident who was physically abusive to other residents. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation.

_____

The facility provided an acceptable plan of protection in accordance with G.S. 131 D-34 on January 04, 2023, for this violation.

THE CORRECTION DATE FOR THE TYPE A2

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D 176	Continued From page 12 VIOLATION SHALL NOT EXCEED FEBRUARY 03, 2023.	D 176		
D 226	10A NCAC 13F .0702(b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident shall be based on one of the following reasons: (1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner; (2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner; (3) the safety of other individuals in the facility is endangered; (4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner; (5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or (6) the discharge is mandated under G.S. 131D-2(a1). This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the discharge of 1 of 1 sampled residents (Resident #1) who was physically aggressive towards three other residents (Resident #2, #3 and #7) on two	D 226		

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separate occasions which endangered the safety of other residents.

The findings are:

Review of Resident #1's current FL2 dated 03/03/22 revealed:
-Diagnoses included dementia and urinary tract infection.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 02/28/22.

Review of Resident #1's Care Plan dated 03/03/22 revealed:
-The resident was totally dependent with eating, toileting, ambulation, bathing, transfers.
-The resident required limited assistance with bathing, dressing and grooming.

Review of Resident #1's Incident and Accident Report dated 09/29/22 revealed:
-He asked Resident #2 to stop talking while in the facility living room.
-He hit Resident #2 with his fist and jerked him out of his wheelchair.
-He bent down over Resident #2 and drew his back like he was going to hit Resident #2.
-Another resident pulled him away from Resident #2.
-Medication Aide (MA) called Resident # 1's guardian and left a voicemail.
-MA called the Administrator and the Administrator contacted the Department of Social Services.

1. Review of Resident #2's current FL2 dated

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D 226	Continued From page 14 12/02/22 revealed: -Diagnoses included Alzheimer's disease, chronic kidney disease, history of stroke and depression. -He was intermittently oriented. -He was semi-ambulatory with a wheelchair. Review of Resident #2's Resident Register revealed an admission date of 06/03/20. Review of Resident #2's Care Plan dated 2/09/22 revealed: -The resident was totally dependent for eating, toileting, bathing, dressing, grooming and transfers. -The resident required extensive assistance with ambulation. 2. Review of Resident #3's current FL2 dated 12/02/22 revealed: -Diagnoses included diabetes, obesity and venous stasis ulcers. -There was no information regarding orientation. -He was non-ambulatory and used a wheelchair. Review of Resident #3's Resident Register revealed an admission date of 10/26/21. Review of Resident #3's Care Plan dated 02/07/22 revealed: -The resident was totally independent with eating, toileting, bathing, dressing, grooming and transfers. -The resident was totally dependent for ambulation. Review of Resident #2's Incident and Accident Report dated 09/29/22 revealed: -Resident #1 asked Resident #2 to stop talking so loud while he was in the living room. -Resident #2 told Resident #1 that he did not	D 226		

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have to stop talking loud.
-Resident #1 hit Resident #2 and jerked Resident #2 out of his wheelchair.
-Resident #1 bent down over Resident #2 like he was going to hit him again.
-Another resident prevented Resident #1 from hitting Resident #2 again.
-The Administrator in Charge (AIC) called the Responsible Party of Resident #2.
-The on-call Social Worker for the local DSS was also contacted via voice mail.
-The AIC called the Administrator to inform him of the incident.

There was no Incident and Accident Report completed for Resident #3 on 09/29/22.

Review of Resident #1's Psychiatry Follow Up Note dated 11/30/22 revealed:
- He had a history of schizophrenia, depression, anxiety, dementia and recent increase in behavioral disturbances.
-Staff reported Resident #1 had been having issues recently and he hit another resident and jerked someone out of their wheelchair.

Review of Resident #1's Psychiatry Follow Up Note dated 12/21/22 revealed:
- He had a history of schizophrenia, adjustment disorder and behavioral disturbances.
-Staff reported Resident #1 did get upset at times, maybe once or twice a month and he recently hit someone.

Attempted telephone interview with Resident #1's Mental Health Provider on 12/29/22 at 12:15pm was unsuccessful.

Interview with the Department of Social Services (DSS) Guardianship Supervisor on 12/29/22 at

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12:13pm revealed:
-Resident #1's guardian was currently out of the office.
-The facility notified Resident #1's guardian of a physical altercation between Resident #1 and Resident #2.
-Documentation from Resident #1's guardian stated Involuntary Commitment paperwork was not completed on 09/29/22.
-Documentation from Resident #1's guardian stated Notice of Discharge was discussed with Resident #1's guardian but was not issued by the facility on 09/29/22.

Interview with the AIC on 01/03/23 at 10:00am revealed:
-She was notified of the 09/29/22 incident by a MA.
-MA informed her that Resident #1 had pulled Resident #2 out of his wheelchair.
-Another Resident was able to redirect Resident #1 before he continued to hit Resident #2.
-She called the Administrator who came to the facility.
-Involuntary Commitment paperwork was not attempted after this altercation.

Interview with the Administrator on 01/03/23 at 11:56am revealed:
-He was notified of the 09/29/22 incident involving Resident #1 and Resident #2.
-He knew that Resident #3's hair was pulled by Resident #1.
-He came to the facility.
-He notified DSS.
-He did not complete Involuntary Commitment paperwork.
-He spoke with both Resident #1 and Resident #7 individually about the incident.
-He asked staff to keep an eye on Resident #1.

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-He did not issue a Notice of Discharge.
-He was not familiar with the facility discharge policy.
-Discharge policy was requested but not provided.

3. Review of Resident #7's current FL2 dated 10/16/22 revealed:
-Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attack.
-She was oriented.
-She was ambulatory.

Review of Resident #7's Care Plan dated 10/27/22 revealed she was independent and did not require any assistance for all activities of daily living.

Review of Resident #7's incident and Accident Report dated 10/24/22 revealed:
-Another Resident had reported to a MA that Resident #1 had hit Resident #7 on the top of her head.
-AIC was notified of the incident and called the Administrator.
-The Administrator notified the DSS who advised the Administrator to complete Involuntary Commitment paperwork.
-Involuntary Commitment Paperwork was completed and local law enforcement transported Resident #1 to the local hospital for evaluation on 10/24/22.
-Resident #1 returned to the facility on 10/25/22 at 2:30am.

Interview with Resident #7 on 12/30/22 at 3:15pm revealed:
-She was waiting in line to receive her medications.

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-Resident #1 walked by her and got in front of her.
-She told Resident #1 to go to the back of the line.
-Resident #1 then hit her on the top of her head with an open hand after telling her to, "Shut your mouth".
-She reported this to a MA but was uncertain which MA she reported this to.
-Administrator came to the facility and Resident #1 was taken to the hospital by the police.
-Administrator asked her if she wanted to press charges and she said no.
-She stated staff never asked if she wanted to go to the local hospital for an evaluation.

Interview with the DSS Guardianship Supervisor on 12/29/22 at 12:13pm revealed:
-Administrator notified the DSS on call Social Worker of the 10/24/22 incident.
-Administrator notified the on call Social Worker that Involuntary Commitment paperwork had been completed and he was leaving Magistrates office.
-She was uncertain if Notice of Discharge was discussed with the on call Social Worker.
-Notice of Discharge was discussed with Resident #1's guardian but was not issued by the facility on 10/24/22.

Interview with AIC on 12/29/22 at 8:30am and on 01/03/23 at 10:00am revealed:
-She was notified of the incident by a MA on 10/24/22.
-MA asked Resident #1 to go to his room which he did after the incident.
-She notified the Administrator who came to the facility.
-Administrator notified the DSS who advised the Administrator to complete Involuntary

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Commitment paperwork.
-Local law enforcement transported Resident #1 to the local hospital for evaluation on 10/24/22.
-Resident #1 returned to the facility on 10/25/22 at 2:30am.
-MA asked Resident #7 several times if she wanted to go to the hospital for an evaluation and Resident #7 declined.
-Notice of Discharge was discussed with the Administrator but was not issued.

Interview with the Administrator on 01/03/23 at 11:56am revealed:
-He was notified of the 10/24/22 incident by the AIC.
-He went to the facility, called the DSS and completed Involuntary Commitment paperwork.
-Local Law Enforcement transported Resident #1 to the local hospital for evaluation.
-He was not familiar with the facility discharge policy.
-Discharge policy was requested but not provided.
-He did not issue a Notice of Discharge to Resident #1.
-He allowed Resident #1 to return to the facility.
-He didn't believe he could refuse to accept Resident # 1 back after his discharge from the hospital and was concerned DSS would accuse him of abandonment.

Facility Discharge policy was requested however was not provided prior to exit on 01/04/23.

Attempted telephone interview with third shift MA on 01/03/23 at 9:28am was unsuccessful.

_____

The facility failed to issue a Notice of Discharge to Resident #1 on 09/29/22 after he hit Resident

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D 226	Continued From page 20 #2 with his fist and pulled him out of his wheelchair and on 10/24/22 after Resident #1 hit Resident #7 on top of her health with an open hand. This failure placed all residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-2 on 12/29/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 02/03/22.	D 226		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.	D 254		

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This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure 1 of 5 sampled residents (#6) had a completed care plan annually after admission.

The findings are:

Review of Resident #6's current FL2 dated 12/02/22 revealed:
-Diagnoses included multiple sclerosis, encephalopathy, and hepatic failure.
-Resident #6 was independent with all activities of daily living.

Review of Resident #6's Resident Register revealed an admission date of 11/04/21.

Review of Resident #6's Care Plan dated 11/08/21 revealed:
-He required assistance with bathing and dressing.
-He was independent with eating, toileting, ambulation, grooming and transfers.

Review of Resident #6's record revealed there was no documentation of a completed care plan after 11/08/21.

Review of Resident #6's licensed health professional support (LHPS) evaluation dated 10/28/22 revealed he received oxygen and emptying of his foley.

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D 254	Continued From page 22 Interview with Resident #6 on 12/29/22 at 2:50pm revealed he required assistance with bathing, dressing and emptying his foley catheter. Interview with the Administrator-in-Charge (AIC) on 01/03/23 at 10:00am revealed: -She was responsible for completing the resident's care plans annually. -She did not know Resident #6 did not have an updated care plan completed. -Staff relied on the documented care plan in Resident #6's record, information from staff, the resident and family members. Interview with the Administrator on 01/03/23 at 11:52am revealed: -The AIC was responsible for completing the resident's care plans soon after admission and annually. -He was not aware that Resident #6 did not have an updated care plan after 11/08/21. -The AIC was responsible for completing chart audits, but he was not sure the last time one was completed.	D 254		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, appropriate for therapeutic diets and documented to indicate the foods actually served to residents. This Rule is not met as evidenced by:	D 292		

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D 292	Continued From page 23 Based on observation, record review and interview the facility failed to document any substitutions made to the menu. The findings are: Observation of the dining room and kitchen during initial tour on 12/28/22 at 10:00am revealed there was not a food substitution list available. Interview with the Cook on 12/28/22 at 10:05am revealed: -She did not maintain a substitution list for changes made to the menu. -She was never instructed to document foods that were substituted. -If she had to substitute foods, she knew she had to substitute with foods with a similar food group and nutritional value. Review of the lunch menu dated for 12/28/22 revealed the menu consisted of beef stew, rice, okra, cornbread and fruit cobbler. Observation of the lunch meal service on 12/28/22 at 12:00pm revealed: -One baked pork chop, green beans, cornbread, water, tea and cranberry juice was served. -Beef stew and fruit cobbler was not served during the lunch meal service on 12/28/22. Interview with the cook on 12/28/22 at 12:20pm revealed: -She did not have beef available, so she substituted with pork chops and green beans. -Residents were to be served the fruit cobbler for dinner. Review of lunch menu dated 12/29/22 at 12:00pm	D 292		

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D 292	Continued From page 24 revealed: -Beef steak, mashed potatoes, stewed squash, a biscuit, a cake square, coffee, tea and water was served. -Lima beans and a biscuit was not served during the lunch meal services on 12/29/22. Observation of lunch meal service on 12/29/22 at 12:00pm revealed the meal consisted of beef steak, mashed potatoes, lima beans, a slice of white bread, a cake square or vanilla pudding, water, tea and cranberry juice. Interview with a resident on 12/28/22 at 9:10am revealed: -He was offered sandwiches a lot when asked for something other than what was on the menu. -He was often served food that was not listed on the menu. Interview with a second resident on 12/28/22 at 9:50am revealed sometimes the food served was not what was on the menu. Interview with the Administrator on 01/03/23 at 11:56am revealed: -He expected the facility to serve what was on the menu. -Staff should write any food substitutions on the menu board. -Staff should keep record of food substitutions. -He had not seen any documentation of food substitutions.	D 292		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes:	D 298		

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D 298	Continued From page 25 (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure snacks were served three times daily to all of the residents. The findings are: Interview with a resident on 12/28/22 at 9:10am revealed: -He was not offered snacks on a daily basis or three times a day. -He kept his own snacks in his room. Interview with a second resident on 12/28/22 at 9:50am revealed: -Snacks were offered two times daily at 10:00am and 2:00pm. -He kept his own snacks in his room. Interview with dietary aide on 12/28/22 at 10:10am revealed: -Snacks should be provided to the residents at 10:00am, 2:00pm and 7:00pm. -The facility did not always have snacks available. -Some of the employees have bought snacks numerous times for the residents using their personal monies. Interview with a personal care aide (PCA) on 12/30/22 at 1:45pm revealed: -Some of the employees have bought snacks numerous times for the residents using their	D 298		

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D 298	Continued From page 26 personal monies. -It had been over a month since snacks were available to give to the residents. Interview with the cook on 12/28/22 at 10:05am revealed: -Snacks should be offered three times a day. -The facility did not always have snacks available. Interview with the Administrator in Charge on 12/29/22 at 10:55am revealed: -Snacks should be offered three times a day. -The facility provides snacks when available however snacks were not always available. -The Administrator was aware snacks were not always available. -The Administrator told her snacks were too expensive and that most residents had their own snacks in their rooms. -Several employees bought snacks for the residents using their personal monies. Interview with the Administrator on 01/03/23 at 11:56 am revealed: -He expected staff to provide snacks to the residents three times daily. -He did not know the facility did not always have snacks available. -Staff should notify him when snacks were not available, and he would purchase snacks. -He does not remember a time when staff had notified him that the facility did not have snacks available.	D 298		
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	D 317		

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activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of a variety of group activities were provided each week for the residents:

The findings are:

Review of the December 2022 activity calendar posted on the wall in the hallway of the facility revealed:
-There were multiple activities listed on the calendar for each day from 12/01/22 to 12/31/22.
-The activities listed on the calendar were scheduled between 10:00am to 8:00pm with start and end times ranging from 1 hour to 2 hours for each activity.
-Some of the activities listed on the calendar included snacks up to three times a day, board games, playing cards, movies, bingo, crafts and a weekly in facility preaching service.

Interviews with residents on 12/28/22 between 9:06am and 10:13am revealed:
-The activities on the calendar were not being done.
-They played bingo once a week and the pastor from a local church visited every Wednesday.
-The only group activity they played was bingo.
-The activity calendar was posted but it was not followed.

Interview with a medication aide (MA) on

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D 317	Continued From page 28 12/29/22 at 10:30am revealed: -Activities were not being done according to what was on the monthly activity calendar. -The residents played bingo when it was offered. -A preacher came once a week. -The Administrator-in-Charge (AIC) was also the Activity Director (AD). -The AIC did not have time to do the activities with the residents. -She did not ask the residents to participate in activities. Interview with the AIC on 12/30/22 at 9:30am revealed: -She had her certification as an AD. -She was responsible for overseeing and conducting activities. -She was aware the calendar listing of 14 hours a week of activities was not being provided for the residents. -She did not have the time to do the activities with the residents because of her other job responsibilities. -Regular activities that occurred were bingo once a week and a preacher from a local church that visited Wednesday night. Interview with the Administrator on 01/03/23 at 11:54am revealed: -The residents should have at least 14 hours a week for activities being offered to them. -The AIC was also the AD. -He was not aware the activity calendar was not being followed and 14 hours of weekly activity were not offered to the residents.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure all residents were protected from physical abuse by another resident and neglect related to three residents (Residents #2, #3, and #7) being assaulted by another resident (Resident #1) and ensuring a resident (Resident #6) received medications from a qualified medication aide instead from a personal care aide (PCA) and housekeeper .

The findings are:

1.Review of Resident #1's current FL2 dated 03/03/22 revealed:
-Diagnoses included dementia and urinary tract infection.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #1's Resident Register revealed an admission date of 02/28/22.

Review of Resident #1's Care Plan dated 03/03/22 revealed:
-The resident was totally dependent with eating, toileting, ambulation, bathing, transfers.
-The resident required limited assistance with bathing, dressing and grooming.

Review of Resident #1's Incident and Accident Report dated 09/29/22 revealed:
-He asked Resident #2 to stop talking while in the

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facility living room.
-He hit Resident #2 with his fist and jerked him out of his wheelchair.
-He bent down over Resident #2 and drew his back like he was going to hit Resident #2.
-Another resident pulled him away from Resident #2.
-The Medication Aide (MA) called Resident # 1's guardian and left a voicemail.
-The MA called the Administrator and the Administrator contacted Department of Social Services (DSS).

Interview with a Resident on 01/03/22 at 3:25pm revealed:
-He was present in the living room and witnessed the incident involving Resident #1 and Resident #2.
-He said Resident #1 jerked Resident #2 out of his wheelchair onto the floor.
-He told Resident #1 to stop and sit down.
-He stated Resident #2 was not hurt.

Interview with MA on 12/29/22 at 10:30am revealed:
-Resident #1 pulled Resident #2 out of the wheelchair onto the floor.
-Resident #2 was uninjured.
-She contacted the AIC to inform her of the incident.
-The AIC contacted the Administrator.
-The Administrator came to the facility to talk with Resident #1.

Review of Resident #1's Psychiatry Follow Up Note dated 11/30/22 revealed:
- He has a history of schizophrenia, depression, anxiety, dementia and recent increase in behavioral disturbances.
-Staff reported Resident #1 has been having

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issues recently and he hit another resident and jerked someone out of their wheelchair.

Review of Resident #1's Psychiatry Follow Up Note dated 12/21/22 revealed:
- He has a history of schizophrenia, adjustment disorder and behavioral disturbances.
-Staff reported Resident #1 gets upset at times, maybe once or twice a month and he recently hit someone.

Attempted telephone interview with Mental Health Provider on 12/29/22 at 12:15pm was unsuccessful.

Interview with DSS Guardianship Supervisor on 12/29/22 at 12:13pm revealed:
-Resident #1's guardian was currently out of the office.
-The facility notified the DSS regarding the incident involving Resident #1 and Resident #2.
-Documentation from Resident #1's guardian stated Involuntary Commitment paperwork was not completed.
-Documentation from Resident #1's guardian stated Notice of Discharge was discussed with Resident #1's guardian but was not issued by the facility.

Telephone interview with Administrator in Charge (AIC) on 01/03/23 at 10:00am revealed:
-She was notified on 09/29/22 by a MA that Resident #1 pulled Resident #2 out of his wheelchair.
-Another Resident was able to redirect Resident #1 before he continued to hit Resident #2.
-She called the Administrator who came to the facility.
-Involuntary Commitment paperwork was not attempted after this altercation.

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-She was not aware of staff monitoring Resident #1 after incident.

Interview with the Administrator on 01/03/23 at 11:56am revealed:
-He was notified of the 09/29/22 physical altercation involving Resident #1 and Resident #2.
-He did know that Resident #3's hair was pulled by Resident #1.
-He did not know that Resident #3 was hit in the head by Resident #1.
-He came to the facility.
-He notified DSS.
-He did not complete Involuntary Commitment paperwork.
-He spoke with both Resident #1 and Resident #7 individually about the incident.
-Resident #2 was unharmed.
-He asked staff to keep an eye on Resident #1.
-He did not issue a Notice of Discharge.

2. Review of Resident #2's current FL2 dated 12/02/22 revealed:
-Diagnoses included Alzheimer's disease, chronic kidney disease, history of stroke and depression.
-He was intermittently oriented.
-He was semi-ambulatory with a wheelchair.

Review of Resident #2's Resident Register revealed an admission date of 06/03/20.

Review of Resident #2's Care Plan dated 2/09/22 revealed:
-The resident was totally dependent for eating, toileting, bathing, dressing, grooming and transfers.
-The resident required extensive assistance with ambulation.

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Review of Resident #2's Incident and Accident Report dated 09/29/22 revealed:
-Resident #1 asked Resident #2 to stop talking so loud while he was in the living room.
-Resident #2 told Resident #1 that he did not have to stop talking loud.
-Resident #1 hit Resident #2 and jerked Resident #2 out of his wheelchair.
-Resident #1 bent down over Resident #2 like he was going to hit him again.
-Another resident prevented Resident #1 from hitting Resident #2 again.
-The AIC called the Responsible Party of Resident #2.
-The on-call Social Worker for the local DSS was also contacted via voice mail.
-The AIC called the Administrator to inform him of the incident.

Interview with Medication Aide (MA) #1 on 12/29/22 at 10:30am revealed:
-Resident #1 pulled Resident #2 out of the wheelchair onto the floor.
-Resident #2 was uninjured.
-She contacted the AIC to inform her of the incident.
-The AIC contacted the Administrator.

Telephone interview with AIC on 01/03/23 at 10:00am revealed:
-She was notified of the 09/29/22 incident between Resident #1 and Resident #2 by a MA. The MA informed her that Resident #1 had hit Resident #2 and pulled him out of his wheelchair.
-Another Resident was able to redirect Resident #1 before he hit Resident #2 again.
-She called the Administrator who came to the facility.
-Involuntary Commitment paperwork was not attempted.

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-She did not know if Resident #1 was monitored by staff after the altercation.

Interview with the Administrator on 01/03/23 at 11:56am revealed:
-He was notified of the 09/29/22 incident involving Resident #1 and Resident #2.
-He did come to the facility.

Interview with a resident on 01/03/22 at 3:25pm revealed:
-He was present in the living room and witnessed the physical altercation between Resident #1 and Resident #2.
-He said Resident #1 jerked Resident #2 out of his wheelchair onto the floor.
-He told Resident #1 to stop and sit down.

3. Review of Resident #3's current FL2 dated 12/02/22 revealed:
-Diagnoses included diabetes, obesity and venous stasis ulcers.
-There was no information regarding orientation.
-He was non-ambulatory and used a wheelchair.

Review of Resident #3's Resident Registry revealed an admission date of 10/26/21.

Review of Resident #3's Care Plan dated 02/07/22 revealed:
-The resident was totally independent with eating, toileting, bathing, dressing, grooming and transfers.
-The resident was totally dependent for ambulation.

Interview with Resident #3 on 12/29/22 at 9:23am revealed:
-Over a month ago he observed Resident #1 force Resident #2, who was in a wheelchair, into

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Resident #2's room.
-He observed Resident #1 would not allow Resident #2 to come out of his room.
-He asked Resident #1 why he pushed Resident #2 into his room and would not let him out.
-Resident #1 told him he would do whatever he wanted to do.
-Resident #1 then lunged forward and grabbed his hair and "snatched" his head backward.
-He told Resident #1 to "get his hands out of his hair."
-Resident #1 proceeded to hit him in the back of the head with his fist.
-The MA intervened and removed Resident #1 from the room.
-The MA asked if he was ok but did not ask him what happened.

Interview with the MA on 12/29/22 at 10:30am revealed:
-Several months ago, Resident #1 and Resident #3 had a physical altercation.
-She observed Resident #1 charge forward and pull Resident #3's hair.
-She notified the Administrator-in-Charge (AIC).
-She did not complete an incident/accident report.
-She did not contact DSS.

Review of a Care Note dated 08/16/22 for Resident #3 revealed:
-The incident between Resident #1 and Resident #3 occurred on 08/16/22.
-Resident #3 told Resident #1 he could not force Resident #2 go to his room and tell him to not come out.
-Resident #1 proceeded to walk up behind Resident #3 and grab him by the hair.
-A PCA and a MA had to make Resident #1 let go of Resident #3's hair.

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Interview with the AIC on 12/30/22 at 10:26am revealed there was a care note that had been completed when the altercation occurred between Resident #1 and Resident #3 on 08/16/22.

Interview with the Administrator on 01/03/23 at 11:54am revealed:
-He was not aware of the incident between Resident #1 and Resident #3 when it occurred.
-He found out about the incident between Resident #1 and Resident #3 about a month later when there was another incident with Resident #1 and two more residents.

4. Review of Resident #7's current FL2 dated 10/16/22 revealed:
-Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attack.
-She was oriented.
-She was ambulatory.

Review of Resident #7's Resident Register revealed an admission date of 11/04/21.

Review of Resident #7's Care Plan dated 10/27/22 revealed she was independent and did not require any assistance for all activities of daily living.

Review of Resident #7's Incident and Accident Report dated 10/24/22 revealed:
-Another Resident reported to a MA that Resident #1 hit Resident #7 on the top of her head.
-The AIC was notified of the incident and called the Administrator.
-The Administrator notified the DSS who advised the Administrator to complete Involuntary Commitment paperwork.
-Involuntary Commitment Paperwork was

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completed and local law enforcement transported Resident #1 to the local hospital for evaluation on 10/24/22.
-Resident #1 returned to the facility on 10/25/22 at 2:30am.

Interview with a resident on 01/03/22 at 3:25pm revealed:
-He was in line to receive his medications when a physical altercation took place between Resident #1 and Resident #7.
-He witnessed Resident #1 and Resident #7 arguing when Resident #1 hit Resident #7 on the top of her head with an open hand.
-He reported the incident to the MA.

Interview with Resident #7 on 12/30/22 at 3:15pm revealed:
-She was waiting in line to receive her medications.
-Resident #1 walked by her and got in front of her.
-She told Resident #1 to go to the back of the line.
-Resident #1 then hit her on the top of her head with an open hand after telling her to shut her mouth.
-She reported this to a MA but is uncertain which MA she reported this to.
-The Administrator came to the facility and Resident #1 was taken to the hospital by the police.
-The Administrator asked her if she wanted to press charges and she said no.
-Staff did not asked if she wanted to go to the local hospital for an evaluation.

Interview with DSS Guardianship Supervisor on 12/29/22 at 12:13pm revealed:
-She was uncertain if Notice of Discharge was

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discussed with the on call Social Worker.
-Notice of Discharge was discussed with Resident #1's guardian on 10/25/22 but was not issued by the facility.

Interview with AIC on 12/29/22 at 8:30am and on 01/03/23 at 10:00am revealed:
-She was notified of the incident by a MA on 10/24/22.
-She notified the Administrator who came to the facility.
-Administrator notified the DSS who advised the Administrator to complete Involuntary Commitment paperwork.
-Local law enforcement transported Resident #1 to the local hospital for evaluation on 10/24/22.
-Resident #1 returned to the facility on 10/25/22 at 2:30am.
-The MA asked Resident #7 several times if she wanted to go to the hospital for an evaluation and Resident #7 declined.
-Notice of Discharge was discussed with the Administrator but Administrator declined to give Resident #7 Notice of Discharge paperwork.

Interview with the Administrator on 01/03/23 at 11:56am revealed:
-He was notified of the 10/24/22 incident by the AIC.
-He came to the facility, called the DSS and completed Involuntary Commitment paperwork.
-Local Law Enforcement transported Resident #1 to the local hospital for evaluation on 10/24/22.
-He did not issue a Notice of Discharge to Resident #1.
-He allowed Resident #1 to return to the facility.
-He didn't believe he could refuse to accept Resident # 1 back and was concerned the Department of Social Services would accuse him of abandonment.

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D 338	Continued From page 39 Attempted telephone interview with third shift MA on 01/03/23 at 9:28am was unsuccessful. 5. Review of Resident #6's current FL2 dated 12/02/22 revealed diagnoses included multiple sclerosis, encephalopathy, and hepatic failure. Review of Resident #6's Resident Register revealed an admission date of 11/04/21. Review of Resident #6's Care Plan dated 11/08/21 revealed: -He required assistance with bathing and dressing. -He was independent with eating, toileting, ambulation, grooming and transfers. Interview with Resident #6 on 12/28/22 at 9:46am and 12/29/22 at 2:50pm revealed: -The MAs were preparing medication and allowing the PCA's or the housekeeper administer the medication. -This happened during 1st (7:00am - 3:00pm) and 2nd (3:00pm - 11:00pm) shifts. -This most recently happened to him last week. -PCA's have brought his medication to him several times before. -Last week the housekeeper brought his medication to him. -He did not recognize a certain medication he was being given and asked the housekeeper what it was. -The housekeeper replied he did not know but would ask the MA. -When the housekeeper returned, he replied it was medication for treatment of his severe depression. -He was upset because a housekeeper was not trained to administer medications.	D 338		

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-He did not want non-medical staff to have access to his private health information.
-He thought this was a violation of his rights.
-He was prescribed narcotics three times a day and still is in pain and was concerned if he actually received the pain medications.
-He is not sure the PCA or housekeeper really gave him all of his medications.
-He informed the Administrator-in-Charge (AIC) sometime in November 2022 but the PCA still gave him his medications.
-He felt if he did not receive all of the medications from the PCA or housekeeper, then he would not receive his medications.

Interview with the Administrator-in-Charge on 12/30/22 at 9:30am revealed:
-Only MAs could administer medications to residents.
-After the MA observed a resident take a medication, the MA was to document the administration on the eMAR.
-The MAs knew they were not to give medications to the PCA's to administer to the residents.
-She was unaware of any PCA's administering medications to residents.

Interview with the Administrator on 01/03/23 at 11:54am revealed:
-MAs are trained to administer medications to residents.
-PCA's are not qualified to administer medications to residents.
-No PCA should every administer a resident's medications.
-He was unaware there was unqualified staff administering medication to the residents.

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The failure of the facility to ensure residents are free of physical abuse related to an incident that

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D 338	Continued From page 41 occurred on 08/16/22 involving Resident #1 and Resident #3, an incident that occurred on 09/29/22 involving Resident #1 and #2 and an incident that occurred on 10/24/22 involving Resident #1 and Resident #7 resulting in residents (Residents #2, #3 and #7) being physically assaulted. The facility failed to ensure a resident (Resident #6) received medications from a trained MA. This failure placed all residents in the facility at substantial risk of serious physical harm and abuse and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 12/29/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 3, 2023.	D 338		
D 359	10A NCAC 13F .1004 (b) Medication Administration 10A NCAC 13F .1004 Medication Administration (b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration. This Rule is not met as evidenced by: Based on record review and interviews, the	D 359		

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facility failed to ensure Staff B, personal care aide (PCA) was qualified to administer medications to residents.

The findings are:

Review of the facility's undated Medication Policies and Procedures revealed:
-Staff who have demonstrated competency according to state rules may prepare and administer medications.
-Documentation will be provided by staff who administers medications to the residents on the facility Medication Administration Record (MAR).
-Staff will provide documentation on the MAR after observing the residents taking the medications.

1. Interview with a resident on 12/28/22 at 9:28am revealed:
-There were several occasions in the past few months when a personal care aide (PCA) administered medications to him.
-There was a medication aide (MA) who prepared his medications ready, but the PCA administered his medications.
-He was concerned the facility may not have enough qualified staff to administer medications.

Interview with a MA on 12/29/22 at 10:30am revealed:
-She spoke with a PCA on the telephone the morning of 12/29/2.
-The PCA verbalized he had administered medications the evening on 12/28/22.
-Only MAs were qualified to administer medications to residents.

Interview with a PCA on 12/29/22 at 2:11pm revealed:

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-She never administered medications to a resident.
-She was not aware of any non-qualified staff administering medications to residents.

Interview with a housekeeper on 12/30/22 at 8:02am revealed:
-He had not administered medications to any residents.
-He was not aware of any PCA's administering medications to residents.

Refer to the interview with the AIC on 12/30/22 at 9:30am.

Refer to the interview with the Administrator on 01/03/23 at 11:54am.

2. Review of Resident #4's current FL2 dated 10/10/22 revealed:
-Diagnoses included dementia and chronic pain.
-She was constantly disoriented.

Interview with a PCA on 12/30/22 at 1:43pm revealed:
-He had given medications to Resident #4 one time, two days ago.
-The MA did not observe him administer Resident #4's medications.
-Resident #4 took longer to administer medications because she could only take them one at a time.
-He was not aware of any other non-trained staff that were administering medications.
-He was not trained as a MA.

Interview with a MA on 12/30/22 at 3:45pm revealed:
-She had prepared medications for a PCA to administer to residents on 4 or 5 occasions.

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-The residents trusted the PCA and sometimes took medications better for him.
-The PCA administered the 8:00pm medications to Resident #4 most recently on 12/28/22.
-She did not observe the PCA administer the medications to Resident #4 on 12/28/22.
-She documented she administered the medications to Resident #4 on 12/28/22.

Review of resident #4's electronic Medication Administration Record (eMAR) dated 12/28/22 revealed:
-The MA documented Hydroxyzine (used to treat itching) 25mg capsule was administered at 8:00pm.
-The MA documented Eliquis (used to prevent blood clots) 2.5mg tablet was administered at 8:00pm.
-The MA documented Seroquel (an antipsychotic used to treat mood disorder) 25mg tablet was administered at 8:00pm.
-The MA documented Gabapentin (used to treat pain) 100mg - 2 capsules (200mg total) was administered at 8:00pm.
-The MA documented Oxycodone (an opioid used to treat moderate to severe pain) 10mg/325mg tablet was administered at 8:00pm.
-The MA documented Doxycycline (used to treat bacterial infections) 100mg tablet was admnistered at 8:00pm.
-The MA documented Klonopin (used to treat panic disorder and seizures) 0.5mg tablet (take ½ tab for .25mg) was administered at 8:00pm.

Refer to the interview with the AIC on 12/30/22 at 9:30am.

Refer to the interview with the Administrator on 01/03/23 at 11:54am.

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D 359	Continued From page 45 3. Review of Resident #6's current FL2 dated 12/02/22 revealed: -Diagnoses included multiple sclerosis, encephalopathy, and hepatic failure. -An order for baclofen (a medication used to treat muscle spasticity) 10mg, two times a day. -An order for klonopin (a medication used to prevent seizures) 0.5mg, ½ a tablet two times a day. -An order for Vistaril (a medication used to reduce activity in the central nervous system) 25mg, two times a day. -An order for KlorCon (a mediation used to treat low potassium) 10mEq, two times a day. -An order for Coreg (a medication used to treat high blood pressure) 6.25mg, two times a day. -An order for Ditropan (a medication used to relax the muscles in the bladder) 5mg, three times a day. -An order for gabapentin (a medication used to treat nerve pain) 100mg, 2 capsules, three times a day. -An order for Mobic (a medication used to treat pain and inflammation), 15mg every day with food. -An order for Cymbalta (a medication used to treat depression), 30mg, 3 capsules every day. -An order for Tylenol (a medication used for pain), 325mg, 2 tablets every day. -An order for Zocor (a medication used to treat high cholesterol), every night. -An order for Lasix (a medication used to treat fluid build up around the heart), 40mg every day. -An order for Norvasc (a medication used to treat high blood pressure), 10mg every day. -An order for aspirin (a medication used to thin the blood), 81mg every day. -An order for Coreg (a medication used to treat high blood pressure), 6.25mg two times a day. -An order for Tegretol (a medication used to treat	D 359		

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epilepsy), 200mg two times a day.
-An order for Pepcid (a medication used to treat stomach problems) 20mg two times a day as needed.
-An order for oxycodone (a medication used to treat pain), three times a day.

Interview with Resident #6 on 12/28/22 at 9:46am and 12/29/22 at 2:50pm revealed:
-The MAs were preparing medication and allowing the PCA's or the housekeeper to administer the medication.
-This happened during 1st (7:00am - 3:00pm) and 2nd (3:00pm - 11:00pm) shifts.
-This most recently happened to him last week.
-PCA's have brought his medication to him several times before.
-Last week the housekeeper brought his medication to him.
-He did not recognize a certain medication he was being given and asked the housekeeper what it was.
-The housekeeper replied he did not know but would ask the MA.
-When the housekeeper returned, he replied it was medication for treatment of his severe depression.
-He was upset because a housekeeper was not trained to administer medications.
-He did not want non-medical staff to have access to his private health information.
-He was prescribed narcotics three times a day and still was in pain and was concerned if he actually received the pain medications.
-He was not sure the PCA or housekeeper really gave him all of his medications.
-He informed the Administrator-in-Charge (AIC) sometime in November 2022 but the PCA still gave him his medications.
-He felt if he did not receive all of the medications

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from the PCA or housekeeper, then he would not receive his medications.

Review of Resident #6's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for baclofen 10mg, two times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for klonopin 0.5mg, ½ a tablet, two times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Vistaril 25mg, two times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for KlorCon 10mEq, two times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Coreg 6.25mg, two times a day documented administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Ditropan 5mg, two times a day documented administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for gabapentin 100mg, 2 capsules, three times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Mobic 15mg every day with food documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Cymbalta 30mg, 3 capsules every day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Tylenol 325mg, 2 tablets every day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Zocor every night documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Lasix 40mg every day

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documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Norvasc 10mg every day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for aspirin 81mg every day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Tegretol 200mg two times a day documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for Pepcid 20mg at bedtime documented as administered by a MA from 12/01/22 to 12/29/22.
-There was an entry for norco 7.5/325mg three times a day as needed documented as administered by a MA from 12/01/22 to 12/29/22.

Refer to the interview with the AIC on 12/30/22 at 9:30am.

Refer to the interview with the Administrator on 01/03/23 at 11:54am.

_____

Interview with the Administrator-in-Charge on 12/30/22 at 9:30am revealed:
-Only MAs could administer medications to residents.
-After the MA observed a resident take a medication, the MA was to document the administration on the eMAR.
-The MAs knew they were not to give medications to the PCA's and other unqualified staff to administer to the residents.
-She was unaware of any PCA's administering medications to residents.

Interview with the Administrator on 01/03/23 at 11:54am revealed:

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D 359	Continued From page 49 -MAs were trained to administer medications to residents. -PCA's were not qualified to administer medications to residents. -No PCA or other unqualified staff should ever administer a resident's medications. -He was unaware there were unqualified staff administering medication to the residents.	D 359		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews the	D 367		

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facility failed to ensure the electronic medication administration records (eMAR) were accurate for 7 of 7 sampled residents (#1, #2, #3, #4, #5, #6 and #7).

The findings are:

Review of the facility's undated Medication Administration Policy revealed:
-The name/initials of the person preparing/administering the medications would be on the eMAR.
-There would be no blank spaces on the eMAR.

1. Review of Resident #1's current FL2 dated 03/03/22 revealed:
-Diagnoses included dementia and urinary tract infection.
-An order for simvastatin (to treat high cholesterol) 40mg by mouth daily.
-An order for Symbicort (to treat chronic obstructive pulmonary disease) 160/4.5mg one puff by mouth twice daily.
-An order for Klonopin (to treat panic disorder) 4mg by mouth at bedtime.
-An order for metformin (to treat high blood sugar levels) 1000mg by mouth at bedtime.
-An order for paroxetine (to treat depression, panic attacks and anxiety) 40mg by mouth daily.
-An order for aspirin (to reduce the risk of having a heart attack or stroke) 81mg by mouth daily.
-An order for glipizide (to treat high blood sugar levels) 5mg, ½ tab (2.5mg) by mouth twice daily.
-An order for lorazepam (to treat anxiety) 1mg by mouth three times daily.

Review of a subsequent physician order dated 07/26/22 revealed an order for Voltaren (to treat symptoms of pain) 1%, apply to head areas twice daily.

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Review of a subsequent physician order dated 07/29/22 revealed an order for Mobic (to treat arthritis and moderate to severe pain) 7.5mg by mouth daily.

Review of a subsequent physician order dated 09/30/22 revealed an order to discontinue klonopin 4mg by mouth at bedtime.

Review of a subsequent physician order dated 10/17/22 revealed an order for hydrocortisone (to reduce pain, itching and swelling) 1%, apply to left elbow three times daily.

Review of a subsequent physician order dated 11/29/22 revealed an order for Depakote (to treat manic symptoms) 250mg by mouth at bedtime.

Review of a subsequent physician order dated 12/20/22 revealed an order for Depakote 500mg by mouth at bedtime.

Review of Resident #1's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for simvastatin 40mg by mouth daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Symbicort 160/4.5mg one puff by mouth twice daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for metformin 1000mg by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for glipizide 5mg, ½ tab (2.5mg) by mouth twice daily documented as not

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recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for lorazepam 1mg by mouth three times daily documented as not recorded as being administered on 11/27/22 at 1:00pm and on 11/29/22 and 11/30/22 at 8:00pm.
-There were no comments related to why the medications were not recorded.

Review of Resident #1's December 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Symbicort 160/4.5mg one puff by mouth twice daily documented as not recorded as being administered on 12/24 and 12/25/22 at 8:00am.
-There was an entry for paroxetine 40mg by mouth daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am
-There was an entry for Aspirin 81mg by mouth daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for glipizide 5mg, ½ tab (2.5mg) by mouth twice daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for lorazepam 1mg by mouth three times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am and 12/24/22 and 12/25/22 at 2:00pm.
-There was an entry for Mobic 7.5mg by mouth daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 9:00am.
-There were no comments related to why the medications were not recorded as being administered.

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D 367	Continued From page 53 Refer to interview with Medication Aide (MA) on 12/29/22 at 10:00am. Refer to interview with the Administrator in Charge (AIC) on 12/30/22 at 9:30am. Refer to interview with a second MA on 01/03/23 at 9:28am. Refer to interview with the Administrator on 01/03/23 at 11:54am. 2. Review of Resident #7's current FL2 dated 10/16/22 revealed: -Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attack. -An order for Pepcid (to treat heartburn) 20mg by mouth daily. -An order for Plavix (to prevent blood clots forming in hardened blood vessels) 75mg by mouth daily. -An order for Effexor (to treat depression and anxiety) 150mg by mouth daily. -An order for multivitamin gummies (to treat vitamin deficiencies) by mouth daily. -An order for Protonix (to relieve heartburn) 40mg by mouth twice daily. -An order for carvedilol (to treat high blood pressure and prevent angina) 3.125mg by mouth twice daily. -An order for Entresto (to treat chronic health failure) 24/26mg by mouth twice daily. -An order for lorazepam (to treat anxiety) 0.5mg by mouth three times daily. -An order for gabapentin (to treat nerve pain) 400mg by mouth three times daily. -An order for ipratropium (to help control symptoms of lung diseases) 0.06% , two sprays in each nostril three times daily.	D 367		

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CEDAR CREEK LIVING LLC	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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
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-An order for oxybutynin (to treat symptoms of an overactive bladder) 5mg by mouth at bedtime.
-An order for senna-plus (to treat constipation) by mouth at bedtime.
-An order for mirtazapine (to treat depression and appetite stimulant) 15 mg by mouth at bedtime.
-An order for Voltaren (to treat symptoms of pain) 1%, apply to knee three times daily.

Review of a subsequent physician order dated 07/07/22 revealed an order for Requip (to treat Parkinson's disease) 0.5mg by mouth at bedtime.

Review of a subsequent physician order dated 10/24/22 revealed an order for oxycodone (used to relieve pain) 10mg by mouth four times daily.

Review of a subsequent physician order dated 12/01/22 revealed an order for nystatin (to treat fungal infection) 5ml by mouth four times daily.

Review of a subsequent physician order dated 12/09/22 revealed an order for trazodone (to treat depression) 100mg via 2 tablets (200mg) by mouth at bedtime.

Review of Resident #7's November 2022 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Protonix 40mg by mouth twice daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for carvedilol 3.125mg by mouth twice daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Entresto 24/26mg by mouth twice daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at

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8:00pm.
-There was an entry for lorazepam 0.5mg by mouth three times daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for gabapentin 400mg by mouth three times daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for ipratropium 0.06%, two sprays in each nostril three times daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for oxybutynin 5mg by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for senna-plus by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for mirtazapine 15 mg by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Voltaren (to treat symptoms of pain) 1%, apply to knee three times daily documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Requip 0.5mg by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for trazodone 100mg via 2 tablets (200mg) by mouth at bedtime documented as not recorded as being administered on 11/29/22 and 11/30/22 at 8:00pm.

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-There were no comments related to why the medications were not recorded as being administered.

Refer to interview with the MA on 12/29/22 at 10:00am.

Refer to interview with the AIC on 12/30/22 at 9:30am.

Refer to interview with a second MA on 01/03/23 at 9:28am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

3. Review of Resident #6's current FL2 dated 12/02/22 revealed:
-Diagnoses included multiple sclerosis, encephalopathy, and hepatic failure.
-An order for baclofen (a medication used to treat muscle spasticity) 10mg, two times a day.
-An order for klonopin (a medication used to prevent seizures) 0.5mg, ½ a tablet two times a day.
-An order for Vistaril (a medication used to reduce activity in the centeral nervous system) 25mg, two times a day.
-An order for KlorCon (a medciation used to treat low potassium) 10mEq, two times a day.
-An order for Coreg (a medication used to treat high blood pressure) 6.25mg, two times a day.
-An order for Ditropan (a medication used to relax the muscles in the bladder) 5mg, three times a day.
-An order for gabapentin (a medication used to treat nerve pain) 100mg, 2 capsules, three times a day.

Review of Resident #6's previous physician's

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orders dated 11/04/22 revealed:
-An order for baclofen 10mg, two times a day.
-An order for klonopin 0.5mg, ½ a tablet, two times a day.
-An order for Vistaril 25mg, two times a day.
-An order for KlorCon 10mEq, two times a day.
-An order for Coreg 6.25mg, two times a day.
-An order for Ditropan 5mg, two times a day.
-An order for gabapentin 100mg, 2 capsules, three times a day.

Review of Resident #6's November 2022 eMAR revealed:
-There was an entry for baclofen 10mg, two times a day documented as blank on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for klonopin 0.5mg, ½ a tablet, two times a day documented as blank on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Vistaril 25mg, two times a day documented as blank on 11/27/22 and 11/29/22 at 8:00pm.
-There was an entry for KlorCon 10mEq, two times a day documented as blank on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Coreg 6.25mg, two times a day documented as blank on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Ditropan 5mg, two times a day documented as blank on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for gabapentin 100mg, 2 capsules, three times a day documented as blank on 11/29/22 and 11/30/22 at 2:00pm and 8:00pm.
-There were no comments related to why the medications were not recorded.

Review of Resident #6's December 2022 eMAR revealed:
-There was an entry for baclofen 10mg, two times

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a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for klonopin 0.5mg, ½ a tablet, two times a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for Vistaril 25mg, two times a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for KlorCon 10mEq, two times a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for Coreg 6.25mg, two times a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for Ditropan 5mg, two times a day documented as blank on 12/29/22 at 8:00pm.
-There was an entry for gabapentin 100mg, 2 capsules, three times a day documented as blank on 12/29/22 at 2:00pm and 8:00pm.
-There were no comments related to why the medications were not recorded.

Refer to interview with MA on 12/29/22 at 10:00am.

Refer to interview with the AIC on 12/30/22 at 9:30am.

Refer to interview with a second MA on 01/03/23 at 9:28am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

4. Review of Resident #2"s current FL2 dated 12/02/22 revealed:
-Diagnoses included Alzheimer's disease, high blood pressure, depression, high cholesterol, enlarged prostate, urinary incontinence and chronic kidney disease.

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-An order for Citalopram (to treat depression) 20mg daily.
-An order for Flomax (to treat urinary incontinence) 0.4mg daily.
-An order for Lipitor (to treat high cholesterol) 80mg daily.
-An order for Protonix (to treat gastric reflux) 40mg daily.
-An order for Aspirin (to reduce the risk of a heart attack or stroke) 81mg daily.
-An order for Magnesium Oxide (to treat low magnesium) 400mg two times daily.
-An order for Lotrel (to treat high blood pressure) 5/20mg two times daily.
-An order for Coreg (to treat high blood pressure) 3.125mg two times daily.
-An order for Vitamin B-12 (supplemental B Vitamin) 1,000mcg daily.
-An order for Metoprolol (to treat high blood pressure and heart failure) 25mg two times daily.
-An order for Glucotrol (used to treat elevated blood sugar) 5mg daily.

Review of Resident #2's December 2022 eMAR revealed:
-There was an entry for Magnesium Oxide 400mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Lotrel 5/20mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Metoprolol 25mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Citalopram 20mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at

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8:00am.
-There was an entry for Flomax 0.4mg dailly documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Lipitor 80mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Glucotrol 5mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Aspirin 81mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Vitamin B-12 1,000mcg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There were no comments related to why the medications were not recorded as being administered.

Refer to interview with Medication Aide (MA) on 12/29/22 at 10:00am.

Refer to interview with the AIC on 12/30/22 at 9:30am.

Refer to interview with a second MA on 01/03/23 at 9:28am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

5. Review of Resident #3's current FL2 dated 12/02/22 revealed:
-Diagnoses included diabetes and obesity.

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-An order for Prozac (to treat depression) 20mg daily.
-An order for Flomax (to treat urinary incontinence) 0.4mg daily.
-An order for Zestril (to treat high blood pressure) 40mg daily.
-An order for Fish Oil (to treat high triglycerides) 1,200mg daily.
-An order for Buspar (to treat anxiety) 7.5mg two times daily.
-An order for Metformin (to treat diabetes) 1,000mg two times daily.
-An order for Toprol (to treat high blood pressure) 25mg two times daily.
-An order for Novolog (to treat diabetes) given per sliding scale three times daily.
-An order for Oxycodone/Acetaminophen (to treat moderate to severe pain) 10/325mg four times daily.
-An order for Gabapentin (to treat nerve pain) 600mg three times daily.
-An order for Xarelto (to help prevent blood clots) 20mg daily.
-An order for Lasix (to decrease fluid in the body) 20mg daily.
-An order for Truicity (to treat diabetes) 1.5mg by injection weekly.

Review of Resident #3's December 2022 eMAR revealed:
-There was an entry for Zestril 40mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Lasix 20mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Prozac 20mg daily documented as not recorded as being

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administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Flomax 0.4mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Xarelto 20mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Fish Oil 1,200mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Buspar 7.5mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Metformin 1,000mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Toprol 25mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Gabapentin 600mg three times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am and 2:00pm.
-There was an entry for Novolog per sliding scale three times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 7:00am, 11:00am, and 4:00pm.
-There was an entry for Oxycodone-Acetaminophen 10/325mg four times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 7:00am and 1:00pm.
-There was no comments related to why the

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medications were not recorded as being administered .

Refer to interview with Medication Aide (MA) on 12/29/22 at 10:00am.

Refer to interview with the AIC on 12/30/22 at 9:30am.

Refer to interview with a second MA on 01/03/23 at 9:28am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

6. Review of Resident #4's current FL2 dated 10/10/22 revealed:
-Diagnoses included dementia, chronic pain and neuropathy.
-An order for Norvasc (to treat high blood pressure) 10mg daily.
-An order for Lasix (to decrease fluid in the body) 10mg daily.
-An order for Gabapentin (to treat nerve pain) 100mg - 2 tablets (total of 200mg) three times daily.
-An order for Toprol (to treat high blood pressure) 50mg daily.
-An order for Oxycodone (to treat moderate to severe pain) 10/325mg three times daily.
-An order for Ambien (to treat insomnia) 10mg every night.
-An order for Eliquis (to help prevent blood clots) 2.5mg two times daily.
-An order for Seroquel (to treat mood disorders) 25mg 1/2 tab (total of 12.5mg) two times daily.
-An order for Klonopin (to treat panic attacks) 0.5mg 1/2 tab (total of 0.25mg) every night.

Review of Resident #4's November 2022

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electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Seroquel 12.5mg two times daily documented as not recorded on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Eliquis 2.5mg two times daily documented as not recorded on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Klonopin 0.25mg every night documented as not recorded on 11/29/22 and 11/30/22 at 7:00pm.
-There was an entry for Oxycodone 10/325mg three times daily documented as not recorded on 11/29/22 and 11/30/22 at 8:00pm.
-There was an entry for Gabapentin 200mg three times daily documented as not recorded on 11/29/22 and 11/30/22 at 8:00pm.
-There was no comments related to why the medications were not recorded.

Review of Resident #4's December 2022 eMAR revealed:
-There was an entry for Lasix 10mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Toprol 50mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Norvasc 10mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Eliquis 2.5mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Seroquel 12.5mg two times daily documented as not recorded as being

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administered on 12/24/22 and 12/25/22 at 8:00am.
-There was an entry for Gabapentin 200mg three times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am and 2:00pm.
-There was an entry for Oxycodone 10mg/325 three times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am and 2:00pm.
-There was no comments related to why the medications were not recorded as being administered .

Refer to interview with Medication Aide (MA) on 12/29/22 at 10:00am.

Refer to interview with the AIC on 12/30/22 at 9:30am.

Refer to interview with a second MA on 01/03/23 at 9:28am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

7. Review of Resident #5's current FL2 dated 12/02/22 revealed:
-Diagnoses included high blood pressure, high cholesterol, high blood glucose, panic disorder, swelling and obesity.
-An order for Lasix (to decrease fluid in the body) 60mg daily.
-An order for Klor-Con (to replace Potassium) 20meq daily.
-An order for Lisinopril/HCTZ (to treat blood pressure and fluid retention) 20/12.5mg daily.
-An order for Norvasc (to treat high blood pressure) 5mg every night.
-An order for Vistaril (used to treat anxiety) 25mg

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D 367	Continued From page 66 two times daily. -An order for Prilosec (used to treat gastric reflux) 20mg daily. Review of Resident #5's December 2022 eMAR revealed: -There was an entry for Lasix 60mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am. -There was an entry for Klor-Con 20meq daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am. -There was an entry for Lisinopril/HCTZ 20/12/5mg daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am. -There was an entry for Vistaril 25mg two times daily documented as not recorded as being administered on 12/24/22 and 12/25/22 at 8:00am. -There was no comments related to why the medications were not recorded as being administered . Refer to interview with Medication Aide (MA) on 12/29/22 at 10:00am. Refer to interview with the AIC on 12/30/22 at 9:30am. Refer to interview with a second MA on 01/03/23 at 9:28am. Refer to interview with the Administrator on 01/03/23 at 11:54am. _____ Interview with a MA on 12/29/22 at 10:00am revealed:	D 367		

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D 367	Continued From page 67 -She was responsible for checking the accuracy of the eMAR's and if there were blanks where no documentation was recorded, she reported to the AIC. -She was aware there were blanks where medications were not documented as administered in the months of November and December and she reported this to the AIC. -Medication Cart audits were completed on Wednesdays by her and the AIC. Interview with the AIC on 12/30/22 at 9:30am revealed: -MA was responsible for checking eMAR's and reports any issues to her. -She was notified of the blanks where no documentation was recorded in the months of November and December, and she did address this with the MA responsible. - Medication Cart audits are completed on Wednesdays by her and the MA. Interview with a second MA on 01/03/23 at 9:28am revealed: -She worked as a MA on 12/24/22 and 12/25/22. -Both days were very busy. -She administered medications to all residents, but forgot to document she had administered them. -She was reminded by the AIC on 12/26/22 that she needed to document, but she had not gotten around to documenting it yet. Interview with the Administrator on 01/03/23 at 11:54am revealed: -One of the MAs and the AIC were responsible for checking the eMAR's for accuracy. -He was not aware there had been missing documentation on the November 2022 eMAR for residents.	D 367		

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D 367	Continued From page 68 -He was not aware there had been missing documentation on the December 2022 eMAR for residents.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 7 sampled residents (Residents #5 and #7) had a physician's order to self-administer medications related to treat pain, vitamin and mineral deficiencies (Resident #5) and ear wax removal, eye irrigation, wart removal and an ointment for pain relief (Resident #7). The findings are: Review of the facility's undated Medication Policies and Procedures related to resident self-administration of medications revealed	D 375		

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D 375	Continued From page 69 "Self-Administration is ordered by Physician." 1. Review of Resident #5's current FL2 dated 12/02/22 revealed: -Diagnoses included hypertension and hyperlipidemia. -There was no information listed regarding his orientation. Observation of Resident #5's bedroom on 12/28/22 at 9:17am revealed: -A bottle of Vitamin C (a medication to treat vitamin C deficiency) 500mg tablets on his dresser. -A bottle of Vitamin D (a medication to treat vitamin D deficiency) 5,000 international units (IU) on his dresser. -A bottle on Tumeric (a medication used to treat pain) 200mg capsules on his dresser. Interview with Resident #5 on12/28/22 at 9:17am revealed: -He self-administered one Vitamin C 500mg tablet daily. -He self-administered one Vitamin D 5,000 IU tablet daily. -He self-administered one Tumeric 200mg capsule daily. Review of Resident #5's current FL2 dated 12/02/22 revealed there was no order for Vitamin C, Vitamin D or Tumeric. Review of Resident #5's Medication Administration Record (MAR) for November 2022 and December 2022 revealed there were no entries for Vitamin C, Vitamin D or Tumeric. Interview with a medication aide (MA) on 12/29/22 at 3:56pm revealed:	D 375		

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D 375	Continued From page 70	D 375		

-Resident #5 did not have an order to self-administer medications.
-She was unaware of any medications he kept in his room.

Telephone interview with the Administrator-in-Charge (AIC) on 01/03/23 at 10:00am revealed:
-She was not aware Resident #5 was self-administering medications.
-Resident #5 did not have a physician's order to self-administer any medications.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

2. Review of Resident #7's current FL2 dated 10/16/22 revealed:
-Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attack.
-She was oriented.
-She was ambulatory.

Observation of Resident #7's bedroom on 12/30/22 at 3:15pm revealed:
-A bottle of Ibuprofen 200mg tablets (to ease mild pain) on the bedside table.
-A bottle of Tiger balm (to alleviate pain) pain relieving ointment on the bedside table.
-Resident provided a bottle of ear wax removal drops from her bedside table drawer.
-Resident provided a bottle of eye itch relief drops from her bedside table drawer.
-Resident provided a bottle of wart remover from her bedside table drawer.

Interview with Resident #7 revealed at 3:15pm revealed:
-She self-administered Ibuprofen 200mg

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D 375	Continued From page 71	D 375		

occasionally.
-She self-administered tiger balm occasionally.
-She self-administered ear wax remover rarely.
-She self-administered wart remover occasionally.
-She self-administered eye itch relief drops occasionally.

Review of Resident #7's current FL2 dated 10/16/22 revealed there were no orders for Ibuprofen, Tiger balm, ear wax removal drops, eye itch relief drops or wart removal drops.

Review of Resident #7's Medication Administration Record (MAR) for November and December of 2022 revealed there were no orders for Ibuprofen, Tiger balm, ear wax removal drops, eye itch relief drops or wart removal drops.

Telephone interview with the AIC on 12/30/22 at 4:00pm revealed:
-She was aware that Resident #7 had over the counter medications in her room.
-Resident #7 did not have a physician's order to self-administer any medications.

Refer to interview with Administrator on 01/03/23 at 11:54am.

_____

Interview with the Administrator on 01/03/23 at 11:54am revealed:
-The facility had a policy for self-administration of medications that should be followed.
-He was not aware of any residents self-administering medications in the facility.
-The AIC would be aware of any residents who self-administered medications in the facility.

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D 400	Continued From page 72	D 400		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record.	D 400		

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D 400	Continued From page 73	D 400		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy reviews were completed for 6 of 7 sampled residents (Residents #1, #2, #3, #5, #6, and #7).

The findings are:

Review of the undated Medication Policies and Procedures revealed:
-A licensed Pharmacist or Registered Nurse was to perform an on-site medication review.
-The on-site medication review was for all residents every 90 days.

1. Review of Resident #2's current FL2 dated 12/02/22 revealed diagnoses included Alzheimer's Disease, depression and chronic kidney disease.

Review of Resident #2's Resident Register revealed an admission date of 06/03/20.

Review of Resident #2's pharmacy reviews revealed:
-Two pharmacy reviews were completed in 2022.
-The first was in June of 2022.
-The second was in December of 2022.
-There was no pharmacy review completed in March of 2022.
-There was no pharmacy review completed in September of 2022.

Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm.

Refer to telephone interview with the

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D 400	Continued From page 74	D 400		

Administrator-in-Charge (AIC) on 01/03/23 at 10:00am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

2. Review of Resident #3's current FL2 dated 12/02/22 revealed diagnoses included diabetes and cognitive impairment.

Review of Resident #3's Resident Register revealed an admission date of 10/26/21.

Review of Resident #3's pharmacy reviews revealed:
-Two pharmacy reviews were completed in 2022.
-The first was in June of 2022.
-The second was in December of 2022.
-There was no pharmacy review completed in March of 2022.
-There was no pharmacy review completed in September of 2022.

Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm.

Refer to telephone interview with the AIC on 01/03/23 at 10:00am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

3. Review of Resident #5's current FL2 dated 12/02/22 revealed diagnoses included high blood pressure, elevated cholesterol and elevated blood sugar.

Review of Resident #5's Resident Register revealed an admission date of 11/08/21.

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Review of Resident #5's pharmacy reviews revealed:
-Two pharmacy reviews were completed in 2022.
-The first was in May of 2022.
-The second was in November of 2022.
-There was no pharmacy review completed in March of 2022.
-There was no pharmacy review completed in September of 2022.

Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm.

Refer to telephone interview with the AIC on 01/03/23 at 10:00am.

Refer to interview with the Administrator on 01/03/23 at 11:54am.

4. Review of Resident #1's current FL2 dated 03/03/22 revealed:
-Diagnoses included dementia and urinary tract infection.
-He was intermittently disoriented.
-He was ambulatory.

Review of Resident #1's Resident Register revealed an admission date of 02/28/22.

Review of Resident #1's pharmacy reviews revealed:
-A review was completed on 06/01/22 and a review was completed on 12/06/22.
-No other reviews were completed or provided for 2022.

Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm.

Refer to telephone interview with the AIC on

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D 400	Continued From page 76 01/03/23 at 10:00am. Refer to interview with the Administrator on 01/03/23 at 11:54am. 5. Review of Resident #7's current FL2 dated 10/16/22 revealed: -Diagnoses included non-ST-elevation myocardial infarction, malnutrition, cerebral aneurysm and transient ischemic attack. -She was oriented. -She was ambulatory. Review of Resident #7's Resident Register revealed an admission date of 11/04/21. Review of Resident #7's pharmacy reviews revealed: -A review was completed on 11/29/21 and a review was completed on 06/01/22. -No other reviews were completed or provided for 2022. Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm. Refer to telephone interview with the AIC on 01/03/23 at 10:00am. Refer to interview with the Administrator on 01/03/23 at 11:54am. 6. Review of Resident #6's current FL2 dated 12/02/22 revealed: -Diagnoses included multiple sclerosis, encephalopathy, and hepatic failure. -He was semi-ambulatory. -He was oriented. Review of Resident #6's Resident Register	D 400		

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D 400	Continued From page 77 revealed an admission date of 11/04/21. Review of Resident #6's pharmacy reviews revealed: -A review was completed on 05/25/22 and a review was completed on 12/05/22. -There were no other reviews were completed or provided for 2022. Refer to telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm. Refer to telephone interview with the Administrator-in-Charge (AIC) on 01/03/23 at 10:00am. Refer to interview with the Administrator on 01/03/23 at 11:54am. _____ Telephone interview with the facility's contracted Pharmacist on 12/28/22 at 3:42pm revealed: -According to the pharmacy records, the Pharmacist who had been providing reviews for the facility had only been reviewing them every 6 months. -She was aware the pharmacy review was supposed to occur every 3 months in assisted living facilities. -She was unsure why the previous Pharmacist had not been providing pharmacy reviews for the facility every 3 months as required. Telephone interview with the AIC on 01/03/22 at 10:00am revealed: -The pharmacist came to review the medications of residents in the facility every 6 months. -She was not aware of the regulation requirement for pharmacy reviews every 3 months. Interview with the Administrator on 01/03/23 at	D 400		

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D 400	Continued From page 78 11:54am revealed: -Pharmacy reviews were handled by their local contracted pharmacy. -He thought they were supposed to be doing quarterly reviews but was not sure. -His AIC would know the regulation timeframe for pharmacy reviews.	D 400		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for an incident involving 1 of 1 sampled resident (Resident #3) who was assaulted by another resident. The findings are: Review of Resident #3's current FL2 dated 12/02/22 revealed diagnoses included diabetes and obesity. Interview with Resident #3 on 12/29/22 at 9:23am revealed: -Over a month ago he observed Resident #1 force Resident #2, who was in a wheelchair, into	D 453		

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D 453	Continued From page 79 Resident #2's room. -He observed Resident #1 would not allow Resident #2 to come out of his room. -He asked Resident #1 why he pushed Resident #2 into his room and would not let him out. -Resident #1 responded "I'll do whatever the *expletive* I want." -Resident #1 then lunged forward and grabbed his hair and "snatched" his head backward. -He told Resident #1 to "get his *expletive* hands out of his hair." -Resident #1 proceeding to hit him in the back of the head with his fist. -A Medication Aide (MA) intervened and removed Resident #1 from the room. -The MA asked if he was ok but did not ask him what happened. Interview with a MA on 12/29/22 at 10:30am revealed: -Several months ago, Resident #1 and Resident #3 had an altercation. -She observed Resident #1 "charge forward" and pull Resident #3's hair. -She did not hear the conversation that occurred between Resident #1 and Resident #3. -She notified her Administrator-in-Charge (AIC). -She did not complete an incident/accident report because she thought the AIC would do it. -She did not contact DSS because she thought the AIC would do it. Interview with the Adult Home Specialist (AHS) for the local DSS on 12/29/22 at 10:51am revealed: -She was not notified of the incident between Resident #1 and Resident #3 when it occurred. -She did not receive an incident/accident report from the facility.	D 453		

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CEDAR CREEK LIVING LLC	2270 OAKLAND ROAD FOREST CITY, NC 28043

(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 453	Continued From page 80 Interview with the AIC on 12/30/22 at 10:26am revealed: -All staff knew they were supposed to fill out an incident/accident report when physical altercations occur between residents. -She had a written example available for staff on how to write an incident/accident report. -Staff was supposed to complete an incident/accident report immediately after the altercation between residents occurred. -She was supposed to receive the incident/accident report so she could notify the Responsible Party, DSS or the local Police Department if needed. -She was not working that day, but if she had been the incident/accident report would have been completed. -There was not an incident/accident report completed on the altercation that had occurred between Resident #1 and Resident #3. -DSS was not notified of the altercation between Resident #1 and Resident #3 when the incident occurred. Interview with the Administrator on 01/03/23 at 11:54am revealed: -When a physical altercation occurred between residents it should always be reported to DSS. -He was unsure why notification to DSS of the altercation between Resident #1 and Resident #3 had not occurred.	D 453		