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D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted a follow-up survey on May 17-18, 2023.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled medication	D 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia S Miller — TITLE: Administrator — (X6) DATE: 6/15/2023

Reviewed and acknowledged
06/30/23 LP

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D 164	Continued From page 1 aides (Staff A) had completed training on the care of diabetic residents prior to obtaining fingerstick blood sugars (FSBS) and administering insulin. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was rehired on 02/16/23. -There was no certification of training on care of diabetic residents. Review of a resident's April 2023 electronic medication administration record (eMAR) revealed there was documentation Staff A checked the resident's FSBS 33 times and administered insulin 33 times from 04/01/23 through 04/30/23. Review of a resident's May 2023 eMAR from 0501/23 to 05/17/23 revealed there was documentation Staff A checked the resident's FSBS 6 times and and administered insulin 2 times from 05/01/23 through 05/17/23. Interview with the Administrator on 05/18/23 at 2:30pm revealed: -She was responsible for ensuring all staff qualifications including training on care of diabetic residents were completed and maintained in the facility. -Staff A worked at the facility a long time ago, when the facility had previous owners. -Some of Staff A's records had been removed from the facility by the previous management. -There was no documentation related to the care of diabetic residents in Staff A's personnel record. -Staff A had not received training related to care of diabetic residents at the facility since rehire in February 2023.	D 164	Administrator will verify that all newly hired staff have certification of training on the care of diabetic residents before allowing said staff to obtain fingerstick blood sugars (FSBS) and administering insulin.	6/30/23

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D 164	Continued From page 2 -There was no system in place for checking to ensure staff had the required training including training on care of diabetic residents. Interview with Staff A on 05/18/23 at 3:30pm revealed: -She had been working at the facility as a MA since February 2023. -She worked at the facility previously, but had been working at a different facility for a couple of years. -When she worked as a MA, she checked residents' FSBS and administered insulin if needed. -She thought she had diabetic training at the previous facility, but did not have any documentation available for review. -Since she started working at the facility, she had not received training related to care of diabetic residents.	D 164		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to provide supervision according to the needs of 1 of 6 sampled	D 270		

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residents (#6), who had a history of wandering into other residents' rooms and becoming aggressive.

The findings are:

Review of Resident #6's current FL2 dated 04/03/23 revealed:
-Diagnoses included anxiety disorder, mental development delay, fetal alcohol syndrome, epilepsy, and acute hyponatremia.
-The resident was constantly disoriented and ambulatory.

Review of Resident #6's care plan dated 06/13/22 revealed:
-The resident's mental health and social history revealed:
-The resident was currently receiving medications for mental illness/behaviors.
-The resident had a history of developmental disabilities and mental illness.
-The resident was always disoriented, had significant loss of memory and must be directed.
-The resident had adequate vision, hearing and speech impediment.
-The resident required supervision with eating, extensive assistance with toileting, was totally dependent on staff for bathing, dressing and grooming, and was independent with ambulation and transferring.

Review of Resident #6's psychiatry progress notes revealed:
-On 03/03/23, staff reported concerns about the resident's mood.
-The resident had a history of physical aggression/resistance with staff.
-The resident would frequently take books out of other residents' rooms; the behaviors upset other

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residents.
-The resident appeared unable to understand the consequences of behaviors due to intellectual deficits and he required frequent redirection by staff.
-On 03/31/23, the resident had a history of physical aggression/resistance with staff.
-Staff reported the resident appeared more anxious recently.
-The resident had been going into other residents' rooms and taking books more often.
-Behaviors have caused conflict with other residents.
-Resident #6 was difficult to redirect and would go back to doing what he was doing before.
-On 04/01/23, the resident had a history of physical aggression/resistance with staff.
-He was going into other residents' rooms.
-Staff reported the resident appeared more agitated recently and had been requiring as needed (PRN) medication (ativan) for anxiety almost daily.
-On 04/28/23, the resident had a history of physical aggression/resistance with staff.
-Staff reported Resident #6 required more PRN ativan for anxiety and behaviors.
-Staff reported Resident #6's behaviors had improved somewhat, but he was still not redirected for very long and had brief attention and went back to what he was doing quickly.

Review of the facility's two hour check logs revealed:
-There was documentation all residents, including Resident #6 were checked every two hours.
-There was no documentation Resident #6 was checked more frequently, then every two hours.

Interview with Resident #6's guardian on 05/18/23 at 3:08pm revealed:

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-She spoke with the Administrator on 04/13/23 about Resident #6's behavior.
-The Administrator talked with her about Resident #6's behaviors and wandering in residents' rooms.
-The Administrator stated the psychiatrist said he felt Resident #6 needed to be moved to a group home.
-She thought the Administrator was trying to find placement in a group home for Resident #6.
-She had not talked to the Administrator since 04/13/23.

Interview with Resident #6's mental health provider (MHP) on 05/18/23 at 11:21am revealed:
-The facility staff had reached out to him a few times regarding medications for Resident #6's behaviors.
-He had adjusted the resident's medications to the maximum.
-The facility did not have the staff needed to provide supervision for Resident #6.
-Due to the resident's mental status, he was not going to improve, but would continually get worse.
-He had recommended to the Administrator it would be best to find a smaller facility for Resident #6 that could provide continual supervision.

Interview with a resident on 05/18/23 at 1:25pm revealed:
-Resident #6 came to her room when she was not in the room, and took things from her.
-Staff would bring things back to her.
-Other residents were upset and complained that Resident #6 took things from their rooms.
-She observed some residents pushed and yelled at Resident #6, because he went into their rooms at times during the day.
-She observed staff try to get Resident #6 out of

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the rooms, but he would not go with staff.

Interview with a second resident on 05/18/23 at 10:25am revealed:
-Resident #6 went into everyone's room all the time.
-Resident #6 went into his room often and went through his stuff.
-Resident #6 went into his room this morning; went through the chest of drawers and pulled out his and his roommate's clothes onto the floor.
-He had to put the clothes back in the chest of drawers after Resident #6 left the room.
-He did not like Resident #6 coming into his room.
-He locked the door, but Resident #6 knew how to unlock his door with his thumbnail.

Interview with a third resident on 05/18/23 at 10:15am revealed:
-Resident #6 went into his room and tried to take his books and he did not like it.
-He had tried to hide his books from Resident #6, but Resident #6 would find them.
-He had made Resident #6 leave his room several times.
-Resident #6 went into everyone's room and the staff had let him get by with it.
-Resident #6 came into his room at any time during the day, even at 12:30am and at 3:00am.
-He had called law enforcement twice, because Resident #6 was in his room taking his stuff.
-The Administrator changed his door lock 3 times to try and keep Resident #6 out of his room.
-Resident #6 could open one of the locks and they would put another lock on his door.
-He had a key to his door, but it could be opened by using a thumbnail; Resident #6 knew how to open the door using his thumbnail.

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D 270	Continued From page 7 Interview with a fourth resident on 05/18/23 at 10:35am revealed: -Resident #6 went into everyone's room. -Resident #6 was in his room this morning and took stuff out of his chest of drawers. -Resident #6 went from room to room and took residents' belongings. -If other residents told Resident #6 not to do something, Resident #6 only got worse. Interview with at fifth resident on 05/18/23 at 2:14pm revealed: -Resident #6 went into residents' rooms daily. -Sometimes the residents who's things that he took, would go after him to get their things back. -There were a few incidents when Resident #6 was pushed to the floor and kicked by other residents because he took things from their rooms. -Resident #6 took things from her, so she tried to hide her things, but he always seemed to find her hiding place. -Resident #6 entered her room once at night time and that was because she forgot to lock her room door. He just startled her because she did not expect to wake up and see him in her room in the dark. Interview with a sixth resident on 05/158/23 at 4:09pm revealed: -A couple of times a day, she sat in the hallway to keep an eye on Resident #6. -She felt sorry for the resident because he did not know what he was doing. -When she observed Resident #6 going to a resident's room, she yelled for the staff and told them Resident #6 went into a room, they would go and get him. -Sometimes Resident #6 was combative and did not come out of the room, but most times he	D 270		

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came out when staff asked him to come out.

Telephone interview with Resident #6's MHP on 05/18/23 at 11:00am revealed:
-He was at the facility routinely.
-There were at least 2 residents that had complained to him that a wandering resident caused them increased anxiety due to his constant wandering in and out of rooms and taking personal items.
-He had increased anti-anxiety medications for at least one resident, but could not recall the residents' names.
-He saw Resident #6 routinely.
-Resident #6 did not have psychotic behaviors, rather his wandering behavior was more from a developmental deficiency.
-Resident #6's medications had been adjusted to help with wandering behavior and restlessness.
-He did not feel treating Resident #6 with anti-psychotic medications would be the appropriate therapy.
-Resident #6 required a lot of redirecting by staff and required additional supervision to keep him from wandering into other residents' rooms.
-He did not know if the facility had adequate staff to continuously monitor or supervise Resident #6.
-Resident #6 would potentially benefit from a different level of care.

Observation of Resident #6 on 05/18/23 at 10:28am revealed:
-Resident #6 was wandering in the front hallway toward the north end of the facility.
-Resident #6 was trying to open the locked door leading to a staff bathroom.
-Resident #6 turned around, crossed the hall, and headed toward the partially opened door to the Resident Care Coordinator's (RCC) office.
-The Administrator attempted to redirect Resident

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#6 away from the RCC's door.
-Resident #6 continued to enter the slightly opened door.
-The Administrator stepped between Resident #6 and the RCC's office door.
-Resident #6 leaned against the Administrator and pushed forward toward the door.
-The Administrator called for staff assistance and a staff came to the Administrator and Resident #6.
-The Administrator and staff walked Resident #6 down the hall away from the RCC's door.

Interview with the Administrator on 05/18/23 at 10:29am revealed:
-The RCC's door would need to be kept locked to prevent Resident #6 from randomly entering the room.
-Resident #6 wandered throughout the facility and would enter residents' rooms uninvited.
-Resident #6 would go into rooms and "go through all the stuff".
-Resident #6 really liked magazines and books and would plunder through boxes, chest of drawers, or cabinets seemingly in search of books.
-He had certain residents that he seemed to be more attracted to and tried to get into their rooms more often.

Interview with a personal care aide (PCA) on 05/18/23 at 1:38pm revealed:
-There were several residents that complained about Resident #6 entering their rooms and taking things.
-Resident #6 usually spent the day in the day room, which was near the nurses' stations.
-She could see the resident from the nurses' station.
-When Resident #6 left the day room she

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followed him to ensure he did not go into a resident's room.
-Resident #6 sometimes entered the same room twice in one day and she had to get him out of the room.
-There had been no system put in place for monitoring or supervising Resident #6.

Observation on 05/18/23 from 3:00pm to 3:26pm revealed:
-Resident #6 was not in the day room.
-The resident was not seen in the common areas of the facility.
-The PCA was at the nurses' station sitting down in a chair and appeared to be writing something.

Interview with the PCA on 05/18/23 at 3:28pm revealed:
-When asked was she busy or in the middle of something, she replied, no, she was not busy.
-She did not know where Resident #6 was at.
-She did not realize the resident had left the day room.
-She did not know the resident was no longer in the day room.
-She would search the facility to locate Resident #6.

Interview with a second PCA on 05/18/23 at 2:10pm revealed:
-There was no system of supervising or monitoring Resident #6.
-When the resident walked by the nurses' station, she followed him to make sure he did not go into a room.
-She checked Resident #6 every two hours and documented his whereabouts.
-There was a previous incident when another resident pushed Resident #6 to the floor and kicked him, but that resident was no longer at the

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facility.

Interview with a third PCA on 05/18/23 at 2:12pm revealed:
-Staff were not doing anything any different pertaining to Resident #6 than they were doing a couple of months ago.
-They watched Resident #6 and redirected him when he went into someone's room.
-She thought Resident #6 might go into other residents' rooms one time a day.

Interview with a medication aide (MA) on 05/18/23 at 2:25pm revealed:
-Staff kept an eye on Resident #6 every day.
-Resident #6 had calmed down in the past few months and was not going into residents' rooms as much.
-Staff conducted 2-hour checks on Resident #6.
-She had witnessed one resident claiming Resident #6 had gone in his room when she saw Resident #6 in the hall.
-Staff tried to make sure Resident #6 was in the facility.
-When staff saw Resident #6 in the hall, they watched him to see where he went and redirected him if needed.

Interview with the Administrator on 05/18/23 at 2:40pm revealed:
-Going into other residents' rooms was an everyday behavior for Resident #6.
-She did not think Resident #6 knew how to open the locked doors to the rooms.
-Some residents did not lock the doors to their rooms as they had been told to do.
-Staff were not doing 15-minute checks on Resident #6, because they did not have time to do 15-minute checks.
-She had staffing issues and could not staff with

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D 270	Continued From page 12 one-to-one for Resident #6. -When staff tried to divert the resident he sometimes would be difficult to turn around as he was today. -When Resident #6 came to the facility he would periodically go into residents' rooms, but lately he did it more often. -There had been some medication changes for Resident #6 and his behavior was not as bad as it was previously and he was easier to redirect. -A few weeks ago, Resident #6's psychiatrist had discussed with her that Resident #6 might need to be placed in a group home. -She had discussed a group home with Resident #6's guardian. Based on observation, record review and interview, it was determined Resident #6 was not interviewable. _____ The facility failed to provide supervision for 1 of 6 sampled residents (#6) who was known to wander, going into residents' rooms at all times of the day and night which resulted in the resident being yelled at by other residents and being kicked and pushed to the floor by other residents. This failure was detrimental to the health and safely of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 for violation on 05/18/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 2, 2023	D 270	Administrator issued a 30-day notice for resident #6 and reached out to Surry County DSS discharge team for assistance in finding a group home or family care home for resident #6. Administrator will instruct staff to notify their supervisor when residents' behaviors indicate a need for increased supervision. Administrator will instruct supervisors to conduct an assessment on residents who have been reported by staff to have increased behavioral problems and if needed, to implement increased supervision for said residents. If increased supervision fails with residents who exhibit ongoing behavior problems, facility will look for other placement options for those residents, including issuing notice of discharge and reaching out to the Adult Care Home discharge team in Surry County.	6/15/23 6/1/23
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

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(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 273	Continued From page 13 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B violation is abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to ensure referrals were completed for 1 of 5 sampled residents (#4) related to refusal of two stool softeners, supplement for the heart and blood, long-acting medication for shortness of breath, long-acting insulin, anti-depressant, cholesterol medication, and antipsychotic medication. The findings are: Review of Resident #4's current FL2 dated 11/21/22 revealed diagnoses included diabetes mellitus type 2, mild intellectual disability, schizoaffective, hypertension and hyperlipidemia. Review of Resident #4's current FL2 dated 11/21/22 revealed: -There was an order for Advair Diskus 250/50mcg, 1 puff by mouth twice daily (long-acting medication used to treat shortness of breath). -There was an order for docqlace 100mg 1 tablet at bedtime (used to treat constipation). -There was an order for fish oil 1000mg, 2 tablets (2,000mg) three times daily (supplement used to improve function of the heart and blood). -There was an order for levemir 85 units subcutaneously twice daily (long-acting insulin	D 273	Administrator will instruct medication aides to report to RCC when residents refuse medications for 3 consecutive days and will instruct RCC to notify PCP of those refusals. Administrator will re-educate medication aides on the proper procedure for administering medication to residents who are asleep at medication administration times and if residents continue to refuse medications after going to bed, RCC will ask physicians to consider changing the administration times of those medications.	6/30/23

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used to help reduce blood sugar).
-There was an order for Mirtazapine 30mg, 1 tablet at bedtime (used to treat depression).
-There was an order for pravastatin 40mg, 1 tablet at bedtime (used to lower cholesterol).
-There was an order for risperidone 0.5mg, 1 tablet twice daily with a 2mg dose (2.5) (used to treat schizophrenia).
-There was an order for risperidone 2mg, 1 tablet twice daily.
-There was an order for sennalax-S 8.6-50mg, 2 tablets at bedtime (used to treat constipation).

Review of Resident #4's facility notes and physician's progress notes revealed there was no documentation the primary care provider (PCP) had been notified regarding refusal of medications.

Review of Resident #4's March 2023 electronic medication administration record (eMAR) reveled:
-There was an entry for Advair Diskus 250/50mcg, 1 puff by mouth twice daily scheduled at 7:00pm.
-There was documentation Advair Diskus was refused for 16 of 31 scheduled opportunities at 7:00pm from 03/01/23 through 03/31/23.
-There was an entry for docqlace 100mg 1 tablet at bedtime scheduled at 7:00pm.
-There was documentation docqlace 100mg was refused for 16 of 31 scheduled opportunities at 7:00pm from 03/01/23 through 03/31/23.
-There was an entry for fish oil 1000mg, 2 tablets (2,000mg) three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation fish oil 1000mg, 2 tablets were refused for 16 of 31 scheduled opportunities at 8:00pm from 03/01/23 through 03/31/23.
-There was an entry for levemir 85 units

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D 273	Continued From page 15 subcutaneously twice daily scheduled at 8:00am and 8:00pm. -There was documentation levemir 85 units were refused for 16 of 31 scheduled opportunities from 03/01/23 through 03/31/23. -There was an entry for Mirtazapine 30mg, 1 tablet at bedtime scheduled at 8:00pm. -There was documentation mirtazapine 30mg was refused for 16 of 31 scheduled opportunities from 03/01/23 through 03/31/23 from 03/01/23 through 03/31/23. -There was an entry for pravastatin 40mg, 1 tablet at bedtime scheduled at 8:00pm. -There was documentation pravastatin 40mg was refused for 16 of 31 scheduled opportunities from 03/01/23 through 03/31/23. -There was an entry for risperidone 0.5mg, 1 tablet twice daily with a 2mg dose (2.5) scheduled at 8:00am and 8:00pm. -There was documentation risperidone 0.5mg was refused for 16 of 31 opportunities from 03/01/23 through 03/03/23. -There was an entry for risperidone 2mg, 1 tablet twice daily scheduled at 8:00am and 8:00pm. -There was documentation risperidone 2mg was refused for 16 of 31 scheduled opportunities at 8:00pm from 03/01/23 through 03/31/23. -There was an entry for sennalax-S 8.6-50mg, 2 tablets at bedtime scheduled at 8:00pm from 03/01/23 through 03/31/23. -There was documentation sennalax-S was refused for 16 of 31 scheduled opportunities at 8:00pm from 03/01/23 through 03/31/23. -There was documentation the resident refused medications on the following dates at 7:00pm and 8:00pm : on 03/01/23, 03/02/23/ 03/03/23, 03/04/23, 03/08/23, 03/09/23, 03/10/23, 03/14/23, 03/17/23, 03/18/23, 03/20/23, 03/21/23, 03/23/23, 03/24/23, 03/30/23, and 03/31/23.	D 273		

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D 273	Continued From page 16 Review of Resident #4's April 2023 eMAR reveled: -There was an entry for Advair Diskus 250/50mcg, 1 puff by mouth twice daily scheduled at 7:00pm. -There was documentation Advair Diskus was refused for 11 of 30 scheduled opportunities at 7:00pm from 04/01/23 through 04/30/23. -There was an entry for docqlace 100mg 1 tablet at bedtime scheduled at 7:00pm. -There was documentation docqlace 100mg was refused for 11 of 30 scheduled opportunities at 7:00pm from 04/01/23 through 04/30/23. -There was an entry for fish oil 1000mg, 2 tablets (2,000mg) three times daily scheduled at 8:00am, 2:00pm and 8:00pm. -There was documentation fish oil 1000mg, 2 tablets were refused for 11 of 30 scheduled opportunities at 8:00pm from 04/01/23 through 04/30/23. -There was an entry for levemir 85 units subcutaneously twice daily scheduled at 8:00am and 8:00pm. -There was documentation levemir 85 units were refused for 11 of 30 scheduled opportunities from 04/01/23 through 04/30/23. -There was an entry for Mirtazapine 30mg, 1 tablet at bedtime scheduled at 8:00pm. -There was documentation mirtazapine 30mg was refused for 11 of 30 scheduled opportunities from 04/01/23 through 04/30/23. -There was an entry for pravastatin 40mg, 1 tablet at bedtime scheduled at 8:00pm. -There was documentation pravastatin 40mg was refused for 11 of 30 scheduled opportunities from 04/01/23 through 04/30/23. -There was an entry for risperidone 0.5mg, 1 tablet twice daily with a 2mg dose (2.5) scheduled at 8:00am and 8:00pm. -There was documentation risperidone 0.5mg	D 273		

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was refused for 11 of 30 opportunities from 04/01/23 through 04/30/23.
-There was an entry for risperidone 2mg, 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation risperidone 2mg was refused for 11 of 30 scheduled opportunities at 8:00pm from 04/01/23 through 04/30/23.
-There was an entry for sennalax-S 8.6-50mg, 2 tablets at bedtime scheduled at 8:00pm from 04/01/23 through 04/30/23.
-There was documentation sennalax-S was refused for 11 of 30 scheduled opportunities at 8:00pm from 04/01/23 through 04/30/23.
-There was documentation the resident refused all the above medications on the following dates at 7:00pm and 8:00pm on 04/01/23, 04/03/23, 04/08/23, 04/14/23, 04/19/23, 04/20/23, 04/22/23, 04/25/23, 04/26/23, 04/28/23, 04/29/30 and 04/30/23.

Review of Resident #4's May (05/01/23 through 05/18/23) 2023 eMAR reveled:
-There was an entry for Advair Diskus 250/50mcg, 1 puff by mouth twice daily scheduled at 7:00pm.
-There was documentation Advair Diskus was refused for 4 of 17 scheduled opportunities at 7:00pm from 05/01/23 through 05/18/23.
-There was an entry for docqlace 100mg 1 tablet at bedtime scheduled at 7:00pm.
-There was documentation docqlace 100mg was refused for 4 of 17 scheduled opportunities at 7:00pm from 05/01/23 through 05/18/23.
-There was an entry for fish oil 1000mg, 2 tablets (2,000mg) three times daily scheduled at 8:00am, 2:00pm and 8:00pm.
-There was documentation fish oil 1000mg, 2 tablets were refused for 4 of 17 scheduled opportunities at 8:00pm from 05/01/23 through 05/18/23.

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-There was an entry for levemir 85 units subcutaneously twice daily scheduled at 8:00am and 8:00pm.
-There was documentation levemir 85 units were refused for 4 of 17 scheduled opportunities from 05/01/23 through 05/18/23.
-There was an entry for Mirtazapine 30mg, 1 tablet at bedtime scheduled at 8:00pm.
-There was documentation mirtazapine 30mg was refused for 4 of 17 scheduled opportunities from 05/01/23 through 05/18/23.
-There was an entry for pravastatin 40mg, 1 tablet at bedtime scheduled at 8:00pm.
-There was documentation pravastatin 40mg was refused for 4 of 17 scheduled opportunities from 05/01/23 through 05/18/23.
-There was an entry for risperidone 0.5mg, 1 tablet twice daily with a 2mg dose (2.5) scheduled at 8:00am and 8:00pm.
-There was documentation risperidone 0.5mg was refused for 4 of 17 opportunities from 05/01/23 through 05/18/23.
-There was an entry for risperidone 2mg, 1 tablet twice daily scheduled at 8:00am and 8:00pm.
-There was documentation risperidone 2mg was refused for 4 of 17 scheduled opportunities at 8:00pm from 05/01/23 through 05/18/23.
-There was an entry for sennalax-S 8.6-50mg, 2 tablets at bedtime scheduled at 8:00pm.
-There was documentation sennalax-S was refused for 4 of 17 scheduled opportunities at 8:00pm from 05/01/23 through 05/18/23.
-There was documentation the resident refused medications on the following dates at 7:00pm and 8:00pm: on 05/01/23, 05/02/23, 05/09/23 and 05/12/23.

Observation of Resident #4's medications on hand on 05/18/23 at 1:34pm revealed:
-Advair Diskus 250/50mcg was available for

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administration.
-Docqlace 100mg was available for administration.
-Fish oil 1000mg, was available for administration.
-Levemir was available for administration.
- Mirtazapine 30mg was available for administration.
-Pravastatin 40mg was available for administration.
-Risperidone 0.5mg was available for administration.
-Risperidone 2mg was available for administration.
-Sennalax-S 8.6-50mg was available for administration.

Interview Resident #4 on 05/17/23 at 3:55pm revealed:
-Staff administered her medications.
-She did not refuse her medications.
-She went to bed usually around 10:00pm or 11:00pm.
-If the MA tried to administer medication to her after that time she might have been sleep.
-She did not recall staff waking up her to take medications.

Telephone interview with Resident #4's primary care provider (PCP) on 05/17/23 at 3:52pm revealed:
-He was in the facility weekly on Mondays.
-If Resident #4 refused her medications the facility should have made him aware so he could adjust the daytime medications to compensate.
-The facility was able to call, text or fax him.
-There was someone to answer the phone service 24 hours per day, seven days per week.
-Depending on the medication missing 1 to 2 doses per month might not be detrimental, but

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continually refusing a medication caused the resident to not get the benefits of the medication.

Telephone interview with a third shift medication aide (MA) on 05/18/23 at 8:42am revealed:
-When he worked if Resident #4 was in the bed and did not come to the medication room for her medications he did not administer the resident's medications.
-He was afraid to give the resident's medications when she was in the bed because the resident had a "thick tongue" and he was afraid she would aspirate if he administered medication when the resident was in bed.
-He had not made the Administrator aware when he did not administer Resident #4's medications.
-The facility's policy for refusal of medications was 3 refusals in a row, then the PCP was notified.
-He was aware the some of Resident #4's 7:00pm and 8:00pm medications were once daily and the resident had refused 3 to 4 times, but he had not attempted to contact the PCP.

Telephone interview with a second third shift MA on 05/18/23 at 9:15am revealed:
-When he administered 7:00pm and 8:00pm medications, sometimes Resident #4 was sleeping and would not get up to come to the medication room to get her medications.
-He had not made Resident #4's PCP, the Administrator or anyone else aware the resident refused her medications because he "guessed" everyone knew because it was on the eMAR.
-The resident had been in the facility a long time, and that was her normal to not get up and come to the medication room for her medications if she was in the bed.
-He worked the night shift and was not aware he could contact the resident's PCP anytime of the

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D 273	Continued From page 21 day or night regarding the refusal of medications. -He thought that he did not have to keep telling everyone the resident refused medications because they already knew she refused. Interview with the Administrator on 05/18/23 at 3:44pm revealed: -She was not aware the night shift staff were documenting Resident #4 refused her medications because the resident did not come to the medication room. -There was no system in place for auditing the eMARs to identify the refusal of medications. -The night shift staff had worked under a previous Resident Care Coordinator (RCC) and she told them not to take the residents medications to the residents' rooms. -After the RCC left she corrected that and told staff if a resident did not come to the medication room, staff were to take the medications to the resident. -If the resident was asleep, they needed to try to awake to take her medications.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure implementation of orders	D 276	RCC will ensure that all orders, treatments, and procedures are properly documented. Administrator will monitor and/or audit charts quarterly for compliance.	6/1/23

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D 276	Continued From page 22 for 3 of 5 sampled residents (#2, #3, and #4) who had orders for monthly weights and vital signs. The findings are: 1. Review of Resident #3's current FL2 dated 02/13/23 revealed diagnoses included depression, anxiety, and a history of chest pain. Review of Resident #3's physician's orders revealed: -There was an order dated 03/06/23 to obtain a monthly weight and vital signs to include blood pressure, heart rate, oxygen saturation, and temperature. -There was an order to obtain weekly blood pressure checks. -There was no order to discontinue (DC) monthly weight and vital signs. Review of Resident #3's electronic medication administration record (eMAR) for March 2023 revealed: -There was an entry for weight and vitals monthly, no specified date. -There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight. -There was a stop date of 03/27/23 and "DC'd [discontinued] marked on the eMAR. -There were no weights or vital signs documented from 03/01/23 to 03/31/23. Review of Resident #3's eMAR for April 2023 revealed: -There was no entry for weight and vitals monthly and no space to document oxygen saturation, pulse, temperature and weight on the April 2023 eMAR. -There were no weights or vital signs documented	D 276		

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D 276	Continued From page 23 from 04/01/23 to 04/30/23. Review of Resident #3's eMAR May 2023 from 05/01/23 to 05/17/23 revealed: -There was no entry for weight and vitals monthly and no space to document oxygen saturation, pulse, temperature and weight on the May 2023 eMAR. -There were no weights or vital signs documented from 04/01/23 to 05/17/23. Review of the facility's monthly weight and vital signs sheet revealed there was no weight and vital signs sheet for Resident #3 for March 2023, April 2023, or May 2023 from 05/01/23 to 05/17/23 available for review. Telephone interview with Resident #3's primary care provider's (PCP) Nurse Practitioner (NP) on 05/17/23 at 4:20pm revealed he expected the facility to obtain the monthly weight and set of vital signs for Resident #3 because it was ordered on the signed physician's orders. Interview with Resident #3 on 05/18/23 at 1:25pm revealed: -He was receiving blood pressure checks routinely (maybe weekly). -He did not know the last time he was weighed or his temperature was checked. Refer to the interview with a personal care aide (PCA) on 05/18/23 at 2:18pm. Refer to the interview with a second PCA on 05/18/23 at 2:42pm. Refer to the interview with the Administrator on 05/17/23 at 3:00pm.	D 276		

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D 276	Continued From page 24 Refer to the telephone interview with the primary care provider (PCP) on 05/17/23 at 4:20pm. 2. Review of Resident #4's current FL2 dated 11/21/22 revealed: -Diagnoses included diabetes mellitus type 2, mild intellectual disability, schizoaffective, hypertension and hyperlipidemia. -There was an order for weight and vital signs monthly. Review of Resident #4's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for weight and vital signs monthly, no specified date. -There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight. -There was a blood pressure, oxygen saturation, pulse, and temperature documented but no weight. Review of Resident #4's eMARs for April 2023 from 05/01/23 to 05/18/23 revealed: -There was no entry for weight and vitals monthly and no space to document oxygen saturation, pulse, temperature and weight on the April 2023 eMARs. -There were no weights or vital signs documented from 04/01/23 to 04/30/23. Review of Resident #4's eMARs for May 2023 from 05/01/23 to 05/18/23 revealed: -There was no entry for weight and vitals monthly and no space to document oxygen saturation, pulse, temperature and weight on the May 2023 eMARs. -There were no weights or vital signs documented from 05/01/23 to 05/18/23.	D 276		

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D 276	Continued From page 25 Review of the facility's monthly weight and vital signs sheet revealed there were no weight and vital signs sheet for Resident #4 for March 2023, April 2023, or May 2023 from 05/01/23 to 05/17/23 available for review. Telephone interview with Resident #4's primary care provider's (PCP) on 05/17/23 at 3:52pm revealed he expected the facility to obtain the monthly weight and set of vital signs for Resident #4 as ordered. Interview with Resident #4 on 05/17/23 at 3:55pm revealed: -She was in a wheelchair and was not weighed. -She was unable to recall the last time she had been weighed. Interview with a medication aide (MA) on 05/18/23 at 9:28am revealed he did not do Resident #4's weights on his shift. Refer to the interview with a personal care aide (PCA) on 05/18/23 at 2:18pm. Refer to the interview with a second PCA on 05/18/23 at 2:42pm. Refer to the interview with the Administrator on 05/17/23 at 3:00pm. Refer to the telephone interview with the primary care provider (PCP) on 05/17/23 at 4:20pm. 3. Review of Resident #2's current FL2 dated 03/20/23 revealed diagnoses included syncope, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, and hypertension.	D 276		

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D 276	Continued From page 26 Review of Resident #2's physician's orders revealed: -There was an order dated 03/23/23 to obtain a monthly weight and vital signs to include blood pressure, heart rate, oxygen saturation, and temperature -There was no order to discontinue (DC) monthly weight and vital signs. Review of Resident #2's electronic medication administration record (eMAR) for March 2023 revealed: -There was an entry for weight and vital signs monthly, no specified date. -There was a space to document blood pressure, oxygen saturation, pulse, temperature and weight. -There was a stop date of 03/27/23 and "DC'd [discontinued] marked on the eMAR. -There were no weights or vital signs documented from 03/01/23 to 03/31/23. Review of Resident #2's eMAR for April 2023 revealed: -There was no entry for weight and vital signs monthly and no space to document oxygen saturation, pulse, temperature and weight on the April 2023 eMAR. -There were no weights or vital signs documented from 04/01/23 to 04/30/23. Review of Resident #2's eMAR for May 2023 from 05/01/23 to 05/17/23 revealed: -There was no entry for weight and vital signs monthly and no space to document oxygen saturation, pulse, temperature and weight on the May 2023 eMAR. -There were no weights or vital signs documented from 05/01/23 to 05/17/23.	D 276		

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D 276	Continued From page 27 Review of the facility's monthly weight and vital signs sheet revealed there was no weight and vital signs sheet for Resident #2 for March 2023, April 2023, or May 2023 from 05/01/23 to 05/17/23 available for review. Interview with Resident #2 on 05/17/23 at 2:15pm revealed: -Facility staff had not weighed her for a couple of months. -She did not think staff checked her pulse or breathing rate. Telephone interview with the primary care provider (PCP) on 05/17/23 at 4:00pm revealed he wanted Resident #2 to be weighed routinely and did not discontinue monthly weights for the resident. Refer to the interview with a personal care aide (PCA) on 05/18/23 at 2:18pm. Refer to the interview with a second PCA on 05/18/23 at 2:42pm. Refer to the interview with the Administrator on 05/17/23 at 3:00pm. Refer to the telephone interview with the primary care provider (PCP) on 05/17/23 at 4:20pm. _____ Interview with a personal care aide (PCA) on 05/18/23 at 2:18pm revealed: -Residents used to be weighed monthly. -The MA on duty gave her a list of residents to weigh. -She had not received a list of residents to weigh she thought since April 2023, but was not certain. Interview with a second PCA on 05/18/23 at	D 276		

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D 276	Continued From page 28 2:42pm revealed: -Weights were supposed to be done monthly. -The MA would give her a paper with a list of resident's names to be weighed. -After she obtained the residents' weight, she gave the paper back to the MA. -She had not received the paper to weigh residents for maybe two months. Interview with the Administrator on 05/17/23 at 3:00pm revealed: -The pharmacy added orders for weight and vital signs monthly for residents on the physician's orders pages signed by the facility's PCP for renewing residents' orders. -She did not realize the orders for weight and vital signs monthly for residents would need to be discontinued by new orders written by the PCP. -The Resident Care Coordinator (RCC) removed the documentation for weight and vital signs monthly from the residents' eMARs with her knowledge since the pharmacy and not the PCP added the information to the physician's orders. Telephone interview with the PCP on 05/17/23 at 4:20pm revealed: -He did not know residents' monthly weights and vitals signs were discontinued by the RCC and Administrator for all residents. -Residents' monthly weights and vital signs would need to be individually reviewed by the PCP for the need to be continued instead of discontinued for all.	D 276		
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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D 317	Continued From page 29 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: Observations during the initial tour on 05/17/23 from 9:30am to 11:00am revealed there were no activity calendars posted. Interview with a resident on 05/17/23 at 9:50am revealed: -She colored on Monday. -She made a ring one day. -She had not done any activities since. Interview with a second resident on 05/17/23 at 10:05am revealed: -They did not do activities at the facility. -They did not take them shopping. -There was nothing to do. Interview with a third resident on 05/17/23 at 10:15am revealed: -Sometimes they colored and played Bingo, but he did not like doing that. -Sometimes they have basketball or football on television, and he liked to watch those games. Observation of the common lounge room on 05/17/23 at 2:00pm revealed:	D 317	Facility will ensure that 14 hours per week of planned activities are offered and will ensure that AD documents the participation or lack of participation for each activity. Administrator will review calendar prior to posting for the month to ensure a minimum of 14 hours are planned for each week. SIC's will monitor activities and help encourage residents to participate.	6/1/23

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-There were chairs and couches for residents to sit on.
-There was one television.
-There was a piano and a stationary bike.
-There was one bookshelf with several books, hymnals, and puzzles.
-There was no activity calendar posted.

The Activity Director (AD) provided an activity calendar for the current month on 5/17/23 at 1:25pm.

Review of the May 2023 activity calendar on 05/17/23 at 1:30 pm revealed:
-There were activities scheduled Monday through Friday.
-There were no activities scheduled on Saturdays or Sundays.
-Every Monday through Friday there was an activity scheduled from 12:00pm to 2:00pm or 1:00pm to 3:00pm.
-Every Monday through Friday there was an activity scheduled from 4:00pm to 5:00pm.
-The activities included music time, religious study, watercolor painting, board games, Bingo, nature walks, book club, exercise, paper crafts, card games, outing, acrylic painting, women's spa day, scrapbooking, jewelry making, wood crafts, and nature walk.
-There was a total of 15 hours listed on the activity calendar for each week.
-On 05/17/23, bingo was scheduled from 1:00pm to 3:00pm.
-On 05/17/23, a nature walk was scheduled from 4:00pm to 5:00pm.

Observation of the dining area on 05/17/23 from 1:30pm to 3:00pm for bingo scheduled on the activity calendar on 05/17/23 at 1:00pm revealed:
-The Activity Director (AD) was in the dining room

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with a volunteer preparing the Bingo game set.
-At 1:30pm, residents were seated in the dining area to play Bingo.
-At 3:00pm, The Bingo game was over and residents were leaving the dining room.
-The activity scheduled on the activity calendar from 1:00pm to 3:00pm on 05/17/23 was observed lasting from 1:30pm to 3:00pm (90 minutes not 120 minutes as scheduled).

Observation of the activity room on 05/17/23 at 3:10pm revealed:
-The activity room door was locked.
-The activity calendar was on a sheet of paper in the activity room.
-The activity room had tables set up for use with several chairs per table.
-Activity supplies observed included markers, pencils, coloring books, jewelry making supplies, construction paper, paint supplies, board games and a bingo set.

Observation of the facility on 05/17/23 at 4:00pm compared to the activity calendar for the nature walk scheduled from 4:00pm to 5:00pm revealed:
-At 4:00pm, the medication aide (MA) was in the medication room preparing to administer medications with several residents lined up in line waiting to receive their medications.
-At 4:00pm, neither the AD, nor the volunteer were outside with residents walking.
-At 4:15pm, the AD and volunteer walked up onto a back porch from an outside area. No residents were walking with them.
-At 4:30pm, the AD and a volunteer were observed pushing one resident in a wheelchair around the building and up onto the porch.
-There were no additional residents were observed participating in the nature walk.

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D 317	Continued From page 32 Interview with a fourth resident on 05/17/23 at 3:30pm revealed: -Today was the first day they played Bingo. -They did not really do activities. Interview with a fifth resident on 05/17/23 at 3:45pm revealed: -She did not know about any activities at the facility yesterday. -She thought they might have played Bingo 3 times in the past year. Interview with a sixth resident on 05/17/23 at 4:18pm revealed: -He had made a necklace a month ago which he was wearing. -That was the only activity he knew about. Interview with a seventh resident on 05/17/23 at 4:22 pm revealed: -They played bingo a month ago. -She made a ring on Monday. -She did not know about any other activities at the facility. Interview with AD on 05/17/23 at 3:20pm revealed: -There was another staff member who did some activities last week. -She tried to do activities 5 days a week. -She had to keep the door locked to the activity room because one resident would come into the activity room and take the activities out of the room, especially the books. -The facilty used to have pre-printed calendars posted and ordered for residents, but the cost of pre-printed calendars had gone up and the facility could not afford them. -She had given residents calendars printed from the facility's computer today.	D 317		

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D 317	Continued From page 33 Interview with the Administrator on 05/18/23 at 3:55pm revealed: -The facilty used to have pre-printed calendars posted and ordered for residents but the cost of pre-printed calendars had gone up and the facility could not afford them. -The AD printed activity calendars for the residents from the facility's computer today for May 2023. -Some of the residents had dementia and did not remember doing activities. -She had witnessed some of the resident's doing activities even though they may not remember. -On 05/17/23, the AD had waited on her to administer medications at 4:00pm before starting the activities.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to maintain privacy for 3 of 8 sampled residents related to a resident wandering into rooms, taking belongings which resulted in mental anguish of 3 residents (#3, #7, and #8) and altercations with the resident who wandered into their room (#7). The findings are:	D 338	Facility will review residents' rights with staff and will instruct staff to make administrator and/or RCC aware of any issues that impact residents and their rights. Residents who continually hinder the rights of other residents will be given a notice of discharge.	6/15/2023

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Interviews with five residents on 05/18/23 from 10:25am to 3:40pm revealed:
-There was a resident at the facility that went from room to room and took residents' belongings.
-If staff and other residents told the resident not to do something, he only got worse.
-The resident went into rooms all hours of the day and night.
-The residents had observed if staff tried to get the resident out of the rooms, the resident would not come out of the room with staff.
-They did not like the resident coming into their rooms.
-They locked the doors, but the resident knew how to unlock the doors using his thumbnail.
-They tried to hide their items, but the resident always found their hiding places.
-When they saw the resident going into other residents' rooms, they yelled for the staff, and staff was told which room the resident went into.
-Sometimes the resident was combative and did not come out of the room, but most times he came out when staff asked him to come out of the room.

1. Review of Resident #7's current FL2 dated 12/02/22 revealed diagnoses included schizophrenia, schizoaffective disorder bipolar type, cluster B personality, and depression.

Review of Resident #7's care plan dated 03/27/23 revealed:
-The resident was oriented, had adequate vision, hearing and speech.
-The resident was independent in eating, toileting, ambulation, and transferring.
-The resident required supervision with bathing and limited assistance with grooming.

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Review of local law enforcement 911 communication call log reports revealed:
-On 04/18/23, Resident #7 called because a resident was breaking into his room and stealing his things.
-On 04/19/23, Resident #7 called because a resident was taking his stuff without his permission.
-On 05/07/23, Resident #7 called because a "guy" was trying to break into his room and steal his stuff. Called facility staff and made them aware.
-On 05/11/23, Resident #7 called complaining that a resident was coming into his room and taking his stuff. Called staff at the facility and made them aware Resident #7 was upset and to keep an eye on the resident.

Interview with Resident #7 on 05/18/23 at 10:15am revealed:
-A resident went into his room and tried to take his books and he did not like it.
-He had tried to hide his books from the other resident, but the other resident would find them.
-He had made the other resident get out of his room several times.
-The other resident came into his room at 12:30am and at 3:00am.
-The other resident went into residents' rooms and the staff did nothing about it.
-The other resident had "made his life miserable".

Second interview with Resident #7 on 05/18/23 at 4:28pm revealed:
-The other resident continually tried to get into his room and mess with personal items like his guitar and took his books.
-He did not like it when the other resident went into his room and tried to take his books.
-He tried to hide his books from the other resident, but the other resident would find them.

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-Daily, he had to make the other resident get out of his room.
-A couple of times, the other resident became upset and he was even pushed by the other resident one time with him landing on the floor.
-He pushed the other resident back and then he left the room.
-He did not tell staff about the incident because they did nothing anyway.
-Staff made him feel like it was his fault the other resident came into his room.
-The other resident went into the residents' rooms and the staff let him get by with it.
-Twice, he had called law enforcement because the other resident was in his room taking his stuff and would not leave.
-The Administrator had changed the locks on his door 3 times to keep the other resident out of his room; but the resident was able to unlock the locks on his room door.
-The locks could be opened by using a thumbnail; and the other resident knew how to open the door using his thumbnail.
-The other resident had caused him emotional problems.
-He told his psychiatrist that the other resident came to his room and tried to take his books, which made his emotional problems worse.
-When the other resident took his books, that was very disturbing to him because the books meant a lot to him.
-He considered his books to be a "treasure".

Interview with Resident #7's family friend on 05/18/23 at 4:40pm revealed:
-She visited Resident #7 on 2 occasions and observed the other resident taking things out of Resident #7's room.
-The staff were in the facility, but did not nothing to stop the other resident.

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D 338	Continued From page 37 -Last week, on Friday 05/12/23, Resident #7 told her that the other resident came into his room and started searching through his drawers. -He asked the other resident to leave, but he would not. -The other resident pushed him, he pushed the resident back and they both ended up on the floor. -She did not think Resident #7 had told the staff about the incident. -Resident #7 had little confidence that staff would help him, because in the past they did not help him by keeping the other resident out of his room. Interview with Resident #7's mental health counselor on 05/18/23 at 4:15pm revealed: -Resident #7 had been complaining to him about another resident coming into his room for roughly six weeks. -Resident #7 complained that there was another resident who continually came into his room at all hours of the day and night, even at 3:00am. -Resident #7 told him, the other resident had a history of going into residents' rooms. -Resident #7 told him that he had called the police on the resident because the resident had assaulted him, pushed him, and was digging through his dresser drawers. -Resident #7 told him that he did not fear the resident, he was annoyed by the resident coming into his room at all hours of the day and night. -Resident #7 told him that he liked living at the facility, but he sometimes considered moving out because he did not like living in fear of another resident, who continually came to his room and messed with his things like his guitar and took his books. -He visited Resident #7 weekly, for 30 minutes to 1 hour. -When he visited Resident #7, staff were in the	D 338		

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facility but they were usually hovered around the nurses' station.
-He had not observed staff out on the floor checking on the residents.

Telephone interview with Resident #7's mental health provider (MHP) on 05/18/23 at 11:21am revealed:
-He was aware another resident wandered and entered Resident #7's room frequently taking things.
-He could see how this would mentally bother Resident #7.
-He was aware there was a resident in the facility that was traumatizing the residents.

Interview with a personal care aide (PCA) on 05/18/23 at 2:10pm revealed:
-Resident #7 complained all the time that another resident came into his room.
-She told Resident #7 that he had to always keep his room door locked, but he did not always lock his door.

Refer to the interview with a personal care aide (PCA) on 05/18/23 at 1:38pm.

Refer to the interview with a second PCA on 05/18/23 at 2:12pm.

Refer to the interview with the Administrator on 05/18/23 at 2:40pm.

2. Review of Resident #3's current FL2 dated 02/13/23 revealed:
-Diagnoses included depression, anxiety, and a history of chest pain.
-Resident #3 was ambulatory.
-There was no information related to orientation.
-There was an order for lorazepam 1mg take

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one-half tablet twice a day, as needed for anxiety.
-There was an order for buspirone (used to treat anxiety/fear) 7.5mg twice a day.

Review of Resident #3's nurse's notes revealed there was no documentation regarding the facility's addressing Resident #3's concerns pertaining to a resident repeatedly wandering into his room and emptying his dresser drawers in the middle of the floor.

Interview with Resident #3 on 05/18/23 at 1:25pm revealed:
-There was a resident that wandered into his room "all the time".
-The other resident had been in his room again this morning (05/18/23), around 7:30am while he was at breakfast, and took all the clothes out of the dresser shared by the two residents in the room.
-The other resident emptied everything in the dresser onto the beds and floor.
-Resident #3's roommate had very poor eye sight so Resident #3 placed everything back into the dresser for both roommates.
-"The resident does that to a lot a people in the building".
-"Administration knew about him wandering into rooms, but they do not keep him from going into rooms".
-He had high blood pressure and a bad heart, and the other resident upset him when he came into his room and messed with his stuff.
-Resident #3 had a medication he took took for his anxiety medication, mainly because the other resident kept him so upset either coming into his room or worrying that the other resident would come into his room.
-He had to take his "as needed" anxiety most days because the wandering resident stressed

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him so bad.
-He talked with his doctors about the other resident coming into his room and how much it upset him.

Telephone interview with the Resident #3's mental health provider (MHP) on 05/18/23 at 11:00am revealed:
-He was at the facility for resident visits routinely.
-There were at least 2 residents that had complained to him about a wandering resident which caused increased anxiety due to his constant wandering in and out of residents' rooms and taking personal items.

Interview with the Administrator on 05/18/23 at 2:40pm revealed:
-She was not informed Resident #3's room was upended on 05/18/23 by the resident or facility staff.
-Resident #3 should have told her that his room was disturbed by another resident.

Refer to the interview with a personal care aide (PCA) on 05/18/23 at 1:38pm.

Refer to the interview with a second PCA on 05/18/23 at 2:12pm.

Refer to the interview with the Administrator on 05/18/23 at 2:40pm.

3. Review of Resident #8's FL2 dated 12/19/22 revealed:
-Diagnoses included schizophrenia paranoid type, paranoid personality disorder, mild mental retardation, glaucoma, blind in left eye, degenerative joint disease, morbid obesity, non-insulin-dependent diabetes mellitus and hypertension.

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D 338	Continued From page 41 -There was no information regarding disorientation. Review of Resident #8's nurse's notes revealed there was no documentation regarding the facility's addressing Resident #8's concerns pertaining to a resident wandering into his room and going through his personal belongings. Interview with Resident #8 on 05/18/23 at 10:35am revealed: -Another resident went into residents' rooms at all hours. -The other resident went from resident room to resident room and took residents' belongings. -The other resident was in his room this morning and took stuff out of his chest of drawers. -If residents and staff told the other resident not to do something, the other resident only got worse. -It bothered him because the other resident would come into his room. -He had thought about leaving the facility because of the other resident. Refer to the interview with a personal care aide (PCA) on 05/18/23 at 1:38pm. Refer to the interview with a second PCA on 05/18/23 at 2:12pm. Refer to the interview with the Administrator on 05/18/23 at 2:40pm. _____ Interview with a PCA on 05/18/23 at 1:38pm revealed: -There were several residents that complained about another resident entering their rooms and taking things. -The other resident sometimes entered the same room twice in one day and she had to get him out	D 338		

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D 338	Continued From page 42 of the room. Interview with a second PCA on 05/18/23 at 2:12pm revealed: -Staff were not doing anything any different pertaining to the other resident than they were doing a couple of months ago. -Staff watched the other resident and redirected him when he went into residents' rooms. -She thought the other resident might go into other residents' rooms one time a day. Interview with the Administrator on 05/18/23 at 2:40pm revealed: -Over the past year, the other resident had a mental status change and his wandering had gotten worse. -The other resident going into the residents' rooms was an everyday behavior. -There had been some medication changes for the other resident, and his behavior was not as bad as it was previously. -The facility was short staffed, and she and the Resident Care Coordinator (RCC) were now doing the medication pass daily. _____ The facility failed to ensure 3 of 8 sampled residents (#3, #7 and #8) were free of mental anguish related to a resident who wandered into residents' rooms taking things, refusing to leave when asked, pulling clothes out of the drawers (#3) and becoming aggressive and pushing residents (#7) resulting in residents experiencing increased anxiety (#3, #7, and #8) and calling the local law enforcement for assistance (#7). This failure placed the residents at substantial risk for mental anguish and abuse which constitutes a Type A2 Violation. _____	D 338		

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D 338	Continued From page 43 [Refer to Tag D 0270, 10A NCAC 13F .0902(b) Personal Care and Supervision (Type B Violation)]. The facility provided a plan of protection in accordance with G.S.131D-34 for this violation on 05/18/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 17, 2023.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on record reviews, observations and interviews the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#2 and #4) related to the administration of insulin based on fingerstick blood sugars (FSBS) obtained (#4) and anti-fungal cream not applied (#2 and #4). The findings are: 1. Review of Resident #4's current FL2 dated 11/21/22 revealed diagnoses included diabetes mellitus type 2, mild intellectual disability,	D 358	RCC will monitor eMAR once per week to ensure that medication aides document the administration of medications and treatments for all residents' orders.	6/15/23

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schizoaffective, hypertension and hyperlipidemia.

a. Review of Resident #4's current FL2 dated 11/21/22 revealed there was an order for Novolog (fast-acting insulin used to decrease blood sugars levels) 3 units four times daily for FSBS greater than 450, recheck in 1 hour, if not lower call physician .

Review of Resident #4's March 2023 electronic medication administration record (eMAR) reveled:
-There was an entry for Novolog 3 units four times daily for FSBS greater than 450, recheck in 1 hour, if not lower call physician scheduled at 7:00am, 11:00am, 5:00pm and 8:00pm.
-There was documentation 8 of 31 opportunities for FSBS was checked at 8:00pm from 03/01/23 through 03/31/23.
-There was no documented FSBS at 8:00pm for 23 dates from 03/01/23 through 03/31/23.
-In March 2023 Resident #4's FSBS ranged between 146 and 431.

Review of Resident #4's April 2023 eMAR reveled:
-There was an entry for Novolog 3 units four times daily for FSBS greater than 450, recheck in 1 hour, if not lower call physician scheduled at 7:00am, 11:00am, 5:00pm and 8:00pm.
-There was documentation 10 of 30 opportunities for FSBS was checked at 8:00pm from 04/01/23 through 04/30/23.
-There was no documented FSBS at 8:00pm for 20 dates from 04/01/23 through 04/30/23.
-In April 2023 Resident #4's FSBS ranged between 132 and 548.

Review of Resident #4's May 2023 (05/01/23 through 05/18/23) eMAR reveled:
-There was an entry for Novolog 3 units four

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D 358	Continued From page 45 times daily for FSBS greater than 450, recheck in 1 hour, if not lower call physician scheduled at 7:00am, 11:00am, 5:00pm and 8:00pm. -There was documentation 8 of 17 opportunities for FSBS was checked at 8:00pm from 05/01/23 through 05/17/23. -There was no documented FSBS at 8:00pm for 9 opportunities from 05/01/23 through 05/17/23. -In May 2023, Resident #4's FSBS ranged between 135 and 422. Observation of Resident #4's medications on hand on 05/18/23 at 1:34pm revealed there were four pens of Novolog available for administration. Interview with Resident #4 on 05/17/23 at 3:55pm revealed: -Staff checked her FSBS several times throughout the day, but she was unable to recall exactly how often and the time FSBS was checked. -Sometimes her FSBS was checked at bedtime but not every day. Telephone interview with Resident #4's primary care provider (PCP) on 05/17/23 at 3:52pm revealed: -Resident #4 was a diabetic and needed Novolog to help control her diabetes. -He ordered the fast-acting insulin four times daily to try and keep FSBS from getting too high. -If the Novolog was not administered he would expect FSBS to be documented to show there was no need for Novolog as ordered. -Not checking the FSBS could cause the resident to have a significant change to her kidneys, eyes and nerves, and could cause a delay in getting medications needed for hypoglycemia causing low blood sugar.	D 358		

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Telephone interview with a third shift medication aide (MA) on 05/18/23 at 8:42am revealed:
-He checked Resident #4's FSBS at 8:00pm and administered insulin.
-He did not check the resident's FSBS if she was lying in the bed.
-If the resident refused to get up and come to the medication room, he did not check her FSBS.
-As far as he knew there was no system in place that audited the eMARs and medications on hand.

Telephone interview with a second third shift MA on 05/18/23 at 9:15am revealed:
-When he checked Resident #4's FSBS and it was not greater than 450, he did not document the FSBS on the eMAR.
-He thought he only had to write the FSBS on the eMAR if he had to administer insulin.
-He had worked at the facility for over 3 years and no one told him to write the FSBS on eMAR.
-The times he did not check Resident #4's FSBS was when the resident was in bed and refused to get up and come to the medication room.
-The facility did not have a system that he knew of related to auditing the eMARs for holes in documentation and administering medications.

Interview with the Administrator on 05/18/23 at 3:44pm revealed:
-There was no system in the facility for auditing the eMAR and medications on hand.
-She was not aware the night shift MA did not know to document FSBS even if he did not administer insulin.
-She was not aware the MAs did not administer medications if the resident did not come to the medication room.
-She expected the MAs to take medications to the residents' rooms if they did not come to the

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D 358	Continued From page 47 medication room. b. Review of Resident #4's current FL2 dated 11/21/22 revealed an order for nystatin 100,000 units/gram cream - apply to the affected area of skin twice daily (used to treat fungal infections on the surface of the skin). Review of Resident #4's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm. -There was documentation nystatin cream was not applied for 35 of 62 opportunities from 03/01/23 through 03/31/23. -There was documentation the resident refused the cream, the cream was "withheld per Dr/RN orders" and the cream was not available for administration and one date with no documentation why the medication was not administered. Review of Resident #4's April 2023 eMAR revealed: -There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm. -There was documentation nystatin cream was not applied for 33 of 60 opportunities from 04/01/23 through 04/30/23. -There was documentation the resident refused the cream, the cream was "withheld per Dr/RN orders", and one date with no documentation why the medication was not administered. Review of Resident #4's May 2023 (05/01/23 through 05/18/23) eMAR revealed: -There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm. -There was documentation nystatin cream was	D 358		

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not applied for 11 of 35 opportunities from 05/01/23 through 05/18/23.
-There was documentation the resident refused the cream and the cream was "withheld per Dr/RN orders.

Observation of Resident #4's medication on hand on 05/18/23 at 8:58am revealed:
-Nystatin cream was dispensed on 05/01/23 for quantity of 30 day supply.
-The cream was in a thin metal tube that was five inches long and one inch wide.
-There were two visible indention's in the showing the cream had been used.
-There was more than three-fourths of the cream remaining in the tube.

Telephone interview with a pharmacist at the facility's contracted pharmacy revealed:
-A 30 gram tube of nystatin cream was last filled and dispensed on 05/01/23.
-If used as ordered; twice daily, the tube would last approximately 15 days.
-The facility had to call and request a refill of the medication.
-Prior to 05/01/23, the facility had not requested a refill of the medication since 09/15/22.

Interview with Resident #4 on 05/17/23 at 3:55pm revealed:
-Staff sometimes applied a cream under her stomach but not every day.
-She thought the cream was for when she used the bathroom.

Telephone interview with Resident #4's primary care provider (PCP) on 05/17/23 at 3:52pm revealed:
-He was at the facility weekly, and no one made him aware Resident #4's nystatin cream was not

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being applied as ordered.
-Resident #4 was wheelchair bound and sat upright all day.
-There was skin irritation, so he ordered the nystatin cream twice daily.
-He did not recall staff at the facility saying the resident refused or they were unable to apply the cream as ordered.

Interview with a personal care aide (PCA) on 05/18/23 at 2:08pm revealed:
-She applied Resident #4's nystatin cream after the resident had a shower.
-The resident's shower days were Tuesdays and Thursdays.
-The cream was also applied in the morning after a bowel movement.

Telephone interview with a third shift medication aide (MA) on 05/18/23 at 8:42am revealed:
-When he worked as a MA, he was responsible for ensuring Resident #4's nystatin cream was applied at bedtime.
-He did not apply the cream himself, if he had a female PCA working the same shift, he had her apply the cream.
-If the PCA working with him was a male, the cream was not applied at all.
-He did not observe the PCA apply the cream, but he verbally asked her if she had applied the cream.
-If he forgot to ask the PCA about the cream, then he documented the resident refused.
-He documented the resident refused, although he nor anyone had attempted to apply the cream.

Telephone interview with a second third shift MA on 05/18/23 at 9:15am revealed:
-When he worked, he sometimes applied Resident #4's nystatin cream but not every time.

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-If the resident was in bed and refused to come to the medication room, he did not apply the cream, but wrote on the eMAR the medication was "withheld per Dr/RN order."

Interview with the Administrator on 05/18/23 at 3:44pm revealed:
-She was not aware the male MAs were not applying Resident #4's cream.
-She was short staff and was not always able to put a female PCA on the night shift.
-If the MAs had made her aware, they did not want to apply the cream she would have consulted with the resident's PCP to have the administration times changed.

2. Review of Resident #'2's current FL2 dated 03/20/23 revealed:
-Diagnoses included syncope, hyperlipidemia, gastroesophageal reflux disease, chronic obstructive pulmonary disease, acute, hypoxemic respiratory failure, constipation, hyperkalemia, obesity, hypertension, anxiety, bipolar with depression and schizophrenia unspecified.
-There was an order for nystatin (used to treat fungal infections on the surface of the skin) 100,000 units/gram cream apply twice daily.

Review of Resident #2's March 2023 electronic medication administration record (eMAR) from 03/20/23 through 03/31/23 revealed:
-There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm.
-There was documentation nystatin cream was not applied for 12 of 24 opportunities from 03/01/23 through 03/31/23.
-There was documentation the resident refused the cream 12 times at 8:00pm.

Review of Resident #2's April 2023 eMAR

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D 358	Continued From page 51 revealed: -There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm. -There was documentation nystatin cream was not applied for 30 of 60 opportunities from 04/01/23 through 04/30/23. -There was documentation the resident refused application of the cream 30 times at 8:00pm. Review of Resident #2's May 2023 eMAR from 05/01/23 through 05/16/23 revealed: -There was an entry for nystatin cream scheduled for application at 8:00am and 8:00pm. -There was documentation nystatin cream was not applied for 4 of 32 opportunities from 05/01/23 through 05/16/23. -There was documentation the resident refused application of the cream 4 times at 8:00pm. Observation of Resident #2's nystatin on 05/18/23 at 1:50pm revealed: -The medication was dispensed on 05/01/23 for a 30-day supply. -There was more than three-fourths of the cream remaining in the tube. Interview with Resident #2 on 05/18/23 at 11:20am revealed: -The cream was applied on her buttocks and groin area. -There were 2 male medication aides (MAs) that worked at night. -One of the male MAs had seen her naked and it did not bother him to put the nystatin on her. -She could not remember if the other male MA had put the nystatin on her. -Sometimes, the male MAs had handed the nystatin to her for her to put it on. -The male MAs had not put the nystatin on her lately.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086014	A. BUILDING: _____ B. WING _____	R 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 52 Telephone interview with Resident #2's primary care provider (PCP) on 05/17/23 at 4:00pm revealed: -Staff had not told him that Resident #2's nystatin cream was not applied at 8:00pm as ordered. -He expected it to be applied twice daily. Telephone interview with a MA on 05/18/23 at 8:50am revealed: -He worked from 7:00pm to 7:00am. -Nystatin was scheduled to be applied on Resident #2 for a rash on her buttocks and groin area at 8:00pm. -Normally they were 2 male personal care aides (PCAs) working on night shift with the male MAs. -When there were no females working on night shift, the male MAs did not apply the nystatin. -When a female PCA worked with the night shift, nystatin cream was applied to Resident #2. -No response was given as to why documentation on the eMAR was "resident refused". Telephone interview with a second MA on 05/18/23 at 9:22am revealed: -He worked from 7:00pm to 7:00am. -Nystatin was scheduled to be applied at 8:00pm on Resident #2. -Resident #2 had refused the nystatin several days in a row. -Resident #2 had told him "no", she did not want the nystatin. -Resident #2 did not always refuse the nystatin. -He thought Resident #2 was uncomfortable with the male MA's applying nystatin. -When a female PCA worked on the night shift, she could help apply nystatin. -Resident #2 had started letting him apply nystatin. -Staff were supposed to notify the physician after	D 358		

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D 358	Continued From page 53 several refusals in a row. -He did not notify the doctor about refusals because he worked at night. -He had not told the Administrator about Resident #2's refusal of Nystatin. -He felt sure the Resident #2's refusal of nystatin had been communicated to the Administrator because it had been an ongoing issue. Interview with the Administrator on 05/18/23 at 3:40 pm revealed: -The facility policy was to notify the doctor if the resident refused a medication 3 consecutive days in a row. -The male nighttime MAs had not informed her about Resident #2's nystatin cream was not applied as ordered. -The male nighttime MAs had not told her they were uncomfortable with applying the nystatin. -If they had told her, she could have called the physician and asked him to change the times of medication administration of the nystatin.	D 358		
D 613	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule.	D 613	Administrator will ensure that staff are trained on the state approved infection control course within 30 days of hire date and annually thereafter. Administrator will arrange for current staff to receive training in infection control policies and procedures.	6/1/23 7/31/23

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D 613	Continued From page 54 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 1 sampled staff (Staff A) within 30 days of hire and for 1 of 1 sampled staff (Staff B) annually. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was rehired on 02/16/23. -There was no documentation Staff A had completed the mandatory annual State approved infection control training. Interview with Staff A on 05/18/23 at 3:30pm revealed: -She had been rehired at the facility as a MA since February 2023. -She thought she completed the mandatory annual State infection control training at the previous facility, but she did not remember the date of the training. -Since she started working at the facility, she had an on-line training on blood borne pathogens and infection control in April 2023. -She had not completed the mandatory State infection control training. Refer to the interview with the Administrator on 05/18/23 at 2:30pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B had been working as a MA in the facility since 09/26/06.	D 613		

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D 613	Continued From page 55 -There was documentation he completed the mandatory annual State approved infection control training on 12/29/20. -There was no documentation Staff B had completed the mandatory annual State approved infection control training since 12/29/20. Attempted telephone interview with Staff B on 05/18/23 at 4:22pm was unsuccessful. Refer to the interview with the Administrator on 05/18/23 at 2:30pm. _____ Interview with the Administrator on 05/18/23 at 2:30pm revealed: -She was responsible for ensuring all staff qualifications including annual infection control training were completed and maintained in the facility. -She had scheduled a Nurse with the contracted pharmacy for completing the mandatory annual State approved infection control training in April 2023, but cancelled the training because she found an on-line computer infection control training for staff. -She had MAs complete the on-line computer training in April 2023. -She did not realize the mandatory annual State approved infection control training was the only training accepted for the MA annual infection control training.	D 613		