STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL009025	A. BUILDING: _____ B. WING _____	R 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 07/25/23 through 07/26/23.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, that facility failed to maintain the water temperatures at the required minimum of 110 degrees Fahrenheit (F) and maximum of 116 degrees F for 10 of 10 water fixtures in the shared and common bathrooms used by residents. The findings are: Review of the American Burn Association Scald Injury Prevention Educator's Guide revealed: -A water temperature of 127 F would cause a third degree burn in 1 minute. -A water temperature of 124 F would cause a third degree burn in 3 minutes. -A water temperature of 120 F would cause a third degree burn in 5 minutes. -Scald injuries could result in considerable pain,	D 113	D 113 10A NCAC 13F .0311(d) Other Requirements The Resident Care Director (RCD) contacted a local contract plumber to review the condition and operating status on the hot water heaters. All hot water heaters were confirmed to be in good operating condition. The Maintenance Director immediately reduced the temperature settings on the hot water heaters. The Maintenance Director initiated hourly checks for the next three days (8am – 5pm) and twice daily checks (M-F) for the next four weeks. Thereafter, resumed once-daily checks (M-F). The Administrator in-serviced the Maintenance Director, RCD and Business Office Manager on how to conduct water temp checks and how to document results. Water temps been in compliance with stated hot water parameter requirements (between 100 degrees F and 116 degrees F) since the date of the initial finding. The procedures were completed on or before September 9, 2023.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 9-6-2023

Reviewed and Acknowledged SCM 09/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 113	Continued From page 1 prolonged treatment, and possible lifelong scarring, and even death. -Older adults have thinner skin so hot liquids could cause deeper burns with even brief exposure. -A third degrees burn affected the full thickness of the skin and resulted in whitish, charred or translucent skin color, and there was no pin prick sensation in the burn area. Review of the facility's license revealed: -The facility was licensed for a capacity of 60 residents. -The facility consisted of an assisted living unit (ALU) and a memory care unit (MCU). Observation of the facility on 07/25/23 at 9:00am revealed: -The facility census was 57. -The ALU had a census of 34 residents. -The MCU had a census of 23 residents. Observation of the residents' shared bathrooms on the MCU on 07/25/23 at 9:45am revealed: -The hot water temperature of the bathroom sink in room 101 was 127 degrees Fahrenheit (F). -The hot water temperature of the bathroom sink in room 109 was 127 degrees F. -The hot water temperature of the bathroom sink in room 113 was 127 degrees F. -The hot water temperature of the bathroom sink in room 110 was 127 degrees F with visible steam. -The hot water temperature of the bathroom sink in the common bathroom was 127 degrees F. -The hot water temperature of the bathroom sink in a second common bathroom was 127 degrees F. Review of the May 2023 water temperature log on	D 113		

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D 113	Continued From page 2 the MCU revealed : -There was documentation the hot water temperature ranged from 110 degrees F to 116 degrees F for two bathroom water fixtures used by residents on 05/01/23 through 05/03/23, 05/08/23, 05/11/23 through 05/12/23, 05/15/23 through 05/16/23, 05/22/23 through 05/24/23, and 05/30/23 through 05/31/23. -There was documentation on the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature. Review of the June 2023 water temperature log on the MCU revealed; -There was documentation the hot water temperature ranged from 110 degrees F to 116 degrees F for two bathroom water fixtures used by residents on 06/01/23, 06/05/23 through 06/07/23, 06/12/23 through 06/15/23, 06/19/23 through 06/21/23, and 06/26/23. -There was documentation at the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature. Review of the July 2023 water temperature log on the MCU revealed: -There was documentation the hot water temperature ranged from 100 degrees F to 116 degrees F for two bathroom water fixtures used by residents on 07/03/23, 07/05/23 through 07/06/23, 07/10/23 through 07/12/23, 07/17/23, and 07/19/23 thorough 07/20/23, and 07/24/23	D 113		

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D 113	Continued From page 3 through 07/25/23. -There was documentation at the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature. Based of observations, record reviews, and interviews, it was determined the residents in the MCU were not interviewable. Observation of the residents' shared bathrooms on the ALU on 07/25/23 at 10:30am revealed: -The hot water temperature of the bathroom sink in room 202 was 125 F. -The hot water temperature of the bathroom sink in room 206 was 125 F. -The hot water temperature of the bathroom sink in room 214 was 121 F. -The hot water temperature of the bathroom sink in room 217 was 124 F. Review of the May 2023 water temperature log on the ALU revealed: -There was documentation the hot water temperature ranged from 110 degrees F to 116 degrees F of two bathroom water fixtures used by residents on 05/01/23 through 05/03/23, 05/08/23, 05/11/23 through 05/12/23, 05/15/23 through 05/16/23, 05/22/23 through 05/24/23, and 05/30/23 through 05/31/23. -There was documentation on the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature.	D 113		

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D 113	Continued From page 4 Review of the June 2023 water temperature log on the ALU revealed: -There was documentation the hot water temperature ranged from 110 degrees F to 115 degrees F of two bathroom water fixtures used by residents on 06/01/23, 06/05/23 through 06/07/23, 06/12/23 through 06/15/23, 06/19/23 through 06/21/23, 06/26/23, and 06/28/23 through 06/29/23. -There was documentation on the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature. Review of the July 2023 water temperature log on the ALU revealed: -There was documentation the hot water temperature ranged from 110 degrees to 117 degrees F of two bathroom water fixtures used by residents on 07/03/23, 07/05/23 through 07/06/23, 07/10/23 through 07/12/23, 07/17/23, 07/19/23 through 07/20/23, and 07/24/23 through 07/25/23. -There was documentation on the bottom of the log that water temperature should be between 110 degrees F and 116 degrees F. -There was documentation on the bottom of the log to notify management should the water temperature be lower or hotter than the required temperature. Interview with a resident in the ALU unit on 07/25/23 at 10:45am revealed she had not noticed the hot water being too hot, she knew how to mix the hot and cold water to obtain the desired temperature.	D 113		

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D 113	Continued From page 5 Interview with a second resident on the ALU on 07/2/23 at 10:50am revealed there were no issues with the hot water being too hot to her knowledge. Observation with the Maintenance Director on 07//25/23 revealed 9:55am. -The surveyor and the Maintenance Director were in room 113 at the sink in the MCU to test the temperature of the hot water. -The surveyor used her digital thermometer to check the temperature of the hot water and obtained a reading of 127 F. -The Maintenance Director held his digital thermometer at the lower end of the hot running water under the faucet with the tip of the thermometer outside of the stream of water and obtained a temperature of 114 F. -The surveyor used the maintenance staff's digital thermometer and held the tip of the thermometer directly under the hot running water under the faucet near the top of the stream and obtained a reading of 126 F. Interview with the Maintenance Director on 07/25/23 at 9:55am revealed -He randomly checked hot water temperature in the ALU and the MCU, usually in the mornings. -He documented the water temperatures on a log. -He had checked the water temperatures that morning on 07/26/23 and they were all within the required range, ranging from 114 degrees F to 116 for two bathroom fixtures in each unit. -He would immediately turn the thermostat down on the water heater and re-check the water temperatures to maintain temperatures within the required range.	D 113		

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D 113	Continued From page 6 Observation of a re-check of bathroom fixtures (3 sinks in the assisted living unit and 3 sinks in the MCU) on 07/25/23 at 3:30pm revealed the hot water temperatures were within the required range and were 109 degrees F to 112 degrees F. Interview with the Memory Care Coordinator (MCU) on 07/26/23 at 10:10am pm revealed: -She was not aware the water temperature in the shared bathrooms were too hot. -She had not been told by a PCA or a resident that the water was too hot. -She was not aware of any resident being scalded as a result of the water temperature being out of the required range. Interview with the personal care aide (PCA) on 07/26/23 at 11:00am revealed: -She had not noticed the hot water in the shared bathrooms being too hot. -All of the resident in the MCU received assistance with bathing. -There were residents who wandered. Interview with a housekeeping staff on 07/26/23 at 11:30pm revealed she had not noticed the hot water temperatures in the bathrooms being too hot. Interview with the Resident Care Coordinator (RCC) on 07/26/23 at 10:15am. -She was not aware of the hot water temperature being hotter than the required temperature in resident's bathrooms and the common bathrooms. -The Maintenance Director worked three times a week and was responsible for checking the water temperature in the shared bathrooms and common bathrooms on those days. -A log of the water temperature checks was	D 113		

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D 113	Continued From page 7 maintained for both units. -She would ensure the maintenance staff would immediately adjust the thermostat to ensure the hot water temperature was within the required range. -She would immediately place signs (requested by the surveyor) on the water fixtures cautioning staff regarding the hot water temperature until the temperature was within the required range. -She would immediately call the local plumber to see if there were any issues with the hot water heater. Interview with the Administrator on 07/26/23 at 2:00pm revealed: -He was not aware the hot water temperature was greater than the required temperature in residents' bathrooms. -The water pipes ran through the attic to the water fixtures in the bathrooms, and that could be the reason the hot water temperatures were reading high due to the attic being very hot because of the hot weather. -The maintenance staff adjusted the thermostat on the hot water heater and re-checked temperatures in both units to ensure they were within the required range for the safety of the residents. -The plumber was also called to check the hot water heater. _____ The facility failed to ensure the hot water temperatures of 10 of 10 water fixtures in residents' shared and common bathrooms were at the required minimum of 110 degrees F and maximum of 116 degrees F. Not ensuring the facility maintained the temperatures per the rule resulted in temperatures ranging from 121F to 127F. This failure was detrimental to the health	D 113		

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D 113	Continued From page 8 and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/25/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 09, 2023.	D 113		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure there was a therapeutic/modified diet menu in the kitchen for food service staff to use as guidance for 2 of 4 sampled residents (#6) who had a physician's order for a mechanical soft diet which resulted in Resident #6 being served large pieces of chicken and choking while eating.	D 296		

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D 296	Continued From page 9 The findings are: Review of the lunch menu on 07/26/23 at 12:00pm revealed the menu was residents' choice. Observation of the lunch meal on 07/26/23 between 12:00pm and 12:30pm revealed the meal served was fried chicken, mashed potatoes, large butter beans, cornbread, and ice cream. Observation of the kitchen on 07/26/23 between 12:00pm and 12:30pm revealed there was no menu for the foodservice staff to follow for guidance for residents receiving a therapeutic and modified diet. 1. Review of Resident #6's FL-2 dated 05/31/23 revealed: -The diagnoses included hypothyroidism, dyslipidemia, type 2 diabetes, hypertensive heart disease with heart failure, and anxiety disorder. -The diet order was mechanical soft, no added salt and no concentrated sweets. (Mechanical soft diet is used for people who have problems chewing or difficulty swallowing). Observation of Resident #6's lunch meal on 07/26/23 between 12:00 and 12:30pm revealed: -He stated to a surveyor he was blind. -He was served fried chicken in large pieces with the bone removed, mashed potatoes, large butter beans, cornbread, and ice cream. -While he was eating the chicken, he started coughing. -A personal care aide (PCA) approached the resident and encouraged him to drink water. -The resident informed the staff he was "choking", he sipped the water and returned to eating.	D 296

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

The Administrator reviewed with the PCP, RCD and the Dietary Manager the difference in therapeutic diet guidance and what was communicated from the PCP to the RCD and Dietary Manager. The PCP had communicated to the RCD that "chopped / cut pieces of meat" was okay to serve with a mechanical soft order. However, the menus utilized by WBAL do not have a "chopped / cut pieces of meat" option. Therefore, the Administrator immediately in-serviced the RCD, Dietary Manager and all dietary cooks on the proper definition of mechanical soft and how to follow the menu guidance instead of the verbal representations from PCP/RCD. Dietary staff immediately began preparing all food according to the technical definition of therapeutic diets by following the menu/recipe guidelines.

As a result of the discussions regarding inconsistencies in terminology, definitions, and menus, the PCP order a swallow study for residents with a therapeutic diet to ensure the residents' diet orders were correct and updated.

Additional training and instruction were provided by the training personnel employed by the contracted food vendor.

The steps were completed on or prior to August 25, 2023.

Additional note of interest – Resident #6's new swallow study resulted in a normal diet order.

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D 296	Continued From page 10 -After an attempt to eat more of the chicken, the resident started to cough again. -The PCA told the resident to drink more water. -The resident told the staff he was "choking", and the food was stuck in his throat, while pointing to his throat. -The fried chicken was not prepared according to mechanical soft diet guidelines. Interview with Resident #6 on 07/26/23 at 3:28pm revealed: -He coughed sometimes when he was eating but if he drank water, the coughing would stop. -He coughed and started choking once or twice per month during meals. -He did not know if his food was supposed to be cut up. Attempted interview with the cook on 07/25/23 at 10:00am and 07/26/23 at 12:30pm was unsuccessful. Attempted interview with the PCP on 07/26/23 at 12:44pm was unsuccessful. Refer to interview with the Dietary Manager on 07/25/23 at 9:56 am. Refer to second interview with the Dietary Manager on 07/26/23 at 12:24pm. Refer to interview with the Office Manager on 07/25/23 at 10:24am. Refer to interview with the Resident Care Coordinator (RCC) on 07/26/23 at 10:24am. Refer to second interview with the RCC on 07/26/23 at 2:30pm.	D 296		

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D 296	Continued From page 11 Refer to interview with the Administrator on 07/26/23 at 2:54pm. 2. Review of Resident #5's FL-2 dated 04/03/23 revealed: -The diagnoses included dementia, diabetes, anemia, cirrhosis of the liver and alcohol encephalopathy. -There was no diet order listed. Review of Resident #5's signed diet order dated 04/03/23 revealed mechanical soft, no added salt and no concentrated sweets. Observation of Resident #5's lunch meal on 07/26/23 between 12:00pm and 12:30pm revealed: -She was served fried chicken in large pieces with the bone removed, mash potatoes, large butter beans, cornbread, and ice cream. -The fried chicken was not prepared according to mechanical soft diet guidelines. Attempted interview with the cook on 07/25/23 at 10:00am and 07/26/23 at 12:30pm was unsuccessful. Attempted interview with the PCP on 07/26/23 at 12:44pm was unsuccessful. Refer to interview with the Dietary Manager on 07/25/23 at 9:56 am. Refer to second interview with the Dietary Manager on 07/26/23 at 12:24pm. Refer to interview with the Office Manager on 07/25/23 at 10:24am. Refer to interview with the RCC on 07/26/23 at	D 296		

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D 296	Continued From page 12 10:24am. Refer to second interview with the RCC on 07/26/23 at 2:30pm. Refer to interview with the Administrator on 07/26/23 at 2:54pm. --- Interview with the Dietary Manager on 07/25/23 at 9:56am revealed: -She had menus for a regular/no added salt diet. -She had never completed any trainings on how to prepare therapeutic and modified diets. -She was not aware she needed therapeutic and modified diet menus signed by a Registered Dietitian (RD). Second interview with the Dietary Manager on 07/26/23 at 12:24pm revealed: -She was trained by the previous dietary manager, to pull meat apart from the bone when serving a mechanical soft diet. -She did not think the fried chicken was served according to the guidelines for a mechanical soft diet because it was in large pieces. -She did not cook today but realized the fried chicken was not served as mechanical soft for residents with the diet order. -She attempted to pull the meat apart from the bone for the residents on a mechanical soft diet. -The beans and the meat should have been grounded for a mechanical soft diet. Interview with the Office Manager on 07/25/23 at 10:24am revealed: -She was responsible for ordering the menus in the facility from the contracted foodservice company. -She informed the contracted foodservice	D 296		

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D 296	Continued From page 13 company the facility had residents with mechanical soft diet orders (not sure of exact date). -She was not aware the facility needed the modified diet menus. Interview with the RCC on 07/26/23 at 10:24am revealed: -She thought there was a book in the kitchen that directed the food service staff on how to prepare modified diets. -The Office Manager was responsible for ordering the menus for the facility. Second interview with the RCC on 07/26/23 at 2:30pm revealed: -She thought residents who received a mechanical soft diet were to have their meats cut up into bite size pieces. -She had not been trained regarding therapeutic and modified diets. Interview with the Administrator on 07/26/23 at 2:54pm revealed: -The meat served to a resident receiving a mechanical soft diet should not be pulled apart from the bone. -A resident receiving a mechanical soft diet should have their foods blended or grounded. -He spoke with a representative from the contracted foodservice company, and they provided therapeutic and modified menus for the facility. -The contracted foodservice company planned to train the kitchen staff on the new menus (not sure of the exact date). The facility failed to provide foodservice staff therapeutic diet menus to use for guidance to	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL009025	A. BUILDING: _____ B. WING _____	R 07/26/2023

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D 296	Continued From page 14 prepare meals for the residents with physician ordered therapeutic diets. Staff served Resident #6 large pieces of chicken, who had an order for a soft mechanical diet, which resulted in the resident to cough and choke twice during the lunch meal. This failure placed the resident 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-34 on 07/27/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 25, 2023.	D 296		
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 observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 3 (#4) residents observed during the medication pass, including a medication used to treat acid reflux, and a medication used to treat asthma and chronic	D 358	D 358 10A NCAC 13F .1004(a) Medication Administration The RCD conducted training with Med Techs emphasizing attention to detail, written orders, MAR instructions to ensure medications are administered according to the written orders. Additionally, the RCD shadowed the Med Techs periodically to supervise and identify potential non-compliant medication administration issues. Additionally, the RCD will conduct periodic med cart audits, MAR reviews and informal trainings with Med Techs to ensure compliance with medication administration written orders. The steps will be completed on or before September 9,2023.	

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D 358	Continued From page 15 obstructive pulmonary disease. The findings are: The medication error rate was 6% as evidenced by 2 errors out of 29 opportunities during the 9:00am medication pass on 07/26/23. Review of Resident #4's current FL-2 dated 05/24/23 revealed diagnoses included shortness of breath, atrial fibrillation, breast cancer, chronic heart failure, chronic obstructive pulmonary disease, hypertension, irritable bowel syndrome and asthma. a. Review of Resident #4's current FL-2 dated 05/24/23 revealed there was an order for Pantoprazole 40mg, 1 tablet to be administered daily before breakfast. (Pantoprazole is a medication used to treat acid reflux). Observation of Resident #4's 9:00am medication pass on 07/26/23 revealed: -The bubble card had a label on it with the instruction to administer Pantoprazole 40mg, 1 tablet daily before breakfast. -Pantoprazole 40mg, 1 tablet was administered at 8:50am on 07/26/23. Observation of Resident #4 on 07/26/23 revealed she was walking down the hall to her room from the the dining room on at 8:40am. Review of Resident #4's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg, 1 tablet every morning before breakfast to be administered at 7:30am. -There was documentation Pantoprazole 40mg, 1	D 358		

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D 358	Continued From page 16	D 358		

tablet was administered at the 8:50am on 07/26/23.

Interview with Resident #4 on 07/26/23 at 8:50am revealed she ate breakfast "around" 8:00am this morning.

Interview with the medication aide (MA) on 07/26/23 at 11:00am revealed:
-She administered Resident #4's medications after the resident returned from breakfast.
-She knew the Pantoprazole was to be administered before breakfast.
-The Pantoprazole should have been administered by the previous shift because it was scheduled for 7:30am.
-The Pantoprazole popped up on the eMAR system because it had not been administered on the previous shift.

Refer to interview with the Resident Care Coordinator (RCC) on at 07/26/23 11:45am.

Refer to interview with the Administrator on 07/26/23 at 11:55am.

b. Review of Resident #4's current FL-2 dated 05/24/23 revealed there was an order for Breo Ellipta INH 100-25, inhale 1 puff via inhaler every day, rinse mouth, to be administered at 7:30am. (Breo Ellipta is an inhaled medication used to treat asthma and chronic obstructive pulmonary disease).

Observation of Resident #4's 9:00am medication pass on 07/26/23 revealed:
-The medication had a label on it with the instruction to administer Breo Ellipta INH 100-23, inhale 1 puff daily, rinse mouth.
-The Breo Ellipta INH 100-23 was administered at

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D 358	Continued From page 17 8:52am on 07/26/23. -The resident was not instructed to rinse her mouth after the administration of the medication as ordered. Review of Resident #4's July 2023 eMAR revealed: -There was an entry for Breo Ellipta INH 100-25, inhale 1 puff every day, rinse mouth, to be administered at 7:30am. -There was documentation Breo Ellipta INH 100-25, inhale 1 puff was administered at 8:52am on 07/26/23. Interview with the MA on 07/26/23 at 11:00am revealed: -She was aware the resident's mouth should be rinsed after the administration of Breo Ellipta INH 100-23 to prevent an infection in the mouth. -She forgot to instruct the resident to rinse her mouth after the administration of the medication. Interview with the RCC on 07/26/23 at 11:45am revealed: - Resident #4's medications should be administered as ordered. -The MA would receive additional training on the administration of the Breo Ellipta medication Interview with the Administrator on 07/26/23 at 11:55am revealed he expected Resident #4's medications to be administered according to the physician order.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those	D 378		

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D 378	Continued From page 18 requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record review, and interviews the facility failed to ensure medications were secure as evidenced by a medication left on top of the medication cart and the key left in the controlled substance drawer when not under the direct physical supervision of a medication aide observed during the 9:00am medication pass on 07/26/23, including a medication used to treat eye pressure and a drawer with controlled substances. The findings are: Review of the facility's license revealed: -The facility was licensed for a capacity of 60 residents. -The facility consisted of an assisted living unit ALU) and a special care unit (SCU). Observation of the facility on 07/25/23 at 9:00am revealed: -The facility census was 57. -The ALU had a census of 34 residents. -The SCU had a census of 23 residents. Observation of the 9:00am medication pass on 07/26/23 in the assisted living unit revealed: -The medication cart was positioned outside the resident's room with the front of the cart facing the resident's door, about a foot from the front of the resident's door. -The surveyor and the medication aide (MA) went	D 378	D 378 10A NCAC 13F .1006(b) Medication Storage The RCD conducted training with all Med Techs to emphasize the importance of not leaving any medications on the top of the cart or any other unsecured location. Additionally, training also stressed the importance of never leaving the keys in the control substance drawer. The RCD and Administrator periodically shadow Med Techs during medication administration passes to observe compliance with medication storage protocols and requirements. The steps will be completed on or before September 9, 2023.	

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D 378	Continued From page 19 into the residents room at 9:10am to apply a topical cream and the MA closed the door of the room to provide privacy, leaving a bottle of Brimo/Timolol Sol 2%/0.5% eye drops in an amber color closed bottle on top of the medication cart unsupervised. -The controlled substance drawer was observed to have the key left in the lock and not under direct supervision of the MA because she was in the resident's room behind a closed door. -There was a resident standing about three feet from the medication cart. Interview with the MA on 07/26/23 at 11:00am revealed -She knew medications should be securely stored and locked in the medication cart and keys not left in the lock when unattended for the safety of residents and others. -She was a little nervous and forgot to put the eye drops back in the medication cart after the administration of the medication and to safeguard the keys. Interview with the Resident Care Coordinator (RCC) on 07/26/23 at 11:45am revealed: -Medications should be locked in the medication cart when unattended by the MA for the safety of residents. -The MA would receive additional training regarding the storage of medications. Interview with the Administrator on 07/26/23 at 11:55am revealed he expected all medications to be securely stored when not under direct supervision of the MA for the safety of residents.	D 378		
D 392	10A NCAC 13F .1008 (a) Controlled Substances	D 392		

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D 392	Continued From page 20 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the documentation of a controlled substance on the controlled drug record for 1 of 5 (#2) sampled residents, including a medication used for agitation and anxiety. The findings are: Review of Resident #2's current FL-2 dated 06/07/23 revealed diagnoses included dementia/Alzheimer's Disease, hypertension, psychosis and anxiety. Review of Resident #2's current FL-2 dated 06/07/23 revealed an order for ABH Gel, apply 1ml topically three times a day as needed for agitation if refused the oral Ativan. (ABH gel is a combination consisting of Ativan, Benadryl, and Haldol). (Ativan is a medication used for agitation and anxiety, Benadryl is a medication used for allergy relief, and Haldol is a medication used to treat mental illnesses/mood disorder). Observation of Resident #2's medications on hand 07/25/26 at 2:15 pm revealed there were 23 ABH Gel syringes in the control drawer where control substances were stored under a second lock.	D 392	D 392 10A NCAC 13F .1008(a) Controlled Substances The Administrator will train the RCD and MCD on proper procedures for documentation, review and reconciliation of Medication Administration Records (MAR) including documentation for controlled substances. The RCD and MCD will be responsible for periodically reviewing the MAR and Control Sheets to ensure the Control Sheet count equals the actual number of meds available and that the number of meds signed off on the MAR equal the number of meds signed off on the Control Sheets. Additionally, the Control Sheets will be reconciled at the time they are completed (all meds are dispensed). These procedures will be completed on or before September 9, 2023.	

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D 392	Continued From page 21 Review of Resident #2's June 2023 control log on 07/25/23 revealed: -There was documentation ABH Gel was administered on 06/05/23, 06/08/23, 06/11/23 and 06/22/23. -There was documentation 26 syringes of ABH Gel was left in the medication cart out of a quantity of 30 ABH Gel syringes dispensed on 05/24/23. Review of Resident #2's July control log on 07/25/23 revealed: -There was no documentation ABH Gel was administered from from 07/01/23 through 07/25/13. -There was documenting that 24 ABH Gel syringes should be in the controlled substance compartment of the medication cart. Review of Resident #2's June 2023 eMAR revealed: -There was an entry for ABH Gel, apply 1ml topically three times a day as needed for agitation if refused the oral Ativan. -There was documentation ABH Gel was applied topically on 06/05/23 at 1:20pm, 06/08/23 at 10:32am, and 06/22/23 at 5:16pm. Review of Resident #2's July 2023 eMAR revealed: -There was an entry for ABH Gel, apply 1ml topically three times a day as needed for agitation if refused the oral Ativan. -There was documentation ABH Gel, 1ml was applied topically on 07/21/23 at 6:02pm. Telephone interview with the facility's contracted pharmacist on 07/26/23 at 12:01pm revealed: -ABH Gel was dispensed on 05/24/23 for a quantity 30 syringes.	D 392		

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D 392	Continued From page 22 -There were no ABH Gel syringes dispensed in June 2023. -ABH Gel was dispensed on 07/11/23 for a quantity of 30 syringes. Interview with the special care unit (SCU) coordinator on 07/25/23 at 2:19pm revealed: -Today (07/25/23) was her second day as the SCU coordinator. -She was the medication aide working on the medication cart today in the SCU. -She had previously worked as a MA on the assisted living unit (ALU). -She did not know why the control log documented 24 ABH Gel syringes should be in the medication cart, and only 23 ABH Gel syringes were observed to be in the medication cart. -She usually reconciled the control medications with the outgoing and incoming MA's, but forgot to do so this morning. -She was taught to do a shift to shift reconciliation of the control medications whether scheduled or as needed. Interview with a second MA on 07/25/23 at 2:19pm revealed: -She was taught by the previous SCU coordinator that a shift to shift reconciliation of the control medication was not necessary if the medication was ordered as needed. -She did not do a reconciliation of control medications if they were ordered as needed. Interview with a third MA on 07/26/23 at 3:30pm revealed: -She was the MA working on the SCU on 07/21/23. -She administered Resident #2's ABH GEL due to agitation on 7/21/23.	D 392		

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D 392	Continued From page 23	D 392		

-She documented the administration of the medication on the eMAR but forgot to document on the control log that she administered the medication.
-There were 23 ABH Gel syringes left in the medication cart after she administered the ABH Gel to Resident #2 on 07/21/23.
-She did not do a reconciliation of the ABH GEL at the end of her shift on 07/21/23 because she thought she did not have to because the medication was as needed.

Interview with the Resident Care Coordinator (RCC) on 07/25/23 at 2:30pm revealed:
-Scheduled and as needed controlled medications were to be reconciled at the end of each shift and documented on the control log.
-She would conduct training today 07/25/23 to the MA's regarding documenting scheduled and as needed controlled medications on the control log.
-She was responsible for conducting medication cart audits weekly.
-There was no discrepancy observed on the control log during the audit because the audit was conducted on 07/21/23 before the administration of the ABH Gel to Resident #2 that evening.
-She returned 26 of the 30 ABH Gel syringes dispensed on 05/24/23 for Resident #2 back to the pharmacist on 07/21/23 because the color of the gel became discolored.
-There were 30 ABH syringes for Resident #2 dispensed on 07/11/23.
-She removed 6 of the ABH Gel syringes and placed them in a locked safe in her office for a back-up supply.
-There were 24 ABH Gel syringes remaining in the medication cart with 24 ABH Gel syringes documented on the controlled drug record dispensed 07/11/23.
-The MA administered the ABH Gel to Resident

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D 392	Continued From page 24 #2 on 07/21/23, so the 23 ABH Gel syringes remaining in the medication cart was the correct count. Observation of Drugs Returned to the Pharmacy log dated 07/21/23 revealed: -ABH GEL 2/25/2mg, 26 syringes dispensed on 05/24/23, were returned to the facility's contracted pharmacy for Resident #2 on 07/21/23. -The log was signed by the pharmacist and a witness on 07/21/23. Observation of a safe with a keyed lock in the RCC's office on 07/26/23 at 3:30 pm revealed there were 6 ABH Gel syringes under the supervision of the RCC with a control log documenting 6 syringes, dispensed 07/11/23. Interview with the Administrator on 07/26/23 at 3:50pm revealed: -All scheduled and as needed controlled medications were to be reconciled at the end of each shift and documented. -Medication aides received additional training on ensuring controlled medications were documented on the controlled log on yesterday (07/25/23).	D 392		