STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001184	A. BUILDING: _____ B. WING _____	R 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIA 1 FAMILY CARE HOME	206 FRIENDLY ROAD BURLINGTON, NC 27217

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on August 30, 2023 to August 31, 2023.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents (#2 and #3) had completed tuberculosis (TB) testing upon admission in compliance with the control measures for the Commission for Health Services. The findings are: 1.Review of Resident #2's FL-2 dated 08/09/23 revealed: -Diagnoses included hypertension, prediabetes, coronary artery disease (CAD), left ventricular hypertrophy, mild dementia, and cerebral infarction. -The admission date was not documented. Review of Resident #2's Resident Register on	C 202		

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C 202	Continued From page 1 08/30/23 revealed there was no admission date for the resident documented and no dated signature. Review of Resident #2's record on 08/30/23 revealed there was no tuberculosis (TB) skin testing available for review. Interview with Resident #2 on 08/31/23 at 11:04am revealed he did not recall a TB test being administered in the past few weeks or since he was admitted to the facility. Telephone interview with a certified medical aide (CMA) at the facility's contracted primary care provider's (PCP) office on 08/31/23 at 11:20am revealed Resident #2 had not been seen by the PCP yet. Interview with the Medication Aide (MA) on 08/30/23 at 9:01am revealed Resident #2 had been admitted to the facility about a week ago. Interview with the Administrator on 08/31/23 at 9:22am revealed: -When Resident #2 was admitted he had been told the resident already had a TB test done. -He had not checked the information provided by when the resident was admitted. -He was responsible for ensuring the TB test were complete. 2. Review of Resident #3's FL-2 dated 08/17/23 revealed: -Diagnoses included chronic kidney disease, hypertension, dementia, and gastroesophageal reflux disease (GERD) -The admission date was not documented. Review of Resident #3's Resident Register on	C 202		

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C 202	Continued From page 2 08/30/23 revealed there was no admission date for the resident documented and no dated signature. Review of Resident #3's record on 08/30/23 revealed there was no tuberculosis (TB) skin testing available for review. Interview with Resident #3 on 08/31/23 at 11:04am revealed: -She had a TB test administered about a week ago at the primary care provider's (PCP) office. -The PCP had drawn blood for the test. -She did not know what the results were. Telephone interview with a certified medical aide (CMA) at the facility's contracted primary care provider's (PCP) office on 08/31/23 at 11:20am revealed: -Resident #3 had blood drawn for a TB Gold Plus test on 08/18/23 but the sample was contaminated and had to be discarded. -Resident #3 had not had another TB test done. Interview with the Medication Aide (MA) on 08/30/23 at 9:01am revealed Resident #3 had been admitted to the facility about a week ago. Interview with the Administrator on 08/31/23 at 9:22am revealed: -When Resident #3 was admitted he had been told the resident already had a TB test done. -He had not checked the information provided by when the resident was admitted. -He was responsible for ensuring the TB test were complete.	C 202		
C 212	10A NCAC 13G .0703 (a) Resident Register	C 212		

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C 212	Continued From page 3 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure a Resident Register was completed and signed within 72 hours of the resident's admission to the home for 3 of 3 sampled residents (#1, #2 and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 02/06/23 revealed diagnosis included diabetes mellitus two, hypothyroidism, hypertension, congestive heart failure, bipolar and chronic pain. Review of Resident #1's Resident Register on 08/30/23 at 9:02am revealed there was no admission date documented and the signature page was missing. Interview with Resident #1 on 08/30/23 at 10:39am revealed he was admitted to the facility about a year ago and did not recall all the papers he signed.	C 212		

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C 212	Continued From page 4 Interview with a medication aide (MA) on 08/31/23 at 11:37am revealed: -She had nothing to do with the Resident Registers; the Administrator did them. -Resident #1 had been at the facility less than a year. Refer to interview with the Administrator 08/30/23 at 11:44am. 2. Review of Resident #2's FL-2 dated 08/09/23 revealed diagnoses included hypertension, coronary artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia. Review of Resident #2's Resident Register on 08/30/23 at 1030am revealed there was no admission date documented, it was signed but not dated. Interview with Resident #2 on 09/31/23 at 11:04am revealed: -He had been admitted to the facility from a hotel. -He did not recall completing paperwork when he was admitted. -He thought he had been admitted to the facility a couple of weeks ago. Interview with a medication aide (MA) on 08/31/23 at 11:37am revealed: -She had nothing to do with the Resident Registers; the Administrator did them. -She thought Resident #2 was admitted to the facility about one week ago. Refer to interview with the Administrator 08/30/23 at 11:44am.	C 212		

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C 212	Continued From page 5 3. Review of Resident #3's current FL-2 dated 08/17/23 revealed diagnoses included dementia, hypertension, chronic kidney disease, and gastroesophageal reflux disease (GERD). Review of Resident #3's Resident Register on 08/30/23 at 2:42pm revealed there was no admission date and no signatures or dates documented on the register. Interview with Resident #3 on 09/31/23 at 11:04am revealed: -She had been admitted to the facility from a hotel with a family member. -She did not know if any paperwork had been completed when she was admitted to the facility. -She did not know how long she had been at the facility. Interview with a medication aide (MA) on 08/31/23 at 11:37am revealed: -She had nothing to do with the Resident Registers; the Administrator did them. -She thought Resident #3 was admitted to the facility about one week ago. Refer to interview with the Administrator 08/30/23 at 11:44am. _____ Interview with the Administrator on 08/30/23 at 11:44am revealed: -He was responsible for keeping up with the resident's records and making sure they were up to date. -He did not know the Resident Registers were not complete. -He had a MA that looked at them, but they missed the signatures and dates as well.	C 212		

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C 270	Continued From page 6	C 270		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a matching therapeutic diet menu to use for guidance when preparing meals for 2 of 3 residents who had physician-ordered diets (#1 and #2) for a no concentrated sweets (NCS) diet (#1), and a low-sodium diet/high fiber diet (#2). The findings are: Observation of the kitchen on 08/30/23 at 8:17am revealed: -There was a weekly menu with regular diets posted on the wall. -There were no therapeutic diet menus available for staff to reference when preparing meals. 1. Review of Resident #1's current FL-2 dated 02/06/23 revealed: -Diagnosis included diabetes mellitus two. -There was an order for a no concentrated sweets (NCS) diet. Interview with Resident #1 on 08/30/23 at 10:39am revealed:	C 270		

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C 270	Continued From page 7 -He was a sever diabetic and took several medications for his diabetes. -He did not think he was ordered any kind of diabetic diet and he was not served an NCS diet. Interview with a Medication Aide (MA) on 08/30/23 at 8:33am revealed Resident #1 was diabetic and could not eat anything with sugar. Interview with a second MA on 08/30/23 at 2:34pm revealed: -Resident #1 was on a low sugar diet because he had high [blood] sugar. -She served him what was on the regular menu and she didn't put sugar in his food. Refer to interview with a Medication Aide (MA) on 08/30/23 at 8:33am. Refer to interview with a second MA on 08/30/23 at 2:34pm. Attempted interview with Resident #1's primary care provider (PCP) on 08/31/23 at 10:25am was unsuccessful. 2. Review of Resident #2's FL-2 dated 08/09/23 revealed: -Diagnoses included hypertension, coronary artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia. -There was an order for a low fat-high fiber diet. Interview with Resident #2 on 09/31/23 at 11:04am revealed he did not think the physician had ordered him a therapeutic diet. Telephone interview with Resident #2's a representative from the primary care provider	C 270		

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C 270	Continued From page 8 (PCP) office on 08/31/23 at 11:20am revealed: -Resident #2 had not been seen by the PCP because he was newly admitted to the facility. -If Resident #2 had an order for a high fiber-low fat diet the facility was expected to follow the order until it was changed by the PCP. Refer to interview with a Medication Aide (MA) on 08/30/23 at 8:33am. Refer to interview with a second MA on 08/30/23 at 2:34pm. Refer to the interview with the Administrator on 08/31/23 at 9:41am. _____ Interview with a Medication Aide (MA) on 08/30/23 at 8:33am revealed: -She followed the weekly menu posted on the wall. -The regular weekly menu was the only menu she had seen. Interview with a second MA on 08/30/23 at 2:34pm revealed: -She did not have therapeutic menus to follow because none of the residents had a therapeutic diet order that required a special menu. -She used the regular menu when she prepared the resident's meals. Interview with the Administrator on 08/31/23 at 9:41am revealed: -Resident #1 was ordered an NCS diet; none of the other residents were ordered a therapeutic diet. -The therapeutic diet menu should have been in the kitchen for the staff to reference but it was in the office and not in the kitchen. -He had not monitored the meal service in about	C 270		

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C 270	Continued From page 9 three months, so he was not aware the staff did not have therapeutic diet menu in the kitchen and were not using it for the diets. -He was not aware Resident #2 had an order for a low fat-high fiber diet. -Resident #2 was a new admission and he had not had a chance to completely review the FI-2. -The MAs should have reviewed Resident #2's FL-d and realized he ad a therapeutic diet order. -The facility did not have a low fat-high fiber therapeutic menu and would have to consult with Resident #2's PCP.	C 270		
C 283	10A NCAC 13G .0904 (e)(3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Therapeutic Diets in Family Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure a listing of residents with physician-ordered therapeutic diets was available for the guidance of the facility staff for 1 of 2 sampled residents with an order for a low fat-high fiber diet (#2). The findings are: Review of Resident #2's FL-2 dated 08/09/23 revealed: -Diagnoses included hypertension, coronary	C 283		

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C 283	Continued From page 10	C 283		

artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia.
-There was an order for a low fat-high fiber diet.

Observation of the kitchen on 08/30/23 at 8:17am revealed:
-There was a diet list posted on the wall in the kitchen.
-The diet list was not dated.
-The list included five residents; only two of the residents currently resided in the facility.
-Only one resident on the list was ordered a therapeutic diet; the other residents were listed as regular diets.
-Resident #2 was not on the list.

Interview with a Medication Aide (MA) on 08/31/23 at 11:37am revealed:
-The Administrator posted the diet list for the residents.
-She had net been told to update the list.
-She referenced the list every day for changes.
-She did not know Resident #2 had an order for a low fat-high fiber diet.

Interview with the Administrator on 08/31/23 at 9:22am revealed:
-The MAs were supposed to post the diet list; they were supposed to reference the resident's records.
-He should have checked the list after Resident #2 was admitted but in had not done it.
-The last time he checked the list was a couple of months ago.
-He was not aware of Resident #2's diet order for a low fat-high fiber diet.

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C 330	Continued From page 11	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 2 of 3 sampled residents (#1, and #3) including a fast short-acting insulin and a diabetic medication used to control blood sugars (#1); and a medication for hemorrhoids (#3). The findings: 1. Review of Resident #1's current FL-2 dated 02/06/23 revealed diagnosis included diabetes mellitus two. a. Review of Resident #1's current FL-2 dated 02/06/23 revealed an order for Humalog (used to treat diabetes) three times daily per sliding scale (SS). Review of Resident #1's physician's order dated 01/16/23 revealed there was an order for Humalog 100unit/ml with food per sliding scale if finger stick blood sugar (FSBS) was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units.	C 330		

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C 330	Continued From page 12	C 330		

Review of Resident #1's signed physician's order dated 08/18/23 revealed:
-There was an order for Humalog per sliding scale.
-There were no other instructions.

Review of Resident #1's after visit physician's summary dated 08/18/23 revealed there was an order for Humalog 100unit/ml with food per sliding scale if FSBS was 150-200= 4 units, 201-250=8 units, 251-300=10 units, 301-350=12 units, 351-400 14 units.

Review of Resident #1's August 2023 medication administration record (MAR) revealed:
-There was an entry for Humalog 100unit/ml per sliding scale if finger stick blood sugar (FSBS) was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units scheduled at 8:00am, 12:00pm and 5:00pm.
-There was documentation the Humalog was administered three times daily; there were no amounts of Humalog administered documented on the MAR.
-There was an entry to check FSBS three times daily before meals scheduled at 7:00am, 12:00pm and 5:00pm.
-There was documentation Resident #1's FSBS were checked three times daily before meals from 08/01/23 to 08/30/23 but there were no FSBS results documented.
-There was no documentation of the 08/18/23 order change for the sliding scale.

Review of Resident #1's August 2023 FSBS log revealed:
-The FSBS log had Resident #1's name and Humalog hand written across the top of the page.
-There were five weekly blocks on the August 2023 FSBS log; each block had the day of the

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C 330	Continued From page 13 week from Monday to Sunday and a documented date across in a row. -Each row had a block for the FSBS result, the units of Humalog administered, the time of the day and initials three times daily. -The first block was dated from 07/31/23 to 08/05/23. -There was a sliding scale hand written on the margin of the log beside the first block. -The sliding scale was not dated but was if finger stick blood sugar (FSBS) was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units. -The second block was dated from 08/07/23 to 08/13/23. -The third block was dated from 08/14/23 to 08/20/23. -There was a second undated sliding scale hand written on the margin beside the third block of the FSBS log; 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -There was a fourth block dated from 08/21/23 to 08/26/23; the last FSBS documented was on 08/26/23 at 7:00am -There was no documentation for Sunday, 08/27/23. -There was a fifth block with only one date and one entry; the date was 08/31/23 at 12:00pm. -On 08/03/23, Resident #1's FSBS was 217 and 2 units of Humalog were documented as administered; per the sliding scale 4 units should have been administered. -On 08/05/23, Resident #1's FSBS was 350 and 10 units of insulin were documented as administered; per the sliding scale 8 units should have been administered. -On 08/09/23, Resident #1's FSBS was 247 and 6 units of insulin were documented as administered; per the sliding scale 4 units should	C 330		

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C 330	Continued From page 14 have been administered. -On 08/11/23, Resident #1's FSBS was 370 and 8 units of insulin were documented as administered; per the sliding scale 10 units should have been administered. -On 08/20/23, Resident #1's FSBS was 285 and 8 units of insulin were documented as administered; per the sliding scale 10 units should have been administered. -On 08/21/23, Resident #1's FSBS was 137 and 4 units of insulin were documented as administered; per the sliding scale 0 units should have been administered. -On 08/31/23, Resident #1's FSBS was 227 and 10 units of insulin were documented as administered; per the sliding scale 8 units should have been administered. -Resident #1's FSBS results and Humalog were not documented as administered on his FSBS log on 13 opportunities from 08/26/23 at 12:00 to 08/31/23 at 7:00am. -There was no documentation of refusals. Observation of Resident #1's medication on hand on 08/30/23 revealed: -Resident #1 had four Humalog pens; two opened in resealable baggies and two unopened together in a box. -The opened pens were not dated with open dates and were in a clear resealable bag with a dispense date on the label of 08/18/23; the sliding scale on the label was 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -One pen had 180mL available for administration and the second pen had 250mL available. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 08/30/23 at 1:14pm revealed:	C 330		

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C 330	Continued From page 15 -Resident #1 had an order for Humalog three times daily per sliding scale. -Resident #1 had a sliding scale order dated 01/16/23 for 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units scheduled at 8:00am, 12:00pm and 5:00pm. -Resident #1's sliding scale order for his Humalog was changed on 08/18/23 to 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -Resident #1's was dispensed two Humalog injectable pens on 07/10/23 and 08/14/23 each pen had 300 units. -A label with the new sliding scale order was dispensed on 08/18/23. -Humalog was used to control blood glucose in the blood by lowering the amount of glucose in the blood. -If Humalog sliding scale was not administered correctly the resident could experience increase blood glucose or low blood glucose. -Depending on how high or low the FSBS results were, it could cause hypoglycemia or hypoglycemia and could put the resident in the hospital. Interview with Resident #1 on 08/30/23 at 10:39am revealed: -He was diabetic. -He was on a sliding scale for his insulin three times daily. -He did not know what the units for the sliding scale were. -He thought his FSBS checks were done every day, but he could not be sure. -He did not require Humalog very often because his FSBS results were below 200. -He could not recall what his FSBS results were for this morning, but he thought the FSBS check was done; he did not require an injection at	C 330		

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breakfast today, 08/30/23.
-The last time he had was administered Humalog was about a week ago.

Interview with the medication aide (MA) on 08/30/23 at 3:03pm revealed:
-She checked Resident #1's FSBS checks right before he ate his meals.
-She used the sliding scale that was on the package and on the FSBS log to administer him his Humalog.
-She had been off since the morning of 08/26/23 and had noticed there was no documentation of FSBS results and units administered since she last worked.
-She did not notice the FSBS log was not complete until the previous MA had already left the facility.
-She tried to be careful and referenced the log before she dialed the Humalog pen and injected Resident #1.

Interview with the Administrator on 08/31/23 at 1:07pm revealed:
-The MAs documented the FSBS checks were completed by initialing the MAR.
-The MAs were supposed to document FSBS results on the FSBS log after every check.
-If Humalog was administered the number of units administered were documented on the log.
-The sliding scale was on the medication label and on the FSBS log.
-The MAs were supposed to reference the scale to determine the amount of Humalog to inject.
-It was very important to carefully follow the sliding scale and document the correct result and the units administered.
-The MAs should not get the units injected wrong because they could make the resident sick.
-Resident #1 was not compliant with orders and

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C 330	Continued From page 17 ate and drank what he wanted so it was even more important to follow the sliding scale correctly and to document correctly. Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful. Attempted interview with Resident #1's primary care provider (PCP) on 08/31/23 at 10:25am was unsuccessful. b. Review of Resident #1's physician's order dated 05/22/23 revealed an order for dulaglutide (used to treat diabetes) 0.75mg/0.5mL inject once weekly. Review of Resident #1's physician's order dated 08/21/23 revealed an order for dulaglutide 1.5mg/0.5mL injection once weekly Review of Resident #1's medication administration record (MAR) for July 2023 revealed: -There was an entry for dulaglutide 0.75mg/0.5mL inject once weekly scheduled at 8:00am. -There was documentation dulaglutide was administered on 07/05/23, 07/12/23, 07/19/23 and 07/26/23 at 8:00am. Review of Resident #1's August 2023 MAR at 11:53am revealed: -There was an entry for dulaglutide 0.75mg/0.5mL inject once weekly scheduled at 8:00am. -There was documentation dulaglutide 0.75mg/0.5mL was administered on 08/02/23, 08/09/23, and 08/16/23 at 8:00am. -There was a second-hand written entry for dulaglutide 1.5mg inject once weekly scheduled	C 330		

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at 8:00am.
-There was documentation dulaglutide was administered on 08/23/23 at 8:00am.
-There was no documented dulaglutide was administered on 08/30/23 at 8:00am.

Observation of Resident #1's medication on hand on 09/30/23 at 11:03am revealed there were no dulaglutide 0.75mg/0.5mL or dulaglutide 1.5mg/0.5mL available for administration.

Interview with Resident #1 on 08/30/23 at 10:39am revealed:
-He was a diabetic.
-He had an order for dulaglutide once a week on Wednesdays at breakfast.
-He had not been administered his dulaglutide today, 08/30/23.
-He had asked the medication aide (MA) about his dulaglutide injection and she told him there was not any available to administer.
-The MA told him it had been ordered by a [named] MA a few days ago and would be at the facility today, 08/30/23.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 08/30/23 at 1:14pm revealed:
-Resident #1's dulaglutide injection was not on a cycle fill and had to be requested to be refilled by the facility.
-The pharmacy had received a telephone request today, 08/30/23 to refill Resident #1's dulaglutide injection.
-The pharmacy could dispense the dulaglutide to the facility before the end of the day.
-The facility should have called prior to today, 08/30/23 to ensure the dulaglutide pens were available for the 8:00am administration.
-Dulaglutide was not an insulin worked along with

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insulin to lower blood glucose.
-If not administered as ordered the resident could experience increased blood glucose levels.

Interview with the MA on 08/30/23 at 3:03pm revealed:
-She had administered Resident #1 his dulaglutide injection on 08/23/23 and had used the last dosage.
-She had told another MA she had used the last pen so he could reorder it from the pharmacy.
-She did not order medications from the pharmacy.
-She had told the MA again today, 08/30/23 that Resident #1 did not have a dulaglutide pen available for his dosage for today.
-When the dulaglutide came in today, 08/30/23 she would administer it to him.

Interview with the Administrator on 08/31/23 at 1:50pm revealed:
-The dulaglutide injection for Resident #1 should have been in the facility for the scheduled 8:00am administration on 08/30/23.
-The dulaglutide pens should have been ordered by the MA before the last pen was used or right after the last pen was administered.
-There was plenty of time to order the medication from the pharmacy when the last dulaglutide injection was administered on 08/23/23.
-He expected the staff to call the pharmacy and request the medication a couple of days before it was needed.

Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful.

Attempted interview with Resident #1's primary care provider (PCP) on 08/31/23 at 10:25am was unsuccessful.

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C 330	Continued From page 20 2. Review of Resident #3's current FL-2 dated 08/17/23 revealed: -Diagnoses included dementia. -There was an order for perianal hydrocortisone (used to shrink hemorrhoids) 2.5 percent cream apply to the rectal area once daily. Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed: -There was an entry for perianal hydrocortisone 2.5 percent cream apply to the rectal area once daily scheduled at 8:00am. -There was documentation perianal hydrocortisone was administered at 8:00am from 08/19/23 to 08/30/23; a total of twelve days. Observation of Resident #3's medications on hand on 08/30/23 at 3:08pm revealed: -There was a box of perianal hydrocortisone 2.5 percent cream dispensed on 08/18/23. -There was an unopened tube of perianal hydrocortisone 2.5 percent cream inside the box; the foil seal was still intact on the end of the tube. -The unopened tube was available for administration. -The label from the contracted pharmacy included the orders and were on the box of perianal hydrocortisone cream; the orders were to apply to the rectal area once daily. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/31/23 at 10:35am revealed: -Resident #3 had an order for perianal hydrocortisone 2.5 percent cream apply to rectal area once daily. -The pharmacy dispensed a tube of perianal hydrocortisone cream on 08/18/23.	C 330		

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-The perianal hydrocortisone cream was to shrink hemorrhoids while also providing relief for itching.
-An outcome of not administering the perianal hydrocortisone cream as ordered would be discomfort from swollen and itching hemorrhoids.

Interview with Resident #3 on 08/31/23 at 11:14am revealed:
-She had hemorrhoids because they protruded when she had bowel movements.
-She usually applied a cream for her hemorrhoids when she had a bowel movement, but she had not had the cream since she had moved into the facility about a week or two ago.
-She was supposed to apply the cream for her hemorrhoids every day.
-Her hemorrhoids had not bothered her since she had been admitted to the facility.

Telephone interview with a representative from Resident #3's primary care provider's (PCP's) office on 08/31/23 at 11:20am revealed:
-Resident #3 had an order for perianal hydrocortisone 2.5 percent cream apply once daily to the rectal area.
-The PCP had only seen Resident #3 once on 08/17/23 and had not examined the resident at the visit.
-Resident #3 had a prior order for the hydrocortisone cream from another PCP.
-The perianal hydrocortisone cream was for use on Resident #3's hemorrhoids.
-The PCP expected the facility to follow the orders as written.

Interviews with the Medication Aide (MA) on 08/30/23 at 3:03pm and 3:08pm revealed:
-She applied the perianal hydrocortisone cream to Resident #3's arms every day for a rash.
-She had used the hydrocortisone cream on

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C 330	Continued From page 22 Resident #3's arms, she did not know why there was an unopened tube. -She followed the orders on the medication and compared them to the MAR. -She thought the orders were to apply to Resident #3's arms. Interview with the Administrator on 08/31/23 at 1:07pm revealed: -He noticed Resident #3's perianal hydrocortisone cream was unopened when he reviewed the medication on 08/30/23. -He expected the MAs to read the orders on the medication labels and compare them to the orders on the MAR when administering medication. -The PCP had written the order for the perianal hydrocortisone cream for Resident #3 for a reason. -He expected the MAs to administer medications as ordered by the PCP. Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C 341		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure documentation of medications including for 2 of 3 residents (#2 and #3) including an anticonvulsant, a medication to prevent heart failure (#2) and diuretics (#3).

The findings are:

Observation of the facility on 08/30/23 at 8:00am revealed:
-There were three residents seated at the dining room table eating breakfast.
-The medication aide (MA) sat at one end of the table with a stack of medication cards.
-She did not have medication administration records (MAR) at the table.
-She was administering medications to two of the residents one at a time by popping the medication from the cards and pouring them into small opaque cups.
-She put the medication cards back into the medication room.
-She did not document on the MARs for the residents.

1. Review of Resident #2's FL-2 dated 08/09/23 revealed:
-Diagnoses included hypertension, coronary artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia.
-There was an order for gabapentin (used to treat seizures) 300mg one tablet three times daily.
-There was an order for lisinopril (used to prevent heart failure) 40mg one tablet twice daily

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C 341	Continued From page 24 Review of Resident #2's Resident Register on 08/30/23 at 1030am revealed there was no admission date documented, it was signed but not dated. Review of Resident #2's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 at 8:49am revealed: -There was an entry for gabapentin 300mg one tablet scheduled three times daily at 8:00am, 2:00pm and 8:00pm. -There was documentation gabapentin was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation gabapentin was administered at 8:00am on 08/30/23. -There was an entry for lisinopril 40mg one tablet scheduled twice daily at 8:00am, and 8:00pm. -There was documentation lisinopril was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation lisinopril was administered at 8:00am on 08/30/23. Observation of Resident #2's medications on hand on 08/30/23 at 11:14am revealed: -Resident #2's medications were dispensed in a multidose bubble packages. -Each bubble listed the medications, the administration time and the administration date. -The 8:00am medications for 08/30/23 had been punched from the bubble; including the gabapentin and the lisinopril. Refer to interviews with the Medication Aide (MA) on 08/31/23 at 12:03pm. Refer to interview with the Administrator on 08/31/23 at 1:20pm.	C 341		

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C 341	Continued From page 25 Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful. 2. Review of Resident #3's current FL-2 dated 08/17/23 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, and gastroesophageal reflux disease (GERD). -There was an order for chlorthalidone (a diuretic used to treat fluid retention) 25mg once daily. -There was an order for furosemide (a diuretic used to treat fluid retention) 40mg once daily. Review of Resident #3's Resident Register on 08/30/23 at 2:42pm revealed there was no admission date and no signatures or dates documented on the register. Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 at 8:49am revealed: -There was an entry for chlorthalidone 25mg once daily scheduled at 8:00am. -There was documentation chlorthalidone was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation chlorthalidone was administered at 8:00am on 08/30/23. -There was an entry for furosemide 40mg once daily scheduled at 8:00am. -There was documentation furosemide was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation furosemide was administered at 8:00am on 08/30/23. Refer to interviews with the Medication Aide (MA) on 08/31/23 at 12:03pm.	C 341		

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C 341	Continued From page 26 Refer to interview with the Administrator on 08/31/23 at 1:20pm. Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful. _____ Interview with the Medication Aide (MA) on 08/31/23 at 12:03pm revealed: -She documented medication administration on the MAR after administering each resident their medication one at a time. -She had seen where another MA had not document administration of medication for two residents on 08/30/23 at 8:00am. -She called the other MA and asked if she had administered the medications and she said she had so she documented on the MAR; she documented her own initials. -The other MA did not always document administration on the MAR; she sometimes forgot. -She should not have documented on the MAR and should have just left the "holes". Interview with the Administrator on 08/31/23 at 1:20pm revealed: -The MAs were trained to punch one medication from the card at a time and then to document on the MAR. -They were to compare the medication in the card to the MAR prior to punching the card. -They were to watch the resident swallow the medication and then document on the MAR after each administration. -The MA were supposed to have the MAR with them while administering the medications. -One MA should not document for another. -He had not looked at the MAR for the residents in a few weeks; he looked for "holes" in the MAR when he audited the MARs.	C 341		

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C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure an assessment and physician's order was in place for 1 of 3 sampled residents (#3) who self-administered a medication used to support heart health and a rectal laxative suppository. The findings are:	C 350		

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C 350	Continued From page 28 Observation of Resident #3's room on 08/30/23 at 8:43am revealed: -There was an open container of rectal laxative suppositories (used to produce bowel movements in a short time) on a table. -There was a sealed container of rectal laxative suppositories in a basket on the floor. -There was an opened bottle of aspirin (used to support heart health by thinning the blood) in a basket on the floor. Review of Resident #3's current FL-2 dated 08/17/23 revealed: -Diagnoses included dementia, chronic kidney disease and non-rheumatic aortic valve insufficiency. -Resident #3 was intermittently confused. Review of Resident #1's record on 08/30/23 at 10:30am revealed: -Resident #1's Resident Register on 08/30/23 did not have a date documented, it was signed but not dated. -There was no care plan or assessment in the record. -There was no documentation of a physician's order for self-administration of any medications. a. Review of Resident #3's current FL-2 dated 08/17/23 revealed there was an order for aspirin 81mg one tablet once daily. Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed: -There was an entry for aspirin 81mg one tablet once daily scheduled at 8:00am. -There was documentation aspirin was administered at 8:00am from 08/19/23 to 08/30/23; a total of twelve days.	C 350		

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C 350	Continued From page 29 Telephone interview with a representative from Resident #3's primary care provider's (PCP's) office on 08/31/23 at 11:20am revealed: -Resident #3 had an order for aspirin 81mg one tablet once daily; it had been ordered by a cardiologist for her heart. -Aspirin was a blood thinner. -Resident #3 had did not have an order to self-administer aspirin. -Resident #3 had not been evaluated for self-administration of any medications. -If Resident #3 was administered two doses of aspirin verse the one tablet her blood could be too thin and make her more susceptible to bruising and possibly bleeding out from a cut or injury. Interview with Resident #3 on 08/31/23 at 11:14am revealed: -She brought the aspirin with her when she was admitted to the facility. -She took the aspirin for her heart. -He physician had told her to take aspirin for her heart. -She had self-administered the medication once a day since she was at the facility. -She did not know if the facility staff knew she had the aspirin in her room, and she was self-administering it. -Aspirin was not dangerous to take so she did not see a problem with having it in her room. -She knew the staff administered her medications, but she did not know what they were or if they administered her an aspirin. Refer to interview with the Medication Aide (MA) on 08/31/23 at 11:37am. Refer to interview with the Administrator on	C 350		

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C 350	Continued From page 30 08/31/23 at 1:07pm. b. Review of Resident #3's current FL-2 dated 08/17/23 revealed there was not order for rectal laxative suppositories Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed: -There was an entry for polyethylene glycol 17gm once daily scheduled at 8:00am. -There was documentation polyethylene glycol was administered at 8:00am from 08/19/23 to 08/30/23; a total of twelve days. -There was no entry for rectal laxative suppositories on the MAR. Interview with Resident #3 on 08/31/23 at 11:04am revealed: -She brought the suppositories with her when she was admitted to the facility. -She had trouble with hemorrhoids and constipation. -She used the rectal laxatives about once daily. -She did not know if the facility staff knew she had the laxatives in her room, she did not hide them. -She knew the staff administered her medications. -She did not know if she was administered a laxative by the staff. Telephone interview with a representative from Resident #3's primary care provider's (PCP's) office on 08/31/23 at 11:20am revealed: -Resident #3 had an order for polyethylene glycol 17gm once daily for constipation. -Resident #3 did not have an order for rectal laxatives. -Resident #3 had did not have an order to	C 350		

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C 350	Continued From page 31 self-administer any laxatives. -Resident #3 had not been evaluated for self-administration of any medications. -If Resident #3 was administered too much laxative her bowel movements could become too loose and cause dehydration and cause her hemorrhoids to become irritated. Refer to interview with the Medication Aide (MA) on 08/31/23 at 11:37am. Refer to interview with the Administrator on 08/31/23 at 1:07pm. _____ Interview with the Medication Aide (MA) on 08/31/23 at 11:37am revealed: -None of the residents administered their own mediations. -None of the residents kept medications in their rooms. -Residents were not allowed to administer medications themselves or to store any mediations in their rooms. -She looked around the residents' rooms daily for any over the counter (OTC) medications while she cleaned their rooms. -If she found OTC medications, she would notify the Administrator about the medications. -She had never found OTC medications in any of the residents' rooms. -Resident #3 had an order for aspirin once daily; she administered it every morning. -She had not seen any medications in Resident #3's room. Interview with the Administrator on 08/31/23 at 1:07pm revealed: -The facility did not have a policy for self-administration of medications because residents were not allowed to administer their	C 350		

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C 350	Continued From page 32 own medications. -He wanted the MAs to be responsible for administration of all medications; he wanted the facility to have control of all medications. -He expected the staff to look in the residents' rooms everyday and to look for medications and to notify him if they found any. -He was not aware Resident #3 had medications in her room including the aspirin and the suppositories.	C 350		
C 352	10A NCAC 13G .1006 (a) Medication Storage 10a NCAC 13G .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the facility's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 1 of 1 sampled resident (#3) who had aspirin and rectal laxative suppositories in a basket in her room. The findings are:	C 352		

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C 352	Continued From page 33 Observation of Resident #3's room on 08/30/23 at 8:43am revealed: -There was an open container of rectal laxative suppositories (used to produce bowel movements in a short time) on a table. -There was a sealed container of rectal laxative suppositories in a basket on the floor. -There was an opened bottle of aspirin (used to support heart health by thinning the blood) in a basket on the floor. Review of Resident #3's current FL-2 dated 08/17/23 revealed: -Diagnoses included dementia. -Resident #3 was intermittently confused. Refer to interview with Resident #3 on 08/31/23 at 11:04am. Refer to interview with the Medication Aide (MA) on 08/31/23 at 11:37am. Refer to interview with the Administrator on 08/31/23 at 1:07pm. a. Review of Resident #3's current FL-2 dated 08/17/23 revealed there was an order for aspirin 81mg one tablet once daily. Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed: -There was an entry for aspirin 81mg one tablet once daily scheduled at 8:00am. -There was documentation aspirin was administered at 8:00am from 08/19/23 to 08/30/23; a total of twelve days. b. Review of Resident #3's current FL-2 dated	C 352		

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C 352	Continued From page 34 08/17/23 revealed there was not order for rectal laxative suppositories Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed there was no entry for rectal laxative suppositories on the MAR. Refer to interview with Resident #3 on 08/31/23 at 11:04am. Refer to interview with the Medication Aide (MA) on 08/31/23 at 11:37am. Refer to interview with the Administrator on 08/31/23 at 1:07pm. _____ Interview with Resident #3 on 08/31/23 at 11:04am revealed: -She brought the medications with her when she was admitted to the facility. -She thought the staff knew about the medications in her room; she did not try to hide them. -She did not have a lock in her room and no way to lock the medications up. Interview with the Medication Aide (MA) on 08/31/23 at 11:37am revealed: -None of the residents kept medications in their rooms. -Residents were not allowed to store any mediations in their rooms. -She looked around the residents' rooms daily for any medications when she cleaned their rooms. -She had not seen any medications in Resident #3's room. Interview with the Administrator on 08/31/23 at 1:07pm revealed:	C 352		

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C 352	Continued From page 35 -Residents were not allowed to keep medications in their rooms. -He expected the staff to look in the residents' rooms every day for medications and to notify him if they found any. -He was not aware Resident #3 had medications in her room.	C 352		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those 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, interviews, and record reviews, the facility failed to ensure medications for 1 of 3 residents (#1) were stored in a locked container in the refrigerator. The findings are: Observation of the kitchen on 08/30/23 at 11:23am revealed: -There was no door that lead from the resident dining area to the kitchen. -The refrigerator in the kitchen was not locked. -The refrigerator contained various food items for residents and staff. -There was a drawer in the refrigerator that contained injectable medications. -There were three clear resealable bags each with a medication label and an injectable pen; one bag had a used Levemir (used to treat diabetes) pen and two had used Humalog (used to treat	C 353		

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C 353	Continued From page 36 diabetes) pen. -There was a box with one unused Levemir pen. -There was a box with three unused Humalog pens. Interview with the Medication Aide (MA) on 08/30/23 at 11:25am revealed the Levemir and Humalog were always kept in the drawer in the refrigerator and were not secured with a lock. Interview with the Administrator on 08/30/23 at 11:30am revealed: -He was aware medications stored in the refrigerator were supposed to be in secured by a lock. -It was an oversite that the medication was not secured by a lock.	C 353		