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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 09/19/23 through 09/22/23 with a desk review and telephone exit on 09/25/23.	D 000		
D 219	10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 Staffing Chart 10A NCAC 13F .0606 STAFFING CHART The following chart specifies the required aide, supervisory and management staffing for each eight-hour shift in facilities with a capacity or census of 21 or more residents according to Rules .0601, .0603, .0602, .0604 and .0605 of this Subchapter. Bed Count Position Type First Shift Second Shift Third Shift 21 - 30 Aide 16 16 8 Supervisor Not Required Not Required Not Required Administrator/SIC In the building, or within 500 feet and immediately available. 31-40 Aide 16 16 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 41-50 Aide 20 20 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 51-60 Aide 24 24 16 Supervisor 8* 8* In the building, or within 500 feet and immediately available.** Administrator On call 61-70 Aide 28 28 24 Supervisor 8* 8* 4 hours within the	D 219		

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facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48

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Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the

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facility failed to ensure required staffing hours were met on first and second shift based on a census of 27-28 for 11 of 36 sampled shifts from 09/01/23 through 09/04/23, 09/08/23 through 09/11/23, and 09/15/23 through 09/18/23.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/23 revealed they were licensed for a capacity of 30 on the assisted living unit.

Review of the facility census record from 09/01/23 through 09/04/23, 09/08/23 through 09/11/23, and 09/15/23 through 09/18/23 revealed there was a census of 27-28 residents in the Assisted Living (AL) Unit which required 16 staff hours on first and second shifts and required 8 staff hours on third shifts.

Review of the AL unit staff time records from 09/01/23 through 09/04/23, 09/08/23 through 09/11/23, and 09/15/23 through 09/18/23 revealed:
-On 09/01/23, the census was 28 requiring 16 staff hours and there were no staff hours provided leaving a shortage of 16 hours on first shift.
-On 09/01/23, the census was 28 requiring 16 staff hours and a total of 12 hours were provided leaving a shortage of 4 hours on second shift.
-On 09/02/23, the census was 28 requiring 16 staff hours and a total of 9.5 hours were provided leaving a shortage of 6.5 hours on first shift.
-On 09/03/23, the census was 28 requiring 16 staff hours and a total of 12 hours were provided leaving a shortage of 4 hours on second shift.
-On 09/04/23, the census was 27 requiring 16 staff hours and a total of 12 hours were provided leaving a shortage of 4 hours on second shift.

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-On 09/09/23, the census was 27 requiring 16 staff hours and a total of 8.5 hours were provided leaving a shortage of 7.5 hours on first shift.
-On 09/10/23, the census was 28 requiring 16 staff hours and a total of 13 hours were provided leaving a shortage of 3 hours on second shift.
-On 09/11/23, the census was 28 requiring 16 staff hours and a total of 8 hours were provided leaving a shortage of 8 hours on first shift.
-On 09/11/23, the census was 28 requiring 16 staff hours and a total of 8 hours were provided leaving a shortage of 8 hours on second shift.
-On 09/15/23, the census was 28 requiring 16 staff hours and a total of 4 hours were provided leaving a shortage of 12 hours on second shift.
-On 09/16/23, the census was 28 requiring 16 staff hours and a total of 14 hours were provided leaving a shortage of 2 hours on second shift.
-On 09/17/23, the census was 28 requiring 16 staff hours and a total of 8 hours were provided leaving a shortage of 8 hours on second shift.

-Interview with a medication aide(MA) on 09/21/23 at 8:00am revealed:
-The facility was having staffing challenges.
-Staff frequently worked short especially on the weekends.
-The MA had come in to work early and left late because there was no one to pass medications.
-The personal care aide (PCA)s were short also with one PCA on one the SCU and one on the AL side.

Interview with a PCA on 09/22/23 at 11:10am revealed:
-The facility was short staffed about every weekend.
-There was 1 MA and 1 PCA for the SCU and the same for the AL unit.
-Showers did not get done on the weekends

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because "we don't have time".
-It had been that way for a least the past three months.

Interview with a second PCA on 09/22/23 at 1:13pm revealed:
-Staffing was always short on the weekends.
-The MAs were not always able to assist because they had to administer medications and complete other work.
-Showers were not getting done on the weekends.
-Dental care was "sometimes put off although it should not be."
-Often when she came to work on first shift on the weekends, third shift had been unable to complete all their tasks so this put her behind in her work from the start of her shift.
-She found residents soiled and residents not out of bed several times when she worked the weekends on first shift.
-Staff had to focus on the big picture when the facility was short staffed which included feeding assistance, dressing and incontinence care.

Interview with a third PCA on 09/22/23 at 1:06pm revealed:
-Weekend staffing was short.
-She worked every other weekend but managed to get everything done as long as she did not take breaks or eat meals.
-She did not feel comfortable leaving the floor with just the MA working.
-The facility only had one MA and one PCA working during the most recent weekend she worked.

Interview with the Resident Care Coordinator (RCC) on 09/21/23 at 2:55pm revealed:
-Since she was rehired at the facility in the

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D 219	Continued From page 6 beginning of September 2023, she frequently worked as a MA since the facility was short staffed. -She was the MA for the AL side. Telephone interview with the Administrator-in-Training on 09/25/23 at 3:08pm revealed: -She worked as a medication aide (MA) on 09/25/23. -She worked overtime hours every week and many days as an MA administering medications. -She was responsible for scheduling staff. -The facility was short staffed, and she completed the staff schedule to the best of her abilities. -She and the RCC often worked extra hours to fill in the gaps on the staffing schedule. -She hired people to work for the facility and many times they would not show up to work. -The staff timecards indicating whether staff worked on the assisted living unit or the special care unit were not always accurate. -The staffing schedule indicated which staff were assigned to the AL unit but was not always accurate due to staff calling out of work or not showing up. -There was no way to distinguish if staff worked on the assisted living unit or the special care unit on the staff time records.	D 219		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273		

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D 273	Continued From page 7 Based on record reviews and interviews the facility failed to ensure referral and follow-up for 1 of 1 sampled residents who did not receive his medication used to treat severe schizophrenia (Resident #1). The findings are: Review of the facility's policy for Health Care Referral and Follow-up on page 63 of the Policy and Procedure Manual revealed: -Documentation in the residents record will include contacts with the physician/provider, other support licensed service providers, family, responsible parties, guardians, when there are illnesses, incidents, accidents and routine care or follow-up as needed. -Visits to providers or onsite visits by providers including any new orders for medications, treatments or procedures. -Hospital discharges follow-up care, medication reconciliation. -Labs, vitals, and parameters, falls and any other routine or acute health care need of the resident. Review of Resident #1 's current FL2 for dated 04/04/23 included: -Diagnoses of chronic paranoid schizophrenia. -There were medication orders for clozapine (a medication used to treat severe schizophrenia) 100mg tablets three times daily, clozapine 25mg tablet three times daily. Review of Resident #1's physician's order for dated 08/01/23 revealed: -The Primary Care Provider (PCP) had written "may hold clozapine when labs are not completed". -There was no end date on this order.	D 273		

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Review of Resident #1's September 2023 electronic medication administration record (eMAR) dated revealed:
-There was an entry for clozapine 100mg tablets three time daily.
-There was an entry for clozapine 25mg tablet three times daily.
-There was documentation the clozapine 100mg and the clozapine 25 mg three times daily was on hold per a 08/01/23 physicians order.
-There was documentation there was no clozapine 100mg and clozapine 25mg documented as administered 09/02/23-09/13/23.
-There was documentation of administration of Resident #1's clozapine administered at 2:00pm on 09/13/23.

Interview with Resident #1 on 09/19/23 at 10:20am and 09/21/23 at 10:37am revealed:
-He had been without his clozapine for 2 weeks.
-He had been walking the halls at night because he couldn't sleep.
-He could not not sit still, he would sit down on the bed and then get back up and walk more.
-He had trouble being able to sit and eat his meal in the dinning room.
-The laboratory came to the facility every month to draw his blood so he did not know why the facility did not have the clozapine.
-Clozapine was the "only" medicine that had worked for him.
-"I just didn't feel like myself when I was off my clozapine."
-He felt so bad he felt like he had "overdosed" when he was started back on his clozapine.

Interview with the medication aide (MA) on 09/21/23 at 8:00am revealed:
-He was the previous RCC and was responsible

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for ensuring Resident #1 had his labs drawn at the facility by the local laboratory and the lab results were sent to the provider and the order sent to the pharmacy so the pharmacy could send the clozapine to the facility to be available for administration.
-He observed Resident #1 experiencing insomnia and increased anxiety while Resident #1 was off his clozapine.
-He notified the PCP and the mental health provider about Resident #1's clozapine needing a refill but he had no documentation to verify he had notified them.

Interview with a personal care aide (PCA) on 09/21/23 at 10:55am revealed:
-Resident #1 had been off his clozapine for several weeks at the first of September 2023.
-Resident #1 had been like "a tiger in a cage".
-Resident #1 was could not relax and would constantly call his family member every hour.
-Resident #1 was usually calm, friendly and sociable but he had been less social, pacing, and could not sit still, even in the dining room to eat his meal.
-She had to keep bringing him back to the dinning room for him to eat and he would not talk to the other residents like he usually did.
-Resident #1 kept telling her he "just wasn't himself".
-She mentioned it to the MA and the MA told her he was trying to get his clozapine.

Interview with the pharmacist at the facility's contracted pharmacy on 09/21/23 at 11:54am revealed:
-The pharmacy had to have an order 30 days after lab work was completed for clozapine for Resident #1.
-The pharmacy was unable to dispense a

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emergency supply of clozapine.
-Clozapine was a medication that needed to be titrated to minimize side effects such as sedation, orthostatic hypotension and seizures.
-The clozapine 100mg and the clozapine 25 mg three times daily was filled on 09/11/23 and the facility had received it on 09/13/23.
- There was 90 tablets of clozapine 100mg and the clozapine 25 mg dispensed on 09/11/23.

Interview with the Resident Care Coordinator (RCC) on 09/21/23 at 2:55pm revealed:
-She was working as a MA on or about 09/08/23.
-As she was administering medications, realized Resident #1 did not have any clozapine available for administration.
-She called the pharmacy and they informed her they needed Resident #1's labs in order the refill the clozapine.
-She faxed the 08/03/23 lab work to the pharmacy but they could not refill the clozapine as the labs were more than 30 days old.
-She called Resident #1's PCP and obtained a lab results for Resident #1 dated 08/31/23 and faxed it to the pharmacy.
-She received the clozapine for Resident #1 on 09/12/23 and it was administered at 2:00pm on 09/13/23.
-Resident #1 had been without his clozapine 100mg tablets three time daily and his clozapine 25mg tablet three times daily since 09/02/13.
-Resident #1 was experiencing increased anxiety and pacing.
-She did not asked Resident #1 how he was feeling as she had observed him being more anxious and pacing.
-She did not notified the mental health provider that she observed Resident #1 was having increased anxiety or pacing.

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Interview with a PCA on 09/22/23 at 11:10am revealed:
-Resident #1 was without his clozapine and was more anxious and pacing a lot.
-She had told the MA she had worked with about Resident #1 experiencing more anxiety and pacing.
--She had told the previous RCC too and he was already aware when she told him.
-"It was an obvious difference."

Telephone interview with Resident #1's mental health provider for on 09/22/23 at 12:45pm revealed:
-He had not been notified Resident #1 was experiencing increased anxiety, insomnia and being less social as a results of not having his clozapine.
-He was not aware there was a hold order for the clozapine if labs were not completed.
-The labs for Resident #1 had to be completed in order for him order the correct dosage and send the order to the pharmacy to so the pharmacy could dispense the medication.
-He was not aware of Resident #1 did not have his clozapine available for administration form 09/02/23-09/13/23 and would have wanted to know because Resident #1 could have experienced rapid psychosis.
-The symptoms Resident #1 was experiencing was directly related to not having his clozapine 125mg three times daily.
-Starting Resident #1 back at 125mg three times daily would have made Resident #1 feel over sedated and not have "felt well at all".

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/22/23 at 1:15pm revealed:
-She wrote a hold order for the clozapine on

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08/01/23 to allow the facility time to get the clozapine in from the pharmacy.
-Lab draws had been drawn each month at the facility by the local lab as ordered.
-The RCC had notified her on 09/12/22 Resident #1 had been out of his clozapine.
-She observed Resident #1 on 09/12/23 having increased anxiety and stated he was "bouncing off the walls".
-She did not order Resident #1's psychiatric medications and had expected the facility staff to notify the mental health provider about his increased anxiety and get him something else to assist with his increased anxiety while waiting on the clozapine.

Interview with the Administrator-in-Training on 09/21/23 at 3:47pm revealed:
-If a medication was not available the staff should call the PCP and let them know and inform them of any symptoms the resident was experiencing.
-She expected to be notified if a resident did not have a medication available for administration so she could assist in getting the medication.
-The MA was responsible for ensuring Resident #1 had his labs completed, for the labs to be sent to the provider and ensuring the clozapine arrived from the pharmacy.
-The new RCC informed her around 09/11/23 Resident #1 was without his clozapine and the new RCC was getting the clozapine from the pharmacy.
-She observed Resident #1 having increased anxiety and not as social as he usually was.

_____

The facility failed to ensure the mental health provider was notified about the resident experiencing increased anxiety, insomnia and decreased social interaction, placing Resident #1 at risk of experiencing rapid psychosis. This

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D 273	Continued From page 13 failure was detrimental to the health and safety of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/22/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 9, 2023.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review, and interviews, the facility failed to administer medications as ordered for 2 of 6 sampled residents (#1 and #6) related to a medication used to treat severe schizophrenia (#1) and hypothyroidism (#6). The findings are: Review of the facility's policies and procedures for Medication Administration dated September 2021 revealed: -Routine medications should be started with the	D 358		

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next regularly scheduled dose following the pharmacy delivery.
-All medications must be verified for accuracy and labeled prior to placing in medication storage.
-The facility should ensure that residents always have all medications ordered in the facility.
-Staff will weekly audit the medication cart to ensure all medications are available to administer.
-Missed doses of medications are considered a medication error and the Resident Care Coordinator or Executive Director, and resident's prescribing provider will be immediately notified.
-The responsible party of the resident was notified of the medication error.
-An incident report was to be completed and given to the Resident Care Coordinator.
-Missed medications were documented on the resident's medication administration record.

1. Review of Resident #1 's current FL2 dated 04/04/23 included:
-Diagnoses of chronic paranoid schizophrenia.
-There were medication orders for clozapine (a medication used to treat severe schizophrenia) 100mg tablets three times daily, clozapine 25mg tablet three times daily.

Review of Resident #1's physician's order for dated 08/01/23 revealed:
-The Primary Care Provider (PCP) had written "may hold clozapine when labs are not completed".
-There was no end date on this order.

Review of Resident #1's September 2023 electronic medication administration record (eMAR) dated revealed:
-There was an entry for clozapine 100mg tablets three time daily.

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-There was an entry for clozapine 25mg tablet three times daily.
-There was documentation the clozapine 100mg and the clozapine 25 mg three times daily was on hold per a 08/01/23 physicians order.
-There was documentation there was no clozapine 100mg and clozapine 25mg documented as administered 09/02/23-09/13/23.
-There was documentation Resident #1's clozapine started being administered at 2:00pm on 09/13/23.

Interview with Resident #1 on 09/19/23 at 10:20am and 09/21/23 at 10:37am revealed:
-He had been without his clozapine for 2 weeks.
-He had been walking the halls at night because he couldn't sleep.
-He could not not sit still, he would sit down on the bed and then get back up and walk more.
-He had trouble being able to sit and eat his meal in the dinning room.
-The local laboratory came to the facility every month to draw his blood so he did not know why the facility did not have the clozapine.
-Clozapine was the "only" medicine that had worked for him.
-"I just didn't feel like myself when I was off my clozapine."
-He felt so bad he felt like he had "overdosed" when he was started back on his clozapine.

Observation of Resident #1's medications on hand on 09/20/23 at 10:20am revealed:
-There was a bubble pack of clozapine 100mg with a dispense date of 09/12/23 in the quantity of 90 tablets with 66 tablets available for administration.
-There was a bubble pack of clozapine 25mg with a dispense date of 09/12/23 in the quantity of 90 tablets with 66 tablets available for administration.

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D 358	Continued From page 16 Interview with the medication aide (MA) on 09/21/23 at 8:00am revealed: -He was the previous RCC and was responsible for ensuring Resident #1 had his labs drawn at the facility by the local laboratory and the lab results were sent to the provider and the order sent to the pharmacy so the pharmacy could send the clozapine to the facility to be available for administration. -He observed Resident #1 experiencing insomnia and increased anxiety while Resident #1 was off his clozapine. -He notified the PCP and the mental health provider about Resident #1's clozapine needing a refill but he had no documentation to verify he had notified them. Interview with the pharmacist at the facility's contracted pharmacy on 09/21/23 at 11:54am revealed: -The pharmacy had to have an order 30 days after lab work was completed for clozapine for Resident #1. -The pharmacy was unable to dispense a emergency supply of clozapine. -The clozapine 100mg and the clozapine 25 mg three times daily was filled on 09/11/23 and the facility had received it on 09/13/23. - There was 90 tablets of clozapine 100mg and clozapine 25 mg dispensed on 09/11/23. Interview with the Resident Care Coordinator (RCC) on 09/21/23 at 2:55pm revealed: -She was working as a MA on or about 09/08/23. -As she was administering medications, realized Resident #1 did not have any clozapine available for administration. -She called the pharmacy and they informed her they needed Resident #1's labs in order the refill	D 358		

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the clozapine.
-She faxed the 08/03/23 lab results to the pharmacy but they could not refill the clozapine as the labs were more than 30 days old.
-She called Resident #1's PCP and obtained a lab results for Resident #1 dated 08/31/23 and faxed it to the pharmacy.
-She received the clozapine for Resident #1 on 09/12/23 and it was administered at 2:00pm on 09/13/23.
-Resident #1 had been without his clozapine 100mg tablets three time daily and his clozapine 25mg tablet three times daily since 09/02/13.
-There was a "hold order" for the clozapine written in August 2023 when the facility was waiting on the August 2023 clozapine to arrive at the facility from the pharmacy.

Telephone interview with Resident #1's mental health provider for on 09/22/23 at 12:45pm revealed:
-He was not aware there was a hold order for the clozapine if labs were not completed.
-The lab results for Resident #1 had to be completed prior to Resident #1 running out of his medicine so he could order the correct dosage, send the order for the clozapine to the pharmacy in order for the pharmacy to dispense the medication.
-He was not aware Resident #1 did not have his clozapine form 09/02/23-09/13/23 and would have wanted to know because Resident #1 could have experienced rapid psychosis.
-The symptoms Resident #1 was experiencing was directly related to not having his clozapine 125mg three times daily.
-Starting Resident #1 back at 125mg three times daily would have made Resident #1 feel over sedated and not have "felt well at all".

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Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/22/23 at 1:15pm revealed:
-She wrote a hold order for the clozapine on 08/01/23 to allow the facility time to get the clozapine in from the pharmacy.
-Labs had been drawn each month at the facility as ordered.
-The RCC had notified her on 09/12/22 Resident #1 had been out of his clozapine.
-She observed Resident #1 on 09/12/23 having increased anxiety and stated he was "bouncing off the walls".
-She did not order Resident #1's psychiatric medications and had expected the facility staff to notify the mental health provider about his increased anxiety and get him something else to assist with his increased anxiety while waiting on the clozapine.

Interview with the Administrator-in-Training on 09/21/23 at 3:47pm revealed:
-If a medication was not available the staff should call the PCP and let them know and inform them of any symptoms the resident was experiencing.
-She expected to be notified if a resident did not have a medication available for administration so she could assist in getting the medication.
-The MA was responsible for ensuring Resident #1 had his labs completed, for the labs to be sent to the provider and ensuring the clozapine arrived from the pharmacy.
-The MA should have made sure the mental health provider had the lab results prior to Resident #1 running out of his clozapine.
-She expected the MAs to administer medications as ordered and document the administration of medications on the eMARs accurately.

2. Review of Resident #6's current FL2 dated

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D 358	Continued From page 19 05/13/22 revealed diagnoses included hypothyroidism, dementia, and Alzheimer's disease. Review of Resident #6's physician's orders dated 02/13/23 revealed a medication order for levothyroxine (used to treat low thyroid hormone) 75mcg take 1 tablet every morning. Review of Resident #6's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am. -Levothyroxine was documented as administered daily at 6:00am from 04/01/23 through 04/30/23. Review of Resident #6's May 2023 eMAR revealed: -There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am. -Levothyroxine was documented as administered daily at 6:00am from 05/01/23 through 05/31/23. Review of Resident #6's June 2023 eMAR revealed: -There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am. -Levothyroxine was documented as administered daily at 6:00am from 06/01/23 through 06/30/23. Review of Resident #6's July 2023 eMAR revealed: -There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am. -Levothyroxine was documented as administered daily at 6:00am from 07/01/23 through 07/31/23. Review of Resident #6's August 2023 eMAR revealed:	D 358		

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-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 08/01/23 through 08/31/23.

Review of Resident #6's 09/01/23 through 09/20/23 eMAR revealed:
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 09/01/23 through 09/09/23.
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 8:00am.
-Levothyroxine was documented as administered daily at 8:00am from 09/10/23 through 09/20/23.

Interview with Resident #6 on 09/19/23 at 10:35am revealed:
-She took many medications but was not sure what the medications were.
-She did not know if staff administered all her medications to her.

Interview with Resident #6's family member on 09/20/23 at 10:38am revealed:
-Resident #6's medications were dispensed by a mail order pharmacy and delivered to her house.
-She brought the medications dispensed by the pharmacy to the facility.
-The facility was supposed to request medication refills from the pharmacy when the medication had 7 to 10 days left available for administration.
-She suspected the facility was not administering the levothyroxine to Resident #6 as ordered and reported her suspicion to the Administrator on 08/31/23.
-The Administrator and Administrator-in-Training offered to have medication aides (MAs) count all of Resident #6's medications at the end of each shift to make sure the medications were being

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administered.
-She requested to count Resident #6's levothyroxine with the Resident Care Coordinator (RCC) when she delivered the medication to the facility and there were 66 tablets of levothyroxine left in the bottle that was dispensed on 05/09/23 in the quantity of 90 tablets.
-She realized Resident #6 would not have had enough levothyroxine to administer daily when she delivered the levothyroxine dispensed on 08/31/23 in the quantity of 90 tablets.
-She knew the facility was not administering Resident #6's levothyroxine because of the remaining tablets in the bottle.
-The facility did not notify her that Resident #6 was out of levothyroxine.

Observation of Resident #6's medications on hand on 09/21/23 at 11:17am revealed:
-There was an open medication bottle labeled as levothyroxine 75mcg with a dispense date of 05/09/23 in the quantity of 90 tablets with 51 tablets available for administration.
-There was a sealed, unopened medication bottle labeled as levothyroxine 75mcg with a quantity of 90 tablets dispensed on 08/31/23.

Telephone interview with a pharmacy technician from Resident #6's pharmacy on 09/21/23 at 10:26am revealed:
-Resident #6's levothyroxine 75mcg was dispensed on 05/09/23 in the quantity of 90 tablets.
-Resident #6's levothyroxine 75mcg was dispensed on 08/31/23 in the quantity of 90 tablets.
-Resident #6's levothyroxine was not on a cycle fill and must be requested to be refilled.
-The pharmacy received a telephone request for a refill for Resident #6's levothyroxine on

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08/29/23.
-There would have been approximately 24 doses of Resident #6's levothyroxine not available to administer between the dispense dates of 08/07/23 and 08/31/23.

Interview with the Administrator-in-Training on 09/21/23 at 8:24am revealed:
-Resident #6's medications were dispensed by a pharmacy, delivered to the home of Resident #6's family member, and Resident #6's family member brought the medications to the facility.
-She and the Administrator implemented counting all of Resident #6's medications each shift on 07/15/23 because Resident #6's family member reported to her that Resident #6 was not being administered all the ordered medications.
-All of Resident #6's medications were counted each shift and the remainder of each medication was recorded on a controlled substance sheet.
-Resident #6's family member requested to count the levothyroxine tablets remaining on the medication cart with the RCC in the beginning of September 2023 when she brought the levothyroxine tablets dispensed on 08/31/23 for Resident #6.

Interview with the RCC on 09/21/23 at 11:22am revealed:
-She completed random medication counts several times with Resident #6's family member for all of Resident #6's prescription medications.
-The facility contacted Resident #6's family member when Resident #6 was low on a medication and the family member would request the medication refill from Resident #6's pharmacy.
-Resident #6's medications were delivered to the home of Resident #6's family member and the family member brought the medication to the

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facility.
-She also worked as a MA and frequently administered Resident #6's medications since she started working for the facility around the beginning of September 2023.
-Resident #6's levothyroxine dispensed on 05/09/23 started being administered to Resident #6 on 08/14/23 because Resident #6 had "backups" of multiple medications but she did not know if levothyroxine was one of the medications.
-The MAs started counting all of Resident #6's prescription medications each shift on 07/19/23.
-Any new prescriptions delivered to the facility by the family member were counted upon arrival and a receipt with the number of pills available was given to the family member.

Telephone interview with Resident #6's primary care provider (PCP) on 09/21/23 at 2:48pm revealed:
-Resident #6 took levothyroxine for not producing enough thyroid hormone.
-She sent a prescription for Resident #6's levothyroxine to Resident #6's pharmacy on 04/25/23 in the quantity of 90 tablets with 1 refill.
-She sent a prescription for Resident #6's levothyroxine to Resident #6's pharmacy on 09/07/23 in the quantity of 90 tablets with 1 refill.
-She was not notified by the facility of any missed doses of levothyroxine for Resident #6.
-It was serious to miss multiple doses of levothyroxine.
-Resident #6 could experience fatigue, constipation, and weight gain for not being administered levothyroxine daily or if she missed levothyroxine for a duration of period, she could experience myxedema coma (a life-threatening complication of hypothyroidism exhibiting multiple organ abnormalities such as low blood pressure and slowed heart rate) and require

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hospitalization.
-She expected the facility to administer levothyroxine to Resident #6 as ordered.

Interview with the Administrator on 09/22/23 at 12:32pm revealed:
-He was not aware of any missed doses of levothyroxine for Resident #6.
-He spoke to Resident #6's family member in late July 2023 or early August 2023 and was told that Resident #6 was not being administered the levothyroxine as ordered and the MAs started counting all Resident #6's prescription medications each shift.
-Resident #6's levothyroxine administration time was changed from 6:00am to 8:00am to make sure the levothyroxine was being administered.
-He expected the MAs to administer medications as ordered to residents and document on the eMAR accurately.

_____

The facility failed to ensure Resident #1 was administered a medication to treat schizophrenia from 09/02/23 through 09/13/23 causing increased anxiety, insomnia, and decreased social interaction placing Resident #1 at risk of experiencing rapid psychosis and Resident #6 was not administered a thyroid medication as ordered and would have missed approximately 24 doses of levothyroxine between the medication dispense dates from 05/09/23 through 08/31/23 and instead had 51 tablets remaining on 09/21/23 when the supply of levothyroxine would have run out on 08/07/23 placing Resident #6 at risk of fatigue, constipation, weight gain, or experiencing myxedema coma (a life-threatening complication of hypothyroidism exhibiting multiple organ abnormalities such as low blood pressure and slowed heart rate) requiring hospitalization. This failure was detrimental to the health and safety of

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D 358	Continued From page 25 Resident #6 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/22/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 9, 2023.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the electronic	D 367		

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medication administration record was accurate for 1 of 6 sampled residents (#6) related to a medication used to treat hypothryroidism.

The findings are:

Review of Resident #6's current FL2 dated 05/13/22 revealed diagnoses included hypothyroidism, dementia, and Alzheimer's disease.

Review of Resident #6's physician's orders dated 02/13/23 revealed a medication order for levothyroxine (used to treat low thyroid hormone) 75mcg take 1 tablet every morning.

Review of Resident #6's May 2023 eMAR revealed:
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 05/01/23 through 05/31/23.

Review of Resident #6's June 2023 eMAR revealed:
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 06/01/23 through 06/30/23.

Review of Resident #6's July 2023 eMAR revealed:
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 07/01/23 through 07/31/23.

Review of Resident #6's August 2023 eMAR revealed:
-There was an entry for levothyroxine 75mcg take

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1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 08/01/23 through 08/31/23.

Review of Resident #6's 09/01/23 through 09/20/23 eMAR revealed:
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 6:00am.
-Levothyroxine was documented as administered daily at 6:00am from 09/01/23 through 09/09/23.
-There was an entry for levothyroxine 75mcg take 1 tablet daily every morning at 8:00am.
-Levothyroxine was documented as administered daily at 8:00am from 09/10/23 through 09/20/23.

Interview with Resident #6's family member on 09/20/23 at 10:38am revealed:
-She requested to count Resident #6's levothyroxine with the Resident Care Coordinator (RCC) when she delivered the medication to the facility and there were 66 tablets of levothyroxine left in the bottle that was dispensed on 05/09/23 in the quantity of 90 tablets.
-She knew the facility was not administering Resident #6's levothyroxine because of the remaining tablets in the bottle.
-The Administrator and Administrator-in-Training offered to have medication aides (MAs) count all of Resident #6's medications at the end of each shift to make sure the medications were being administered.

Observation of Resident #6's medications on hand on 09/21/23 at 11:17am revealed:
-There was an open medication bottle labeled as levothyroxine 75mcg with a dispense date of 05/09/23 in the quantity of 90 tablets with 51 tablets available for administration.
-There was a sealed, unopened medication bottle for Resident #6 labeled as levothyroxine 75mcg

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with a quantity of 90 tablets dispensed on 08/31/23.
-The opened medication bottle for Resident #6's levothyroxine would have lasted until 08/07/23 if administration began on 05/09/23.
-Resident #6 should not have had 24 doses of levothyroxine available to administer between 08/07/23 through 08/31/23 and instead had a remaining balance of 51 tablets available to administer on 09/21/23.

Interview with a MA on 09/22/23 at 12:05pm revealed:
-Resident #6 was administered levothyroxine daily at 8:00am.
-Resident #6 never refused to take the scheduled levothyroxine for her.
-She did not know why there were so many levothyroxine pills available to administer to Resident #6.
-When a resident refused to take a medication, the medication was supposed to be documented on the eMAR as not administered and a note was documented with the reason why the medication was not administered.
-There was no documentation provided on Resident #6's eMARs that levothyroxine was not administered daily.

Interview with the Administrator-in-Training on 09/21/23 at 8:24am revealed:
-All of Resident #6's medications were counted each shift and the remainder of each medication was recorded on a controlled substance sheet.
-She and the Administrator implemented counting all of Resident #6's medications each shift on 07/15/23 because Resident #6's family member reported to her that Resident #6 was not being administered all the ordered medications.
-She expected the MAs to administer medications

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D 367	Continued From page 29 as ordered and document the administration of medications on the eMARs accurately. Interview with the RCC on 09/21/23 at 11:22am revealed: -She completed random medication counts several times with Resident #6's family member for all of Resident #6's prescription medications. -The facility contacted Resident #6's family member when Resident #6 was low on a medication and the family member would request the medication refill from Resident #6's pharmacy. -She also worked as a MA and frequently administered Resident #6's medications since she started working for the facility around the beginning of September 2023. -Resident #6's levothyroxine dispensed on 05/09/23 started being administered to Resident #6 on 08/14/23. Interview with the Administrator on 09/22/23 at 12:32pm revealed he expected the MAs to administer medications as ordered to residents and document on the eMAR accurately.	D 367		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.	D 465		

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D 465	Continued From page 30 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure required staffing hours were met on all three shifts in the special care unit (SCU) based on a census of 28 for 17 sampled shifts from 09/01/23 through 09/04/23, a census of 29 for 2 sampled shifts on 09/04/23, a census of 28 for 11 sampled shifts from 09/08/23 through 09/11/23, and a census of 27 for 9 sampled shifts from 09/15/23 through 09/18/23. The findings are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/2023 revealed they had a SCU with a capacity of 40 . Review of the facility census record from 09/01/23 through 09/04/23, and 09/08/23 through 09/11/23 revealed there was a census of 28 residents in the special care unit which required 28 staff hours on first and second shifts and 22.4 on third shift. Review of the facility census record from 09/15/23 through 09/18/23 revealed there was a census of 27 residents in the special care unit which required 27 staff hours on first and second shifts and 21.6 on third shift. Review of the staff time records from 09/01/23 through 09/04/23, 09/08/23 through 09/11/23, and 09/15/23 through 09/18/23 revealed: -On 09/01/23, the census was 28 requiring 28 staff hours on second shift and a total of 25 hours were provided leaving a shortage of 3 hours.	D 465		

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-On 09/01/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 5 hours were provided leaving a shortage of 17.4 hours.
-On 09/02/23, the census was 28 requiring 28 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 4 hours.
-On 09/02/23, the census was 28 requiring 28 staff hours on second shift and a total of 22 hours were provided leaving a shortage of 6 hours.
-On 09/02/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 8 hours were provided leaving a shortage of 14.4 hours.
-On 09/03/23, the census was 28 requiring 28 staff hours on first shift and a total of 16 hours were provided leaving a shortage of 12 hours.
-On 09/03/23, the census was 28 requiring 28 staff hours on second shift and a total of 18 hours were provided leaving a shortage of 10 hours.
-On 09/03/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 16.5 hours were provided leaving a shortage of 5.9 hours.
-On 09/04/23, the census was 29 requiring 29 staff hours on second shift and a total of 20 hours were provided leaving a shortage of 9 hours.
-On 09/04/23, the census was 29 requiring 23.2 staff hours on third shift and a total of 14.5 hours were provided leaving a shortage of 8.7 hours.
-On 09/08/23, the census was 28 requiring 28 staff hours on second shift and a total of 20.75 hours were provided leaving a shortage of 7.25 hours.
-On 09/08/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 11 hours were provided leaving a shortage of 11.4 hours.
-On 09/09/23, the census was 28 requiring 28 staff hours on second shift and a total of 7.5 hours were provided leaving a shortage of 20.5 hours.
-On 09/09/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 8 hours

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were provided leaving a shortage of 14.4 hours.
-On 09/10/23, the census was 28 requiring 27 staff hours on first shift and a total of 26 hours were provided leaving a shortage of 1 hour.
-On 09/10/23, the census was 28 requiring 27 staff hours on second shift and a total of 15 hours were provided leaving a shortage of 13 hours.
-On 09/10/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 18 hours were provided leaving a shortage of 4.4 hours.
-On 09/11/23, the census was 28 requiring 27 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 3 hours.
-On 09/11/23, the census was 28 requiring 22.4 staff hours on third shift and a total of 11 hours were provided leaving a shortage of 11.4 hours.
-On 09/15/23, the census was 27 requiring 27 staff hours on second shift and a total of 16 hours were provided leaving a shortage of 11.6 hours.
-On 09/15/23, the census was 27 requiring 21.6 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 5.6 hours.
-On 09/16/23, the census was 27 requiring 27 staff hours on first shift and a total of 14 hours were provided leaving a shortage of 13 hours.
-On 09/16/23, the census was 27 requiring 27 staff hours on second shift and a total of 15 hours were provided leaving a shortage of 12 hours.
-On 09/16/23, the census was 27 requiring 21.6 staff hours on third shift and a total of 20 hours were provided leaving a shortage of 1.6 hours.
-On 09/17/23, the census was 27 requiring 27 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 3 hours.
-On 09/17/23, the census was 27 requiring 27 staff hours on second shift and a total of 20 hours were provided leaving a shortage of 7 hours.
-On 09/17/23, the census was 27 requiring 21.6 staff hours on third shift and a total of 17 hours

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were provided leaving a shortage of 4.6 hours.
-On 09/18/23, the census was 27 requiring 21.6 staff hours on third shift and a total of 0 hours were provided leaving a shortage of 21.6 hours.

Interview with the Resident Care Coordinator (RCC) on 09/21/23 at 2:55pm revealed:
-Since she was rehired at the facility in the beginning of September 2023 and frequently worked as a medication aide (MA) since the facility was short MAs.
-She worked as a MA for the AL side and the Administrator-in-Training worked the Special Care Unit (SCU) as a MA.

Interview with a personal care aide (PCA) on 09/22/23 at 11:10am revealed:
-The facility was short staffed about every weekend.
-There was 1 MA and 1 PCA for the SCU.
-It has been that way for a least the past three months.
-She had worked the past 7 days straight as the facility was short of staff.

Interview with a second PCA on 09/22/23 at 1:06pm revealed:
-Weekend staffing was always short.
-The SCU needed at least one extra PCA per shift on the weekends.
-She worked every other weekend but could manage to get everything done as long as she did not take breaks or eat meals.
-She did not feel comfortable leaving the floor with just the MA working.
-The facility only had one MA and one PCA working during the most recent weekend she worked.

Interview with a third PCA on 09/22/23 at 1:13pm

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revealed:
-Staffing was always short on the weekends.
-The MAs were not always able to assist because they had to administer medications and complete other work.
-The residents needed a lot of help on the SCU at mealtimes.
-Several residents required total assistance with eating, and several others needed assistance cutting up their food and with verbal prompting to eat in the SCU.
-The residents seemed to be more stressed at mealtimes on the SCU during meal times on the weekends.
-Showers were not getting done on the weekends.
-The Residents' oral hygiene was "sometimes put off although it should not be."
-Often when she came to work on first shift on the weekends, third shift had been unable to complete all their tasks so this put her behind in her work from the start of her shift.
-She found residents soiled and residents still in bed several times when she came in to work the weekends on first shift.
-Staff had to focus on the "big picture" when the facility was short staffed which included assistance with eating, dressing, and changing residents.

Interview with a SCU's family member on 09/22/23 at 2:35pm revealed:
-They were at the facility every weekend.
-There was usually only 1 MA and 1 PCA for all the residents on the SCU.
-They came to assist their family member with meals and care because there was not enough staff to help all the residents.
-Staffing was "bad" most weekends.

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D 465	Continued From page 35 Telephone interview with the Administrator-in-Training on 09/25/23 at 3:08pm revealed: -She worked as a medication aide (MA) on 09/25/23. -She worked overtime hours every week and many days as an MA administering medications. -She was responsible for scheduling staff. -The facility was short staffed, and she completed the staff schedule to the best of her abilities. -She and the RCC often worked extra hours to fill in the gaps on the staffing schedule. -She hired people to work for the facility and many times they would not show up to work. -The staff timecards indicating whether staff worked on the assisted living unit or the special care unit were not always accurate. -There was no way to distinguish if staff worked on the assisted living unit or the special care unit on the staff time records. _____ The facility failed to ensure there was adequate SCU staff for 28 of 36 sampled shifts from 09/01/23-09/04/23, 09/08/23-09/11/23, and 09/15/23-09/18/23 to meet the daily needs of the residents. This failure was detrimental to the health, safety, and welfare of the residents on the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/22/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 9, 2023.	D 465		