STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	C 09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey with county complaints on September 05, 2023-September 11, 2023. The County initiated the first complaint on 08/10/23.	D 000		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain a North Carolina Division of Environmental Health approved sanitation classification of 85 or above at all times. The findings are: Observation on 09/05/23 at 8:30am upon entrance to the facility revealed the sanitation score for the kitchen was 81.5 based on the inspection completed on 08/23/23. Review of the facility's current Environmental	D 077		

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D 077	Continued From page 1 Health Inspection report for the kitchen dated 08/23/23 revealed the inspection included demerits related to inadequate supervision in the kitchen; good hygienic practices; preventing contamination by hands; protection from contamination; potentially hazardous food time/temperature; high susceptible populations (pasteurized foods used; prohibited foods not offered); prevention of food contamination; proper use of utensils; utensils and equipment (non food surfaces clean) and physical facilities. Telephone interview with the Environmental Health Inspector on 09/06/23 at 10:40am revealed: -She inspected the facility's kitchen on 08/23/23 due to an anonymous complaint that there were untrained staff working in the kitchen. -The facility was required to have someone that was Serve Safe certified and a Dietary Manager (DM) that had managerial control over the kitchen. -The DM quit prior to the inspection and the cook in charge of the kitchen on the day of the inspection did not have any training documented. -The cook exhibited poor managerial control by violating the handwashing rules and engaging in bare hand contact with ready to eat foods. -The facility's kitchen was inspected quarterly and the last three inspections had multiple repeat violations including: proper storage of beverages, proper storage of personal beverages (for kitchen staff), handwashing, mold on the ice machine guard, date marking and disposition and food storage and cleaning. -The most detrimental violations that were cited on 08/23/23 included pasteurized foods used/prohibited foods not offered and food separated and protected. -Staff working in the kitchen on 08/23/23 did not	D 077		

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D 077	Continued From page 2	D 077		

know the difference between pasteurized and unpasteurized eggs and unpasteurized eggs were purchased at the grocery store then served without being fully cooked due to residents' requests for over easy eggs.
-Consuming undercooked eggs could expose residents to salmonella which could result in vomiting, diarrhea and dehydration.
-On 08/23/23, raw chicken was stored over potatoes and presented a potential risk of contamination with salmonella if the raw chicken dripped onto the potatoes.
-On 08/23/23, packaged deli meat was in the same container as raw ground beef and juice from the raw ground beef leaked onto the package of deli meat.
-If the deli meat package was not properly sanitized before handling and opening it, there would be concern for cross contamination of pathogens such as Escherichia coli (E. coli) from the raw beef juice.
-If a resident was exposed to E. coli it could cause vomiting, diarrhea and dehydration; however, if an immunocompromised resident was exposed to E. coli it could also cause kidney damage.
-The inspector came back to the facility on 08/31/23 and a thawing violation was identified due to thawing cryovac packaged steaks in a water bath.
-Food that could grow pathogens required proper thawing in the refrigerator, during cooking or under running water that was less than 70 degrees Fahrenheit (F).
-Food cannot be thawed under running water in the summer because the tap water would not get below 70 degrees F.
-Everything in the cooler should be covered unless it is in the process of cooling, slices of cake should not be stored in the cooler without

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D 077	Continued From page 3	D 077		

being covered.

Observations in the kitchen on 09/05/23 from 11:02am to 4:08pm revealed:
-There were slices of cake stored on a cart in the cooler that were not covered.
-There were slices of turkey stored on a cart in the cooler that were not covered.
-There were three plastic containers of beverages in the refrigerator that were not labeled or dated.
-There were plastic storage bags of deli meat and block cheese that had been opened but not labeled with the date they were opened.
-There was dust on the vent of the ice machine.
-Inside the floor drain next to the steam table had dirt, individual condiment packages and a bottle cap in it.

Interview with a resident on 09/05/23 at 10:17am revealed he kept a lot of food in his room because he did not like eating in the dining room after he noticed the sanitation score of 81.5.

Interview with a resident on 09/11/23 at 2:57pm revealed he was bothered that the kitchen had a sanitation score of 81.5.

Interview with a dietary aide on 09/07/23 at 1:18pm revealed:
-If there was not enough time to defrost meat in the cooler, the previous DM told staff to fill up a large bucket of hot water and let the meat sit in the hot water until it was defrosted.
-He did not remember receiving any education on preventing cross contamination.

Telephone interview with a cook on 09/09/23 at 4:40pm revealed:
-She was working at the facility when the Environmental Health Inspector visited on

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D 077	Continued From page 4 08/23/23. -If meat was not taken out of the freezer the night before, she would thaw it under cool running water. -She did not receive any training upon hire and still had not been trained but worked in food service previously and relied on the training received there. -She was not Serve Safe certified. Interview with the DM on 09/05/23 at 3:52pm and 09/08/23 at 2:15pm revealed: -There was not a current cleaning schedule for the kitchen when he started on 09/01/23 so he cleaned the refrigerators, deep freezer, pantry and the hallway in the kitchen. -Shortly after he started, he and the Chef held an in-service for most of the kitchen staff on proper handwashing, labeling and dating food and how to store food in the cooler. -Bare hands should not touch food and gloves should be worn when cooking and preparing food. -Gloves did not have to be worn while serving food but staff had to wash and dry their hands prior to serving. -Staff were expected to wash their hands before and after wearing gloves. -He expected kitchen staff to take meat out the freezer three days before it was supposed to served and thaw it in the cooler. -Raw meat cannot be thawed under running water in the sink. -Raw meat should be thawed on a rack alone, a raw meat rack and ready to eat meat rack had been established in the cooler. -He expected food to be cooked to the appropriate temperature before it was moved to the steam table and expected the food to be held at the appropriate temperature while on the	D 077		

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D 077	Continued From page 5	D 077		

steam table.
-He expected only pasteurized eggs to be served and eggs would only be scrambled or hard boiled, no undercooked eggs were allowed to be served.
-He and the Chef planned to ensure new employees had food service training within their first week of working at the facility.
-He planned to have all of the cooks become Serve Safe certified.

Interview with the Chef on 09/05/23 at 4:15pm revealed:
-The food and beverages in the refrigerator should be labeled and dated with the date that they were opened.
-Prepared foods and beverages should be stored in the refrigerator and thrown out after three days if they had not been used.

Interview with the Administrator 09/11/23 at 4:41pm revealed:
-The previous DM quit before the Environmental Health inspection on 08/23/23 and the facility did not have a DM at that time.
-After the previous DM quit, the Activity Director oversaw meals to ensure that they went smoothly but she did not oversee the sanitation of the kitchen.
-The Administrator was able to consult with a DM at another facility; however, none of the kitchen staff made her aware of any concerns.
-All of the kitchen staff that were hired after she started working in the facility had their food service orientation training and she asked the previous DM to audit the other staff's records.
-She was aware none of the kitchen staff were Serve Safe certified at the time of the Environmental Health inspection and had been working on setting up the certification with staff.
-There was not an established cleaning schedule

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D 077	Continued From page 6 for the kitchen during when the Environmental Health inspection was completed on 08/23/23. _____ The facility failed to ensure the kitchen maintained a sanitation score above 85 by not having appropriately trained staff who supervised the kitchen which resulted in an Environmental Health Inspection violation in prohibited foods not offered and residents were served undercooked unpasteurized eggs which could have exposed them to salmonella and caused vomiting, diarrhea and dehydration. This failure was detrimental to the residents' health and safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 09/06/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 077		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action;	D 164		

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D 164	Continued From page 7 (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to ensure 1 of 3 sampled medication aides (MA) (Staff C) completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff C's MA personnel record revealed: -Staff C's hire date was 08/23/23. -There was no documentation of training on diabetic care for residents. Review of a resident's August 2023 electronic medication administration record (eMAR) revealed there was documentation Staff C checked the resident's finger stick blood sugar (FSBS) 6 times and administered insulin 5 times from 08/25/23 through 08/27/23.	D 164		

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D 164	Continued From page 8 Review of a resident's September 2023 eMAR revealed there was documentation Staff C checked the resident's FSBS 4 times and administered insulin 3 times from 09/04/23 through 09/05/23. Interview with Staff C on 09/11/23 at 11:46am revealed: -She had been working at the facility as a MA since 08/23/23. -Her MA duties included administering insulin when needed and checking residents' FSBS as ordered. -Since she started working at the facility, she had not received any training related to care of diabetic residents. Interview with the Special Care Coordinator (SCC) on 09/11/23 at 2:15pm revealed: -The Business Office Manager (BOM) does the scheduling for staff training for MAs on the Special Care Unit. -She did not know Staff C did not have diabetic training prior to giving insulin. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -The BOM was to keep up with the check off on diabetic training and scheduled classes with the registered nurse (RN) consultant. -She was trying to schedule the class because the BOM was new and started 08/28/23. -The BOM should be auditing the staff files weekly. -She and the BOM were responsible for ensuring the MAs had training on diabetic residents. [Refer to tag 0358, 10A NCAC 13F 1004 Medication Administration (Type B Violation)]	D 164		

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D 164	Continued From page 9 The facility failed to ensure 1 of 3 sampled MA staff completed diabetic training on the care of residents with diabetes, resulting in staff being unable to have the knowledge needed to care for residents with a diagnosis of Diabetes. The facility's failure was detrimental to the health, safety, and well-being of the residents, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 164		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by:	D 167		

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D 167	Continued From page 10 TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure at least one staff person was always on the premises who completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24-months for 5 of 10 sampled shifts from 08/10/23 to 08/28/23. Review of Staff Assignment Sheets and the time punch detail reports for second and third shifts dated 08/14/23 revealed: -There were no CPR certified staff that worked second shift from 7:33pm to 12:00am. -There were no CPR certified staff that worked third shift from 12:00am to 6:54am. Review of Staff Assignment Sheets and the time punch detail reports for second and third shifts dated 08/18/23 revealed: -There were no CPR certified staff that worked second shift from 7:14pm to 12:00am. -There were no CPR certified staff that worked third shift from 12:00am to 6:13am. Review of Staff Assignment Sheets and the time punch detail reports for second and third shifts dated 08/19/23 revealed: -There were no CPR certified staff that worked second shift from 8:14pm to 12:00am. -There were no CPR certified staff that worked third shift from 12:00am to 6:03am. Review of Staff Assignment Sheets and the time punch detail reports for second and third shifts dated 08/20/23 revealed: -There were no CPR certified staff that worked second shift from 7:00pm to 12:00am. -There were no CPR certified staff that worked	D 167		

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D 167	Continued From page 11 third shift from 12:00am to 5:51am. Review of Staff Assignment Sheets and the time punch detail reports for second and third shifts dated 08/23/23 revealed: -There were no CPR certified staff that worked second shift from 8:23pm to 12:00am. -There were no CPR certified staff that worked third shift from 12:00am to 6:22am. Interview with the Special Care Unit Coordinator (SCC) on 09/11/12 at 12:02pm revealed: -She was responsible to schedule staff on each shift. -Between 08/10/23 and 08/18/23, the facility had utilized a staff schedule completed by the former SCC. -On 08/18/23, she completed staff schedules through 09/01/23. -On 08/18/23, she utilized an outdated staff roster to schedule staff. -The former Business Office Manager (BOM) had been responsible for updating the staff roster and noted staff with a valid CPR certification. -On or about 08/23/23, she and the Administrator identified the facility's staff roster did not accurately reflect staff with valid CPR certification. -Between 08/10/23 and 08/23/23, second and third shifts did not ensure at least one valid CPR certified staff worked. Interview with the Administrator on 09/11/23 at 11:37am revealed: -The facility was responsible to ensure at least one CPR certified staff worked in the facility on each shift. -In August 2023, a staff roster was utilized to schedule staff for each shift between 08/10/23 and 08/28/23.	D 167		

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D 167	Continued From page 12 -The former BOM had been responsible to maintain an accurate staff roster of valid CPR certified staff. -The current SCC was assigned to be responsible for staff schedules on or about 08/18/23. -On or about 08/23/23, she identified the facility did not have an accurate staff roster which should have reflected staff with a valid CPR certification. -On 08/25/23, the facility utilized a contracted CPR trainer to provide CPR training to staff and updated the staff roster to reflect which staff had a valid CPR certification. [Refer to tag 0465, 10A NCAC 13F 1308 Special Care Unit Staff (Type B Violation)] _____ The facility failed to ensure there was staff on duty who had training on CPR and choking management in the last 24-months on second and third shifts for 5 of 10 shifts sampled, resulting in no staff available to perform life saving measures in the event of an emergency. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-32 on 09/11/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 167		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations	D 234		

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(a) Upon admission to an adult 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 3 of 5 residents sampled (#1, #4, and #5) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1. Review of Resident #4's current FL2 dated 01/24/23 revealed diagnoses included seizures, diabetes, chronic Schizophrenia, hypertension, and acute ischemic stroke.

Review of Resident #4's Resident Register revealed there was an admission date of 01/31/23.

Review of Resident #4's record for a tuberculosis (TB) skin test revealed there was no documentation of a second TB skin test for Resident #3.

Interview with Resident #4 on 09/08/23 at 10:00am revealed he did not know when he had a TB skin test.

Telephone interview with Resident #4's guardian

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on 09/11/23 at 10:48am revealed she could not recall if Resident #4 received a TB skin test or not.

2. Review of Resident #1's current FL2 dated 07/31/23 revealed diagnoses included memory loss, hyperlipidemia, and osteoarthritis of the knee.

Review of Resident #1's Admission Record revealed an admission date of 08/10/23.

Review of Resident #5's record revealed there was no documentation a TB skin test was completed prior to admission.

Refer to the interview with the Administrator on 09/11/23 at 4:41pm.

3. Review of Resident #5's current FL2 dated 02/20/23 revealed diagnoses included multiple myeloma (a blood cancer), Type 2 diabetes, chronic kidney disease, hypertension, and hyperlipidemia.

Review of Resident #5's Primary Care Provider's (PCP) orders dated 06/14/23 revealed an admission date of 02/22/23.

Review of Resident #5's record revealed there was no documentation a TB skin test was completed prior to admission.

Interview with Resident #5 on 09/11/23 at 12:40pm revealed he did not know if a TB test was done prior to admission.

Interview with the Special Care Unit Coordinator (SCC) on 09/07/23 at 11:50am revealed she did

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D 234	Continued From page 15 not have documentation Resident #5 had a TB test prior to admission. Refer to the interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with the Administrator on 09/11/23 at 4:41pm revealed the SCC or the Resident Care Coordinator (RCC) were responsible for ensuring residents had a TB test prior to admission.	D 234		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents had an accurate care plan that was signed by a provider within 15 days of the residents' being assessed (#3). The findings are: 1. Review of Resident #3's current FL2 dated 06/30/23 revealed: -Diagnoses included severe vascular dementia,	D 263		

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Alzheimer's dementia, history of cerebral vascular accident, and lethargy.
-Resident #3's recommended level of care was the Special Care Unit (SCU).
-He was constantly disoriented.

Review of Resident #3's resident register revealed an admission date of 07/06/23.

Review of Resident #3's undated Care Plan revealed:
-Resident #3 required supervision with bathing as well as dressing and limited assistance with grooming.
-Resident #3's care plan was not signed by the physician.

Interview with a medication aide (MA) on 09/06/23 at 4:45pm revealed:
-Resident #3 required supervision with bathing and dressing as well as exit seeking behaviors.
-Resident #3 required limited assistance with grooming.

Interview with Resident #3's Primary Care Provider (PCP) on 09/07/23 at 3:30pm revealed:
-She saw Resident #3 as a new patient on 07/12/23 and there was no care plan available for her to review.
-The Health and Wellness Director (HWD) was responsible for completing a care plan and placing it in a folder for her to review at the first appointment with Resident #3 on 07/12/23.

Telephone interview with the previous HWD on 09/08/23 at 3:00pm revealed:
-She was responsible for completing the care plans within 15 days of admission.
-Resident #3 was admitted in July 2023 and she completed the care plan, but it was not signed

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D 263	Continued From page 17 before she resigned. -She forgot to get it signed by the physician. Interview with the Administrator on 09/11/23 at 4:11pm revealed: -The HWD was responsible for completing the care plan and obtaining the physician's signature. -Care plans were supposed to be completed during the initial assessment for new residents and then annually or with significant changes in condition. -Once the care plan was completed at the initial assessment, the document should be faxed or emailed to their PCP for review and to be signed. -She was not aware Resident #3's care plan was not signed by the PCP.	D 263		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to provide supervision for 3 of 3 sampled residents on the Special Care Unit (SCU) related to two residents who verbally and physically abused other residents resulting in one resident physically assaulting another resident with a cane (Resident #1), one resident who	D 270		

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verbally threatened residents with a butter knife (Resident #7) and a resident who experienced 4 unwitnessed falls in 2 months (Resident #3).

The findings are:

1. Review of Resident #1's current FL2 dated 07/31/23 revealed:
-Diagnoses included memory loss.
-There was no documentation related to orientation, ambulation or behaviors.
-His level of care was Special Care Unit (SCU).

Review of Resident #1's Pre-admission Screening dated 07/31/23 revealed:
-He was admitted to the facility on 08/10/23.
-He had moderate dementia with significant short-term memory loss and possibly long-term memory loss.
-He did not require assistance with transfers or mobility.
-Behaviors included wandering with a history of leaving a building unsupervised.
-Tasks included to monitor for behaviors.

Review of Resident #1's hourly checks dated 08/10/23 revealed:
-There was documentation Resident #1 was checked on at 3:00pm and 4:00pm.
-There was no other documentation checks were completed.

Review of Resident #1's hourly checks dated 08/11/23 revealed:
-There was documentation Resident #1 was checked on hourly from 7:00am until 11:00am.
-There was no other documentation checks were completed.

Review of Resident #1's Incident/Accident report

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dated 08/11/23 at 5:20pm revealed:
-Resident #1 was found in the room of another resident and was hitting her with a cane.
-Resident #1 stated he was going to kill the other resident.
-A staff member heard the altercation and took the cane from Resident #1 while re-directing him from the room.
-Emergency Medical Services (EMS) was called and transported Resident #1 to the Emergency Department (ED).

Review of Resident #1's progress note dated 08/11/23 at approximately 5:20pm revealed Resident #1 was sent to the ED for aggressive behaviors.

Review of Resident #1 progress note dated 08/12/23 at 7:33pm revealed:
-It was a late entry.
-Resident #1 was found in the room of another resident and was hitting her with a cane.
-Resident #1 stated he was going to kill the other resident.
-A staff member heard the altercation and took the cane from Resident #1 while re-directing him from the room.
-EMS was called and transported Resident #1 to the ED.

Review of Resident #1's ED visit note dated 08/11/23 at 8:25pm revealed:
-The resident was brought to the ED for aggressive behaviors.
-Resident #1 hit another resident with a cane several times causing lacerations to her right scalp, right shin and to her left wrist.

Review of Resident #1's behavioral health visit note dated 08/11/23 at 8:43pm revealed:

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-Resident #1 was in the ED.
-The reason for the consult was crisis assessment for commitment.
-Resident #1 was brought to the ED after he had a violent altercation at the memory care facility.
-Resident #1 was found beating another resident with a cane.
-The resident spent one evening in the facility prior to the altercation.
-The resident had been threatening toward two family members previously.
-Resident #1 was at a different facility previously, had aggressive behaviors while there and was sent out to the hospital.

Review of Resident #1's psychiatry consult note dated 08/12/23 at 11:42pm revealed:
-The reason for the consult was aggressive behaviors.
-Resident #1 had dementia and family provided most of the history of the resident.
-The family reported Resident #1 was previously discharged from another memory care facility for assaulting staff.
-Resident #1 was brought to the ED on 08/11/23 for physically assaulting another resident with a cane while she slept, causing injuries requiring sutures.
-The family reported Resident #1 was started on citalopram previously by neurology to help with irritability but had no improvement.

Review of Resident #1's hospital discharge summary dated 08/14/23 revealed:
-Diagnoses included dementia with aggressive behaviors.
-The resident was brought to the ED on 08/11/23 from his memory care facility due to aggressive behaviors.
-He was found on his first night at the memory

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care facility, in another resident's room, hitting her multiple times with her cane.
-Resident #1 showed intermittent physical aggression towards hospital staff, by hitting and kicking them.
-While in the hospital, Resident #1 was calm and cooperative when family were present but became combative when they left.
-Resident #1was discharged home with family on 08/14/23 and did not return to the facility.

Telephone interview with Resident #1's family member on 09/07/23 at 3:33pm revealed:
-Resident #1 was at another facility previously and had an altercation on his first night at that facility.
-Family members were told Resident #1 had put his hands on a staff member at the previous facility, and either had to return to his home that night or be sent to the hospital.
-Facility staff visited Resident #1 and family members prior to his admission to the facility and were informed of his incident at the previous facility.

Telephone interview with a Law Enforcement Officer (LEO) on 09/08/23 at 4:40pm revealed:
-He was on duty on 08/11/23 at 5:14pm when a call came from the facility for a resident assaulting another resident.
-He arrived to the facility within a couple of minutes.
-Resident #1 was in the courtyard with staff.
-Resident #1 did not appear to be aware of his surroundings and denied assaulting another resident.
-He did not see the victim.

Interview with a personal care aide (PCA) on 09/07/23 at 5:12pm revealed:

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D 270	Continued From page 22 -Resident #1 was admitted to the facility on 08/10/23 around 5:00pm. -She worked on 08/10/23 and her shift ended at 7:00pm. -She worked 08/11/23 from 7:00am to 7:00pm. -On 08/11/23 at approximately 6:30pm she heard a resident screaming, and another resident screaming "I'm going to kill you". -She ran down the hall to the resident's room and saw Resident #1 beating the resident with her cane. -The resident was lying in her bed with her arm up in a defensive position. -The resident was bleeding from a wound on her head and on her shin and her wrist was very swollen. -She tried to get the cane from Resident #1 and when she couldn't she held onto it with him and guided him from the room. Telephone interview with a medication aide (MA) on 09/08/23 at 6:45am revealed: -She worked night shift on 08/10/23, Resident #1's first night in the facility. -Resident #1 verbally threatened some staff and had swung his fists at staff. -She reported Resident #1's behaviors on to the oncoming MA the following morning. Telephone interview with a PCA on 09/08/23 at 6:52am revealed: -He worked night shift on 08/10/23, Resident #1's first night in the facility. -Resident #1 had verbally threatened him and another PCA that night but had no physical behavior toward staff. -He reported Resident #1's behaviors to the MA on duty and the oncoming shift the following morning.	D 270		

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D 270	Continued From page 23 Telephone interview with the previous Health and Wellness Director (HWD) on 09/08/23 at 3:00pm revealed: -She and the Sales and Marketing Manager (SMM) did the home visit prior to Resident #1's admission to the facility. -She was not made aware of any behaviors for Resident #1 except he had wandered to the street when at his home. -She specifically asked the family if Resident #1 had any other behaviors. -Hourly checks were to be completed and documented for all new residents in the SCU for 72 hours. -The SCC was to ensure the hourly checks were completed and the documentation was done. Interview with the SMM on 09/0823 at 11:03am revealed: -She spoke with Resident #1's family member prior to the home visit and was made aware the resident was in a facility previously. -The family member stated there was an incident at the other facility, the police were called, the resident went to the hospital and was not able to return to that facility. -The family member stated she did not have details related to the incident at the other facility. -She and the HWD visited Resident #1 and family members for a home visit on 08/04/23. -The HWD was responsible for getting medical and activities of daily living information during the home visit and she was responsible for the admission paperwork. -The family member at the home visit did not mention any behaviors for Resident #1. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -Resident #1 was to be checked on each hour	D 270		

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after admission for 72 hours.
-The PCAs were responsible for documenting the hourly checks.
-The MAs and the SCC were responsible for auditing the hourly checks documentation to ensure it was being completed.

Attempted telephone interview on 09/08/23 at 2:16pm with Resident #1's Primary Care Provider (PCP) was unsuccessful.

2. Review of Resident #7's current FL-2 dated 08/21/23 revealed:
-Diagnosis included subdural hemorrhage.
-No additional diagnoses were documented.
-The recommended level of care was SCU.
-Resident #7 was constantly disoriented.
-Resident #7 was continent of bladder and bowel.
-Resident #7 required assistance with bathing.

Review of Resident #7's Resident Register revealed:
-Resident #7's responsible party signed and dated the Resident Register on 08/10/23.
-The facility Administrator signed and dated the Resident Register on 08/10/23.

Review of Resident #7's resident record revealed:
-Resident #7 was admitted to the SCU on 08/22/23.
-Resident #7 was assessed by her PCP on 08/30/23.

Review of Resident #7's Level of Care assessment dated 08/25/23 revealed:
-Resident #7 required behavior monitoring and interventions.
-Resident #7 required limited assistance with bathing and toileting.
-Resident #7 did not require assistance with

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grooming, dressing, eating, transfers, and ambulation.
-The document was not signed by Resident #7's PCP.

Review of Resident #7's August 2023 incident reports revealed:
-An incident report dated 08/23/23 documented Resident #7 engaged in a physical altercation with another resident and struck staff with a pill crusher.
-On 08/23/23, Resident #7 was sent to the hospital for evaluation.
-An incident report dated 08/31/23 documented Resident #7 engaged in a physical altercation with another resident and grabbed a butter knife.
-On 08/31/23, Resident #7 was sent to the hospital for evaluation.
-No additional incident reports were documented.

Review of Resident #7's August 2023 Progress Notes revealed:
-An entry dated 08/22/23 at 7:30pm documented Resident #7 was admitted to the facility without any accompanied medications.
-On 08/26/23 at 2:28pm, staff documented Resident #7 engaged in an altercation with another resident and engaged in a physical altercation with staff.
-On 08/26/23 at 6:51pm, staff documented Resident #7 engaged in a physical altercation with another resident and staff; EMS transported Resident #7 to the ED for evaluation.
-On 08/27/23 at 4:53pm, staff documented Resident #7 engaged in a physical altercation with another resident; staff redirected Resident #7 on several opportunities. EMS transported Resident #7 to the ED for evaluation.
-On 08/31/23 at 2:39pm, staff documented Resident #7 engaged in a physical altercation

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with another resident while obtaining a butter knife: Resident #7 was admitted to the ED for evaluation.

Review of Resident #7's August 2023 ED visits revealed:
-Resident #7 was discharged to the facility on 08/22/23 with diagnoses of dementia, hypertension, and subdural hematoma.
-Resident #7's discharge summary dated 08/22/23 documented Resident #7 exhibited acute agitation and delirium secondary to sundowning and hospital induced delirium.
-Resident #7 was evaluated on 08/23/23 at 9:34pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/24/23 at 5:23am with a recommendation to permit Resident #7 to acclimate to the facility setting.
-Resident #7 was evaluated on 08/26/23 at 7:12pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/27/23 at 2:20am with no recommendations.
-Resident #7 was evaluated on 08/27/23 at 6:22pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/28/23 at 5:45am with no recommendations.
-Resident #7 was evaluated on 08/31/23 at 4:56pm due to aggressive behavior and admitted for further behavioral assessment.

Review of Resident #3's August 2023 Resident Observation Hourly Checks form revealed:
-Instructions for staff to initial at each one-hour interval for a visual observation of a resident and a list of actions provided to the resident, which included: Ask resident of needs, toileted, offered something to eat, turned and repositioned,

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sleeping, involved in activities, and offered something to drink.
-On 08/23/23, staff documented an hourly check of Resident #7 between 7:00am and 7:00pm.
-On 08/25/23, staff documented an hourly check of Resident #7 between 12:00am and 7:00am, and 7:00pm and 11:00pm.
-There were no additional documented hourly checks for Resident #7 between 08/22/23 and 08/31/23.

Review of August 2023 facility 24-Hour Report forms revealed:
-On 08/23/23, staff documented Resident #7 was newly admitted and exhibited wandering behaviors.
-On 08/24/23, staff documented Resident #7 refused breakfast and exhibited physical aggression all night.
-On 08/26/23, staff documented Resident #7 exhibited physical aggression and urinated on the floor.
-On 08/27/23, staff documented Resident #7 ate meals and exhibited aggression towards residents and staff, refused personal care, and was up all night.
-There were no additional 24-Hour Report forms.

Telephone interview with Resident #7's Power of Attorney (POA) on 09/07/23 at 2:45pm revealed:
-Resident #7 was admitted to the SCU on 08/22/23 upon discharge from a hospital due to a fall which occurred on 08/02/23.
-Prior to Resident #7's admission to the facility, Resident #7 had a history of agitation but not aggressive behavior.
-The facility staff had notified her on 08/23/23, 08/26/23, 08/27/23, and 08/31/23 that due to Resident #7's verbal and physical altercations the facility had Resident #7 evaluated at the ED.

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D 270	Continued From page 28 -Resident #7 was admitted for in-patient evaluation to the hospital on 08/31/23 due to ongoing aggressive behaviors at the facility. Interview with Resident #7's PCP on 09/07/23 between 3:30pm and 4:30pm revealed: -She was the facility's contracted Primary Care Provider (PCP) for residents that preferred to utilize her services. -She completed an initial in-person assessment of Resident #7 on 08/30/23 to obtain a baseline assessment of Resident #7's care needs, physical condition, and medication review. -On 08/30/23, she was notified by the SCC related to Resident #7's Emergency Department evaluations for aggressive behaviors on 08/23/23, 08/26/23, and 08/27/23. -She expected the facility to notify her every time Resident #7 was sent to the Emergency Department for evaluation. -On 08/31/23, she was notified by the SCC related to Resident #7's hospital admission for aggressive behaviors. -On 08/30/23, she wrote a medication order for Resident #7 to be administered Seroquel 25mg tablets to be administered twice daily. -On 08/30/23, she wrote a medication order for Resident #7 to be administered Trazodone 50mg tablets to be administered daily at bedtime. -On 08/30/23, the facility had not provided any Emergency Department discharge summaries for Resident #7's evaluations on 08/23/23, 08/26/23, and 08/27/23 for her review. -On 08/30/23, she instructed the SCC to ensure staff performed at least every one-hour safety checks for Resident #7 indefinitely and encourage redirection of Resident #7 to reduce opportunities for aggression. Interview with a first shift PCA on 09/11/23 at	D 270		

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D 270	Continued From page 29 11:10am revealed: -Resident #7 was admitted on 08/22/23. -Between 08/22/23 and 08/31/23, she was not aware of any instructions provided by MAs, SCC, or facility Administrator related to Resident #7's care needs or interventions to address behaviors. -On or about 08/23/23, Resident #7 was observed to easily agitated and engage in physical aggression towards other residents and staff. -Resident #7 was to be placed on every one-hour documented safety checks for 72 hours upon admission and upon return from each ED visit. -She did not know if PCA's performed hourly checks on Resident #7 consistently between 08/22/23 and 08/31/23. -The SCC or MA was responsible to notify PCAs when a resident required documented one-hour safety checks. Interview with an additional PCA on 09/08/23 at 10:15am revealed: -She worked on first and second shifts in the SCU. -Resident #7 was admitted to the SCU on 08/22/23. -Based on her observations of Resident #7 between 08/23/23 and 08/31/23, Resident #7 preferred to be a helper at meals in the dining room but became easily agitated and aggressive throughout the unit at different times. -Resident #7 was placed on every one-hour documented safety checks for 72 hours upon admission. -She did not know if PCA's performed hourly checks on Resident #7 consistently between 08/22/23 and 08/31/23. -The SCC or MA was responsible to notify PCA's when a resident required documented one-hour safety checks.	D 270		

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D 270	Continued From page 30 -She had not received any recommendations from MAs, SCC, or facility Administrator related to how to approach Resident #7 or Resident #7's preferences. -PCAs were expected to redirect residents from exit doors, bedrooms, or when exhibiting agitation to ensure resident safety. -On 08/23/23, Resident #7 became agitated when redirected from wandering into another resident's bedroom and repeatedly struck her and other staff and another resident until exiting the area. -Between 08/23/23 and 08/31/23, Resident #7 was sent to the ED on several occasions due to aggressiveness. Interview with a MA on 09/08/23 at 10:30am revealed: -She worked on first and second shifts. -She was responsible to communicate with PCAs to ensure resident safety and provide interventions to reduce resident aggression. -PCAs were responsible to complete documented one-hour safety checks on residents that were newly admitted, returned from an ED visit, high fall risk, or exit seeking for a minimum of 72 hours. -MAs were responsible to ensure the PCAs' documentation was accurate and complete on each shift. -She did not know if PCAs consistently performed or documented one-hour safety checks for Resident #7 between 08/22/23 and 08/31/23. -On 08/27/23, Resident #7 exhibited unprovoked aggression towards another resident and staff and the Administrator instructed her to have Resident #7 evaluated at the ED. -On 08/27/23, she had EMS transport Resident #7 to the ED for evaluation. -She was not aware of any additional interventions to address Resident #7's behaviors.	D 270		

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D 270	Continued From page 31 Interview with the interim RCC on 09/07/23 at 2:44pm revealed: -PCAs were expected to perform one-hour documented safety checks of residents for 72 hours upon admission, after falls, and upon return from Emergency Department evaluations. -On 08/23/23, Resident #7 began exhibiting agitation and aggressive behaviors towards staff. -Between 08/23/23 and 08/31/23, Resident #7 was sent on several occasions to the ED for evaluation due to ongoing physical aggression towards other residents and staff. -On 08/28/23 she instructed SCU staff to avoid Resident #7 when she began exhibiting agitation but ensure that Resident #7 did not engage in any unsafe behavior, including harming herself, other residents, or staff. -Staff were instructed to have Resident #7 sent for ED evaluation if she continued to have physical aggressive behaviors. -On 08/31/23, Resident #7 was sent to the hospital in the afternoon because she had engaged in a verbal and physical altercation with another resident in the SCU dining room, subsequently picking up a butter knife from a place setting but staff intervened to remove it from Resident #7's hand. Interview with the SCC on 09/11/23 at 12:02pm revealed: -On 08/29/23, she was aware of Resident #7's Emergency Department evaluations which had occurred on 08/23/23, 08/26/23, and 08/27/23. -The PCAs were expected to complete every one-hour documented safety checks on Resident #7 upon admission for 72 hours and upon return from each ED evaluation. -The MAs were responsible to communicate with PCAs on every shift to ensure Resident #7's	D 270		

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one-hour checks were performed.
-She was not aware if PCAs had been consistently performed one-hour documented safety checks for Resident #7 between 08/22/23 and 08/31/23.
-PCAs were expected to redirect residents from exit doors, bedrooms, and situations of agitation.
-Between 08/29/23 and 08/31/23, Resident #7 was easily agitated and exhibited physical aggression.
-On 08/31/23, Resident #7 exhibited physical aggression in the dining room after lunch and was subsequently sent to the hospital to be admitted for evaluation until she could re-assess Resident #7's behavioral needs and interventions to ensure safety of Resident #7, SCU residents and staff.
-Between 08/29/23 and 08/31/23, apart from redirecting Resident #7 and seeking ED evaluation, no additional interventions had been discussed with the facility Administrator, MAs, PCAs, or Resident #7's POA.

Interview with the Administrator on 09/08/23 at 4:15pm revealed:
-Upon admission to the SCU, residents were to be placed on one-hour documented safety checks for at least 72 hours.
-Residents were to be placed on one-hour documented safety checks for at least 72 hours upon return from ED evaluations.
-The MAs were responsible to ensure PCAs conducted supervision and safety observations of SCU residents at least every two-hours and hourly documented checks for Resident #7.
-She was not aware Resident #7's one-hour documented checks were inconsistently completed between 08/22/23 and 08/31/23.
-On 08/24/23, the interim RCC had instructed MAs and first shift PCAs to be careful when approaching Resident #7 and not engage

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Resident #7 when she exhibited agitation while ensuring Resident #7 and other SCU residents remained safe from physical harm.

3. Review of Resident #2's current FL2 dated 08/04/23 revealed:
-Diagnoses included Alzheimer's disease and delirium due to known physiological condition.
-He was documented to be constantly disoriented and ambulatory.
-The documented level of recommended care was the special care unit (SCU).

Review of Resident #2's current Care Plan dated 02/20/23 revealed:
-Resident #2 wandered around the unit all day.
-He had no problems with ambulation and did not have any assistive devices.
-Resident #2 was sometimes disoriented and required reminders due to being forgetful.
-He was independent with ambulation and did not require any assistance.

Review of Resident #2's SCU Resident Profile dated 06/09/23 revealed:
-He was not able to ambulate independently and used a walker.
-The level of assistance required was not documented.

Review of Resident #2's licensed health professional support (LHPS) assessment dated 07/14/23 revealed Resident #2's tasks included ambulation using assistive devices that required physical assistance.

Review of Resident #2's progress notes revealed:
-On 07/17/23, Resident #2 was walking to his room without his walker and fell in the hallway, he hit his head on the wall as he was falling.

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-On 07/17/23 Resident #2 was sent to the ED.
-On 07/30/23, Resident #2 fell out of bed around midnight and had a gash on the back of his head as well as old wounds on his arm that reopened.
-On 07/30/23, Resident #2 was sent to the ED.
-On 08/23/23, Resident #2 was observed on his back on the floor, halfway under his roommate's bed and could not tell staff how he fell.
-On 08/28/23 Resident #2 was sent to the ED.

Review of Resident #2's Incident and Accident report dated 07/17/23 revealed:
-Resident #2 was walking to his room without his walker and fell in the hallway.
-He had a knot on the left side of his forehead as well as a bleeding skin tear on his arm and was sent to the hospital.
-Resident #2 was alert and able to ambulate without assistance.
-Predisposing factors included confusion, ambulating without assistance and not using his walker.

Review of Resident #2's Incident and Accident reports revealed there was not a report for the incidents on 07/30/23 or 08/28/23.

Review of Resident #2's ED visit note dated 07/17/23 revealed:
-Resident #2 presented with a mechanical fall due to tripping while not using his walker.
-He presented with an acute uncomplicated head injury and no loss of consciousness.
-Resident #2 was discharged back to the facility on 07/17/23.

Review of Resident #2's ED visit note dated 07/29/23 revealed:
-Resident #2 presented with a mechanical fall and had a history of frequent and recurrent falls

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at a memory care facility.
-Resident #2 was found next to the bed after he rolled out of bed and hit his head on the edge of his nightstand.
-Resident #2 was discharged back to the facility on 07/30/23.

Review of Resident #2's Incident and Accident report dated 08/22/23 revealed:
-Resident #2 was having dinner in the dining room and when he got up from the chair, he fell onto the floor.
-He hit his head on the arm of the chair and his arm hit the ground which caused a skin tear that bled heavily.
-The medic was called and Resident #2 was taken to the hospital.
-Resident #2's level of consciousness was documented as lethargic.
-No predisposing factors were identified.

Review of Resident #2's ED visit note dated 08/22/23 revealed:
-Resident #2 had a witnessed fall, hit his head on the floor and caused skin tears on his left forearm.
-He suffered from frequent falls secondary to malnourishment secondary to chronic conditions.
-Resident #2's frequent falls should be addressed at the facility.
-He was discharged back to the facility on 08/22/23.

Review of Resident #2's hospital note dated 08/28/23 revealed:
-Resident #2's history of present illness included: fall and laceration with a history of multiple falls, he had an unwitnessed fall this morning (08/28/23) and was found on the floor, for an unknown amount of time, with complaints of neck

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pain and multiple skin tears on bilateral arms.
-While in the ED Resident #2 was found to be hypothermic requiring Bair hugger (a temperature management system used in a hospital to maintain a person's core body temperature) and had a chest x-ray that was concerning for pneumonia, so he was started on intravenous (IV) antibiotics.

Review of Resident #2's hospital visit note on 08/30/23 revealed:
-Resident #2 hypothermia was resolved but was likely due to laying on the floor for several hours.
-There was concern that Resident #2's caretaker had difficulty caring for him due to a history of multiple witnessed and unwitnessed falls.
-The hospital physician may consider consulting a social worker to address whether Resident #2 needed to be placed in a different facility.

Review of the facility's Incident Reports- Falls and Mobility Management Policy dated 10/01/20 revealed:
-It is the policy of the facility to ensure residents are systematically assessed to determine their risk for falls and appropriate interventions to identify any potential issues and determine procedures to be implemented to decrease fall and/or minimize injuries.
-Upon move in, with significant change in condition, every 6 months, annually and after every fall episode, the nurse will assess the resident to determine their risk for falls or repeat falls.
-Should a resident fall, the community must show documentation of an analysis of the circumstances of the fall and interventions that were initiated to prevent or reduce the risk of subsequent falls.

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Interview with the SCC on 09/06/23 at 2:00pm and 09/07/23 at 10:00am revealed:
-A physical therapist (PT) called her during Resident #2's last hospitalization called to inquire about Resident #2's baseline and what kind of care the facility could provide.
-The PT said Resident #2's cognitive ability kept him from truly understanding his walker and upon return to the facility he would be a high fall risk that would require one on one supervision.
-Resident #2 was going to be admitted to a smaller facility after that hospitalization due to falling frequently and needed increased supervision.

Review of Resident #2's rounding sheets revealed:
-Resident #2 had a sheet titled "Every 30 Minutes Check" that was dated 08/23/23 and had documentation of staff's initials every hour from 7:00am to 7:00pm.
-Resident #2 had a sheet titled "Resident Observation Hour Checks" that was not dated and had documentation of staff's initials every hour from 12:00am to 6:00pm.
-No other rounding sheets were documented.

Review of Resident #2's 24-hour reports revealed:
-On 08/11/23, it was documented that Resident #2 was up moving all night from 7:00pm to 7:00am.
-There were no additional 24-hour report forms.

Telephone interview with Resident #2's family member on 09/07/23 at 11:10am revealed:
-Resident #2 required frequent reminders to use his walker.
-The family member was not aware of any fall interventions the facility put in place for Resident

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D 270	Continued From page 38 #2. Interview with a personal care aide (PCA) on 09/06/23 at 4:10pm revealed: -Resident #2 could not remember to use his walker so staff tried to keep the walker close to him and check on him every hour during the day. -Resident #2 received physical therapy but he would fall if he did not use his walker. Interview with a second PCA on 09/06/23 at 4:19pm revealed: -Resident #2 liked to go to bed after meals and he was able to get in and out of bed on his own. -He would fall if he did not use his walker and was not easily redirected so staff would need to hold onto him if he did not have his walker. -She checked on Resident #2 hourly but most of his falls were unwitnessed. Interview with a third PCA on 09/07/23 at 1:59pm revealed: -After Resident #2 fell, he had to be checked on every 30 minutes for 72 hours to ensure that he was safe, then she started checking on him every 30 minutes every day when he was awake due to his frequent falls. -Resident #2 liked to get into bed during the day so she checked on him every two hours while he was sleeping. -Staff encouraged him to use his walker but Resident #2 frequently forgot to use it and he was unstable on his feet, so sometimes she would ask Resident #2 to sit in a wheelchair and kept him close to her during the day. -The medication aides (MA) documented on the staff progress notes when Resident #2 fell. Telephone interview with a night shift PCA on 09/08/23 at 4:08pm revealed:	D 270		

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D 270	Continued From page 39 -He used the 24-hour report to document on the residents that required their brief to be changed frequently and did not document his two hour rounds because he was not trained on how to document them on the computer. -He checked on residents every two hours at night and Resident #2 would normally get out of bed around 2:00am to 5:00am to request something. -He found Resident #2 on the floor of his room the morning of 08/28/23 during the morning rounds, unsure of the exact time. -He was not sure of the last time he checked on Resident #2 before he was found on the floor on 08/28/23. Interview with a PT with the facility's contracted therapy company on 09/07/23 at 1:12pm revealed: -He did not treat Resident #2 but was able to review Resident #2's record. -Resident #2 had been discharged from PT services at the end of June 2023 due to meeting his maximum functional level with physical therapy. Interview with the SCC on 09/07/23 at 10:00am revealed: -She was not sure what fall interventions the facility had put in place for Resident #2 since she was new to her position. -The incident reports were used to analyize falls and should have the interventions that had been implemented documented on them. -She expected staff to check on Resident #2 at least every two hours during the day and night. -After Resident #2 went to the hospital on 08/28/23, she felt he was no longer appropriate for the SCU setting due to requiring stand by assistance for all tasks to prevent falling.	D 270		

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D 270	Continued From page 40 Telephone interview with the previous Health and Wellness Director (HWD) on 09/08/23 at 3:00pm revealed: -Resident #2's fall interventions were based on his needs, so she talked to PT about working with him to use his walker frequently and the PCP evaluated his medications to make sure none of them were causing him to fall. -Resident #2 usually fell when he walked away from his walker, and she asked staff to ensure he had the walker as well as remind him to use it. -Although he had dementia, a constant reminder to use his walker and the repetitive action of having the walker with him would help him remember to use the walker. -She expected staff to check on Resident #2 every two hours, but it would change to hourly for 72 hours after he experienced a fall. -She was on vacation in August 2023 and was only aware of Resident #2's two falls that occurred in July 2023. -She spoke with Resident #2's family, PT and PCP to create his fall interventions; but is not sure what interventions she would have implemented if she knew about Resident #2's falls in August 2023. Interview with the PCP on 09/07/23 at 3:30pm revealed: -She discussed fall interventions for Resident #2 with the previous HWD and his family member. -The interventions included: ordering PT and evaluating his medication to ensure it was not contributing to him falling. -Resident #2 was very active, unsteady on his feet and did not use his walker consistently. -The facility had exhausted interventions to keep him from falling and she thought the increased supervision that a skilled nursing facility could	D 270		

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provide would have been beneficial; however, he was not eligible for a skilled nursing facility.
-Resident #2 required more supervision than the facility could provide to keep him from falling.
-She was unaware Resident #2 was admitted to the hospital on 08/28/23 with hypothermia and was not sure how long it would take to get hypothermia from laying on the floor; however, she suspected Resident #2's hypothermia was related to the pneumonia.

Interview with the Administrator on 09/11/23 at 4:41pm revealed:
-Residents in the SCU should be monitored every 15 minutes to every hour for 72 hours after experiencing a fall.
-The rounding should be documented on an hourly rounding sheet by the PCAs and the MAs should check that the documentation was completed for each shift.
-The SCC or RCC was responsible for auditing this documentation daily.
-MAs were expected to notify the RCC or SCC after a resident fell and then the RCC or SCC would notify her of the fall.
-Resident #2's falls were discussed in the facility's daily stand-up meetings.
-She, the RCC/SCC and PCP discussed fall interventions and the facility's Vice President of Clinical Operations reviewed the interventions; however, Resident #2's family member decided to move him to a different facility before any fall interventions could be put into place.
-She was not aware Resident #2 fell four times in two months and was sent to the ED for an evaluation after each fall.
-After the second or third fall, she would have expected the SCC to reevaluate Resident #2's placement at the facility with the PCP.
-Unfortunately, the SCC was not in her position

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D 270	Continued From page 42 when Resident #2 fell on 07/30/23 and the SCC was on vacation when he fell on 08/28/23. Resident #2 was not available to interview. Attempted telephone interview with Resident #2's PT on 09/08/23 at 10:08am was unsuccessful. [Refer to tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)] [Refer to tag 0468, 10A NCAC 13F .1309 Special Care Unit Staff Orientation and Training (Type B Violation)] _____ The facility failed to ensure supervision of residents who resided on the SCU resulting in a resident physically and verbally assaulting another resident requiring the resident to be sent to the ED where she received sutures for a laceration to her forehead, leg and a contusion to her wrist and another resident who experienced four falls in two months resulting in the resident being hospitalized and unable to return to the facility. The failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 12, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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to meet the routine and acute health care needs of residents.

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

Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 4 of 5 sampled residents (Resident #2, #3, #5 and #12) related to not notifying the prescriber of missed, and refused doses of an antidepressant medication and a mood stabilizer (#3), medications used to treat high cholesterol (#3, #2), elevated finger stick blood sugar (FSBS) readings (#5), a blood thinner (#3, #2), medications used to treat vitamin D and vitamin B12 deficiences, a supplement used for sleeplessness, a medication used to treat dementia (#2) and missed blood pressure readings (#5).

The findings are:

1. Review of Resident #2's current FL2 dated 08/04/23 revealed diagnoses included anxiety disorder, Alzheimer's disease, essential hypertension, benign hypertension, hyperlipidemia and major depressive disorder.

Review of Resident #2's signed Physician's orders dated 02/20/23 revealed:
-An order for atorvastatin calcium 80 mg (used to prevent cardiovascular disease and treat abnormal lipid levels) tablet at bedtime.
-An order for cholecalciferol 1000-unit (a D vitamin essential for depositing calcium in bones) tablet daily.
-An order for cyanocobalamin 1000 mcg (used to treat a vitamin B12 deficiency and pernicious

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anemia) tablet daily.
-An order for donepezil HCl 10 mg (used to treat Alzheimer's dementia) tablet at bedtime.
-An order for lisinopril 5 mg (used to treat high blood pressure) tablet daily.
-An order for melatonin 3 mg (used as a sleep aid) at bedtime.
-An order for apixaban 2.5 mg (used to treat and prevent blood clots) tablet twice daily.

a. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 07/25/22 for atorvastatin calcium 80 mg one tablet daily scheduled for 6:00pm.
-Atorvastatin was documented as not administered from 07/08/23 to 07/15/23.

Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why atorvastatin was not administered from 07/08/23 to 07/15/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 8 consecutive doses of atorvastatin increased Resident #2's lipid levels for 8 days and his chance of having a stroke or heart event.

Refer to interview with a medication aide (MA) on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23 at 11:20am.

Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm.

Refer to interview with the PCP on 09/07/23 at

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D 273	Continued From page 45 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. b. Review of Resident #2's July 2023 eMAR revealed: -There was an entry dated 12/02/21 for cholecalciferol 1000 unit one tablet daily scheduled at 8:00am. -Cholecalciferol was documented as not administered on 07/08/23, 07/15/23 and from 07/17/23 to 07/26/23. Review of Resident #2's July 2023 progress notes revealed: -Cholecalciferol was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue. -There was no documentation that indicated why cholecalciferol was not administered on 07/08/23, 07/15/23 or from 07/17/23 to 07/26/23. Interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am revealed: -On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart. -The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys. -All resident medications were late or not administered that morning. Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed: -She was not aware Resident #2 had missed any doses of cholecalciferol in July 2023. -Resident #2 was prescribed cholecalciferol as a dietary supplement, and she did not anticipate any outcome of missing 12 doses.	D 273		

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D 273	Continued From page 46 Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. c. Review of Resident #2's July 2023 eMAR revealed: -There was an entry dated 12/21/21 for cyanocobalamin 1000 mcg one tablet daily scheduled at 9:00am. -Cyanocobalamin was documented as not administered on 07/08/23, from 07/11/23 to 07/15/23, from 07/27/23 to 07/29/23 and 07/31/23. Review of Resident #2's July 2023 progress notes revealed: -Cyanocobalamin was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue. -There was no documentation that indicated why cyanocobalamin was not administered from 07/11/23 to 07/15/23, from 07/27/23 to 07/29/23 or 07/31/23. Interview with the RCC on 09/11/23 at 11:18am revealed: -On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.	D 273		

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-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry dated 12/21/21 for cyanocobalamin 1000 mcg one tablet daily scheduled at 9:00am.
-Cyanocobalamin was documented as not administered on 08/01/23 and 08/02/23.

Review of Resident #2's August 2023 progress notes revealed there was no documentation that indicated why cyanocobalamin was not administered on 08/01/23 and 08/02/23.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-She was not aware Resident #2 had missed any doses of cyanocobalamin in July 2023 or August 2023.
-Resident #2 was prescribed cyanocobalamin as a dietary supplement, and she did not anticipate any outcome after missing 8 doses.

Refer to interview with a MA on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23 at 11:20am.

Refer to interview with the SCC on 09/11/23 at 3:24pm.

Refer to interview with the PCP on 09/07/23 at 3:30pm.

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Refer to interview with the Administrator on 09/11/23 at 4:41pm.

d. Review of Resident #2's July 2023 eMAR revealed:
-An entry dated 07/26/22 for donepezil HCl 10 mg one tablet at bedtime scheduled at 6:00pm.
-Donepezil HCl was documented as not administered from 07/08/23 to 07/15/23.

Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why donepezil HCl was not administered from 07/08/23 to 07/15/23.

Review of Resident #2's August 2023 eMAR revealed:
-An entry dated 07/26/22 for donepezil HCl 10 mg one tablet at bedtime scheduled at 6:00pm.
-Donepezil was documented as not administered on 08/18/23, 08/19/23, 08/23/23 and 08/25/23.

Review of Resident #2's August 2023 progress notes revealed there was no documentation that indicated why donepezil was not administered on 08/18/23, 08/19/23, 08/23/23 or 08/25/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 8 consecutive doses of donepezil may increase Resident #2's confusion.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-She was not aware Resident #2 had missed any doses of donepezil in July 2023 or August 2023.
-Resident #2 was prescribed donepezil to help decrease his confusion related to dementia; however, Resident #2's dementia was far too advanced for donepezil to make a significant

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difference.

Refer to interview with a MA on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23 at 11:20am.

Refer to interview with the SCC on 09/11/23 at 3:24pm.

Refer to interview with the PCP on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

e. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 11/27/22 for lisinopril 5 mg once daily scheduled at 8:00am.
-Lisinopril was documented as not administered from 07/08/23 to 07/15/23 and from 07/17/23 to 07/22/23.

Review of Resident #2's July 2023 progress notes revealed:
-Lisinopril was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue.
-There was no documentation that indicated why lisinopril was not administered from 07/08/23 to 07/15/23 or from 07/17/23 to 07/22/23.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart

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containing all the keys.
-All resident medications were late or not administered that morning.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed:
-Missing 8 consecutive doses of lisinopril put Resident #2 at risk of a heart event and high blood pressure.
-Missing 8 consecutive doses of lisinopril and atorvastatin at the same time would compound the effects and increase Resident #2's risks of a heart event and high blood pressure.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed she was not aware he missed any doses of lisinopril in July 2023.

Refer to interview with a MA on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23 at 11:20am.

Refer to interview with the SCC on 09/11/23 at 3:24pm.

Refer to interview with the PCP on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

f. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 12/01/21 for melatonin 3 mg once at bedtime scheduled for 6:00pm.
-Melatonin was documented as not administered from 07/08/23 to 07/15/23.

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D 273	Continued From page 51 Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why melatonin was not administered from 07/08/23 to 07/15/23. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed: -Missing 8 consecutive doses of melatonin increased Resident #2's chances for insomnia. -Missing 8 consecutive doses of melatonin and donepezil at the same time would compound the effects of insomnia and could cause more confusion or abnormal behaviors. Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed she was not aware he missed any doses of melatonin in July 2023. Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. g. Review of Resident #2's July 2023 eMAR revealed: -There was an entry dated 12/01/21 for apixaban 2.5 mg twice daily scheduled at 8:00am and 6:00pm.	D 273		

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D 273	Continued From page 52 -Apixaban was documented as not administered from 07/08/23 to 07/15/23. Review of Resident #2's July 2023 progress notes revealed: -Apixaban was not administered on 07/08/23 at 8:00am due to the medication carts were locked/pharmacy issue. -There was no documentation to indicate why apixaban was not administered from 07/08/23 at 6:00pm to 07/15/23. Interview with the RCC on 09/11/23 at 11:18am revealed: -On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart. -The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys. -All resident medications were late or not administered that morning. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 16 consecutive doses of apixaban could lead to a blood clot formation and deep vein thrombosis (a condition in which the blood clots form in veins located deep inside the body, usually in the thigh or lower legs, which can cause pain and swelling in the area) or a stroke like event. Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed: -Resident #2 was prescribed apixaban due to a history of a stroke and atrial flutter (an abnormal heart rhythm). -Missing 16 consecutive doses of apixaban put Resident #2 at risk for blood clot in his heart and could have led to a stroke.	D 273		

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D 273	Continued From page 53 -She was not aware Resident #2 missed any doses of apixaban in July 2023. Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 2. Review of Resident #12's current FL2 dated 07/07/23 revealed diagnoses included hypertension and cardiomegaly (enlarged heart). a. Review of Resident #12's Primary Care Provider's (PCP) order dated 08/15/23 revealed: -There was an order the Resident #1's blood pressure to be taken once daily and recorded in the resident's electronic Medication Administration Record (eMAR). -The PCP was to be notified if the resident's systolic blood pressure was greater than 180. Review of Resident #12's August 2023 eMAR revealed. -There was an entry for carvedilol (a medication to treat hypertension) 12.5mg, one tablet twice daily at 8:00am and 4:00pm with blood pressures documented for each administration. -From 08/16/23 to 08/31/23 there were 14 instances out of 32 opportunities Resident #1's systolic blood pressure was greater than 180,	D 273		

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ranging from 188 on 08/26/23 at 8:00am to 208 on 08/27/23 at 8:00am.

Review of Resident #12's September 2023 eMAR revealed.
-There was an entry for carvedilol; 12.5mg, one tablet twice daily at 8:00am and 4:00pm with blood pressures documented for each administration.
-From 09/01/23 to 09/06/23 there were 5 instances out of 11 opportunities Resident #1's systolic blood pressure was greater than 180, ranging from 184 on 09/03/23 at 4:00pm to 217 on 09/01/23 at 4:00pm.

Review of Resident #12's progress notes for August 2023 and September 2023 revealed there was no documentation Resident #12's PCP was notified of systolic blood pressures greater than 180.

Interview with Resident #12's PCP on 09/07/23 at 3:30pm revealed:
-She expected to be notified by facility staff if Resident #12's systolic blood pressure was greater than 180.
-Resident #12 was at risk for strokes, falls and dizziness due to her elevated blood pressures.

Interview with a medication aide (MA) on 09/08/27 at 3:36pm revealed the MA was responsible for notifying the PCP when Resident #12's systolic blood pressure was greater than 180.

Interview with the Administrator on 09/11/23 at 4:41pm revealed she was not aware Resident #12's PCP was not notified of systolic blood pressures outside of ordered parameters.

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D 273	Continued From page 55 Refer to interview with a medication aide (MA) on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 3. Review of Resident #5's current FL2 dated 02/20/23 revealed diagnoses included Type 2 diabetes. Review of Resident #5's PCP orders dated 06/14/23 revealed: -There was an order for sliding scale insulin before meals and at bedtime. -Finger stick blood sugar (FSBS) readings were to be done before meals and at bedtime and for FSBS results 401-450 Resident #5 was to receive 12 units of insulin and the PCP was to be notified. Review of Resident #5's August 2023 eMAR revealed a FSBS reading of 450 on 08/02/23 at 5:30pm. Review of Resident #5's record revealed there was no documentation the PCP was notified of the FSBS reading of 450 on 08/02/23 at 5:30pm. Interview with a medication aide (MA) on 09/08/27 at 3:36pm revealed the MA was responsible for notifying the PCP when Resident #5's FSBS was greater than 401.	D 273		

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D 273	Continued From page 56 Refer to interview with a medication aide (MA) on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 4. Review of Resident #3's current FL2 dated 06/30/23 revealed: -Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy. Review of Resident #3's FL2 dated 05/31/23 revealed: -There was an order for amlodipine besy-benazepril (a medication used to treat high blood pressure) 2.5-10mg daily. -There was an order for atorvastatin (a medication used to treat high cholosterol) 40mg daily. -There was an order for citalopram (a mood stablizer) 10mg daily. -There was an order for clopidogrel (a platlet aggrivator) 75mg daily. -There was an order for divalproex (a mood stabilizer) 125mg two times a day. Review of Resident #3 signed physician's orders dated 07/12/23 revealed: -There was an order for atorvastatin (a	D 273		

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medication used to treat high cholosterol) 40mg daily.
-There was an order for citalopram (a mood stablizer) 10mg daily.
-There was an order for clopidogrel (a platlet aggrivator) 75mg daily.
-There was an order for divalproex (a mood stablizer) 125mg two times a day.

a. Review of Resident #3's July 2023 electronic Medication Administration Record (eMAR) revealed.
-There was an entry for amlodipine besy-benazepril 2.5-10mg, daily.
-The amlodipine besy-benazepril was documented as administered at 9:00am from 07/11/23 through 07/31/23.
-The amlodipine besy-benazepril was documented with the code "09" indicating "other/see nurse notes" on 07/08/23, 07/09/23 and 07/10/23.

Review of Resident #3's progress notes revealed:
-The amlodipine besy-benazepril was not administered on 07/08/23 due to the amlodipine besy-benazepril were locked in the medication cart and amlodipine besy-benazepril not received from the pharmacy.
-There was no documentation of why the amlodipine besy-benazepril was not administered on 07/09/23 and 07/10/23.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry dated 07/08/23 for amlodipine besy-benazepril 2.5-10mg, daily.
-The amlodipine besy-benazepril was documented as administered at 9:00pm from 08/01/23 through 08/31/23.

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D 273	Continued From page 58 Review of Resident #3's September 2023 eMAR revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The amlodipine besy-benazepril was documented as administered at 9:00pm from 09/01/23 through 09/05/23. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 11:32am revealed: -Resident #3 had an order dated 07/08/23 for amlodipine besy-benazepril 2.5-10mg, one tablet daily. -Amlodipine besy-benazepril 2.5-10mg, 30 tablets were dispensed to the facility for Resident #3 on 07/10/23. -The facility's most recent request for the amlodipine be refilled on 07/10/23. Interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed: -She was not aware Resident #3's amlodipine besy-benazepril was not administered because the amlodipine benazepril was not refilled or in the building. -It was the facility's responsibility to notify her if Resident #3 did not receive amlodipine besy-benazepril after the third dose was missed. -Missing more than 3 doses of amlodipine could cause Resident #3's blood pressure to increase and place the resident at risk of a stroke or a heart attack. Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am.	D 273		

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D 273	Continued From page 59 Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. b. Review of Resident #3's July 2023 eMAR revealed. -There was an entry dated 07/07/23 for atorvastatin 40mg daily. -The atorvastatin was documented as administered at 9:00pm from 07/08/23 through 07/31/23. -The atorvastatin was documented with the code "09" indicating "other/see nurse notes" on 07/07/2. Review of Resident #3's progress notes revealed the atorvastatin was not available to administer on 07/07/23. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The atorvastatin was documented as administered at 9:00pm from 08/01/23 through 08/06/23 and 08/08/23 to 08/31/23. -There was no documentation of why the atorvastatin was not administered on 08/07/23 Review of Resident #3's progress notes revealed there was no documentation to explain why the atorvastatin was not administered on 08/07/23. Review of Resident #3's September 2023 eMAR revealed.	D 273		

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-There was an entry for atorvastatin 40mg daily.
-The atorvastatin was documented as administered at 9:00pm from 09/01/23, 09/03/23 and 09/04/23.
-The atorvastatin was documented with the code "09" indicating "other/see nurse notes" on 09/02/23.

Review of Resident #3's progress notes revealed there was no documentation to explain why the atrovastatin was not administered on 09/02/23.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #3 had an order dated 07/08/23 for atorvastatin 40mg daily, one tablet daily.
-Atorvastatin 40mg daily 30 tablets were dispensed to the facility for Resident #3 on 07/08/23.
-The facility's most recent request for the atorvastatin be refilled on 07/10/23.

Interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed:
-She was not aware Resident #3's atorvastatin was not administered because the atorvastatin was not refilled or in the building.
-It was the facility's responsibility to notify her if Resident #3 did not receive atorvastatin after the third dose was missed.
-Missing more than 3 doses of atorvastatin could place Resident #3 at an increased risk of a stroke or heart attack.

Refer to interview with a MA on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23

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D 273	Continued From page 61 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. c. Review of Resident #3's July 2023 eMAR revealed. -There was an entry dated 07/08/23 for citalopram 10mg daily. -The citalopram was documented as administered at 9:00am from 07/09/23 through 07/31/23. -The citalopram was documented with the code "09" indicating "other/see nurse notes" on 07/08/2. Review of Resident #3's progress notes revealed the citalopram was not documented as administered on 07/08/23 due to locked medication carts. Interview with the RCC on 09/11/23 at 11:18am revealed: -On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart. -The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys. -All resident medications were late or not administered that morning. Review of Resident #3's August 2023 eMAR revealed: -There was an entry for citalopram 10mg daily.	D 273		

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-The citalopram was documented as administered at 9:00am from 08/01/23 through 08/07/23, 08/14/23, 08/20/23, and 08/23/23.
-The citalopram was documented with the code "09" indicating "other/see nurse notes" on 08/08/23 to 08/13/23, 08/15/23 to 08/19/23, and 08/21/23 to 08/22/23.
-There was an entry for citalopram 20mg daily.
-The citalopram was documented as administered at 9:00am from 08/25/23 to 08/31/23.
-The citalopram was documented with the code "09" indicating "other/see nurse notes" on 08/24/23.

Review of Resident #3's progress notes revealed:
-The citalopram was not administered on 08/08/23 because it was not available.
-There was no documentation why the citalopram was not administered on 08/09/23.
-The citalopram was not administered because it was not available.
-There was no documentation of why the citalopram was not administered on 08/08/23 to 08/13/23, 08/15/23 to 08/19/23, and 08/21/23 to 08/22/23, 08/25/23 to 08/31/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for citalopram 20mg daily.
-The citalopram was documented as administered at 9:00am from 09/01/23 and 09/05/23.
-The citalopram was documented with the code "09" indicating "other/see nurse notes" on 09/02/23 to 09/04/23.

Review of Resident #3's progress notes revealed there was no documentation to explain why the citalopram was not administered on 09/02/23 to

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D 273	Continued From page 63 09/04/23. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed: -Resident #3 had an order dated 07/08/23 for citalopram 20mg, one tablet daily. -Citalopram 20mg daily 30 tablets were dispensed to the facility for Resident #3 on 07/08/23. -The facility's most recent request for the citalopram be refilled on 08/24/23. Interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed: -She was not aware Resident #3's citalopram was not administered because the citalopram was not refilled or in the building. -It was the facility's responsibility to notify her if Resident #3 did not receive citalopram after the third dose was missed. -Missing more than 3 doses of citalopram could result in Resident #3's expericing increased anxiety and behaviors. Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm.	D 273		

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d. Review of Resident #3's July 2023 eMAR revealed.
-There was an entry dated 07/08/23 for Plavix 75mg daily.
-The Plavix was documented as administered at 9:00am from 07/09/23 through 07/31/23.
-The Plavix was documented with the code "09" indicating "other/see nurse notes" on 07/08/2.

Review of Resident #3's progress notes revealed the Plavix was not administered on 07/08/23 due to locked medication carts.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for Plavix 75mg daily.
-The Plavix was documented as administered at 9:00am from 08/01/23 through 08/05/23, 08/20/23, 08/23/23, 08/25/23, 08/26/23, and 08/28/23 to 08/31/23.
-The Plavix was documented with the code "09" indicating "other/see nurse notes" on 08/06/23 to 08/19/23, 08/21/23, 08/22/23, 08/24/23, and 08/27/23.

Review of Resident #3's progress notes revealed:
-Plavix was not administered on 08/06/23 and 08/08/23 due to the medication not available.
-Plavix was not administered on 08/07/23 due to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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the medication was on order.
-There was no documentation of why the Plavix was not administered on 08/06/23 to 08/19/23, 08/21/23, 08/22/23, 08/24/23, and 08/27/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for Plavix 75mg daily.
-The Plavix was documented as administered at 9:00am from on 09/01/23.
-The Plavix was documented with the code "09" indicating "other/see nurse notes" on 09/02/23 to 09/05/23.

Review of Resident #3's progress notes revealed there was no documentation to explain why the Plavix was not administered on 09/02/23 to 09/05/23.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #3 had an order dated 07/08/23 for Plavix 75mg , one tablet daily.
-Plavix 75mg daily 30 tablets were dispensed to the facility for Resident #3 on 07/08/23.
-The facility's most recent request for the Plavix be refilled on 07/08/23.

Interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed:
-She was not aware Resident #3's Plavix was not administered because the Plavix was not refilled or in the building.
-It was the facility's responsibility to notify her if Resident #3 did not receive Plavix after the third dose was missed.
-Missing more than 3 doses of Plavix could place Resident #3's at an increased risk of a stroke or

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heart attack.

Refer to interview with a MA on 09/11/23 at 10:42am.

Refer to interview with a second MA on 09/11/23 at 11:20am.

Refer to interview with the SCC on 09/11/23 at 3:24pm.

Refer to interview with the PCP on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

e. Review of Resident #3's July 2023 eMAR revealed.
-There was an entry dated 07/07/23 for Depakote 125mg, two times daily.
-The Depakote was documented as administered at 9:00am from 07/09/23 through 07/31/23.
-The Depakote was documented as administered at 9:00pm from 07/08/23 through 07/31/23.
-The Depakote was documented with the code "09" indicating "other/see nurse notes" on 07/07/23 and 07/08/2.

Review of Resident #3's progress notes revealed the Depakote was not administered on 07/08/23 due to locked medication carts.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.

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D 273	Continued From page 67 -All resident medications were late or not administered that morning. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for Depakote 125mg two times daily. -The Depakote was documented as administered at 9:00am from 08/01/23 to 08/12/23, and 08/23/23. -The Depakote was documented with the code "09" indicating "other/see nurse notes" on 08/13/23 to 08/19/23, 08/21/23 and 08/22/23. -The Depakote was documented as administered at 9:00pm from 08/01/23 to 08/06/23, and 08/08/23 to 08/22/23. -The Depakote was not documented as administered on 08/07/23. -There was an entry for Depakote 250mg two times daily. -The Depakote was documented as administered at 9:00am from 08/25/23 to 08/31/23. -The Depakote was documented with the code "09" indicating "other/see nurse notes" on 08/24/23. -The was documented as administered at 6:00pm from 08/24/23 to 08/31/23. Review of Resident #3's progress notes revealed: -There was no documentation as to why the Depakote 125mg was not administered on 08/07/23, 08/13/23 to 08/19/23, 08/21/23 and 08/22/23. -There was no documentation the Depakote 250mg was administered 08/24/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for Depakote 250mg two times daily.	D 273		

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-The Depakote was documented as administered at 8:00am from on 09/01/23 and 09/05/23.
-The Depakote was documented with the code "09" indicating "other/see nurse notes" on 09/02/23 to 09/04/23.
-The Depakote was documented as administered at 4:00pm from on 09/01/23 and 09/03/23 to 09/04/23.
-The entry was documented with the code "09" indicating "other/see nurse notes" on 09/02/23.

Review of Resident #3's progress notes revealed there was no documentation as to why the Depakote was not administered on 09/02/23 to 09/04/23 at 8:00am, and on 09/02/23 at 4:00pm.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #3 had an order dated 07/07/23 for Depakote 125mg, one tablet two times daily.
-Depakote 125mg two times daily, 60 tablets were dispensed to the facility for Resident #3 on 07/08/23.
-Resident #3 had an order for Depakote 250mg, one tablet two times daily.
-Depakote 250mg two times daily, 12 tablets were dispensed to the facility for Resident #3 on 08/24/23, and 46 tablets on 09/04/23.

Interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed:
-She was not aware Resident #3's Depakote was not administered because the Depakote was not refilled or in the building.
-It was the facility's responsibility to notify her if Resident #3 did not receive Depakote after the third dose was missed.
-Missing more than 3 doses of Depakote could

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D 273	Continued From page 69 result in an increased Resident #3's risk of anxiety and behaviors. Refer to interview with a MA on 09/11/23 at 10:42am. Refer to interview with a second MA on 09/11/23 at 11:20am. Refer to interview with the SCC on 09/11/23 at 3:24pm. Refer to interview with the PCP on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with a MA on 09/11/23 at 10:42am revealed she was not trained to contact PCP if a resident missed the same medication several days in a row. Interview with a second MA on 09/11/23 at 11:20am revealed she only contacted the PCP if a resident needed a medication refill and was not trained to contact the PCP if a resident missed the same medication several days a in row. Interview with the SCC on 09/11/23 at 3:24pm revealed MAs were expected to contact the PCP after a resident missed the first dose of their medication. Interview with the PCP on 09/07/23 at 3:30pm revealed she expected the facility to notify her after a resident missed a medication 2-3 times in a row by leaving a note in her folder, faxing her office or calling her office.	D 273		

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D 273	Continued From page 70 Interview with the Administrator on 09/11/23 at 4:41pm revealed: -The MA was expected to notify the RCC or SCC after a resident missed a medication one time. -The RCC or SCC was expected to notify the PCP of the missed medication. -The MAs were responsible for notifying the PCP of any results outside of ordered parameters. The facility failed to notify the physician of a resident's elevated blood pressure placing the resident at risk for strokes, falls and dizziness (#12); a resident who was not administered three medications for eight consecutive days that were used to prevent cardiovascular disease, treat high blood pressure, treat and prevent the formation of blood clots placing the resident (#2) at an increased risk for a heart attack and stroke. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on September 11, 2023 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 11, 2023.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care	D 280		

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plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on interviews and record review the facility failed to ensure 2 of 5 sampled residents had quarterly licensed health professional services (LHPS) assessments for tasks related to ambulation with an assistive device (#2) and ambulation using assistive devices, urinary catheter, and collecting and testing fingerstick blood sugars (FSBS) (#5).

The findings are:

1. Review of Resident #2's current FL2 dated 08/04/23 revealed:
-Diagnoses included Alzheimer's disease and heteronymous bilateral field defects (a visual field defect on the opposite side of each eye).
-The recommended level of care was the Special Care Unit (SCU).
-There was documentation he was constantly disoriented and ambulatory.

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D 280	Continued From page 72 Review of Resident #2's LHPS assessments revealed: -The most recent LHPS assessment was dated 07/14/23. -Ambulation using assistive devices that required physical assistance was identified as a task for Resident #2. -"Uses walker for ambulation, staff assist him with activities of daily living" was documented on the LHPS evaluation. -The date of last evaluation on the assessment sheet was blank. -There was no previous LHPS assessment for review. Review of Resident #2's SCU Resident Profile dated 06/09/23 revealed Resident #2 was not able to ambulate independently and used a walker. Telephone interview with Resident #2's family memeber on 09/07/23 at 11:10am revealed Resident #2 needed to be frequently reminded to use his walker. Interview with a personal care aide (PCA) on 09/06/23 at 4:19pm revealed: -Resident #2 fell frequently and required his walker to ambulate. -Resident #2 was not easily redirected so she would place her hand on his back to help guide him. Interview with the Special Care Unit Coordinator (SCC) on 09/07/23 at 11:50am revealed she had no LHPS assessments for Resident #2 prior to the one dated 07/14/23 Refer to interview with the SCC on 09/11/23 at	D 280		

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D 280	Continued From page 73 2:15pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 2. Review of Resident #5's current FL2 dated 02/20/23 revealed: -Diagnoses included obstructive kidney disease, Type 2 diabetes, chronic kidney disease, and multiple myeloma (a blood cancer). -The recommended level of care was assisted living. -There was documentation he had an indwelling catheter. -The resident was semi-ambulatory. -There was documentation the resident received sliding scale insulin. Review of Resident #5's Primary Care Provider's (PCP) orders dated 06/14/23 revealed: -The resident was admitted to the facility on 02/22/23. -There was an order for insulin aspart injections per sliding scale before meals and at bedtime. Review of Resident #5's LHPS assessments revealed: -The most recent LHPS assessment was dated 08/05/23. -Ambulation using assistive devices, urinary catheter, and collecting and testing fingerstick blood samples (FSBS) were identified tasks for Resident #5. -The resident used a wheelchair and walker for ambulation. -The resident had an indwelling catheter. -The date of last evaluation on the assessment sheet was blank. -There was no previous LHPS assessment for review.	D 280		

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D 280	Continued From page 74 Interview with a medication aide (MA) on 09/05/23 at 8:45am revealed: -Resident #5 received FSBS and sliding scale insulin injections. -Resident #5 had a urinary catheter. Interview with the SCC on 09/07/23 at 11:50am revealed she had no LHPS assessments for Resident #5 prior to the one dated 08/05/23. Refer to interview with the SCC on 09/11/23 at 2:15pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with the SCC on 09/11/23 at 2:15pm revealed: -She was responsible for scheduling the contracted nurse (RN) to complete the LHPS assessments. -She had a list from the previous Health and Wellness Director (HWD) of residents that needed updated LHPS assessments. -She thought the LHPS assessments were required annually and was not aware they were required quarterly. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -The RCC and the SCC were responsible for scheduling the assessments with the nurse consultant. -The RCC and the SCC were responsible for auditing resident charts monthly to ensure the LHPS assessments were completed quarterly.	D 280		

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D 297	Continued From page 75	D 297		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure meals were served at regular hours comparable to mealtimes in the community related to breakfast and lunch meals. The findings are: Observation of the lunch meal service in the assisted living dining room on 09/05/23 from 12:05pm to 12:43pm revealed: -At 12:05pm beverages were poured and served to residents. -At 12:14pm salads were served to some of the residents. -At 12:26pm more salads were brought out of the kitchen and served to some of the residents. -At 12:26 some of the residents were served their main course. -At 12:43pm the last two residents received their main course and did not receive a salad. Interview with a resident on 09/11/23 at 2:57pm revealed:	D 297		

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-When he moved into the facility a couple of years ago, meals were served at 8:00am, 12:00pm and 5:00pm daily.
-Currently on the weekend, breakfast does not get served until 8:30am or 9:00am so he and other residents are often just sitting and waiting in the dining room.
-It was hard for him when breakfast was served late because he got very hungry.
-Yesterday (09/10/23), he was served his entire meal at lunch and finished it before another resident at his table was served a sandwich.

Interview with the Resident Care Coordinator on 09/05/23 at 9:30am revealed:
-Breakfast was not served until 9:00am yesterday (09/04/23) because six gallons of milk had expired, and a staff member had to go to the store to purchase more milk.
-The kitchen had been short staffed in August 2023 and she was asked to cook breakfast on 08/27/23.
-The residents were served breakfast later than usual on 08/27/23 but she could not remember what time it was served.

Interview with the Dietary Manager on 11:00am on 09/05/23 revealed:
-He started working at the facility on 09/01/23.
-He expected residents to be served their meals at the posted mealtimes of 8:00am, 12:00pm and 5:00pm.

Interview with the Administrator on 09/11/23 at 4:41pm revealed:
-She was aware the kitchen was short staffed in August 2023 and worked to get more staff hired.
-One weekend, the cook left, and care staff had to help prepare breakfast, so the meal was not served until 10:00am.

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D 297	Continued From page 77 -She expected mealtimes to start with beverages and appetizers being served at 8:00am, 12:00pm and 5:00pm. -She tried to schedule two cooks in the kitchen so the assisted living and special care unit could be served meals at the same time. -She expected all residents to be served their entrees within fifteen minutes of the first entrée coming out of the kitchen.	D 297		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews for 1 of 1 sampled residents, the facility failed to immediately notify local law enforcement when a Special Care Unit (SCU) resident (Resident #3) eloped from the facility and was not immediately located. The findings are: Review of the facility's Elopement/Missing resident policy and procedure dated 10/01/20	D 328		

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revealed:
-A missing resident was a resident who was absent from his/her expected location and could not be located.
-An elopement occurred when a resident, who was assessed as incapable of adequately protecting him or herself, entered an area, unexpected or unaccompanied, unsafe for that resident, such as; stairwells; egress to open doors and windows; outside of the building; courtyards or grounds; and construction/restricted areas.
-If a resident was not located within a "reasonable" amount of time (depending on cognitive abilities of the resident; weather; etc., but not to exceed 30 minutes), the Administrator will notify 911.

Review of Resident #3's current FL2 dated 06/30/23 revealed:
-Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy.
-Resident #3 level of care was SCU.
-The resident was ambulatory and constantly disoriented.
-Resident #5's behaviors included wandering.

Review of Resident #3's Resident Register revealed an admission date of 07/06/23.

Review of Resident #3's undated Care Plan revealed:
-The Care Plan was not dated or signed.
-He was ambulatory and did not require assistive devices.
-His memory was a significant loss and must be directed.
-If he wandered out of the building he would not be able to find his way back.

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D 328	Continued From page 79 Review of Resident #3's record revealed there was no resident profile provided. Review of Resident #3's Emergency Department (ED) provider notes dated 08/09/23 at 2:32pm revealed: -Resident #3 presented to the ED with a chief complaint of being sent in for a medical screening exam after eloping from the facility where he resided. -Resident #3 was administered a liter of intravenous fluids. -Resident #3 was discharged in stable condition. Review of Resident #3's Primary Care Provider's (PCP) progress note dated 07/12/23 revealed: -Resident #3 was seen for a new resident visit. -Resident #3's chief complaint was a significant medical history of dementia. -Resident #3 diagnoses included, dementia and Alzheimer's disease. Review of Resident #3's facility progress note dated 08/09/23 at 1:38pm revealed: -At approximately 10:30am, staff were not able to locate Resident #3. -The elopement process was implemented immediately, and staff began the search for Resident #3. -The search consisted of resident room checks including closets, parked cars, outside surrounding wooded areas and community. -The Administrator was notified then local law enforcement was notified and arrived at the facility at approximately 12:30PM. -The local law enforcement officer (LEO) stated they were notified about an elderly man walking down the road at 10:30am. -At approximately 12:45pm, the officer was able	D 328		

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to locate the elderly man who turned out to be Resident #3 and bring him back to the facility.
-Resident #3 was taken to the hospital by ambulance for evaluation.

Review of an incident report dated 08/09/23 at 10:30am revealed:
-At approximately 10:30am, staff was not able to locate Resident #3.
-The elopement process was implemented immediately, and staff began the search for Resident #5.
-The search consisted of resident room checks including closets, parked cars, outside surrounding wooded areas and community.
-The Administrator was notified and then local law enforcement was notified and arrived at the facility at approximately 12:30PM.
-The LEO stated that they were notified about an elderly man walking down the road at 10:30am.
-At approximately 12:45pm, the officer was able to locate the elderly man who turned out to be Resident #3 and bring him back to the facility.
-Resident #3 was taken to the hospital by ambulance for evaluation.

Interview with a local LEO on 09/08/23 at 9:30am revealed:
-On 08/09/23 at 10:44am she and another LEO responded to a report of an elderly man walking on the main road and the caller was a concerned citizen and requested a welfare check.
-The elderly man was wearing a long sleeve trench medium weight trench coat and was able to give the officer his name and stated, he went walking all of the time.
-The LEO noticed the elderly man was wearing a coat in 90 degree weather, walking so close to the road an instructed him to be careful.
-After the discussion with the elderly man, and

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calling dispatch and no report of a missing person's report, the second officer gave the elderly man a bottle of water and left the scene.
-On 08/09/23 at 12:39pm, she and a second officer were called to the facility to investigate a missing person.
-She recalled the elderly man walking down the road, who fit the description of the missing person report.
-Instead of responding to the facility she drove to the last known location and began her search for the elderly man.
-She arrived at a local gas station located 3.3 miles from the facility where she saw local Sheriff department vehicles and an ambulance.
-Upon further inspection the EMT's were providing care for the elderly man.
-Because Resident #3 was found across NC State line, she obtained clearance from her supervisor, and then she was able to transport Resident #3 back across the state line to the facility.
-On 08/09/23 at 12:45pm Resident #3 was transported back to the facility and then to the hospital for evaluation.
-There was a "substantial" length of time between when Resident #3 went missing and notification to local law enforcement.
-If he facility notified local law enforcement at 10:44am when Resident #3 was first reported missing, then the elderly man walking on the street would have been identified as the missing resident.
-The temperature at the time was approximately in the low 90's and was too hot for Resident #3 to be wearing the medium weight trench coat and that was a concern for Resident #3's health.
-Also, the traffic on that highway was very busy, with speeds of 45 and 55 miles per hour that was a concern for Resident #3's safety.

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D 328	Continued From page 82 -There was limited access to sidewalks and a bridge at the lake that caused concern for the safety of Resident #3. Observation of Resident #3's route on 09/08/23 at 10:00am to 10:10am revealed: -On 08/09/23, Resident #3 left his room located in the SCU, through his bedroom window, walked around the building, up the hill to a busy 4-lane highway with a median, with minimal sidewalk availability and a grassy side area. -Resident #3 would have crossed 20 side streets, 4 major intersections and a bridge over a nearby lake. -During the 10 minutes observation of traffic there were 90 cars, 1 bus, and 6 large trucks displaying average speeds of 55 miles per hour. -Resident #3 passed one local fire department. Observation of Resident #3's GPS route on 09/08/23 at 10:00am revealed: -On 08/09/23 at 10:44am, Resident #3 was located 2.6 miles from the facility after a concerned citizen called local law enforcement for a welfare check on an elderly man who was seen walking down the busy highway. -The time required to walk 2.6 miles at an average pace was 50 minutes. -On 08/09/23 at 12:30pm, resident was located 3.3 miles from the facility. -The time required to walk 3.3 miles at an average pace was 1 hour and 9 minutes. Telephone interview with Resident #3's Power of Attorney (POA) on 09/06/23 at 3:00pm revealed: -On 08/09/23 at 12:30pm, the facility staff contacted her and said Resident #3 was considered a missing person. -On 08/09/23, between 1:00pm and 1:30pm, the facility staff contacted her about Resident #3 was	D 328		

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now at the facility.
-She did not know how long he was missing.
-She expected the facility to contact 911 as soon as the staff were concerned Resident #3 was not in the SCU.

Interview with a personal care aide (PCA) on 09/06/23 at 4:45pm revealed:
-On 08/09/23, she worked in the SCU.
-Resident #3 had wandering behaviors and displayed exit seeking behaviors.
-On 08/09/23 around 11:30, she was notified that Resident #3 was missing.
-She helped look for Resident #3.
-She last saw Resident #3 around 11:00am.
-On 08/09/23 around 12:30pm the local law enforcement was notified by the Special Care Coordinator (SCC).

Telephone interview with a medication aide (MA) on 09/07/23 at 10:29am revealed:
-She worked in the SCU.
-On 08/09/23, during breakfast was the last time she saw Resident #3.
-On 08/09/23, around 11:00 am was when she was informed Resident #3 was missing and to begin the search.
-The Administrator was responsible for notification to the local law enforcement after the search was completed if he was not located.

Interview with Resident #3's primary care physician (PCP) on 09/07/23 at 3:30pm revealed:
-On 08/09/23 she was aware of Resident #3's elopement out of the SCU earlier that morning.
-She was at the facility when Resident #3 was brought back to the facility by the LEO.
-She evaluated Resident #3 and went ahead and sent him to the ED for further testing and evaluation.

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D 328	Continued From page 84 -Around 11:00am she was notified that Resident #3 was missing and law enforcement not been notified at that point. -She expected the staff to notify local law enforcement immediately when Resident #3 was reported missing because of his dementia. -Resident #3 was wearing a long sleeve medium weight coat when he was brought back to the facility which could cause some heat related illnesses such as dehydration, heat exhaustion and or a heat stroke and when the facility did not notify the local law enforcement immediately that also put Resident #3 at a higher risk of developing a heat related illness. -Because of Resident #3's dementia, there was an increase safety concern with Resident #3 walking down a very busy highway, with the risk of stepping out into traffic and being hit by a car or falling and being injured. Interview with the Administrator on 09/07/23 at 9:10am revealed: -On 08/09/23 around 11:00am, the staff were making their rounds when Resident #3 was not able to be located and the RCC was notified. -On 08/09/23, about 11:10am she was notified Resident #3 could not be located. -The elopement procedure was implemented around 11:00am. -The elopement procedure consisted of the search of the entire facility inside and out and the immediate area around the facility. -If after that search the resident was not located, the staff would expand to the areas beyond the facility. -The local law enforcement was to be called after the first initial search was completed and the resident was not located, which should have taken only 10-15 minutes. -On 08/09/23 around 11:30am she went outside	D 328		

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the facility and drove down the street to the next block which was a grocery store area and could not locate Resident #3.
-On 08/09/23 at 12:30pm, she was informed by the RCC and a PCA that Resident #3's window had been pried open, the screen was pushed out, the bushes were flattened, and they found a butter knife laying on the ground.
-On 08/09/23 at 12:30pm, the local law enforcement was notified.
-The officer who responded to the call at 12:30pm received a request for a welfare check an elderly man walking down the road located in front of the facility.
-The officer stated that the elderly man matched the description on the Resident #3 and would go back to where they met with the elderly man about 2 miles away from the facility.
-The officer found Resident #3 at a gas station 3 miles away from the facility and brought him back to the facility.
-Resident #3 was assessed by the facility's PCP who was here at the time and sent to the ED for further evaluation.
-If the local law enforcement was notified when Resident #3 was initially reported as missing, then the welfare check the officer responded to at 10:30am would have been identified as Resident #3 and then Resident #3 would have been returned to the facility faster.

_____

The facility failed to notify local law enforcement immediately after notification that Resident #3 was reported as missing resulted in Resident #3 traveling approximately 2 miles away from the facility at 10:30am when the local law enforcement officer completed a welfare check called in by a concerned citizen, related to an elderly man not yet identified as Resident #3. After the local law enforcement officer contacted

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D 328	Continued From page 86 dispatch and there was no missing persons report from the facility, Resident #3 continued to walk a total 3.3 miles down a busy 4-lane highway with minimal sidewalk access and grassy edges to the road, and crossing 20 streets, 4 major intersections and a bridge over a nearby lake. This put Resident #3 at serious risk of being hit by a vehicle or a heat related illness due to Resident #3 wearing a long sleeve coat in 90-degree weather for over 2 hours. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 7, 2023 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 12, 2023.	D 328		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to protect a resident from physical and mental abuse who was assaulted by another resident with a cane and required sutures for a forehead laceration and right shin laceration and left wrist contusion (Resident #6).	D 338		

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The findings are:

Review of Resident #6's FL2 dated 07/13/23 revealed:
-Diagnoses included dementia.
-She resided on the Special Care Unit (SCU).
-The resident was ambulatory and intermittently disoriented.
-There was no documentation of behaviors.

Review of Resident #6's Resident Register revealed she was admitted to the facility on 07/11/19.

Review of Resident #6's hospital discharge report dated 08/11/23 revealed she was treated in the emergency department (ED) for a facial laceration, laceration of the right shin, and a contusion of the left wrist.

Review of Resident #6's facility progress notes dated 08/11/23 at approximately 5:20pm revealed:
-Resident #6 was sent to the ED for evaluation and treatment after being hit with a cane by another resident and received multiple injuries.
-The resident had a 1.25 inch laceration to the forehead, 4 inch contusion to the left wrist and a laceration to the right shin.
-Resident stated she felt dizzy, did not have any nausea or vomiting and did not lose consciousness.

Telephone interview with Resident #6's Responsible Party on 09/08/23 at 1:05pm revealed:
-She was made aware of the assault right after it happened, and the post ED visit.
-The Resident enjoyed living at the facility and

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participated in activities, going out to the day room, and watching television with other residents.
-She had not seen Resident #6 since the assault.

Interview with Resident #6's Primary Care Provider (PCP) on 09/07/23 at 3:31pm:
-She was informed of the assault on Resident #6 by the Health and Wellness Director (HWD).
-She saw Resident #6 on 08/16/23.
-All the lacerations and contusion were healing, and Home Health was providing care for the right shin dressing.

Interview with a personal care aide (PCA) on 09/07/23 at 10:45am revealed:
-She worked day shift on the SCU.
-Before the assault the Resident would come out to the day room everyday for activities, watched television or sat at one of the tables and watched what was going on.
-The Resident did not come out of her room much anymore and must be encouraged, which was not like her.

Interview with a second PCA on 09/07/23 at 11:20am revealed:
-Since the assault on 08/11/23, Resident #6 did not come out of her room anymore unless it was mealtime.
-The resident seemed to be afraid it would happen again.
-She was encouraged to come out for activities or to walk but she stated she would rather be in her room with her roommate.

Interview with a medication aide (MA) on 09/06/23 at 8:05am revealed:
-She never saw her out of her room and when I gave medications, and was always laying across

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D 338	Continued From page 89 the bed. Interview with a previous Health and Wellness Director (HWD) on 09/08/23 at 3:03pm revealed: -Resident #6 was always out of her room before the assault and attended activities and ate her meals in the day room. -She talked with her the day after the assault and she was sore and did not understand why it had happened to her. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -She was made aware of the assault right after it happened. -She was not aware Resident #6 was not coming out of her room since the assault. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision Special Care Unit Staff Orientation and Training (Type A1 Violation)] _____ The facility failed to ensure Resident #6 was protected from physical and mental abuse from a resident hitting her with his cane resulting in sutures to her forehead, a laceration to her right shin and a left wrist contusion. The failure resulted in serious physical harm and mental abuse as she is afraid to come out of her room. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/23 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 12, 2023.	D 338		

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) regarding orders for The findings are: Review of Resident #3's current FL2 dated 06/30/23 revealed: -Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy. -There were no medication orders. a. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for amlodipine-benazepril (a medication used to treat high blood pressure) 2.5-10mg daily. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated	D 344		

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D 344	Continued From page 91 06/30/23 revealed there was a paper prescription for atorvastatin 40mg daily. Review of Resident #3's July 2023 electronic Medication Administration Record (eMAR) revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The entry was documented as administered at 9:00am from 07/11/23 through 07/31/23. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The entry was documented as administered at 9:00pm from 08/01/23 through 08/31/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The entry was documented as administered at 9:00pm from 09/01/23 through 09/05/23. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no amlodipine besy-benazepril available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 11:32am revealed: -Resident #3 had an order for amlodipine besy-benazepril 2.5-10mg, one tablet daily. -Amlodipine besy-benazepril 2.5-10mg, 30 tablets were dispensed to the facility for Resident #3 on 07/10/23. -The amlodipine was not dispensed since 07/10/23.	D 344		

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D 344	Continued From page 92 Telephone interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed amlodipine was used to treat Resident #3's high blood pressure and not getting the medications as ordered could increase the risk of his blood pressure rising and and if left untreated could cause a stroke or a heart attack. Refer to interview with a medication aide (MA) on 09/11/23 at 12:16pm. Refer to interview with the previous HWD on 09/08/23 at 3:00pm. Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:11pm. b. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for atorvastatin (a medication used to treat cardiovascular disease) 40mg daily. Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for atorvastatin 40mg daily. Review of Resident #3's July 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The entry was documented as administered at 9:00pm from 07/08/23 through 07/31/23. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The entry was documented as administered at	D 344		

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D 344	Continued From page 93 9:00pm from 09/01/23 through 08/06/23 and 08/08/23 to 08/31/23. -The entry was left blank on 08/07/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The entry was documented as administered at 9:00pm from 09/01/23, 09/03/23 and 09/04/23. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no atorvastatin available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed: -Resident #3 had an order for atorvastatin 40mg daily, one tablet daily. -Atorvastatin 40mg daily, 30 tablets were dispensed to the facility for Resident #3 on 07/08/23. -The atorvastatin was not dispensed since 07/10/23. Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed atorvastatin was used to treat Resident #3's cardiovascular disease and if the medication was not taken as ordered it could cause an increase in Resident #3's blood pressure which could lead to a stroke or a heart attack. Refer to interview with a MA on 09/11/23 at 12:16pm. Refer to interview with the previous HWD on 09/08/23 at 3:00pm.	D 344		

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Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

c. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for citalopram (a medication used to treat depression) 10mg daily.

Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for citalopram 10mg daily.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for citalopram 10mg daily.
-The entry was documented as administered at 9:00am from 07/09/23 through 07/31/23.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for citalopram 10mg daily.
-The entry was documented as administered at 9:00am from 08/01/23 through 08/07/23, 08/14/23, 08/20/23, and 08/23/23.
-There was an entry for citalopram 20mg daily.
-The entry was documented as administered at 9:00am from 08/25/23 to 08/31/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for citalopram 20mg daily.
-The entry was documented as administered at 9:00am from 09/01/23 and 09/05/23.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed:
-There was a bubble pack with a label

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documenting citalopram 20mg every day with 22 of 23 tablets remaining.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 11:32am revealed:
-Resident #3 had an order for citalopram 10mg daily.
-Citalopram 10mg daily, 30 tablet was dispensed to the facility for Resident #3 on 07/08/23.
-Resident #3 had an order for citalopram 20mg daily, one tablet daily.
-Citalopram 20mg daily, 6 tablets were dispensed to the facility for Resident #3 on 08/24/23.
-Citalopram 20mg daily, 23 tablets were dispensed to the facility for Resident #3 on 09/04/23.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed citalopram was used to treat Resident #3's mood disorders and if the medication was not taken as directed it could cause increased anxiety and increased behaviors.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

d. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for Plavix (a medication used to decrease the risk of a blood

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D 344	Continued From page 96 clot, stroke or heart attack) 75mg daily. Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for Plavix 75mg daily. Review of Resident #3's July 2023 eMAR revealed. -There was an entry for Plavix 75mg daily. -The entry was documented as administered at 9:00am from 07/09/23 through 07/31/23. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for Plavix 75mg daily. -The entry was documented as administered at 9:00am from 08/01/23 through 08/05/23, 08/20/23, 08/23/23, 08/25/23, 08/26/23, and 08/28/23 to 08/31/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for Plavix 75mg daily. -The entry was documented as administered at 9:00am from on 09/01/23. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no Plavix available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed: -Resident #3 had an order for Plavix 75mg, one tablet daily. -Plavix 75mg daily, 30 tablets were dispensed to the facility for Resident #3 on 07/08/23. -The Plavix was not refilled since 07/10/23.	D 344		

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Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed Plavix was used as an antiplatelet and if the medication was not taken as order it could increase the chance of Resident #3 developing a stroke.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

e. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for depakote (a medications used to treat mood disorders) 125mg two times a day.

Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed there was a paper prescription for depakote 125mg two times daily.

Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for depakote 125mg two times a day.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for Depakote 125mg two times daily.
-The entry was documented as administered at 9:00am from 07/09/23 through 07/31/23.
-The entry was documented as administered at 9:00pm from 07/08/23 through 07/31/23.

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D 344	Continued From page 98 Review of Resident #3's August 2023 eMAR revealed. -There was an entry for Depakote 125mg two times daily. -The entry was documented as administered at 9:00am from 08/01/23 to 08/12/23, and 08/23/23. -The entry was documented as administered at 9:00pm from 08/01/23 to 08/06/23, and 08/08/23 to 08/22/23. -The entry was blank on 08/07/23. -There was an entry for Depakote 250mg two times daily. -The entry was documented as administered at 9:00am from 08/25/23 to 08/31/23. -The entry was documented as administered at 6:00pm from 08/24/23 to 08/31/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for Depakote 250mg two times daily. -The entry was documented as administered at 8:00am from on 09/01/23 and 09/05/23. -The entry was documented as administered at 4:00pm from on 09/01/23 and 09/03/23 to 09/04/23. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed: -There was a bubble pack with a label documenting depakote 250mg two times a day with 29 of 30 tablets remaining. -There was a bubble pack with a label documenting depakote 250mg two times a day with 16 of 16 tablets remaining. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at	D 344		

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1:03pm revealed:
-Resident #3 had an order for Depakote 125mg, one tablet two times daily.
-Depakote 125mg two times daily, 60 tablets were dispensed to the facility for Resident #3 on 07/08/23.
-Resident #3 had an order for Depakote 250mg, one tablet two times daily.
-Depakote 250mg two times daily, 12 tablets were dispensed to the facility for Resident #3 on 08/24/23, and 46 tablets on 09/04/23.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed depakote was used to treat Resident #3's mood disorders and if not administered as ordered it could cause an increase in anxiety and behaviors.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

f. Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for Ativan (medication used for anxiety) 0.5mg every 6 hours as needed for anxiety.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for Ativan 0.5mg every 6 hours as needed for anxiety.
-The entry was documented as not administered

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from 07/07/23 through 07/31/23.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for Ativan 0.5mg every 6 hours as needed for anxiety.
-The entry was documented as not administered from 08/01/23 through 08/31/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for Ativan 0.5mg every 6 hours as needed for anxiety.
-The entry was documented as not administered from 09/01/23 through 09/05/23.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no Ativan available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for Ativan for Resident #3.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed ativan was used to treat anxiety and if not taken as ordered could cause Resident #3 to have increased anxiety and behaviors.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted

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physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

g. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed:
-There was a paper prescription for Zyprexa (a medication used to treat anxiety) 2.5mg every 6 hours as needed for anxiety.

Review of Resident #3's July 2023 eMAR revealed there was no entry for Zyprexa 2.5mg every 6 hours as needed for anxiety.

Review of Resident #3's August 2023 eMAR revealed there was no entry for Zyprexa 2.5mg every 6 hours as needed for anxiety.

Review of Resident #3's September 2023 eMAR revealed there was no entry for Zyprexa 2.5mg every 6 hours as needed for anxiety.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no Zyprexa available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for Zyprexa or Resident #3.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed:
-The Zyprexa was used for anxiety.
-The hard copy prescription was given as the discharge prescriptions and that was why there

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were no medication orders on the FL2 dated 06/30/23.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

h. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed there was a paper prescription for B complex plus Vitamin D (a medication used to treat vitamin deficiencies) daily.

Review of Resident #3's July 2023 eMAR revealed there was no entry for B complex plus Vitamin D daily.

Review of Resident #3's August 2023 eMAR revealed there was no entry for B complex plus Vitamin D daily.

Review of Resident #3's September 2023 eMAR revealed there was no entry for B complex plus Vitamin D daily.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no B complex plus vitamin D available for administration.

Telephone interview with a representative with the

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facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for B complex plus Vitamin D for Resident #3.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed:
-The B Complex plus Vitamin D was to treat vitamin deficiency.
-The hard copy prescription was given as the discharge prescriptions and that was why there were no medication orders on the FL2 dated 06/30/23.

Refer to interview with a medication aide (MA) on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

i. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed there was a paper prescription for amlodipine (a medication used to treat high blood pressure) 2.5mg daily.

Review of Resident #3's July 2023 eMAR revealed there was no entry for amlodipine 2.5mg daily.

Review of Resident #3's August 2023 eMAR revealed there was no entry for amlodipine 2.5mg daily.

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D 344	Continued From page 104 Review of Resident #3's September 2023 eMAR revealed there was no entry for amlodipine 2.5mg daily. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no amlodipine available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for amlodipine for Resident #3. Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed: -The amlodipine was used to treat high blood pressure. -The hard copy prescription was given as the discharge prescriptions and that was why there were no medication orders on the FL2 dated 06/30/23. Refer to interview with a MA on 09/11/23 at 12:16pm. Refer to interview with the previous HWD on 09/08/23 at 3:00pm. Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:11pm. j. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed there was a paper prescription for melatonin (a medication used to treat sleep	D 344		

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disorders) 3mg two times daily.

Review of Resident #3's July 2023 eMAR revealed there was no entry for melatonin 3mg two times daily.

Review of Resident #3's August 2023 eMAR revealed there was no entry for melatonin 3mg two times daily.

Review of Resident #3's September 2023 eMAR revealed there was no entry for melatonin 3mg two times daily.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no melatonin available for administration for Resident #3.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for melatonin for Resident #3.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed:
-The melatonin was used to help with sleep.
-The hard copy prescription was given as the discharge prescriptions and that was why there were no medication orders on the FL2 dated 06/30/23.

Refer to interview with a MA on 09/11/23 at 12:16pm.

Refer to interview with the previous HWD on 09/08/23 at 3:00pm.

Refer to interview with the facility' contracted

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physician on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:11pm.

k. Review of Resident #3's discharge prescriptions dated 07/05/23 from a hospital admission dated 06/30/23 revealed there was a paper prescription for risperidone (an antipsychotic) 1mg two times daily.

Review of Resident #3's July 2023 eMAR revealed there was no entry for risperidone 1mg two times daily.

Review of Resident #3's August 2023 eMAR revealed there was no entry for risperidone 1mg two times daily.

Review of Resident #3's September 2023 eMAR revealed there was no entry for risperidone 1mg two times daily.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no risperidone available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed there was no prescription received dated 07/05/23 for risperidone for Resident #3.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed:
-The risperidone was used to treat mood disorders.
-The hard copy prescription was given as the discharge prescriptions and that was why there

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D 344	Continued From page 107 were no medication orders on the FL2 dated 06/30/23. Refer to interview with a MA on 09/11/23 at 12:16pm. Refer to interview with the previous HWD on 09/08/23 at 3:00pm. Refer to interview with the facility' contracted physician on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:11pm. _____ Interview with a MA on 09/11/23 at 12:16pm revealed: -When Resident #3 was admitted to the facility with 2 FL2's and hard copy prescriptions, it was the responsibility of the MA on duty at the time to call the physician or clarification of the orders. -It was the Special Care Coordinator (SCC) and the Health and Wellness Director's responsibility to check the day after the resident was admitted to the facility in order to make sure the clarification was made. -She was not aware there was a clarification needed to be made. Interview with the previous HWD on 09/08/23 at 3:00pm revealed: -The SCC was responsible notifying the physician to obtain clarification of orders. -There was a 2-step process to make sure the medications were clarified. -The first step was the SCC received clarification from the physician. -The second step was when the orders were enter into the eMAR system by her or the SCC,	D 344		

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D 344	Continued From page 108 the orders were checked for clarification. -She entered the Resident #3's medication orders from the FL2 dated 05/31/23 into the eMAR system. -She did not use the hard prescriptions because she had an FL2 that was in date and had medication orders on it and she would receive new orders from the facility physician once Resident #3 saw her. -She left the facility before Resident #3 was seen by the facility physician on 07/12/23. Interview with the facility' contracted physician on 09/07/23 at 3:30pm revealed: -The MA, SCC or the HWD were responsible for notification to Resident #3's physician who wrote the orders or contacted her for clarification of the medication orders since there were paper prescriptions and and two different FL2's. -She did not receive notification pertaining to Resident #3's admission medication orders. Interview with the Administrator on 09/11/23 at 4:11pm revealed: -It was the SCC responsibility to clarify orders received with two FL2's and paper prescriptions. -It was her responsibility to check on a weekly basis to make sure the orders were clarified. -She was not aware Resident #3 orders needed to be clarified.	D 344		
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:	D 358		

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(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, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 6 sampled residents (#11 & #12) observed during the medication pass on 09/06/23 at 8:00am for medications to lower blood pressure and to treat allergies (#12), potassium supplement and lower blood pressure (#11), and 4 of 5 sampled residents (#2, #3, #5 & #7) related to medications to treat high cholesterol, a vitamin D and calcium supplement, dementia, hypertension, insomnia, prevent blood clots (#2), hypertension, depression, high cholesterol, bipolar disorder, prevent clots (#3), hypertension, viral infections (#5), and hypertension, depression, insomnia, dementia, and cough (#7).

The findings are:

1. Review of Resident #12's current FL2 dated 07/07/23 revealed:
-Diagnoses included hypertension and cardiomegaly (enlarged heart).
-There was an order for loratadine (a medication to treat allergies) 10mg daily.

a. Review of Resident #12's Primary Care Provider's (PCP) order dated 08/23/23 revealed an order for amlodipine (a medication to treat high blood pressure) 2.5mg daily.

Observation of the medication pass on 09/06/23

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at 8:00am revealed:
-The medication aide (MA) was administering Resident #12's morning medications.
-Resident #12's amlodipine 2.5mg was not available to administer to Resident #12.

Review of Resident #12's August 2023 electronic Medication Administration Record (eMAR) revealed.
-There was an entry dated 08/24/23 for amlodipine 2.5mg, one tablet daily.
-Resident #12's amlodipine 2.5mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 08/24/23, 08/30/23 and 08/31/23.

Review of Resident #12's progress notes revealed:
-Resident #12's amlodipine was not administered on 08/24/23 due to waiting on prescription.
-Resident #12's amlodipine was not administered on 08/30/23 and 8/31/23 due to the medication not being available.

Review of Resident #12's September 2023 eMAR revealed.
-There was an entry dated 08/24/23 for amlodipine 2.5mg, one tablet daily.
-Resident #12's amlodipine 2.5mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" from 09/01/23 to 09/03/23 and 09/05/23 to 09/06/23.

Review of Resident #12's progress notes revealed:
-Resident #12's amlodipine was not administered on 09/01/23, 09/02/23 and 09/06/23 due to the medication being unavailable/on order.
-There was no explanation documented for

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amlodipine not being administered on 09/03/23 and 09/05/23.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #12 had an order for amlodipine 2.5mg, one tablet daily.
-On 08/24/23 there were 6 doses of amlodipine 2.5mg dispensed to the facility for Resident #12.
-The amlodipine was not dispensed to the facility on a 28-day cycle because of the timing of when the order was received, the facility would have needed to call the pharmacy to get the remainder of the medication dispensed.

Interview with a MA on 09/06/23 at 8:00am revealed:
-She did not know how long Resident #12 was out of the amlodipine because she worked for an agency and was not familiar with the resident or her medications.
-She informed another MA that Resident #12's amlodipine was not available to administer.
-The other MA informed her the amlodipine for Resident #12 was being sent "stat" from the pharmacy that day (09/06/23).

Interview with Resident #12's PCP on 09/07/23 at 3:30pm revealed:
-She was not notified Resident #12 was not receiving her amlodipine.
-Resident #12's ongoing elevated blood pressures could be a result of not receiving the amlodipine.

b. Observation of the medication pass on 09/06/23 at 8:00am revealed:
-The MA was administering Resident #12's morning medications.

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D 358	Continued From page 112 -Resident #12's loratadine 10mg was not available to administer. Review of Resident #12's August 2023 eMAR revealed. -There was an entry dated 07/22/23 for loratadine 10mg, one tablet daily. -Resident #12's loratadine 10mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 08/24/23, and from 08/27/23 to 08/31/23. Review of Resident #12's progress notes revealed: -Resident #12's loratadine was not administered on 08/24/23 due to waiting on prescription. -Resident #12's loratadine was not administered 08/27/23 through 08/31/23 due to the medication not being available. Review of Resident #12's September 2023 eMAR revealed. -There was an entry dated 07/22/23 for loratadine 10mg, one tablet daily. -Resident #12's loratadine 10mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" from 09/01/23 to 09/06/23. Review of Resident #12's progress notes revealed: -Resident #12's loratadine was not administered on 09/01/23, 09/02/23, 09/04/23 and 09/06/23 due to the medication being unavailable/on order. -There was no explanation documented for loratadine not being administered on 09/03/23 and 09/05/23. Telephone interview with a representative with the	D 358		

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facility's contracted pharmacy on 09/11/23 at 2:37pm revealed they did not have an order for Resident #12's loratadine.

Interview with the MA on 09/06/23 at 8:00am revealed:
-She did not know how long Resident #12 was out of the loratadine because she worked for an agency and was not familiar with the resident or her medications.
-She informed another MA that Resident #12's loratadine was not available to administer.
-The other MA informed her the loratadine for Resident #12 was being sent "stat" from the pharmacy that day (09/06/23).

Interview with Resident #12's PCP on 09/07/23 at 3:30pm revealed:
-She was not notified Resident #12 was not receiving her loratadine.
-She expected the facility to notify her if a resident missed two or three doses of a medication.

2. Review of Resident #11's current FL2 dated 09/20/22 revealed diagnoses included Alzheimer's Disease and essential hypertension.

Review of Resident #11's signed medication review report dated 06/14/23 revealed:
-An order for metoprolol tartrate tablet, 50mg, 1/2 tablet two times a day (a medication used to treat high blood pressure).
-An order for potassium tablet, one tablet daily (a medication used to treat and prevent low potassium levels).

Review of Resident #11's hospital discharge summary dated 08/18/23 revealed:
-An order to discontinue metoprolol tartrate, 50mg, ½ tablet two times a day

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D 358	Continued From page 114 -An order to discontinue potassium tablet daily. Review of Resident #11's August 2023 eMAR revealed: -There was an entry dated 11/01/22 for metoprolol tartrate 50mg, 1/2 tablet two times a day. -Metoprolol tartrate 50mg, 1/2 tablet two times a day was documented as administered from 08/18/23 to 08/31/23. -There was an entry dated 10/29/22 for potassium one tablet daily. -Potassium one tablet was documented as administered on 08/20/23, 08/23/23, and 08/25/23 to 08/30/23. Observation of a medication pass for Resident #11 on 09/06/23 at 8:05am revealed: -Metoprolol tartrate 50mg, ½ tablet was administered. -Potassium 1 tablet was to be administered but the MA did not have any on the medication cart and made a note on the eMAR to reorder. Observation of Resident #11's medications on hand on 09/06/23 at 2:55pm revealed: -There was no potassium on the medication cart. -Metoprolol tartrate 50mg, ½ tablet was in a bubble pack with 17 tablets remaining. Telephone interview with the facility's contracted pharmacy on 09/06/23 at 3:11pm revealed: -The pharmacy had an active order for metoprolol tartrate 50mg, ½ tablet two times daily. -The pharmacy dispensed a 28-day supply of metoprolol tartrate on 08/25/23. -The pharmacy had an active order for potassium tablet, 1 tablet daily. -The pharmacy dispensed 15 tablets of potassium on 07/07/23 with no refills left.	D 358		

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D 358	Continued From page 115 Interview with the Special Care Unit Coordinator (SCC) on 09/06/23 at 4:20pm revealed: -She did not know the metoprolol tartrate 50mg 1/2 tablet two times a day and the potassium tablet daily were discontinued. -She verified the metoprolol tartrate 50mg ½ tablet, two times a day potassium one tablet daily was discontinued on 08/18/23 when Resident #11 returned from the hospital. -The order was changed on the eMAR on 09/06/23. -She had not seen the discharge order on Resident #11. Interview with Resident #11's PCP on 09/07/23 at 3:31pm revealed: -She was not aware that Resident #11's metoprolol tartrate and potassium had been discontinued by the hospital. -She did not have any discharge paperwork from the hospital or the facility. -She would like for the facility to put the discharge paperwork in her file at the facility so she could date it and sign off on it. -Receiving the metoprolol tartrate could cause Resident #11's blood pressure to be high.. -Receiving the potassium could cause heart problems if the potassium was too high. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -She was not aware of the medication error on Resident #11. -When residents are discharged from the hospital, the discharge papers are to be put in the SCC's communication box and the SCC or the RCC was to make the changes. -SCC was responsible for chart audits monthly on the memory care unit.	D 358		

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D 358	Continued From page 116 -She was not sure when the last audit was completed. 3. Review of Resident #2's current FL2 dated 08/04/23 revealed diagnoses included anxiety disorder, Alzheimer's disease, essential hypertension, benign hypertension, hyperlipidemia and major depressive disorder. Review of Resident #2's signed Physician's orders dated 02/20/23 revealed: -An order for atorvastatin calcium 80 mg (used to prevent cardiovascular disease and treat abnormal lipid levels) tablet at bedtime. -An order for cholecalciferol 1000-unit (a D vitamin essential for depositing calcium in bones) tablet daily. -An order for cyanocobalamin 1000 mcg (used to treat a vitamin B12 deficiency and pernicious anemia) tablet daily. -An order for donepezil HCl 10 mg (used to treat Alzheimer's dementia) tablet at bedtime. -An order for lisinopril 5 mg (used to treat high blood pressure) tablet daily. -An order for melatonin 3 mg (used as a sleep aid) at bedtime. -An order for apixaban 2.5 mg (used to treat and prevent blood clots) tablet twice daily. a. Review of Resident #2's July 2023 eMAR revealed: -There was an entry dated 07/25/22 for atorvastatin calcium 80 mg, one tablet daily. -Atorvastatin was documented with the exception code "09" indicating "other/see nurse notes" from 07/08/23 to 07/15/23. -Atorvastatin was documented with the exception code "07" indicating "sleeping" on 07/29/23.	D 358		

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Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why atorvastatin was not administered from 07/08/23 to 07/15/23.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of atorvastatin for Resident #2 on 06/07/23 which should have been available to administer until around 07/06/23.
-The pharmacy dispensed 28 tablets of atorvastatin for Resident #2 on 07/15/23 which should have been available to administer until about 08/11/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 8 consecutive doses of atorvastatin increased Resident #2's lipid levels for 8 days and his chance of having a stroke or heart event.

Attempted telephone interview with Resident #2's PCP on 09/11/23 at 2:08pm was unsuccessful.

b. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 12/02/21 for cholecalciferol 1000 unit, one tablet daily.
-Cholecalciferol was documented with the exception code "09" indicating "other/see nurse notes" on 07/08/23, 07/15/23 and from 07/17/23 to 07/26/23.
-Cholecalciferol was documented with the exception code "06" indicating "hospitalized" on 07/30/23.

Review of Resident #2's July 2023 progress notes revealed:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-Cholecalciferol was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue.
-There was no documentation that indicated why cholecalciferol was not administered on 07/08/23, 07/15/23 or from 07/17/23 to 07/26/23.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of cholecalciferol for Resident #2 on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 30 tablets of cholecalciferol for Resident #2 on 07/22/23 which should have been available to administer until around 08/20/23.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-Resident #2 was prescribed cholecalciferol as a dietary supplement.
-She did not anticipate any outcome of missing 12 doses but did expect Resident #2 to receive the cholecalciferol as ordered.

c. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 12/21/21 for cyanocobalamin 1000 mcg, one tablet daily.

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-Cyanocobalamin was documented with the exception code "09" indicating "other/see nurse note" on 07/08/23, from 07/11/23 to 07/15/23, from 07/27/23 to 07/29/23 and 07/31/23.
-Cyanocobalamin was documented with the exception code "06" indicating "hospitalized" on 07/30/23.

Review of Resident #2's July 2023 progress notes revealed:
-Cyanocobalamin was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue.
-There was no documentation that indicated why cyanocobalamin was not administered from 07/11/23 to 07/15/23, from 07/27/23 to 07/29/23 or 07/31/23.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Review of Resident #2's August 2023 eMAR revealed:
-There was an entry dated 12/21/21 for cyanocobalamin 1000 mcg, one tablet daily.
-Cyanocobalamin was documented with the exception code "09" indicating "other/see nurse note" on 08/01/23 and 08/02/23.
-Cyanocobalamin was documented with the exception code "06" indicating "hospitalized" from 08/28/23 to 08/31/23.

Review of Resident #2's August 2023 progress

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notes revealed there was no documentation that indicated why cyanocobalamin was not administered on 08/01/23 and 08/02/23.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of cyanocobalamin for Resident #2 on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 28 tablets of cyanocobalamin for Resident #2 on 08/02/23 which should have been available to administer until around 08/30/23.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-Resident #2 was prescribed cyanocobalamin as a dietary supplement.
-She did not anticipate any outcome after missing 8 doses but did expect Resident #2 to receive cyanocobalamin as ordered.

d. Review of Resident #2's July 2023 eMAR revealed:
-An entry dated 07/26/22 for donepezil HCl 10 mg, one tablet at bedtime.
-Donepezil HCl was documented with the exception code "09" indicating "other/see nurse note" from 07/08/23 to 07/15/23.
-Donepezil HCl was documented with the exception code "07" indicating "sleeping".

Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why donepezil HCl was not administered from 07/08/23 to 07/15/23.

Review of Resident #2's August 2023 eMAR revealed:

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-An entry dated 07/26/22 for donepezil HCl 10 mg, one tablet at bedtime.
-Donepezil was documented with the exception code "09" indicating "other/see nurse note" on 08/18/23, 08/19/23, 08/23/23 and 08/25/23.
-Donepezil was documented with the exception code "06" indicating "hospitalized" on 08/22/23 and from 08/28/23 to 08/31/23.

Review of Resident #2's August 2023 progress notes revealed there was no documentation that indicated why donepezil was not administered on 08/18/23, 08/19/23, 08/23/23 or 08/25/23.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of donepezil for Resident #2 on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 28 tablets of donepezil for Resident #2 on 07/15/23 which should have been available to administer until around 08/11/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 8 consecutive doses of donepezil may increase Resident #2's confusion.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-Resident #2 was prescribed donepezil to help decrease his confusion related to dementia; however, Resident #2's dementia was far too advanced for donepezil to make a big difference.
-She expected Resident #2 to receive donepezil as ordered.

e. Review of Resident #2's July 2023 eMAR

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revealed:
-There was an entry dated 11/27/22 for lisinopril 5 mg, once daily.
-Lisinopril was documented with the exception code "09" indicating "other/see nurse note" from 07/08/23 to 07/15/23 and from 07/17/23 to 07/22/23.
-Lisinopril was documented with the exception code "06" on 07/30/23 indicating "hospitalized".

Review of Resident #'2 July 2023 progress notes revealed:
-Lisinopril was not administered on 07/08/23 due to the medication carts were locked/pharmacy issue.
-There was no documentation that indicated why lisinopril was not administered from 07/08/23 to 07/15/23 or from 07/17/23 to 07/22/23.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.
-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of lisinopril for Resident #2 on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 30 tablets of lisinopril for Resident #2 on 07/22/23 which should have been available to administer until around 08/20/23.

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Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed:
-Missing 8 consecutive doses of lisinopril put Resident #2 at risk of a heart event and high blood pressure.
-Missing 8 consecutive doses of lisinopril and atorvastatin at the same time would compound and increase Resident #2's risks of a heart event and high blood pressure.

Attempted telephone interview with Resident #2's PCP on 09/11/23 at 2:08pm was unsuccessful.

f. Review of Resident #2's July 2023 eMAR revealed:
-There was an entry dated 12/01/21 for melatonin 3 mg, once at bedtime.
-Melatonin was documented with the exception code "09" indicating "other/see nurse note" from 07/08/23 to 07/15/23.
-Melatonin was documented with the exception code "07" indicating "sleeping" on 07/29/23.

Review of Resident #2's July 2023 progress notes revealed there was no documentation that indicated why melatonin was not administered from 07/08/23 to 07/15/23.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 28 tablets of melatonin for Resident #2 on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 28 tablets of melatonin for Resident #2 on 07/15/23 which should have been available to administer until around 08/11/23.

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D 358	Continued From page 124 Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed: -Missing 8 consecutive doses of melatonin increased Resident #2's chances for insomnia. -Missing 8 consecutive doses of melatonin and donepezil at the same time would compound the effects of insomnia and could cause more confusion or abnormal behaviors. Attempted telephone interview with Resident #2's PCP on 09/11/23 at 2:08pm was unsuccessful. g. Review of Resident #2's July 2023 eMAR revealed: -There was an entry dated 12/01/21 for apixaban 2.5 mg, twice daily. -Apixaban was documented with the exception code "09" indicating "other/see nurse note" from 07/08/23 to 07/15/23. -Apixaban was documented with the exception code "07" indicating "sleeping" on 07/29/23 at 6:00pm. -Apixaban was documented with the exception code "06" indicating "hospitalized" on 07/30/23 at 8:00am. Review of Resident #2's July 2023 progress notes reveal: -Apixaban was not administered on 07/08/23 at 8:00am due to the medication carts were locked/pharmacy issue. -There was no documentation to indicate why apixaban was not administered from 07/08/23 to 07/15/23. Interview with the RCC on 09/11/23 at 11:18am revealed: -On 07/08/23, the night shift MA locked all the medication cart keys in one medication cart.	D 358		

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-The pharmacy had to be called and a pharmacy technician came to the facility to unlock the cart containing all the keys.
-All resident medications were late or not administered that morning.

Telephone interview with a pharmacy technician on 09/11/23 at 10:00am revealed:
-The pharmacy dispensed 56 tablets of apixaban on 06/06/23 which should have been available to administer until around 07/03/23.
-The pharmacy dispensed 56 tablets of apixaban on 07/15/23 which should have been available to administer until around 08/11/23.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed missing 16 consecutive doses of apixaban could lead to a blood clot formation and deep vein thrombosis (a condition in which the blood clots form in veins located deep inside the body, usually in the thigh or lower legs, which can cause pain and swelling in the area) or a stroke like event.

Interview with Resident #2's PCP on 09/07/23 at 3:30pm revealed:
-Resident #2 was prescribed apixaban due to a history of a stroke and atrial flutter (an abnormal heart rhythm).
-Missing 16 consecutive doses of apixaban put Resident #2 at risk for blood clot in his heart which could have led to a stroke.

4. Review of Resident #3's current FL2 dated 06/30/23 revealed:
-Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy.
-There were no medication orders.

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D 358	Continued From page 126 Review of Resident #3's FL2 dated 05/31/23 revealed: -There was an order for amlodipine-benazepril (a medication used to treat high blood pressure) 2.5mg-10mg daily. -There was an order for atorvastatin (a medication used to treat cardiovascular disease) 40mg daily. -There was an order for citalopram (a medication used to treat depression) 10mg daily. -There was an order for clopidogrel (a medication used to decrease the risk of a blood clot, stroke or heart attack) 75mg daily. -There was an order for divalproex (a medications used to treat mood disorders) 125mg two times a day. Review of Resident #3 signed physician's orders dated 07/12/23 revealed: -There was an order for atorvastatin 40mg daily. -There was an order for citalopram 10mg daily. -There was an order for clopidogrel 75mg daily. -There was an order for divalproex 125mg two times a day. a. Review of Resident #3's July 2023 electronic Medication Administration Record (eMAR) revealed. -There was an entry for amlodipine-benazepril 2.5mg-10mg, daily. -The entry was not documented as administered at 9:00am on 07/08/23 through 07/10/23. Review of Resident #3's progress notes revealed: -The amlodipine-benazepril was not administered on 07/08/23 due to the medications were locked in the medication cart and medications not received from the pharmacy. -There was no documentation of why the	D 358		

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medications were not administered on 07/09/23 and 07/10/23.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for amlodipine-benazepril 2.5-10mg, daily.
-The entry was documented as administered at 9:00am from 08/01/23 through 08/31/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for amlodipine-benazepril 2.5-10mg, daily.
-The entry was documented as administered at 9:00pm from 09/01/23 through 09/05/23.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no amlodipine-benazepril available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 11:32am revealed:
-Resident #3 had an order dated 07/08/23, for amlodipine Benazepril 2.5-10mg, one tablet daily.
-Amlodipine-benazepril 2.5-10mg, 30 tablets were dispensed to the facility for Resident #3 on 07/10/23.
-The amlodipine was not refilled since 07/10/23 and would have been out of amlodipine-benazepril on 08/09/23.
-Resident #3 required 27 more doses of amlodipine-benazepril, for 08/10/23 to 09/05/23, in order to follow the PCP's order.

Telephone interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at

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4:22pm revealed amlodipine was used to treat Resident #3's high blood pressure and not getting the medications as ordered could increase the risk of his blood pressure rising and and if left untreated could cause a stroke or a heart attack.

Interview with the Administrator on 09/11/23 at 4:11pm revealed:
-There was no receipts of amlodipine-benazepril brought into the facility when Resident #3 was admitted to the facility.
-She was not aware Resident #3 ran out of amlodipine-benazepril and wqs not administered as ordered,

b. Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for atorvastatin 40mg daily.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 07/07/2.

Review of Resident #3's progress notes revealed the atorvastatin was not administered on 07/07/23 due to the medications were not available.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for atorvastatin 40mg daily.
-The entry was left blank on 08/07/23.

Review of Resident #3's progress notes revealed there was documentation of why the atorvastatin was left blank.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for atorvastatin 40mg daily.
-The entry was documented with the exception

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D 358	Continued From page 129 code "09" indicating "other/see nurse notes" on 09/02/23. Review of Resident #3's progress notes revealed there was no documentation of why the atorvastatin was not administered. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no atorvastatin available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed: -Resident #3 had an order dated 07/08/23 for atorvastatin 40mg daily, one tablet daily. -Atorvastatin 40mg daily, 30 tablets were dispensed to the facility for Resident #3 on 07/08/23. -The atorvastatin was not refilled since 07/08/23 and would have been out of atorvastatin on 08/07/23. -Resident #3 required 29 more doses of atorvastatin for 08/08/23 to 09/05/23, in order to follow the PCP's order. Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed atorvastatin was used to treat Resident #3's cardiovascular disease and if the medication was not taken as ordered it could cause an increase in Resident #3's blood pressure which could lead to a stroke or a heart attack. Interview with the Administrator on 09/11/23 at 4:11pm revealed: -There was no receipts of atorvastatin brought into the facility when Resident #3 was admitted to the facility.	D 358		

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 130 -She was not aware Resident #3 ran out of atorvastatin and was not administered as ordered, c. Review of Resident #3's July 2023 eMAR revealed. -There was an entry for citalopram 10mg daily. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 07/08/2. Review of Resident #3's progress notes revealed the atorvastatin was not administered on 07/08/23 due to the citalopram was locked in the medication carts. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for citalopram 10mg daily last administered on 08/23/23 at 9:00am. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 08/08/23 to 08/13/23, 08/15/23 to 08/19/23, and 08/21/23 to 08/22/23. -There was an entry for citalopram 20mg daily first administered on 08/25/23 at 8:00am. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 08/24/23. Review of Resident #3's progress notes revealed: -The citalopram 10mg was not administered on 08/08/23 due to the citalopram was not available. -There was no documentation of why the citalopram was not administered on 08/09/23. -The citalopram 20mg was not administered due to the citalopram was not available. -There was no documentation the citalopram 20mg was administered 08/11/23 to 08/13/23, 08/15/23 to 08/19/23, and 08/21/23 to 08/22/23,	D 358		

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D 358	Continued From page 131 08/25/23 to 08/31/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for citalopram 20mg daily. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 09/02/23 to 09/04/23. Review of Resident #3's progress notes revealed on 09/02/23 to 09/04/23, there was no documentation as to why the citalopram was not administered. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was a bubble pack with a label documenting citalopram 20mg every day with 22 of 23 tablets remaining. Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 11:32am revealed: -Resident #3 had an order dated 07/08/23 for citalopram 10mg daily. -Citalopram 10mg daily, 30 tablets were dispensed to the facility for Resident #3 on 07/08/23 and would have required a refill on 08/07/23. -Resident #3 required 17 more doses of citalopram 10mg in order to administer the citalopram as ordered from 08/08/23 to 08/24/23. -Resident #3 had an order dated 08/24/23 for citalopram 20mg daily, one tablet daily. -Citalopram 20mg daily, 6 tablets were dispensed to the facility for Resident #3 on 08/24/23. -Citalopram 20mg daily, 23 tablets were dispensed to the facility for Resident #3 on 09/04/23. -Resident #3 required 6 more doses of citalopram	D 358		

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20mg in order to administer the citalopram as ordered from 08/30/23 to 09/05/23.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed citalopram was used to treat Resident #3's mood disorders and if the medication was not taken as directed it could cause increased anxiety and increased behaviors.

Interview with the Administrator on 09/11/23 at 4:11pm revealed:
-There was no receipts of citalopram brought into the facility when Resident #3 was admitted to the facility.
-She was not aware Resident #3 ran out of citalopram and was not administered as ordered,

d. Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for Plavix 75mg daily.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 07/08/2.

Review of Resident #3's progress notes revealed the atorvastatin was not administered on 07/08/23 due to the Plavix was locked in the medication cart.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for Plavix 75mg daily.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 08/06/23 to 08/19/23, 08/21/23, 08/22/23, 08/24/23, and 08/27/23.

Review of Resident #3's progress notes revealed:
-The Plavix was not administered on 08/06/23

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and 08/08/23 due to the medication not available.
-The Plavix was not administered on 08/07/23 due to the medication was on order.
-There was no documentation as to why the Plavix was not administered 08/09/23 to 08/19/23, 08/21/23, 08/22/23, 08/24/23 and 08/27/23.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for Plavix 75mg daily.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 09/02/23 to 09/05/23.

Review of Resident #3's progress notes revealed on 09/02/23 to 09/05/23, there was no documentation as to why the Plavix was not administered.

Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed there was no Plavix available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #3 had an order dated 07/08/23 for Plavix 75mg, one tablet daily.
-Plavix 75mg daily, 30 tablets were dispensed to the facility for Resident #3 on 07/08/23 and would be out of Plavix on 08/07/23.
-The Plavix was not refilled since 07/08/23 and Resident #3 required 29 more doses of Plavix for 08/08/23 to 09/05/23, in order to follow the PCP's order.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed Plavix was

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used as an antiplatelet and if the medication was not taken as ordered it could increase the chance of Resident #3 developing a stroke.

Interview with the Administrator on 09/11/23 at 4:11pm revealed:
-There was no receipts of Plavix brought into the facility when Resident #3 was admitted to the facility.
-She was not aware Resident #3 ran out of Plavix and was not administered as ordered,

e. Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for Depakote 125mg two times daily.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 07/07/23 at 9:00pm and on 07/08/23 at 9:00am.
-The entry was documented with the exception code "09" indicating "other/see nurse notes" on 07/08/23.

Review of Resident #3's progress notes revealed the Depakote 125mg was not administered on 07/08//23 due to locked medication cart and no reason as to why the Depakote was not administered on 07/07/23.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for Depakote 125mg two times daily and last administered on 08/23/23 at 9:00am.
-The entry was documented with the code "09" indicating "other/see nurse notes" on 08/13/23 to 08/19/23, 08/21/23 and 08/22/23.
-The entry was blank on 08/07/23.
-There was an entry for Depakote 250mg two times daily and first administered on 08/24/23 at

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D 358	Continued From page 135 4:00pm -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 08/24/23. Review of Resident #3's progress notes revealed: -There was no documentation as to why the Depakote 125mg was not administered on 08/07/23, 08/13/23 to 08/19/23, 08/21/23 and 08/22/23. -There was no documentation as to why the Depakote 250mg was not administered 08/24/23. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for Depakote 250mg two times daily. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 09/02/23 to 09/04/23. -The entry was documented with the exception code "09" indicating "other/see nurse notes" on 09/02/23. Review of Resident #3's progress notes revealed there was no documentation as to why the Depakote was not administered on 09/02/23 to 09/04/23 at 8:00am, and on 09/02/23 at 4:00pm. Observation of Resident #3's medications available for administration on 09/06/23 at 11:20am revealed: -There was a bubble pack with a label documenting depakote 250mg two times a day with 29 of 30 tablets remaining. -There was a bubble pack with a label documenting depakote 250mg two times a day with 16 of 16 tablets remaining. Telephone interview with a representative with the	D 358		

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facility's contracted pharmacy on 09/06/23 at 1:03pm revealed:
-Resident #3 had an order dated 07/08/23 for Depakote 125mg, one tablet two times daily.
-Depakote 125mg two times daily, 60 tablets were dispensed to the facility for Resident #3 on 07/08/23 and would have run out on 08/07/23.
-Resident #3 required 17 more doses of Depakote 125mg in order to administer as ordered from 08/08/23 to 08/24/23.
-Resident #3 had an order dated 08/24/23 for Depakote 250mg, one tablet two times daily.
-Depakote 250mg two times daily, 12 tablets were dispensed to the facility for Resident #3 on 08/24/23, and 46 tablets on 09/04/23.
-Resident #3 required 6 more doses of Depakote 250mg in order to administer the as ordered from 08/30/23 to 09/05/23.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed depakote was used to treat Resident #3's mood disorders and if not administered as ordered it could cause an increase in anxiety and behaviors.

Interview with the Administrator on 09/11/23 at 4:11pm revealed:
-There was no receipts of Depakote brought into the facility when Resident #3 was admitted to the facility.
-She was not aware Resident #3 ran out of Depakote and was not administered as ordered.

5. Review of Resident #5's current FL2 dated 02/20/23 revealed diagnoses included multiple myeloma (a blood cancer), and hypertension.

Review of Resident #5's Primary Care Provider's (PCP) orders dated 06/14/23 revealed:
-There was an order for acyclovir (a medication to

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treat viral infections) 400mg, one tablet daily.
-There was an order for amlodipine (a medication to treat hypertension) 10mg, one tablet daily.

a. Review of Resident #5's September 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for acyclovir 400mg, one tablet daily.
-The entry was documented with the exception code "09", indicating see progress notes, from 09/02/23 through 09/05/23.

Review of Resident #5's progress notes revealed:
-Resident #5's acyclovir 400mg was not administered on 09/02/23 due to the medication was on order.
-There was no documentation why Resident #5's acyclovir was not administered on 09/03/23 through 09/05/23.

Telephone interview with a representative from the facility's contracted pharmacy on 09/08/23 at 10:09am revealed:
-Resident #5 had an order dated 03/21/23 for acyclovir 400mg, one tablet daily.
-Acyclovir 400mg, 28 tablets were dispensed for Resident #5 on 06/02/23, 06/30/23 and 07/28/23.
-Resident #5's acyclovir was not dispensed after 07/28/23 due to a hold placed on his account.

Observation of medications on hand for Resident #5 on 09/11/23 at 9:31am revealed there was no acyclovir available for administration.

Interview with a Medication Aide (MA) on 09/11/23 at 9:34am revealed:
-She spoke with Resident #5's family member the previous week and they requested a change of pharmacy.

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-She was unsure how long the medication would take to come in from the new pharmacy.

Interview with Resident #5 on 09/11/23 at 12:40pm revealed he was unsure what medications staff administered but thought he did not always get them because the quantity in the medication cup varied from day to day.

Refer to the interview with the Administrator on 09/11/23 at 4:41pm.

b. Review of Resident #5's September 2023 eMAR revealed:
-There was an entry for amlodipine 10mg, one tablet daily.
-The entry was documented with the exception code "09", indicating see progress notes, from 09/02/23 through 09/05/23.

Review of Resident #5's progress notes revealed:
-Resident #5's amlodipine was not administered on 09/02/23 and 09/04/23 because the medication was on order.
-There was no documentation why Resident #5's amlodipine was not administered on 09/03/23 and 09/05/23.

Telephone interview with a representative from the facility's contracted pharmacy on 09/08/23 at 10:09am revealed:
-Resident #5 had an order dated 03/21/23 for amlodipine 10mg, one tablet daily.
-Amlodipine 10mg, 28 tablets were dispensed for Resident #5 on 06/02/23, 06/30/23 and 07/28/23.
-Resident #5's amlodipine was not dispensed after 07/28/23 due to a hold placed on his account.

Telephone interview with a representative from

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the facility's contracted pharmacy on 09/11/23 at 2:37pm revealed Resident #5 could experience elevated blood pressures or headaches if he did not receive his amlodipine as prescribed.

Observation of medications on hand for Resident #5 on 09/11/23 at 9:31am revealed there was no amlodipine available for administration.

Interview with a Medication Aide (MA) on 09/11/23 at 9:34am revealed:
-She spoke with Resident #5's family member the previous week and they requested a change of pharmacy.
-She was unsure how long the medication would take to come in from the new pharmacy.

Interview with Resident #5 on 09/11/23 at 12:40pm revealed he was unsure what medications staff administered but thought he did not always get them because the quantity in the medication cup varied from day to day.

Refer to the interview with the Administrator on 09/11/23 at 4:41pm.

6. Review of Resident #7's current FL-2 dated 08/21/23 revealed:
-Diagnosis included subdural hemorrhage.
-An order for amlodipine 10mg tablet (a medication used to treat hypertension) one tablet by mouth daily.
-An order for citalopram 20mg tablet (a medication used to treat depression) one tablet by mouth daily.
-An order for mirtazapine 7.5mg tablet (a medication used to treat dementia) one tablet by mouth twice daily.

Review of Resident #7's August 2023 Progress

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D 358	Continued From page 140 Notes revealed an entry dated 08/22/23 at 7:30pm documented Resident #7 was admitted to the facility without any accompanied medications. a. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 08/21/23 for Amlodipine 10mg tablet one tablet by mouth daily at 7:00am. -Amlodipine 10mg was documented as not administered with the exception code "09" indicating "other/see nurses notes" on 08/24/23 and 08/25/23. Review of Resident #7's August 2023 Progress Notes revealed Resident #7's Amlodipine 10mg was not administered on 08/24/23 and 08/25/23 due to waiting on delivery from pharmacy. Telephone interview with the facility's contracted pharmacy technician on 09/08/23 at 2:19pm revealed: -The pharmacy was responsible for supplying Resident #7's medications. -On 08/24/23, the pharmacy received a fax request from the facility to fill Resident #7's Amlodipine 10mg one tablet by mouth daily. -On 08/24/23, the pharmacy dispensed Resident #7's Amlodipine 10mg for 30 tablets. -On 08/24/23 at 4:39pm, Resident #7's Amlodipine 10mg medication was delivered to the facility. Interview with Resident #7's PCP on 09/07/23 at 3:30pm revealed: -She was not aware Resident #7's Amlodipine 10mg medication was not available for administration on 08/23/23 and 08/24/23. -She expected MAs to administer Resident #7's	D 358		

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Amlodipine 10mg on 08/25/23.
-She expected Resident #7's medications to be available for administration upon admission.

Interview with a MA on 09/08/23 at 10:30am revealed:
-She was not aware Resident #7's Amlodipine 10mg medication had two doses unaccounted for.
-Resident #7 Amlodipine 10mg could not have been administered on 08/23/23 because the facility's contracted pharmacy delivered Resident #7's medications on 08/24/23 during second shift.
-Resident #7's Amlodipine 10mg should have been administered on 08/25/23.
-The SCC and MAs were responsible to request medication refills.
-The SCC or Administrator were responsible for ordering newly admitted residents' medications from the facility's contracted pharmacy.
-Residents medications were to be available for administration upon admission.
-MAs were not permitted to borrow medications between residents.
-MAs were required to document in residents progress notes for any medication that was wasted.

Observation of Resident #7's medications available for administration on 09/07/23 revealed Resident #7's Amlodipine 10mg tablet medication one tablet by mouth daily was filled on 08/24/23 for 30 doses with 26 doses remaining in the medication blister card, and a dispense date of 08/24/23.

b. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry dated 08/21/23 for

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Citalopram 20mg tablet one tablet by mouth daily at 7:00am.
-Citalopram 20mg was documented as not administered with the exception code "09" indicating "other/see nurses notes" on 08/24/23 and 08/25/23.

Review of Resident #7's August 2023 Progress Notes revealed Resident #7's Citalopram 20mg was not administered on 08/24/23 and 08/25/23 due to waiting on delivery from pharmacy.

Telephone interview with the facility's contracted pharmacy technician on 09/08/23 at 2:19pm revealed:
-The pharmacy was responsible for supplying Resident #7's medications.
-On 08/24/23, the pharmacy received a fax request from the facility to fill Resident #7's Citalopram 20mg one tablet by mouth daily.
-On 08/24/23, the pharmacy dispensed Resident #7's Citalopram 20mg for 30 tablets.
-On 08/24/23 at 4:39pm, Resident #7's Citalopram 20mg medication was delivered to the facility.

Interview with Resident #7's PCP on 09/07/23 at 3:30pm revealed:
-She was not aware Resident #7's Citalopram 20mg medication was not available for administration on 08/23/23 and 08/24/23.
-She expected MAs to administer Resident #7's Citalopram 20mg on 08/25/23.
-If Resident #7 had missed doses of Citalopram 20mg, it had a potential to cause Resident #7 to exhibit behavioral difficulties, including agitation.
-She expected Resident #7's medications to be available for administration upon admission.

Interview with a MA on 09/08/23 at 10:30am

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revealed:
-She was not aware Resident #7's Citalopram 20mg medication had two doses unaccounted for.
-Resident #7's Citalopram 20mg could not have been administered on 08/23/23 because the facility's contracted pharmacy delivered Resident #7's medications on 08/24/23 during second shift.
-Resident #7's Citalopram 20mg should have been administered on 08/25/23.
-The SCC and MAs were responsible to request medication refills.
-The SCC or Administrator were responsible for ordering newly admitted residents' medications from the facility's contracted pharmacy.
-Residents medications were to be available for administration upon admission.
-MAs were not permitted to borrow medications between residents.
-MAs were required to document in residents progress notes for any medication that was wasted.

Observation of Resident #7's medications available for administration on 09/07/23 revealed Resident #7's Citalopram 20 mg tablet medication one tablet by mouth daily was filled on 08/24/23 for 30 doses with 26 doses remaining in the medication blister card, and a dispense date of 08/24/23.

c. Review of Resident #7's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry dated 08/21/23 for Mirtazapine 7.5mg tablet one tablet by mouth twice daily at 8:00am and 4:00pm.
-Mirtazapine 7.5mg was documented as not administered with the exception code "09" indicating "other/see nurses notes" on 08/24/23

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D 358	Continued From page 144 and 08/25/23. Review of Resident #7's August 2023 Progress Notes revealed Resident #7's Mirtazapine 7.5mg was not administered on 08/24/23 and 08/25/23 due to waiting on delivery from pharmacy. Telephone interview with the facility's contracted pharmacy technician on 09/08/23 at 2:19pm revealed: -The pharmacy was responsible for supplying Resident #7's medications. -On 08/24/23, the pharmacy received a fax request from the facility to fill Resident #7's Mirtazapine 7.5mg one tablet by mouth twice daily. -On 08/24/23, the pharmacy dispensed Resident #7's Mirtazapine 7.5mg for 60 tablets. -On 08/24/23 at 4:39pm, Resident #7's Mirtazapine 7.5mg medication was delivered to the facility. Interview with Resident #7's PCP on 09/07/23 at 3:30pm revealed: -She was not aware Resident #7's Mirtazapine 7.5mg medication was not available for administration on 08/23/23 and 08/24/23. -She expected MAs to administer Resident #7's Mirtazapine 7.5mg on 08/25/23. -She expected Resident #7's medications to be available for administration upon admission. Interview with a MA on 09/08/23 at 10:30am revealed: -She was not aware Resident #7's Mirtazapine 7.5mg medication had two doses unaccounted for. -Resident #7 Mirtazapine 7.5mg could not have been administered on 08/23/23 because the facility's contracted pharmacy delivered Resident	D 358		

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#7's medications on 08/24/23 during second shift.
-Resident #7's Mirtazapine 7.5mg should have been administered on 08/25/23.
-The SCC and MAs were responsible to request medication refills.
-The SCC or Administrator were responsible for ordering newly admitted residents' medications from the facility's contracted pharmacy.
-Residents medications were to be available for administration upon admission.
-MAs were not permitted to borrow medications between residents.
-MAs were required to document in residents progress notes for any medication that was wasted.

Observation of Resident #7's medications available for administration on 09/07/23 revealed Resident #7's Mirtazapine 7.5 mg medication one tablet by mouth twice daily was filled on 08/24/23 for two medication blister cards of 30 doses per card, with 48 doses remaining in the medication blister cards, and a dispense date of 08/24/23.

Interview with the current SCC on 09/11/23 at 12:02pm revealed:
-The SCC, RCC, or Administrator were responsible to transcribe residents' medication orders in the facility's eMAR.
-The facility's contracted pharmacy was not permitted to utilize the facility's eMAR.
-The SCC, RCC, or Administrator were responsible to ensure newly admitted residents medication orders were transcribed in the facility's eMAR prior to admission.
-She did not know who entered Resident #7's medication orders into the facility's eMAR prior to or upon admission.
-Resident #7 utilized the facility's contracted pharmacy for all medication refills.

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D 358	Continued From page 146 -Resident #7 was admitted on 08/22/23 in the evening. -Resident #7 did not bring medications from another pharmacy upon admission. -She did not know why Resident #7's medications were not ordered from the facility's contracted pharmacy until 08/24/23. -Resident #7 was sent to the Emergency Department for evaluation on 08/23/23, 08/26/23, and 8/27/23. -Resident #7 was sent to the Emergency Department for evaluation on 08/31/31 in the afternoon and remained hospitalized. -MAs were not permitted to borrow medications between residents. -MAs were required to document wasted medications in the residents' progress notes. -She did not know why Resident #7's medication count did not match Resident #7's eMAR documentation. Interview with the Administrator on 09/8/23 at 4:15pm revealed: -The SCC or RCC were responsible to transcribe residents' medication orders in the facility's eMAR. -The facility's contracted pharmacy was not permitted to utilize the facility's eMAR. -The SCC or RCC were responsible to ensure newly admitted residents' medication orders were transcribed in the facility's eMAR prior to admission. -She did not know who entered Resident #7's medication orders into the facility's eMAR prior to or upon admission. -Resident #7 utilized the facility's contracted pharmacy for all medication refills. -She did not know why Resident #7's medications were not ordered from the facility's contracted pharmacy on 08/24/23.	D 358		

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D 358	Continued From page 147 -Resident #7 was sent to the Emergency Department (ED) for evaluation on 08/23/23, 08/26/23, and 08/27/23. -Resident #7 was sent to the ED for evaluation on 08/31/23 in the afternoon and remained hospitalized. _____ Interview with a MA on 09/07/23 at 10:15am revealed: -She thought the eMAR' s were checked by the SCC when orders were changed. -She was taught to make the SCC aware of any medication changes and they would change them. -She did not know if any cart audits were done. -Her job was to check the medication on the cart with the order on the computer before she gave the medication. Interview with a MA on 09/08/23 at 10:30am revealed: -The SCC and MAs were responsible to request medication refills. -The SCC or Administrator were responsible to order newly admitted residents' medications from the facility's contracted pharmacy. -Residents medications were to be available for administration upon admission. -MAs were not permitted to borrow medications between residents. -MAs were required to document in residents progress notes for any medication that was wasted. Interview with a MA on 09/11/23 at 10:42am revealed if a residents' medication was not available to administer, she would alert the Special Care Unit Coordinator (SCC), select code "09" in the electronic medication administration record (eMAR) and document "medication not	D 358		

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available" in the nurse notes section.

Interview with a MA on 09/11/23 at 10:57am revealed if a medication is not available to administer, she contacted the SCC or Resident Care Coordinator (RCC), selected code "09" on the eMAR and documented "on order from pharmacy" in the nurse notes.

Interview with the RCC on 09/08/23 at 3:36 revealed:
-If a residents' medication is not available to administer, the MA is expected to call the pharmacy to find out why the medication is not available and then have the medication sent immediately.
-The MA was responsible for contacting the Primary Care Provider (PCP) if a new order was needed.
-The SCC was responsible for checking the missed medication report daily.

Interview with the current SCC on 09/11/23 at 12:02pm revealed:
-MAs were not permitted to borrow medications between residents.
-MAs were required to document missed medications in the residents' progress notes.
-The SCC, RCC, or Administrator were responsible to transcribe residents' medication orders in the facility's eMAR.
-The facility's contracted pharmacy was not permitted to utilize the facility's eMAR.
-The SCC, RCC, or Facility Administrator were responsible to ensure new admission residents medication orders were transcribed in the facility's eMAR prior to admission.
-The SCC, RCC, or Facility Administrator were responsible to request new admission which utilized the facility's contract pharmacy had all

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medications available for administration upon admission.

Interview with the Administrator on 09/8/23 at 4:15pm revealed:
-The SCC or RCC were responsible for transcribing the residents' medication orders in the facility's eMAR.
-The facility's contracted pharmacy was not permitted to utilize the facility's eMAR.
-The SCC or RCC were responsible for ensuring new admission residents medication orders were transcribed in the facility's eMAR prior to admission.
-The SCC or RCC were responsible to request new admission which utilized the facility's contract pharmacy had all medications available for administration upon admission.
-She did not know if MAs were permitted to borrow medications between residents.
-She did not know if MAs were required to document wasted non-narcotic medications.

Telephone interview with a Pharmacist on 09/11/23 at 3:56pm revealed:
-The pharmacy is only able to see the facility's MARs when they are sent in with the provider's signature to refill medications.
-There is a report that the cycle medication team runs weekly which flags prescriptions that only have 30 doses left or are 45 days away from expiration.
-The report is sent to the provider and the facility if there is a contact person listed for the facility.

Interview with the Administrator on 09/11/23 at 4:41pm revealed:
-The MAs were responsible for calling the pharmacy if a residents' medication was not available to administer.

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D 358	Continued From page 150 -If a resident missed a medication more than one day in a row then the SCC/RCC and she should be notified. -The SCC and RCC were responsible for ensuring the medications were available to administer and they should be running the missed medication report daily, Monday through Friday. _____ The facility failed to ensure 5 of 5 sampled residents (#2, #3, #7, #11 & #12) medications were administrated as order which included mediations to prevent blood clots, dementia, high blood pressure, and bipolar disorder. Failure to administer the medications as order were detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 09/07/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were	D 364		

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administered within one hour before or after the prescribed time for 6 of 6 sampled residents resulting in some medications with multiple administration times being administered too close to the next scheduled administration time (Residents #1, #2, #3, #4, #5 and #7).

1. Review of Resident #5's FL2 dated 02/20/23 revealed: diagnoses included multiple myeloma, diabetes type 2, chronic kidney disease, obstructive kidney disease, hypertension, and hyperlipidemia.

Review of Resident #5's Primary Care Provider's (PCP) orders dated 06/14/23 revealed:
-There was an order for acyclovir (a medication to treat viral infections) 400mg, one tablet daily.
-There was an order for amlodipine (a medication to treat high blood pressure) 10mg, one tablet daily.
-There was an order for aspirin (a medication to prevent heart attacks or strokes) 81mg, one tablet daily.
-There was an order for atorvastatin (a medication to treat high cholesterol) 10mg, one tablet daily.
-There was an order for empagliflozin (a medication to treat diabetes type 2) 25mg, one-half tablet daily.
-There was an order for tamsulosin (a medication to treat symptoms of enlarged prostate gland) 0.4mg, one capsule daily.
-There was an order for miralax (a medication to treat constipation) 17gm daily.
-There was an order for multivitamin (vitamin supplement), one tablet daily.
-There was an order for apixaban (a medication to treat or prevent blood clots) 2.5mg, one tablet daily.
-There was an order for metformin (a medication

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to treat diabetes type 2) 500mg, one tablet twice daily.
-There was an order for nystatin powder (a medication to treat fungal infections), apply topically twice daily.
-There was an order for acetaminophen (a medication to treat pain) 325mg, three tablets three times daily for pain.
-There was an order for sliding scale insulin (a medication to lower blood sugar) before meals and at bedtime.

Review of Resident #5's July 2023 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for acyclovir 400mg daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for amlodipine 10mg daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for aspirin 81mg daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for atorvastatin 10mg daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for empagliflozin 25mg, one-half tablet daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for tamsulosin 0.4mg daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23.
-There was an entry for miralax 17gms daily at

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8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/10/23, 07/19/23 and 07/22/23.
-There was an entry for multivitamin daily at 8:00am with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/10/23, 07/19/23 and 07/22/23.
-There was an entry for apixaban 2.5mg scheduled twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/23 and at 4:00pm on 07/01/23, 07/02/23, 07/04/23, 07/05/23, 07/07/23, 07/09/23, 07/10/23, 07/12/23, 07/14/23, 07/15/23, 07/20/23-07/23/23, 07/27/23 and 07/30/23.
-There was an entry for metformin 500mg scheduled twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/10/23, 07/19/23 and 07/22/23 and at 4:00pm on 07/01/23-07/05/23, 07/07/23, 07/09/23, 07/10/23, 07/12/23-07/15/23, 07/20/23-07/23/23, 07/25/23-07/28/23 and 07/30/23.
-There was an entry for nystatin powder scheduled twice daily at 9:00am and 8:00pm with documentation of administration at 9:00am on 07/02/23 and 07/08/23.
-There was an entry for acetaminophen 325mg, three tablets three times daily at 8:00am, 1:00pm and 6:00pm with documentation of administration at 8:00am on 07/02/23, 07/08/23, 07/19/23 and 07/22/19 and at 1:00pm on 07/08/23, 07/09/23 and 07/26/23.
-There was an entry for sliding scale aspart insulin before meals and at bedtime at 7:30am, 11:30am, 5:30pm and 8:00pm with documentation of administration at 7:30am on 07/02/23, 07/10/23, 07/19/23, 07/22/23, 07/24/23 and 07/31/23, at 11:30am on 07/04/23, 07/09/23, 07/11/23, 07/13/23 and 07/28/23, and at 5:30pm

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D 364	Continued From page 154 on 07/04/23, 07/05/23, 07/18/23 and 07/24/23. Review of Resident #5's July 2023 Medication Administration Audit Report revealed: -Acyclovir, aspirin, atorvastatin, empagliflozin were each administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being on 07/08/23 at 11:04am. -Amlodipine was administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being on 07/08/23 at 11:06am. -Tamsulosin and miralax were each administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being on 07/08/23 at 11:05am. -The multivitamin was administered outside of the one hour before/after time frame 4 occurrences out of 30 opportunities with the latest administration being on 07/08/23 at 11:07am. -Apixaban was administered outside of the one hour before/after time frame 20 occurrences out of 49 opportunities with the latest administration being for the dose scheduled at 8:00am on 07/08/23 and administered at 11:04am. -Metformin was administered outside of the one hour before/after time frame 26 occurrences out of 57 opportunities with the latest administration being for the dose scheduled at 8:00am on 07/08/23 and administered at 11:05am. -Nystatin powder was administered outside of the one hour before/after time frame 2 occurrences out of 59 opportunities with the latest administration being for the dose scheduled at 9:00am on 07/08/23 and administered at 11:07am. -Acetaminophen was administered outside of the one hour before/after time frame 7 occurrences out of 83 opportunities with the latest	D 364		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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administration being for the dose scheduled at 1:00pm on 07/09/23 and administered at 5:41pm.
-Sliding scale insulin was administered outside of the one hour before/after time frame 15 occurrences out of 95 opportunities with the latest administration being for the dose scheduled at 7:30am on 07/19/23 and administered at 9:20am.

Review of Resident #5's August 2023 eMAR revealed:
-There was an entry for apixaban 2.5mg scheduled twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 08/29/23 and at 4:00pm on 08/01/23 through 08/04/23, 08/06/23 through 08/09/23, 08/13/23, 08/16/23 through 08/18/23, 08/20/23, 08/21/23, 08/23/23, 08/24/23 and 08/28/23.
-There was an entry for metformin 500mg scheduled twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 08/28/23 and 08/29/23 and at 4:00pm on 08/01/23 through 08/04/23, 08/06/23 through 08/10/23, 08/12/23, 08/13/23, 08/16/23 through 08/18/23, 08/20/23, 08/21/23, 08/23/23, 08/24/23 and 08/28/23.
-There was an entry for nystatin powder scheduled twice daily at 9:00am and 8:00pm with documentation of administration at 9:00am on 08/14/23 and 08/16/23.
-There was an entry for acetaminophen 325mg, three tablets three times daily at 8:00am, 1:00pm and 6:00pm with documentation of administration at 8:00am on 08/28/23 and 08/29/23, at 1:00pm on 08/20/23 and 08/30/23 and at 6:00pm 08/07/23 and 08/08/23.
-There was an entry for sliding scale aspart insulin before meals and at bedtime at 7:30am, 11:30am, 5:30pm and 8:00pm with documentation of administration at 7:30am on 08/19/23, 08/22/23, 08/28/23 and 08/29/23 and at

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D 364	Continued From page 156 11:30am on 08/02/23, 08/09/23, 08/12/23, 08/13/23, 08/24/23 and 08/30/23. Review of Resident #5's August 2023 Medication Administration Audit Report revealed: -Apixaban was administered outside of the one hour before/after time frame 18 occurrences out of 56 opportunities with the latest administration being for the dose scheduled at 4:00pm on 08/02/23 and administered at 5:52pm. -Metformin was administered outside of the one hour before/after time frame 21 occurrences out of 60 opportunities with the latest administration being for the dose scheduled at 4:00pm on 08/02/23 and administered at 5:52pm. -Nystatin powder was administered outside of the one hour before/after time frame 2 occurrences out of 57 opportunities with the latest administration being for the dose scheduled at 9:00am on 08/16/23 and administered at 12:03pm. -Acetaminophen was administered outside of the one hour before/after time frame 6 occurrences out of 89 opportunities with the latest administration being for the dose scheduled at 1:00pm on 08/20/23 and administered at 5:45pm. -Sliding scale insulin was administered outside of the one hour before/after time frame 10 occurrences out of 98 opportunities with the latest administration being for the dose scheduled at 11:30am on 08/30/23 and administered at 2:41pm. Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am. Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am. Refer to interview with the Special Care Unit	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 157 Coordinator (SCC) on 09/11/23 at 3:24pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm. Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 2. Review of Resident #1's FL2 dated 07/31/23 revealed: -Diagnoses included memory loss and osteoarthritis of the knee. -There was an order for citalopram (a medication to treat depression) 10mg daily. -There was an order for combigan (a medication to treat glaucoma) eye drops 0.2-0.5%, one drop every 12 hours. -There was an order for memantine (a medication to treat memory loss) 28mg one tablet daily. -There was an order for aspirin (a medication to prevent heart attacks or strokes) 81mg, one tablet daily. -There was an order for donepezil (a medication to treat memory loss) 10mg, one tablet daily. Review of Resident #1's pre-admission screening dated 07/31/23 revealed an admission date of 08/10/23. Review of Resident #1's August 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for citalopram 10mg daily at 8:00am with documentation of administration at 8:00am on 08/11/23.	D 364		

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D 364	Continued From page 158 -There was an entry for combigan 0.2-0.5% one drop both eyes every 12 hours at 8:00am and 8:00pm with documentation of administration at 8:00am on 08/11/23. -There was an entry for memantine 28mg daily at 8:00am with documentation of administration at 8:00am on 08/11/23. -There was an entry for aspirin 81mg daily at 8:00am with documentation of administration at 8:00am on 08/11/23. -There was an entry for donepezil 10mg daily at 8:00am with documentation of administration at 8:00am on 08/11/23. Review of Resident #1's August 2023 Medication Administration Audit Report revealed: -Citalopram was administered outside of the one hour before/after time frame with administration on 08/11/23 at 3:43pm. -Combigan eye drops were administered outside of the one hour before/after time frame with administration on 08/11/23 at 3:42pm. -Memantine was administered outside of the one hour before/after time frame with administration on 08/11/23 at 3:44pm. -Aspirin was administered outside of the one hour before/after time frame with administration on 08/11/23 at 3:43pm. -Donepezil was administered outside of the one hour before/after time frame with administration on 08/11/23 at 3:44pm. Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am. Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am. Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 364	Continued From page 159 Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm. Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 3. Review of Resident #7's current FL-2 dated 08/21/23 revealed: -Diagnosis included subdural hemorrhage. -No additional diagnoses were documented. -The recommended level of care was SCU. -An order for Amlodipine 10mg tablet (a medication used to treat hypertension) one tablet daily. -An order for Citalopram 20mg tablet (a medication used to treat depression) one tablet daily. -An order for Mirtazapine 7.5mg tablet (a medication used to treat dementia) one tablet twice daily. Review of Resident #7's August 2023 eMAR revealed: -There was an entry for Amlodipine 10mg scheduled daily at 7:00am with documentation of administration at 7:00am on 08/26/23, 08/28/23, 08/29/23, and 08/30/23. -There was an entry for Citalopram 20mg scheduled daily at 7:00am with documentation of administration at 7:00am on 08/26/23, 08/28/23, 08/29/23, and 08/30/23. -There was an entry for Mirtazapine 7.5mg, scheduled daily at 8:00am and 4:00pm with	D 364		

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documentation of administration at 8:00am on 08/26/23, 08/27/23, and 08/29/23 and at 4:00pm on 08/26/23, 08/27/23, 08/28/23, and 08/30/23.

Review of Resident #7's August 2023 Medication Administration Audit Report revealed:
-Amlodipine 10mg was administered outside of the one hour before/after time frame 4 occurrences out of 5 opportunities with the latest administration being for the dose scheduled at 7:00am on 08/29/23 and administered at 10:41am.
-Citalopram 20mg was administered outside of the one hour before/after time frame on 4 occurrences out of 5 opportunities with the latest administration being for the dose scheduled at 7:00am on 08/29/23 and administered at 10:41am.
-Mirtazapine 7.5mg was administered outside of the one hour before/after time frame on 5 occurrences out of 8 opportunities with the latest administration being for the dose scheduled at 8:00am on 08/26/23 and administered at 3:40pm.

Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am.

Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm.

Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm.

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D 364	Continued From page 161 Refer to interview with the Administrator on 09/11/23 at 4:41pm. 4. Review of Resident #3's current FL2 dated 06/30/23 revealed: -Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy. -There were no medication orders listed. a. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for amlodipine-benazepril (a medication used to treat high blood pressure) 2.5-10mg daily. Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for atorvastatin 40mg daily. Review of Resident #3's July 2023 electronic Medication Administration Record (eMAR) revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The entry was documented as administered at 9:00am from 07/11/23 through 07/31/23. Review of Resident #3's July 2023 Medication Administration Audit Report revealed: -Amlodipine besy-benazepril was administered outside of the one hour before/after time frame 15 occurrences out of 23 opportunities with the latest administration being on 07/08/23 at 3:44pm. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for amlodipine besy-benazepril 2.5-10mg, daily. -The amlodipine besy-benazepril was	D 364		

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documented as administered at 9:00am from 08/01/23 through 08/31/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed amlodipine besy-benazepril was administered outside of the one hour before/after time frame 17 occurrences out of 31 opportunities with the latest administration being on 08/20/23 at 4:29pm.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for amlodipine besy-benazepril 2.5-10mg, daily.
-The entry was documented as administered at 9:00am from 09/01/23 through 09/05/23.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed amlodipine besy-benazepril was administered outside of the one hour before/after time frame 2 occurrences out of 8 opportunities with the latest administration being on 09/02/23 at 10:59am.

Telephone interview with Resident #3's previous Primary Care Provider (PCP) on 09/06/23 at 4:22pm revealed amlodipine besy-benazepril was used to treat Resident #3's high blood pressure and if the medication was administered too close together, then the blood pressure could drop more than intended.

b. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for atorvastatin (a medication used to treat cardiovascular disease) 40mg daily.

Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for atorvastatin 40mg daily.

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D 364	Continued From page 163 Review of Resident #3's July 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The atorvastatin was documented as administered at 9:00pm from 07/08/23 through 07/31/23. Review of Resident #3's July 2023 Medication Administration Audit Report revealed: -Atorvastatin was administered outside of the one hour before/after time frame 3 occurrences out of 24 opportunities with the latest administration being on 07/10/23 at 10:46pm. Review of Resident #3's August 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The atorvastatin was documented as administered at 9:00pm from 09/01/23 through 08/06/23 and 08/08/23 to 08/31/23. Review of Resident #3's August 2023 Medication Administration Audit Report revealed atorvastatin was administered outside of the one hour before/after time frame 3 occurrences out of 31 opportunities with the latest administration being on 08/14/23 at 5:25am for the 08/13/23 9:00pm dose. Review of Resident #3's September 2023 eMAR revealed. -There was an entry for atorvastatin 40mg daily. -The atorvastatin was documented as administered at 9:00pm from 09/01/23, 09/03/23 and 09/04/23. Review of Resident #3's September 2023 Medication Administration Audit Report revealed: -Atorvastatin was administered outside of the one	D 364		

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hour before/after time frame 1 occurrences out of 8 opportunities with the latest administration being on 09/04/23 at 11:07pm.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed atorvastatin was used to treat Resident #3's cardiovascular disease and if the medication was administered too close together, then there would not be a constant level of the medication in the body to do its job effectively.

c. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for citalopram (a medication used to treat depression) 10mg daily.

Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for citalopram 10mg daily.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for citalopram 10mg daily.
-The citalopram was documented as administered at 9:00am from 07/09/23 through 07/31/23.

Review of Resident #3's July 2023 Medication Administration Audit Report revealed citalopram was administered outside of the one hour before/after time frame 14 occurrences out of 24 opportunities with the latest administration being on 07/08/23 at 3:44pm.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for citalopram 10mg daily.
-The citalopram was documented as administered at 9:00am from 08/01/23 through 08/07/23, 08/14/23, 08/20/23, and 08/23/23.

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-There was an entry for citalopram 20mg daily.
-The citalopram was documented as administered at 9:00am from 08/25/23 to 08/31/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed citalopram was administered outside of the one hour before/after time frame 16 occurrences out of 31 opportunities with the latest administration being on 08/20/23 at 4:29pm.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for citalopram 20mg daily.
-The citalopram was documented as administered at 9:00am from 09/01/23 and 09/05/23.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed citalopram was administered outside of the one hour before/after time frame 5 occurrences out of 8 opportunities with the latest administration being on 09/02/23 at 10:59am.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed citalopram was used to treat Resident #3's mood disorders and if the medication was taken too close together then there would not be the desired affect due to the medication not being constant in the body.

d. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for clopidogrel (a medication used to decrease the risk of a blood clot, stroke or heart attack) 75mg daily.

Review of Resident #3 signed physician's orders

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dated 07/12/23 revealed there was an order for clopidogrel 75mg daily.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for clopidogrel 75mg daily.
-The clopidogrel was documented as administered at 9:00am from 07/09/23 through 07/31/23.

Review of Resident #3's July 2023 Medication Administration Audit Report revealed clopidogrel was administered outside of the one hour before/after time frame 12 occurrences out of 24 opportunities with the latest administration being on 07/08/23 at 3:44pm.

Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for clopidogrel 75mg daily.
-The clopidogrel was documented as administered at 9:00am from 08/01/23 through 08/05/23, 08/20/23, 08/23/23, 08/25/23, 08/26/23, and 08/28/23 to 08/31/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed clopidogrel was administered outside of the one hour before/after time frame 18 occurrences out of 31 opportunities with the latest administration being on 08/20/23 at 4:29pm.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for clopidogrel 75mg daily.
-The clopidogrel was documented as administered at 9:00am from on 09/01/23.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed

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clopidogrel was administered outside of the one hour before/after time frame 2 occurrences out of 8 opportunities with the latest administration being on 09/02/23 at 10:59am.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed clopidogrel was used as an antiplatelet and if the medication was administered too close together could result in the medication not be a constant level of the medication in the body to do its job effectively and increase the risk of stomach irritation.

e. Review of Resident #3's FL2 dated 05/31/23 revealed there was an order for divalproex (a medications used to treat mood disorders) 125mg two times a day.

Review of Resident #3 signed physician's orders dated 07/12/23 revealed there was an order for divalproex 125mg two times a day.

Review of Resident #3's July 2023 eMAR revealed.
-There was an entry for divalproex 125mg two times daily.
-The divalproex was documented as administered at 9:00am from 07/09/23 through 07/31/23.
-The divalproex was documented as administered at 9:00pm from 07/08/23 through 07/31/23.

Review of Resident #3's July 2023 Medication Administration Audit Report revealed divalproex was administered outside of the one hour before/after time frame 14 occurrences out of 24 opportunities with the latest administration being on 07/08/23 at 3:44pm for the 9:00am dose.

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

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Review of Resident #3's August 2023 eMAR revealed.
-There was an entry for divalproex 125mg two times daily.
-The divalproex was documented as administered at 9:00am from 08/01/23 to 08/12/23, and 08/23/23.
-The divalproex was documented as administered at 9:00pm from 08/01/23 to 08/06/23, and 08/08/23 to 08/22/23.
-There was an entry for divalproex 250mg two times daily.
-The divalproex was documented as administered at 8:00am from 08/25/23 to 08/31/23.
-The divalproex was documented as administered at 4:00pm from 08/24/23 to 08/31/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed divalproex was administered outside of the one hour before/after time frame 25 occurrences out of 62 opportunities with the latest administration being on 08/20/23 at 4:29pm for the 9:00am dose and on 08/25/23 at 6:53pm for the 6:00pm dose.

Review of Resident #3's September 2023 eMAR revealed.
-There was an entry for divalproex 250mg two times daily.
-The divalproex was documented as administered at 8:00am from on 09/01/23 and 09/05/23.
-The divalproex was documented as administered at 4:00pm from on 09/01/23 and 09/03/23 to 09/04/23.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed:

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-Divalproex was administered outside of the one hour before/after time frame 5 occurrences out of 16 opportunities with the latest administration being on 09/02/23 at 10:59am for the AM dose and on 09/03/23 at 7:09pm for the PM dose.

Telephone interview with Resident #3's previous PCP on 09/06/23 at 4:22pm revealed divalproex was used to treat Resident #3's mood disorders and if administered too close together then there would not be a constant level of the medication in the blood to work effectively.

Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am.

Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm.

Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

5. Review of Resident #4's current FL2 dated 01/24/23 revealed diagnoses included seizures, diabetes, chronic Schizophrenia, hypertension, and acute ischemic stroke.

Review of Resident #4's signed physician's order dated 06/01/23 revealed an order for risperdal

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D 364	Continued From page 170 4mg two times a day. a. Review of Resident #4's signed physician's orders dated 03/15/23 revealed there was an order for donepezil (a medication used to treat dementia) 10mg at bedtime. Review of Resident #4's July 2023 eMAR revealed: -There was an entry for donepezil 10mg at bedtime. -The donepezil was documented as administered at 8:00pm from 07/01/23 to 07/28/23. Review of Resident #4's July 2023 Medication Administration Audit Report revealed donepezil was administered outside of the one hour before/after time frame 4 occurrences out of 31 opportunities with the latest administration being on 07/14/23 at 9:44pm. Review of Resident #4's August 2023 eMAR revealed: -There was an entry for donepezil 10mg at bedtime. -The entry was documented as administered at 10:00pm from 08/02/23 to 08/22/23, 08/24/23, 08/25/23, 08/27/23 and 08/28/23. Review of Resident #3's August 2023 Medication Administration Audit Report revealed donepezil was administered outside of the one hour before/after time frame 2 occurrences out of 31 opportunities with the latest administration being on 08/20/23 at 9:58pm. Review of Resident #4's September 2023 eMAR revealed: -There was an entry for donepezil 10mg at bedtime.	D 364		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 364	Continued From page 171 -The donepezil was documented as administered at 8:00pm from 09/03/23 and 09/05/23. Review of Resident #3's September 2023 Medication Administration Audit Report revealed donepezil was administered within the one hour before/after time frame 8 occurrences out of 8 opportunities. Telephone interview with a representative with the facility's contracted pharmacy on 09/11/23 at 11:42am revealed it was best to give at the same time in order to have the intended effect. b. Review of Resident #4's signed physician's orders dated 03/15/23 revealed there was an order for levetiracetam (a medication used to treat seizures) 500mg two times a day. Review of Resident #4's July 2023 eMAR revealed: -There was an entry for levetiracetam 500mg two times a day. -The levetiracetam was documented as administered at 9:00am from 07/01/23 to 07/29/23 and at 9:00pm from 07/01/23 to 07/29/23. Review of Resident #4's July 2023 Medication Administration Audit Report revealed levetiracetam was administered outside of the one hour before/after time frame 25 occurrences out of 62 opportunities with the latest administration being on 07/23/23 at 3:59pm for the 9:00am dose and on 07/02/23 at 10:50pm for the 9:00pm dose. Review of Resident #4's August 2023 eMAR revealed: -There was an entry for levetiracetam 500mg two	D 364		

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times a day.
-The levetiracetam was documented as administered at 9:00am from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23 and 08/29/23 and at 9:00pm from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23 and 08/29/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed levetiracetam was administered outside of the one hour before/after time frame 24 occurrences out of 62 opportunities with the latest administration being on 08/03/23 at 11:51am for the 9:00am dose and on 08/01/23 at 10:30am for the 9:00pm dose.

Review of Resident #4's September 2023 eMAR revealed:
-There was an entry for levetiracetam 500mg two times a day.
-The levetiracetam was documented as administered at 9:00am from 09/01/23.
-The levetiracetam was not documented as administered 09/01/23 at 9:00pm through 09/05/23 at 9:00pm.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed levetiracetam was not administered outside of the one hour before/after time frame 1 occurrences out of 1 opportunities.

Telephone interview with a representative with the facility's contracted pharmacy on 09/11/23 at 11:42am revealed:
-The levetiracetam was best to give at the same time in order to have the intended effect.
-If administered too close together the levetiracetam could increase the risk of seizures.

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c. Review of Resident #4's signed physician's orders dated 03/15/23 revealed there was an order for oxcarbazepin (a medication used to treat seizures) 300mg two times a day.

Review of Resident #4's July 2023 eMAR revealed:
-There was an entry for oxcarbazepin 300mg two times a day.
-The oxcarbazepin was documented as administered at 9:00am from 07/01/23 to 07/29/23 and at 9:00pm from 07/01/23 to 07/29/23.

Review of Resident #4's July 2023 Medication Administration Audit Report revealed oxcarbazepin was administered outside of the one hour before/after time frame 25 occurrences out of 62 opportunities with the latest administration being on 07/23/23 at 3:59pm for the AM dose and on 07/14/23 at 9:43pm for the PM dose..

Review of Resident #4's August 2023 eMAR revealed:
-There was an entry for oxcarbazepin 300mg two times a day.
-The oxcarbazepin was documented as administered at 9:00am from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23 and 08/29/23 and at 9:00pm from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23 and 08/29/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed oxcarbazepin was administered outside of the one hour before/after time frame 24 occurrences out of 62 opportunities with the latest administration being on 08/03/23 at 11:51am for the AM dose and on 08/01/23 at 10:30am for the

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PM dose.

Review of Resident #4's September 2023 eMAR revealed:
-There was an entry for oxcarbazepin 300mg two times a day.
-The oxcarbazepin was documented as administered at 9:00am from 09/01/23.
-The oxcarbazepin was not documented as administered 09/01/23 at 9:00pm through 09/05/23 at 9:00pm.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed oxcarbazepin was not administered outside of the one hour before/after time frame 1 occurrences out of 1 opportunities.

Telephone interview with a representative with the facility's contracted pharmacy on 09/11/23 at 11:42am revealed:
-The oxcarbazepin was best to give at the same time in order to have the intended effect.
-If administered too close together the oxcarbazepin could increase the risk of seizures.

d. Review of Resident #4's signed physician's orders dated 03/15/23 revealed there was an order for tamulosin (a medication used to treat prostrate issues) 0.4mg daily.

Review of Resident #4's July 2023 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily.
-The tamulosin was documented as administered at 9:00am from 07/01/23 to 07/29/23.

Review of Resident #4's July 2023 Medication Administration Audit Report revealed tamsulosin was administered outside of the one hour

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before/after time frame 16 occurrences out of 31 opportunities with the latest administration being on 07/19/23 at 2:48pm.

Review of Resident #4's August 2023 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily.
-The tamulosin was documented as administered at 9:00am from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23, 08/26/23, 08/27/23 and 08/29/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed tamsulosin was administered outside of the one hour before/after time frame 12 occurrences out of 31 opportunities with the latest administration being on 08/03/23 at 11:51am.

Review of Resident #4's September 2023 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily.
-The entry was documented as administered at 9:00am from 09/01/23.
-The tamulosin was not documented as administered 09/01/23 at 9:00am through 09/05/23.

Review of Resident #3's September 2023 Medication Administration Audit Report revealed tamsulosin was not administered outside of the one hour before/after time frame 1 occurrences out of 1 opportunities.

Telephone interview with a representative with the facility's contracted pharmacy on 09/11/23 at 11:42am revealed it was best to give the tamulosin at the same time in order to have the intended effect.

e. Review of Resident #4's signed physician's

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orders revealed there was an order for tamsulosin (a medication used to treat prostrate issues) 0.4mg daily.

Review of Resident #4's July 2023 eMAR revealed:
-There was an entry for risperdal 4mg two times a day.
-The risperdal was documented as administered at 8:00am from 07/01/23 to 07/29/23 and at 8:00pm 07/01/23 to 07/28/23.

Review of Resident #4's July 2023 Medication Administration Audit Report revealed risperdal was administered outside of the one hour before/after time frame 29 occurrences out of 62 opportunities with the latest administration being on 07/19/23 at 2:48pm for the 8:00am dose and 07/14/23 at 9:44pm for the 8:00pm.

Review of Resident #4's August 2023 eMAR revealed:
-There was an entry for risperdal 4mg two times a day.
-The risperdal was documented as administered at 8:00am from 08/03/23 to 08/06/23, 08/08/23 to 08/24/23, and 08/29/23, and at 8:00pm 08/03/23 to 08/06/23, 08/08/23 to 08/24/23, 08/27/23 and 08/28/23.

Review of Resident #3's August 2023 Medication Administration Audit Report revealed risperdal was administered outside of the one hour before/after time frame 22 occurrences out of 62 opportunities with the latest administration being on 08/03/23 at 11:51am for the 8:00am dose and on 08/20/23 at 9:58pm for the 8:00pm dose.

Review of Resident #4's September 2023 eMAR revealed:

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D 364	Continued From page 177 -There was an entry for risperdal 4mg two times a day. -The risperdal was documented as administered at 8:00am on 09/01/23. -The risperdal was not documented as administered 09/01/23 at 8:00am through 09/05/23 at 8:00pm. Review of Resident #3's September 2023 Medication Administration Audit Report revealed risperdal was not administered outside of the one hour before/after time frame 1 occurrences out of 1 opportunities. Telephone interview with a representative with the facility's contracted pharmacy on 09/11/23 at 11:42am revealed risperdal was best to give at the same time in order to have the intended effect. Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am. Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am. Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm. Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm. Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm.	D 364		

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D 364	Continued From page 178 6. Review of Resident #2's current FL2 dated 08/04/23 revealed diagnoses included anxiety disorder, Alzheimer's disease, essential hypertension, benign prostatic hypertension, hyperlipidemia and major depressive disorder. Review of Resident #2's Physician's orders dated 02/20/23 revealed: -An order for atorvastatin calcium 80 mg (used to prevent cardiovascular disease and treat abnormal lipid levels) tablet at bedtime. -An order for buspirone HCl 10 mg (used to treat anxiety) tablet, half tablet twice daily. -An order for cholecalciferol 1000-unit (a D vitamin essential for depositing calcium in bones) tablet once daily. -An order for cyanocobalamin 1000 mcg tablet (used to treat a vitamin B12 deficiency and pernicious anemia) once daily. -An order for donepezil 10 mg (used to treat Alzheimer's dementia) tablet at bedtime. -An order for apixaban 2.5 mg (used to treat and prevent blood clots) tablet twice daily. -An order for lisinopril 5 mg (used to treat high blood pressure) tablet once daily. -An order for melatonin 3 mg (used as a sleep aid) tablet at bedtime. -An order for nystatin cream 10,000 unit/gm (used as an antifungal medication) twice daily. -An order for zinc 50 mg (vitamin that aids in metabolism an immune system function) tablet once daily. Review of Resident #2's Physician's order dated 08/18/23 revealed doxycycline 100 mg (used to treat infections caused by bacteria) capsule twice daily for 10 days. Review of Resident #2's August 2023 eMAR revealed:	D 364		

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D 364	Continued From page 179 -There was an entry for atorvastatin calcium 80 mg scheduled daily at 6:00pm with documentation of administration at 6:00pm on 08/01/23, 08/02/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23 and 08/20/23. -There was an entry for buspirone HCl 10 mg, half tablet scheduled twice daily at 8:00am and 6:00pm with documentation of administration at 8:00am on 08/01/23, 08/03/23, 08/05/23, 08/12/23, 08/15/23, 08/16/23, 08/18/23, 08/19/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23 and at 6:00pm 08/01/23, 08/02/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23, 08/20/23 and 08/21/23. -There was an entry for cholecalciferol 1000-units scheduled once daily at 8:00am with documentation of administration at 8:00am on 08/01/23, 08/02/23, 08/05/23, 08/11/23, 08/12/23, 08/13/23, 08/15/23, 08/16/23, 08/18/23, 08/19/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23. -There was an entry for cyanocobalamin 1000 mcg scheduled daily at 9:00am with documentation of administration at 9:00am on 08/11/23, 08/12/23, 08/16/23, 08/19/23, 08/20/23, 08/23/23, 08/25/23 and 08/27/23. -There was an entry for donepezil 10 mg scheduled at 6:00pm with documentation of administration at 6:00pm on 08/01/23, 08/02/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23, 08/20/23 and 08/21/23. -There was an entry for apixaban 2.5 mg scheduled at 8:00am and 6:00pm with documentation of administration at 8:00am on 08/01/23, 08/03/23, 08/05/23, 08/11/23, 08/12/23, 08/13/23, 08/15/23, 08/16/23, 08/18/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23 and at 6:00pm on 08/01/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23, 08/19/23, 08/20/23 and 08/21/23. -There was an entry for lisinopril 5 mg scheduled	D 364		

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at 8:00am with documentation of administration at 8:00am on 08/01/23, 08/03/23, 08/05/23, 08/11/23, 08/12/23, 08/13/23, 08/15/23, 08/16/23, 08/18/23, 08/19/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23.
-There was an entry for melatonin 3 mg scheduled at 6:00pm with documentation of administration at 6:00pm on 08/01/23, 08/02/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23 and 08/20/23.
-There was an entry for nystatin cream 10,000 unit/gm scheduled for 8:00am and 6:00pm with documentation of administration at 8:00am on 08/01/23, 08/03/23, 08/05/23, 08/08/23, 08/11/23, 08/12/23, 08/15/23, 08/16/23, 08/18/23, 08/19/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23 and at 6:00pm on 08/01/23, 08/02/23, 08/07/23, 08/14/23, 08/15/23, 08/17/23, 08/20/23 and 08/21/23.
-An entry for zinc 50 mg scheduled at 8:00am with documentation of administration at 8:00am on 08/01/23, 08/03/23, 08/05/23, 08/11/23, 08/12/23, 08/13/23, 08/15/23 and 08/27/23.
-An entry for doxycycline 100 mg scheduled at 8:00am and 4:00pm with documentation of administration at 8:00am on 08/19/23, 08/20/23, 08/21/23, 08/23/23, 08/25/23 and 08/27/23 and at 4:00pm on 08/19/23, 08/25/23 and 08/26/23.

Review of Resident #2's August 2023 Medication Administration Audit Report revealed:
-Atorvastatin calcium was administered outside of the one hour before/after time frame 7 occurrences out of 25 opportunities with the latest administration being for the dose scheduled at 6:00pm on 08/17/23 and administered at 8:29pm.
-Buspirone HCl was administered outside of the one hour before/after time frame 20 occurrences out of 53 opportunities with the latest administration being for the dose scheduled at

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8:00am on 08/27/23 and administered at 5:31pm.
-Cholecalciferol was administered outside of the one hour before/after time frame 15 occurrences out of 27 opportunities with the latest administration being for the dose scheduled at 8:00am on 08/27/23 and administered at 5:31pm.
-Cyanocobalamin was administered outside of the one hour before/after time frame 8 occurrences out of 25 opportunities with the latest administration time being for the dose scheduled at 9:00am on 08/27/23 and administered at 5:31pm.
-Donepezil was administered outside of the one hour before/after time frame 8 occurrences out of 21 opportunities with the latest administration time being for the dose scheduled at 6:00pm on 08/17/23 and administered at 8:29pm.
-Apixaban was administered outside of the one hour before/after time frame 22 occurrences out of 52 opportunities with the latest administration time being for the dose scheduled at 8:00am on 08/27/23 and administered at 5:31pm.
-Lisinopril was administered outside of the one hour before/after time frame 15 occurrences out of 27 opportunities with the latest administration time being for the dose scheduled at 8:00am on 08/27/23 and administered at 5:31pm.
-Melatonin was administered outside of the one hour before/after time frame 8 occurrences out of 25 opportunities with the latest administration time being for the dose scheduled at 6:00pm on 08/17/23 and administered at 8:29pm.
-Nystatin was administered outside of the one hour before/after time frame 23 occurrences out of 52 opportunities with the latest administration time being for the dose scheduled at 8:00am on 08/27/23 and administered at 5:32pm.
-Zinc was administered outside of the one hour before/after time frame 7 occurrences out of 27 opportunities with the latest administration being

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for the dose scheduled at 8:00am on 08/27/23 and administered at 5:31pm.
-Doxycycline was administered outside of the one hour before/after time frame 9 occurrences out of 17 opportunities with the latest administration being for the dose scheduled at 8:00am on 08/27/23 and administered at 5:31pm.

Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 11:18am.

Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 3:24pm.

Refer to telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm.

Refer to interview with the facility's contracted Primary Care Provider (PCP) on 09/07/23 at 3:30pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

_____

Interview with a MA on 09/11/23 at 10:57am revealed she had administered medication late due to residents' eating when their medication was scheduled to be administered but did not document it in the staff progress notes or alert the SCC.

Interview with the RCC on 09/11/23 at 11:18am revealed:
-She was aware some medications had been administered an hour after they were scheduled due to not having enough MAs to administer

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medication on time.
-The MA was expected to document in the staff progress notes if a medication was administered more than an hour before/after the scheduled administration time.
-The MA was also expected to alert the RCC or SCC of the late medication so the RCC or SCC could contact the PCP and document any instructions for administering the medication outside of the scheduled time.

Interview with the SCC on 09/11/23 at 3:24pm revealed:
-She was aware medications had been administered outside of the one hour before/after timeframe and was working with corporate to hire more MAs or change the times the medications were scheduled to be administered.
-The previous HWD was aware of the late medications but was not able to resolve the issue before she left in August 2023.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/11/23 at 3:56pm revealed medication that was ordered twice daily needed to be administered at least eight hours apart to be effective.

Interview with the facility's contracted PCP on 09/07/23 at 3:30pm revealed:
-She was aware the MAs had been behind on some of their medication passes which caused medications to be administered late around the middle of August 2023.
-She expressed concerns about medications being administered more than one hour after their scheduled time to the RCC.
-If a medication was given too close together or too far apart from the scheduled time, the medication would not be consistant in the system

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D 364	Continued From page 184 so it could not do its job appropriately. -She would be concerned about any medications ordered twice daily that were related to psychiatry, anxiety and pain that were administered one hour or more after their scheduled time. Interview with the Administrator on 09/11/23 at 4:41pm revealed she was aware medications had been administered late on certain days due to staffing and expected medication to be administered within an hour before or after the time the medication was scheduled. The facility failed to ensure 6 of 6 sampled residents' (#1. #2, #3, #4, #5 and #7) medications were administrated within one hour before or after the prescribed time resulting in Resident #5's pain medication administered three times daily, Resident #3's mood disorder medication administered twice daily and Resident #2's anxiety medication administered twice daily being administered too close together or too far apart. Failure to administer the medications timely was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 09/07/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 364		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each	D 433		

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D 433	Continued From page 185 resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.	D 433		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to maintain resident records that were readily available for review for 4 of 5 sampled residents (Resident # 2,# 3, #4, and #5).

The findings are:

1. Review of Resident #2's current FL2 dated 08/04/23 revealed diagnoses included Alzheimer's disease, essential hypertension and hyperlipidemia.

Review of Resident #2's PCP visit notes on 09/07/23 at 3:00pm revealed visit notes from two different PCP encounters, dated 12/05/22 and 08/16/23.

Review of Resident #2's record on 09/05/23 revealed there were not any PCP notes available to review.

Refer to interview with the SCC on 09/07/23 at 3:00pm.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 12:16pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

2. Review of Resident #3's current FL2 dated 06/30/23 revealed diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy.

Review of Resident #3's record revealed:
-There were not any PCP visit notes.

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D 433	Continued From page 187 -There were not any Emergency Room (ER) visit notes dated 08/09/23. Interview with Resident #3's PCP on 09/07/23 at 3:30pm revealed: -On 08/09/23, she saw Resident #3 while she was at the facility and Resident #3 eloped. -She faxed all office notes to the facility for his record the day after he was seen at the facility, Refer to interview with the SCC on 09/07/23 at 3:00pm. Refer to interview with the RCC on 09/11/23 at 12:16pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 3. Review of Resident #4's current FL2 dated 01/24/23 revealed diagnoses included seizures, diabetes, chronic Schizophrenia, hypertension, and acute ischemic stroke. Review of Resident #4's record revealed: -There were not any Primary Care Provider (PCP) visit notes. -There was not a physician order in the record for a podiatry referral. -There was not a podiatry visit note. Interview with the facility's contracted provider on 09/07/23 at 3:30pm revealed: -On 08/01/23, she saw Resident #4 and trimmed his toe nails and wrote an order for him to see a podiatrist. -On 08/30/23, she saw Resident #4 and wrote a second referral order or Resident #4 to see a podiatrist for his toe nails. -On 09/01/23, the faciity reported to her Resident	D 433		

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D 433	Continued From page 188 #4 saw a podiatrist that day. Refer to interview with the SCC on 09/07/23 at 3:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 12:16pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. 5. Review of Resident #5's current FL2 dated 02/20/23 revealed diagnoses included multiple myeloma (a blood cancer), hypertension and Type 2 diabetes. Resident #5's PCP visit notes were requested from the Administrator on 09/05/23 at 11:57am and 09/07/23 at 9:01am. Review of Resident #5's record revealed there were not any Primary Care Provider (PCP) notes available to review. Interview with the SCC on 09/07/23 at 10:04am revealed she and the Regional Health and Wellness Director (HWD) were not able to retrieve Resident #5's PCP notes from the electronic medical record system. Refer to interview with the SCC on 09/07/23 at 3:00pm. Refer to interview with the RCC on 09/11/23 at 12:16pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with the SCC on 09/07/23 at 3:00pm	D 433		

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D 433	Continued From page 189 revealed: -The facility's contracted provider came to the facility today and showed her how to get into the electronic database to view the residents' visit notes. -The previous HWD was the last person with access to the database to view the PCP's visit notes and the previous HWD quit on 08/16/23. -No one at the facility has had access to the PCP's notes since 08/16/23. Interview with the RCC on 09/11/23 at 12:16pm revealed the SCC was responsible for scanning documents into the facility's electronic record system. Interview with the Administrator on 09/11/23 at 4:41pm revealed the SCC and RCC were responsible for scanning documents into the facility's electronic record system and it should be done on a daily basis.	D 433		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 3	D 451		

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of 6 sampled residents (Resident #2, #4 and #7) who received injuries that required emergency medical treatment.

The findings are:

1. Review of Resident #4's current FL2 dated 01/24/23 revealed diagnoses included seizures, diabetes, chronic Schizophrenia, hypertension, and acute ischemic stroke.

Review of Resident #4's Incident and Accident Report dated 07/05/23 revealed:
-Resident #4 had an unwitnessed fall resulting in a head laceration which required a visit to the emergency department (ED) and staples to the back of his head.
-There was no documentation DSS was notified of the incident.

Review of the Resident #4's ED discharge summary dated 07/05/23 revealed Resident #4 fell and received a laceration to the back of his head and staples were placed.

Interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 12:02pm revealed
-She was not aware the medication aides (MA) did not document an incident report for Resident #4 incidents on 07/05/23.
-She was responsible for faxing the Incident and Accident Report to DSS.
-She did not fax the Incident and Accident Report dated 07/05/23 to DSS because the MA did not fill out a report.

Interview with the Administrator on 09/11/23 at 4:11pm revealed:
-On 07/05/23, Resident #4 fell and resulted in a laceration to the back of his head which required

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a visit to the ED for staples.
-The medication aide was responsible for completing the Incident and Accident report on 07/05/23 for Resident #4.
-The SCC was responsible for faxing the Incident and Accident Report to DSS.
-DSS was not notified of the incident and accident related to Resident #4 fall which required a visit to the ED and staples to the back of his head because an Incident and Accident report was not completed dated 07/05/23.

Refer to interview with a MA on 09/11/23 at 10:57am.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 12:16pm.

Refer to interview with the SCC on 09/11/23 at 12:02pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

2. Review of Resident #7's current FL-2 dated 08/21/23 revealed diagnoses included subdural hemorrhage.

Review of Resident #7's resident record revealed Resident #7 was admitted to the SCU on 08/22/23.

Review of Resident #7's August 2023 Emergency Department (ED) Records revealed:
-Resident #7 was discharged to the facility on 08/22/23 with diagnoses of dementia, hypertension, and subdural hematoma
-Resident #7's ED discharge summary dated 08/22/23 documented Resident #7 exhibited acute agitation and delirium secondary to

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sundowning and hospital induced delirium.
-Resident #7 was evaluated on 08/23/23 at 9:34pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/24/23 at 5:23am with a recommendation to permit Resident #7 to acclimate to the facility setting.
-Resident #7 was evaluated on 08/26/23 at 7:12pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/27/23 at 2:20am with no recommendations.
-Resident #7 was evaluated on 08/27/23 at 6:22pm due to aggressive behavior.
-Resident #7 was discharged to return to the facility on 08/28/23 at 5:45am with no recommendations.
-Resident #7 was evaluated on 08/31/23 at 4:56pm due to aggressive behavior and admitted for further behavioral assessment.

Review of Resident #7's August 2023 incident reports revealed:
-An incident report dated 08/23/23 documented Resident #7 engaged in a physical altercation with another resident and struck staff with a pill crusher.
-On 08/23/23, Resident #7 was sent to the hospital for evaluation.
-An incident report dated 08/31/23 documented Resident #7 engaged in a physical altercation with another resident and grabbed a butter knife.
-On 08/31/23, Resident #7 was sent to the hospital for evaluation.
-No additional incident reports were documented.

Review of facility facsimile dated 09/01/23 at 2:48pm revealed on 08/31/23 at 2:25pm, Resident #7 was sent to the Emergency Department for evaluation related to physical

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aggression towards another resident.

Telephone interview with Resident #7's Power of Attorney (POA) on 09/07/23 at 2:45pm revealed:
-Resident #7 was admitted to the SCU on 08/22/23 upon discharge from a hospital due to a fall which occurred on 08/02/23.
-Facility staff had notified her on 08/23/23, 08/26/23, 08/27/23, and 08/31/23 that due to Resident #7's verbal and physical altercations the facility had Resident #7 evaluated at the ED.
-Resident #7 was admitted for in-patient evaluation to the hospital on 08/31/23 due to ongoing aggressive behaviors at the facility.

Interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 12:02pm revealed:
-Between 08/23/23 and 08/28/23, the Administrator was responsible to send facsimiles to the local DSS for Resident #7's incidents dated 08/23/23. 08/26/23, and 08/27/23.
-She was not aware MAs did not document an incident report for Resident #7 incidents on 08/26/23 or 08/27/23.

Interview with the Administrator on 09/08/23 at 4:15pm revealed:
-Resident #7 was sent to the Emergency Department on 08/23/23, 08/26/23, 08/27/23 and 08/31/23 related to incidents of physical aggression.
-The MAs were responsible for documenting Resident #7's incident reports in the facility's electronic resident record.
-On 08/23/23, a MA completed an incident report for Resident #7 which required Resident #7 to be sent to the Emergency Department for evaluation.
-The local DSS was not notified of Resident #7's incident dated 08/23/23.
-On 08/26/23, staff did not complete an incident

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report for Resident #7.
-The local DSS was not notified of Resident #7's incident dated 08/26/23.
-On 08/27/23, staff did not complete an incident report for Resident #7.
-The local DSS was not notified of Resident #7's incident dated 08/27/23.

Refer to interview with a MA on 09/11/23 at 10:57am.

Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 12:16pm.

Refer to interview with the SCC on 09/11/23 at 12:02pm.

Refer to interview with the Administrator on 09/11/23 at 4:41pm.

3. Review of Resident #2's current FL2 dated 08/04/23 revealed:
-Diagnoses included Alzheimer's disease, delirium due to known physiological condition and essential hypertension.
-The recommended level of care was the Special Care Unit (SCU).

Review of Resident #2's Emergency Department (ED) visit reports revealed:
-Resident #2 was sent to the ED on 07/17/23 after tripping in the hall and hitting the left side of his head.
-Resident #2 was sent to the ED on 07/29/23 after rolling out of bed and hitting his head on the edge of his nightstand.
-Resident #2 was sent to the ED on 08/22/23 after tripping and hitting his head on the floor.
-Resident #2 was sent to the ED on 08/28/23 when he was found on the floor after an

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D 451	Continued From page 195 unwitnessed fall. Review of Resident #2's Incident/Accident Reports revealed: -There were incident/accident reports dated 07/17/23 and 08/22/23 when Resident #2 was sent to the ER. -There were not any incident/accident reports dated 07/29/23 or 08/28/23. Interview with the Administrator on 09/11/23 at 4:41pm revealed she was not aware Resident #2 did not have incident/accident reports sent to the Department of Social Services (DSS) after he required care at the ED on 07/29/23 and 08/28/23. Refer to interview with a medication aide (MA) on 09/11/23 at 10:57am. Refer to interview with the Resident Care Coordinator (RCC) on 09/11/23 at 12:16pm. Refer to interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 12:02pm. Refer to interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with a MA on 09/11/23 at 10:57am revealed: -She had not been trained on how to fill out an incident/accident report but thought whoever found the resident or witnessed the accident should fill out the report then inform the RCC or SCC. -She had not witnessed an incident or accident since she started working at the facility. Interview with the RCC on 09/11/23 at 12:16pm	D 451		

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D 451	Continued From page 196 revealed: -If an incident or accident occurred on her shift then she would fill out the incident/accident report. -The report was scanned and sent to the SCC and the Administrator. -The SCC or the Administrator were responsible for notifying the DSS. Interview with the SCC on 09/11/23 at 12:02pm revealed: -She or the Administrator were responsible for sending a facsimile to the local DSS for each resident that required medical intervention greater than first aid within 48 hours of the incident or accident. -The MAs were responsible to document any incidents or accidents which required medical interventions greater than first aid and notify her or Administrator immediately. -Between 08/23/23 and 08/28/23, the Administrator was responsible for sending facsimiles to the local DSS. Interview with the Administrator on 09/11/23 at 4:41pm revealed she and the SCC were responsible for notification to the DSS after an incident or accident happened and the resident required more than first aid.	D 451		
D 459	10A NCAC 13F .1302 Special Care Unit Disclosure 10A NCAC 13F .1302 Special Care Unit Disclosure (a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as	D 459		

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providing special care units for persons with Alzheimer's Disease or related disorders.
(b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to disclose the form of care and treatment provided for residents in the Special Care Unit (SCU) for 1 of 3 residents (Resident #2).

The findings are:

Review of Resident #2's current FL2 dated 08/04/23 revealed:
-Diagnosis included Alzheimer's disease.
-The recommended level of care was the SCU.

Review of Resident #2's Resident Register revealed an admission date of 12/01/21.

Review of Resident #2's resident record revealed there was no SCU disclosure statement.

Interview with the Special Care Unit Coordinator (SCC) on 09/05/23 at 1:39pm revealed she could not locate Resident #2's SCU disclosure.

Telephone interview with Resident #2's family member on 09/07/23 at 11:10am revealed she did not remember signing a SCU disclosure.

Interview with the Administrator on 09/06/23 at 9:07am revealed:
-The previous Resident Care Coordinator (RCC), the previous SCC and previous Health and

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D 459	Continued From page 198 Wellness Director (HWD) audited the records of residents in the SCU three months ago. -They found multiple documents were missing from the residents' records including the SCU disclosure. -The team contacted family members to sign the SCU disclosures and she was not aware that Resident #2's SCU disclosure had not been signed. -Since she started three months ago, the Business Office Manager (BOM) was responsible for ensuring the SCU disclosure was reviewed and signed. Attempted interview with the BOM on 09/11/23 at 5:05pm was unsuccessful.	D 459		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of	D 463		

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this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure documentation of a pre-admission screening for one of four residents (Resident #7).

Review of Resident #7's current FL-2 dated 08/21/23 revealed:
-Diagnosis included subdural hemorrhage.
-No additional diagnoses were documented.
-The recommended level of care was Special Care Unit (SCU).

Review of Resident #7's Resident Register revealed:
-Resident #7's responsible party signed and dated the Resident Register on 08/10/23.
-The facility Administrator signed and dated the Resident Register on 08/10/23.

Review of Resident #7's resident record revealed:
-Resident #7 was admitted to the SCU on 08/22/23.
-A pre-admission screening assessment for Resident #7 was not documented.

Telephone interview with Resident #7's Power of Attorney (POA) on 09/07/23 at 2:45pm revealed:
-Resident #7 was admitted to the SCU on 08/22/23 upon discharge from a hospital due to a fall which occurred on 08/02/23.
-The hospital had performed a screening assessment for Resident #7 and determined she required discharge to a SCU.
-She did not know if the facility had performed a SCU pre-admission screening for Resident #7.

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D 463	Continued From page 200 Telephone interview with the former Health and Wellness Director (HWD) on 09/08/23 between 3:00 and 4:00pm revealed: -Prior to her resignation on 08/14/23, she or the former Special Care Unit Coordinator (SCC) were responsible to complete a SCU pre-admission screening for potential SCU residents to be admitted to the facility. -The SCU pre-admission screening was to be documented and electronically filed in the facility's resident record system upon admission. -SCU pre-admission screenings were to be performed during an in-person observation of the potential SCU resident. -She did not complete an SCU pre-admission screening with Resident #7. -The former SCC was responsible to complete an SCU pre-admission screening with Resident #7. Telephone interview with the former SCC on 09/11/23 at 11:15am revealed: -The former HWD had been responsible to complete SCU pre-admission screenings for potential SCU residents. -The former HWD was responsible to electronically file all resident pre-admission documentation into the facility's electronic resident record system upon a residents' admission. -Potential SCU residents required an in-person pre-admission screening prior to admission. -She did not recall completing an SCU pre-admission screening with Resident #7. Interview with the SCC on 09/11/23 at 12:05pm revealed: -She was assigned to be the MCC effective on or about 08/20/23. -She did not work between 08/21/23 and	D 463		

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08/28/23.
-She was responsible to complete an SCU pre-admission screening for all potential SCU residents prior to admission to determine if the potential candidate was appropriate for the SCU.
-The SCU pre-admission screening was to be documented and electronically filed in the facility's resident record system upon admission.
-SCU pre-admission screenings were to be performed during an in-person observation of the potential SCU resident.
-She did not know if facility staff had completed an SCU pre-admission screening for Resident #7 prior to Resident #7's admission on 08/22/23.

Interview with the Director of Marketing on 09/08/23 at 11:35am revealed:
-The SCC or HWD was responsible to complete SCU pre-admission screening documentation for any potential SCU residents.
-During August 2023, the former SCC was responsible to complete an SCU pre-admission screening for Resident #7.

Interview with the Facility Administrator on 09/08/23 at 4:15pm revealed:
-The SCC or HWD was responsible to complete SCU pre-admission screening documentation for any potential SCU residents.
-During August 2023, the former SCC was responsible to complete an SCU pre-admission screening for Resident #7.
-Upon admission, Resident #7's pre-admission screening should have been electronically filed in the facility's electronic resident record and a copy maintained in the business office.
-Resident #7's pre-admission screening documentation was unaccounted for.

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D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 3 sampled Special Care Unit (SCU) residents (Resident #3) had a written resident profile completed quarterly, that contained assessment data that described the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. The findings are: Review of Resident #3's current FL2 dated 06/30/23 revealed:	D 464		

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-Diagnoses included severe vascular dementia, Alzheimer's dementia, history of cerebral vascular accident, and lethargy.
-Resident #3's recommended level of care was the Special Care Unit (SCU).
-He was constantly disoriented.

Review of Resident #3's resident register revealed an admission date of 07/06/23.

Review of Resident #3's undated Care Plan revealed:
-Resident #3 required supervision with bathing as well as dressing and limited assistance with grooming.
-Resident #3's care plan was not signed by the physician.

Review of Resident #3's record revealed:
-There was no documentation of a quarterly SCU resident profile.

Interview with a medication aide (MA) on 09/06/23 at 4:45pm revealed:
-Resident #3 required supervision with bathing and dressing as well as exit seeking behaviors.
-Resident #3 required limited assistance with grooming.

Interview with Resident #3's Primary Care Provider (PCP) on 09/07/23 at 3:30pm revealed:
-She saw Resident #3 as a new patient on 07/12/23 and there was no resident profile available for her to review.
-The HWD was responsible for completing a resident profile and placing it in a folder for her to review at the first appointment with Resident #3 on 07/12/23.

Telephone interview with the previous Health and

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D 464	Continued From page 204 Wellness Director (HWD) on 09/08/23 at 3:00pm revealed: -She was responsible for completing the resident profile quarterly. -Resident #3 was admitted in July 2023 and she completed the resident profile, but it was not signed before she resigned. -She forgot to get it signed by the physician. Interview with the Administrator on 09/11/23 at 4:11pm revealed: -The HWD was responsible for completing the quarterly resident profile. -Resident profiles were supposed to be completed during the initial assessment for new residents and then quarterly there after. -Once the care plan and the resident profile were completed at the initial assessment, the document should be faxed or emailed to their primary physician for review and to be signed. -She was not aware Resident #3's care plan was not signed by the physician.	D 464		
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. This Rule is not met as evidenced by: TYPE B VIOLATION	D 465		

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D 465	Continued From page 205 Based on record reviews and interviews, the facility failed to ensure there was adequate staff working in the Special Care unit (SCU), for 5 of 19 shifts on first shift, 8 of 19 shifts on second shift, and 4 of 19 shifts on third shift between 08/10/23 and 08/28/23. 1. Review of the facility census documented on for 08/11/23 for the SCU revealed there were 45 residents. -Review of employee time punches for 08/11/23 revealed there was documentation of 40.36 hours worked for first shift. -Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for first shift. Review of the facility census documented on 08/14/23 for the SCU revealed there were 45 residents. -Review of employee time punches for 08/14/23 revealed there was documentation of 24.46 hours worked for first shift. -Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for first shift. Review of the facility census documented on 08/15/23 for the SCU revealed there were 45 residents. -Review of employee time punches for 08/15/23 revealed there was documentation of 42.56 hours worked for first shift. -Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for first shift. Review of the facility census documented on 08/16/23 for the SCU revealed there were 45	D 465		

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residents.
-Review of employee time punches for 08/16/23 revealed there was documentation of 32.43 hours worked for first shift.
-Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for first shift.

Review of the facility census documented on 08/27/23 for the SCU revealed there were 46 residents.
-Review of employee time punches for 08/27/23 revealed there was documentation of 24.90 hours worked for first shift.
-Based on a census of 46 residents, the SCU required a minimum of 46 staff hours for first shift.

2. Review of the facility census documented on 08/11/23 for the SCU revealed there were 45 residents.
-Review of employee time punches for 08/11/23 revealed there was documentation of 29.36 hours worked for second shift.
-Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for second shift.

Review of the facility census documented on 08/12/23 for the SCU revealed there were 46 residents.
-Review of employee time punches for 08/12/23 revealed there was documentation of 27.19 hours worked for second shift.
-Based on a census of 45 residents, the SCU required a minimum of 46 staff hours for second shift.

Review of the facility census documented on 08/13/23 for the SCU revealed there were 46

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residents.
-Review of employee time punches for 08/13/23 revealed there was documentation of 40.89 hours worked for second shift.
-Based on a census of 46 residents, the SCU required a minimum of 46 staff hours for second shift.

Review of the facility census documented on 08/14/23 for the SCU revealed there were 45 residents.
-Review of employee time punches for 08/14/23 revealed there was documentation of 29.73 hours worked for second shift.
-Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for second shift.

Review of the facility census documented on 08/15/23 for the SCU revealed there were 45 residents.
-Review of employee time punches for 08/15/23 revealed there was documentation of 37.51 hours worked for second shift.
-Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for second shift.

Review of the facility census documented on 08/16/23 for the SCU revealed there were 45 residents.
-Review of employee time punches for 08/16/23 revealed there was documentation of 32.32 hours worked for second shift.
-Based on a census of 45 residents, the SCU required a minimum of 45 staff hours for second shift.

Review of the facility census documented on 08/19/23 for the SCU revealed there were 44

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residents.
-Review of employee time punches for 08/19/23 revealed there was documentation of 41.51 hours worked for second shift.
-Based on a census of 44 residents, the SCU required a minimum of 44 staff hours for second shift.

Review of the facility census documented on 08/27/23 for the SCU revealed there were 46 residents.
-Review of employee time punches for 08/27/23 revealed there was documentation of 29.64 hours worked for second shift.
-Based on a census of 46 residents, the SCU required a minimum of 46 staff hours for second shift.

3. Review of the facility census documented on 08/13/23 for the SCU revealed there were 46 residents.
-Review of employee time punches for 08/13/23 revealed there was documentation of 25.57 hours worked for third shift.
-Based on a census of 46 residents, the SCU required a minimum of 36.8 staff hours for third shift.

Review of the facility census documented on 08/14/23 for the SCU revealed there were 45 residents.
-Review of employee time punches for 08/14/23 revealed there was documentation of 24.33 hours worked for third shift.
-Based on a census of 45 residents, the SCU required a minimum of 36.0 staff hours for third shift.

Review of the facility census documented on 08/20/23 for the SCU revealed there were 44

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residents.
-Review of employee time punches for 08/20/23 revealed there was documentation of 24.07 hours worked for third shift.
-Based on a census of 44 residents, the SCU required a minimum of 35.20 staff hours for third shift.

Review of the facility census documented on 08/27/23 for the SCU revealed there were 46 residents.
-Review of employee time punches for 08/27/23 revealed there was documentation of 31.71 hours worked for third shift.
-Based on a census of 46 residents, the SCU required a minimum of 36.8 staff hours for third shift.

Interview with a first and second shift medication aide (MA) on 09/11/23 at 10:00am revealed:
-SCU MAs were not assigned to resident care needs.
-SCU MAs would assist PCAs with resident care when necessary.
-SCU MAs were responsible for medication administration, and pharmacy communication, among additional duties.
-The current SCC was responsible to develop staff schedules.
-She did not know if the SCC had an accurate list of current facility staff when developing staff schedules because in August 2023, some staff listed on the staffing schedules no longer worked for the facility.
-In August 2023, the Administrator required MAs to notify her at the beginning of each shift if the SCU was short staffed.
-In late August 2023, the Administrator was able to utilize staffing agency staff for SCU staffing needs.

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D 465	Continued From page 210 Interview with a first and second shift PCA on 09/08/23 at 10:15am revealed: -She worked in the SCU. -The SCC was responsible for developing the staff schedule. -MAs were not assigned residents to assist with residents' personal care needs. -PCAs were expected to provide resident care and supervision according to resident assignments. -In August 2023, the SCU would be staffed with three or four PCAs per shift, occasionally five PCAs worked on first shift and second shift. -During a weekend in August 2023, the SCU first shift was staffed with two PCAs until mid-morning. -In August 2023, the SCC and Administrator were aware of SCU staffing needs because the MAs notified them at the beginning of each shift. -When the SCU was short staffed in August 2023, staff from the facility's assisted living unit rarely came on the SCU to assist staff with resident care because the facility staffed each shift to the minimum requirements. -The facility began utilizing staffing agency staff in late August 2023. Interview with the SCC on 09/11/23 at 12:02pm revealed: -She began making staff schedules on or about 08/17/23. -The facility utilized a 12-hour, two-shift schedule. -On 08/17/23, she was trained by the Administrator about the SCU staffing minimum requirements according to census. -She was aware first and second shift SCU staffing required a 1:8 staff to resident ratio. -She was aware third shift SCU staffing required at 1:10 staff to resident ratio.	D 465		

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D 465	Continued From page 211 -The Administrator was responsible for SCU staffing needs between 08/21/23 and 08/28/23. -SCU MAs were not counted as care staff because they were not assigned to resident care. -SCU MAs were responsible for medication administration, and pharmacy communication, among other duties, and oversight of the PCAs and MAs would assist with resident personal care only when necessary and available. -In August 2023, she and the Administrator were aware of SCU staffing shortages and attempted to utilize the facility's available staff to work. -In August 2023, the Administrator began communication with a staffing agency to assist with SCU staffing needs. Interview with the Administrator on 09/08/23 between 10:45am and 4:15pm revealed: -She was aware first and second shift SCU staffing required a 1:8 care staff to resident ratio. -She was aware third shift SCU staffing required at 1:10 care staff to resident ratio. -The facility utilized a 12-hour, two-shift schedule. -On or about 08/17/23, the current SCC received training on SCU staff scheduling. -In August 2023, she and the SCC were aware of SCU staffing shortages and attempted to utilize the facility's available staff to work. -In Mid-August 2023, she communicated with a staffing agency to initiate utilization agency staff to assist with SCU staffing needs. -In August 2023, on occasion, if the facility's assisted living unit had additional care staff available, she re-assigned assisted living unit PCAs to work in the SCU. -In August 2023, she required SCU MAs to communicate with her or the SCC at the beginning of shifts of any SCU staffing shortages. [Refer to tag 0270, 10A NCAC 13F .0901(b)	D 465		

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D 465	Continued From page 212 Personal Care and Supervision (Type A1 Violation)] [Refer to tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)] _____ The facility failed to ensure adequate SCU care staff according to the daily census on 17 of 57 shifts between 08/10/23 and 08/28/23 which increase the risk of incidents for all the residents who received assistance with supervision and personal care. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and	D 468		

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schedules regarding training achievement.
(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.
(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

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

Based on record reviews and interviews the facility failed to ensure that 5 of 6 sampled staff, (Staff A, C, D, E and F) completed 6 hours of orientation on the nature and needs for the residents of a Special Care Unit (SCU) within the first week of employment.

The findings are:

Review of the facility's current license dated 01/01/23 revealed the facility was licensed as an Alzheimer's/Dementia SCU with a capacity of 48 residents.

Review of the facility's current census tracking log revealed the census on 09/05/23 was 44 residents.

1. Review of Staff A's personnel record revealed:

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D 468	Continued From page 214 -She was hired on 07/24/23 as a personal care aide (PCA). -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff A. Review of the employee schedule for 08/27/23 through 09/09/23 revealed Staff A worked 08/27/23, 08/29/23, 08/30/23, 08/31/23, 09/04/23, 09/07/23, 09/08/23 and 09/09/23. Attempted telephone interview with Staff A on 09/11/23 at 2:00pm was unsuccessful. Refer to the interview with the Special Care Unit Coordinator (SCC) on 09/11/23 at 11:15am. Refer to the interview with the Administrator on 09/11/23 at 4:41pm. 2. Review of Staff C's personnel record revealed: -She was hired on 08/23/23 as a medication aide (MA). -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff C. Review of the employee schedule for 08/27/23 through 09/09/23 revealed Staff C worked 08/28/23, 09/01/23, 09/02/23, 09/03/23, 09/05/23, 09/07/23 and 09/08/23. Telephone interview with Staff C on 09/11/23 at 11:46am revealed she did not have a 6-hour orientation on the nature and needs of the SCU residents. Refer to the interview with the SCC on 09/11/23 at 11:15am.	D 468		

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D 468	Continued From page 215 Refer to the interview with the Administrator on 09/11/23 at 4:41pm. 3. Review of Staff D's personnel record revealed: -She was hired on 08/28/23 as a MA. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff D. Review of the employee schedule for 08/27/23 through 09/09/23 revealed Staff D worked 08/28/23, 08/29/23, 09/01/23, 09/02/23, 09/03/23, 09/06/23 and 09/11/23. Interview with Staff D on 09/06/23 revealed she did not have a 6-hour orientation on the nature and needs of the SCU residents. Refer to the interview with the SCC on 09/11/23 at 11:15am. Refer to the interview with the Administrator on 09/11/23 at 4:41pm. 4. Review of Staff E's personnel record revealed: -She was hired on 08/03/23 as a PCA. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff E. Review of the employee schedule for 08/27/23 through 09/09/23 revealed Staff E worked 08/27/23, 08/29/23, 08/30/23, 08/31/23, 09/04/23, 09/06/23, 09/08/23 and 09/09/23. Attempted telephone interview with Staff E on 09/11/23 at 3:20pm was unsuccessful. Refer to the interview with the SCC on 09/11/23 at 11:15am.	D 468		

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D 468	Continued From page 216 Refer to the interview with the Administrator on 09/11/23 at 4:41pm. 5. Review of the former Special Care Unit Coordinator's (SCC) personnel record revealed: -She was hired on 06/05/23. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents. Attempted telephone interview with the former SCC was unsuccessful. Refer to the interview with the SCC on 09/11/23 at 11:15am. Refer to the interview with the Administrator on 09/11/23 at 4:41pm. _____ Interview with the SCC on 09/11/23 at 11:15am revealed: -She was not responsible for any training for the SCU. -Her responsibility was to give each new SCU staff a tour, introduce them to the other staff and residents and show them where keys and medications on the unit were kept. Interview with the Administrator on 09/11/23 at 4:41pm revealed: -The 6-hour training for the SCU was done on a software program. -Her expectation was to have it completed the first week of orientation for all SCU staff. -It was the responsibility of the Business Office Manager (BOM) to keep all personnel files up to date. -Staff charts should be audited weekly. -She did not know when the last audit was	D 468		

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D 468	Continued From page 217 completed. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] The facility failed to ensure 5 of 6 sampled staff completed 6 hours of orientation training on the nature and needs for the residents of a SCU within the first week of employment, resulting in staff being unable to have the basic knowledge needed to care for all the residents on the SCU who had diagnoses of Alzheimer's/Dementia. The facility's failure was detrimental to the health, safety, and well-being of the residents, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2023.	D 468		