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D 000	Initial Comments The Adult Care Licensure Section and the Hoke County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 09/06/23 - 09/08/23. The complaint investigations were initiated by the Hoke County Department of Social Services on 07/07/23, 08/01/23, and 08/21/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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 an environment free of hazards including razors, broken furniture, body wash, personal hygiene products, nail polish remover, medicated salve, hand sanitizer, bottles of wine, bottles of beer, scissors, and other craft supplies on the special care unit (SCU). The findings are: Review of the facility's census report dated 09/06/23 revealed there were 30 residents on the special care unit (SCU). Observation of Activities Director (AD) office on	D 079		

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09/06/23 at 12:30pm revealed:
-Her office was located in the SCU.
-Hazards in her office included: scissors, bottles of wine, bottles of beer, oxygen tank, craft supplies, and hand sanitizer.
-The AD left her office and did not lock office door.

Interview with AD on 09/06/23 at 12:30pm revealed:
-She did not lock her office door because she had one key and the Activities Assistant (AA) needed access to the room.
-She left the office door unlocked regularly.
-The office door should be locked because of the hazards that could be accessed by SCU residents.

Interview with the Memory Care Coordinator (MCC) on 09/06/23 at 1:00pm revealed:
-She was able to open the AD's office door without a key.
-There were hazards in the activities office that should not be accessible to residents.
-The AD office should be locked at all times.

Interview with the Administrator on 09/06/23 at 1:20pm revealed:
-It was the responsibility of the Administrator and MCC to ensure the SCU was free of hazards.
-There were hazards in the activities office that should not be accessible to residents.
-The AD's office should be locked at all times.

Observation of the clean linen room on the 400 hall in the SCU on 09/06/23 at 9:48am revealed:
-The clean linen room on 400 hall in the SCU was located on the hall with residents' rooms including a resident room directly beside it and resident rooms across the hall.

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-There was a sign on the clean linen door that read, "please keep this door locked at all times".
-At 9:48am, the door to the clean linen room was unlocked.
-There was no staff in the room or in the hallway.
-There were SCU residents in the living room just down the hall and some residents walking independently up and down the 400 hall.
-There were racks with shelving against the walls around the room.
-There were 16 plastic clear containers, some labeled with residents' names that contained personal care products.
-The personal care products included body wash, shampoo, conditioner, hair spray, deodorant/anti-perspirant, shave cream, body lotion, hand soap, skin protectant ointment, medication body powder, nail polish remover, medicated salve, mouthwash, and toothpaste.
-Warnings on the labels of some of the personal care products included: keep out of reach of children; for external use only; if swallowed get medical help or contact poison control center (PCC); avoid contact with eyes; harmful if ingested; in case of accidental ingestion, give fluids and consult with local PCC; deliberately concentrating and inhaling contents can be harmful or fatal; and extremely flammable.

Interview with a personal care aide (PCA) in the SCU on 09/06/23 at 10:00am revealed:
-The clean linen room on the 400 hall in the SCU was used to store incontinence supplies and the residents' personal care products.
-The residents did not keep personal care products in their rooms because they would "play with it".
-They kept the personal care products locked in the clean linen room so the residents would not hurt themselves by putting the products in their

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mouths.
-She had been working at the facility for about 2 years and she was not aware of any residents ingesting any personal care products.
-She forgot to lock the linen closet about 30 minutes ago when she opened the door and got some incontinence supplies.
-The medication aides (MAs), Resident Care Coordinator (RCC), MCC, and the Administrator had keys to the linen closet.
-The PCAs did not have keys to the linen closet so they usually got the MAs to unlock it when they needed supplies.

Interview with the MCC on 09/06/23 at 10:07am revealed:
-The clean linen room in the SCU was used for storage of incontinence supplies, linens, and residents' personal care products.
-The SCU residents' personal care products were kept locked in the clean linen room because they did not want the residents to drink something they were not supposed to drink.
-No residents had attempted to ingest any personal care products to her knowledge.
-There was a sign on the door reminding staff to keep that door locked at all times.
-The MAs had the key to the clean linen room and the PCAs could get the key from the MAs to get what they needed from the clean linen room.
-She checked the door of the clean linen room every morning around 9:30am, and again at shift change at 3:00pm to make sure it was locked.
-The MAs on second shift were supposed to check the clean linen room door at night at the end of the shift.
-The clean linen room door was not locked this morning when she checked it around 9:45am so she locked it.
-She did not get a chance to check with staff to

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see why it was unlocked.
-She was not aware the clean linen door was left unlocked again that morning; it should be locked at all times.

Observations of the SCU on 09/06/23 from 9:36am until 1:18pm revealed:
-There was lotion and toothpaste on the bathroom counter and barrier skin ointment and hand sanitizer on the table/shelf in the bathroom shared by residents in rooms 309-d and 309-w.
-Residents were observed in both rooms in bed.
-There were 2 of the 3 oxygen tanks stored on the floor and not secured in a holder in between a table and nightstand on the opposite wall of the bed in resident room 309-d (unable to determine if the tanks were empty or full).
-There was mouthwash, lotion, deodorant and shaving gel on the bathroom shelf of resident room 301-d.
-There was body lotion, body wash, shampoo, deodorant on the bathroom shelf in resident rooms 302-d and 302-w.
-There was body lotion, deodorant and toothpaste on the bathroom shelf in resident rooms 303-d and 303-w.
-There was body lotion, deodorant, shampoo, petroleum jelly on the bathroom shelf in resident room 305.
-There was body lotion, deodorant, shampoo, and hand soap on the counter and shelf in the bathroom in resident room 308.
-There was deodorant and shampoo on the counter of the unlocked 300 hall spa bathroom.
-There were scissors, a tall non-portable oxygen tank on the floor in between a chair and supply cart about 3 or 4 feet from a wall outlet, bottles of alcoholic beverages in the AD's unlocked office on hall 300 and were accessible to the residents.

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Observations of the SCU on 09/06/23 from 12:53pm until 1:03pm revealed:
-There was barrier cream and body lotion on the shelf in the bathroom in resident room 401.
-There was body lotion on the bedside table and shampoo, body wash and body lotion on the shelf and counter in the bathroom in resident room 402.
-The top drawer of the bedside table in resident room 405 was missing, exposing the sharp edges around the inner framework.
-The top drawer of the dresser in resident room 405 was misaligned and not closed properly and 2 additional drawers were missing or had broken handles.
-There was body wash on the bathroom shelf in resident room 405.
-There was body wash on the counter in the bathroom in resident room 406.
-There was body wash, shampoo, shaving cream, toothpaste, deodorant and a razor on the counter and shelf in the bathroom in resident room 407.
-There was hand sanitizer, conditioner and barrier ointment on the counter and shelf in the bathroom in resident room 411.
-There were multiple containers of body wash, body lotion, and barrier cream on the shelf in the bathroom in resident room 412.
-There were multiple containers of body lotion, foot cream, petroleum jelly, deodorant and body wash on the bedside table in resident room 414.

Interview with a PCA on 09/06/23 at 1:05pm revealed:
-Personal care products like body wash, barrier cream, hand sanitizer, shampoo and razors were supposed to be kept in the clean linen room.
-Each resident had a plastic bin with their name on it for their personal care supplies.
-The clean linen room was kept locked.

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-Hospice aides were in and out of resident rooms helping with bathing and probably left personal care products in the residents' rooms.
-The resident in room 407 was not on hospice services and the body wash might have been left by a family member.
-She did not know how the resident in room 407 got a razor because his family member normally took him to a barber shop for shaves.
-If PCAs had a chance, they sometimes went through and checked for hazardous items left in resident rooms by hospice aides and family members.

Interview with the MCC on 09/06/23 at 2:30pm revealed:
-PCAs were responsible for making sure personal care items were not in resident rooms.
-PCAs and MAs were responsible for rounding every 2 hours on the SCU.
-PCAs and MAs were responsible for making sure personal care items were not in resident rooms when they were completing rounds and providing personal care assistance.
-She tried to check resident rooms at the beginning and end of her day.
-She did not have a chance to check that morning (09/06/23) because there was a lot going on at the facility.
-Personal care items including razors, hand sanitizer and body wash should not be kept in resident rooms on the SCU for the safety of the residents.
-Staff were responsible for reporting broken furniture and repair concerns to the front desk person or directly to the Maintenance Director.

Interview with the Maintenance Director on 09/06/23 at 5:30pm revealed:
-He did not know about broken furniture in

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resident room 405.
-Staff were supposed to tell the front desk person about any maintenance concerns.
-The front desk person was responsible for entering the concern into an electronic system that tracked maintenance requests.
-No one really followed the system; staff might tell him verbally, but no one had reported the broken furniture to him.

Interview with the Administrator on 09/06/23 at 2:00pm revealed:
-Family members may have brought items that should not be kept in resident rooms on the SCU.
-Personal care items such as razors, body wash, barrier cream and hand sanitizer should be kept in the locked clean linen room for the safety of the residents.
-PCAs were responsible for checking resident rooms daily.
-The lead MA was responsible for checking behind PCAs and making sure personal care items were stored in the clean linen room.
-The MCC was responsible for monitoring the environment on the SCU daily.
-Staff reported the items found in resident rooms on 09/06/23 to the MCC and the MCC told her.

____

The facility failed to maintain an environment free of hazards including razors, broken dressers and bedside table, body wash, shampoo, conditioner, hair spray, deodorant/anti-perspirant, shave cream, body lotion, hand soap, skin protectant ointment, medication body powder, nail polish remover, medicated salve, mouthwash, toothpaste, hand sanitizer, wine, beer, scissors, and other craft supplies on the special care unit (SCU) resulting in all of the cognitively impaired residents at risk for injuries and harm due to potential ingestion of harmful substances and

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D 079	Continued From page 8 misuse of sharp objects. The facility's failure was detrimental to the health, safety, and wellbeing of residents on the SCU and constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/06/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2023.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide incontinence care 1 of 2 sampled residents (#4) on the special care unit (SCU) related to applying two incontinence briefs with changes. The findings are: Review of Resident #4's current FL-2 dated 10/19/22 revealed: -Diagnoses included vascular dementia, psychotic disturbance, vitamin D deficiency, history of a hip fracture, history of cervical vertebrae fracture.	D 269		

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-Resident #4 required total personal care assistance and was incontinent of bowel and bladder.

Review of Resident #4's current care plan dated 07/26/23 revealed:
-She was oriented and ambulatory.
-She had bowel and bladder incontinence and was dependent on staff for toileting and incontinence care.
-The assessor did not sign the care plan and there was no date with the primary care provider's (PCP's) signature.
-The assessment date was documented on the top right corner of the first page.

Review of Resident #4's current special care unit (SCU) quarterly profile dated 07/11/23 revealed:
-She had incoherent speech and short and long-term memory loss.
-She was totally dependent on staff for toileting, bathing, and dressing.

Observations of Resident #4 on 09/06/23 from 4:40pm until 4:45pm revealed:
-She was walking around the SCU including hallways, dining room and common area where other residents and staff were present.
-The back of her pants had wet areas on both sides from her buttocks to mid-thighs.
-The Memory Care Coordinator (MCC) saw the resident as she walked by her (MCC) in the hallway.
-The MCC checked her clothing and directed staff to assist the resident with incontinence care.
-A personal care aide (PCA) walked with the resident to the bathroom in her room.
-The PCA removed the resident's pants and began removing the incontinence brief when she said, "What in the world?"

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-The resident had on 2 incontinence briefs that were saturated with urine.
-There were no open or reddened areas on the resident's buttocks or groin.
-The PCA assisted the resident with cleansing and redressing with one clean incontinence brief and clean plants.

Interview with the PCA on 09/07/23 at 4:45pm revealed:
-Resident #4 did not speak much English which made prompting and redirecting while assisting with incontinence care difficult.
-She had checked the resident at change of shift (3:00pm) on 09/06/23 and she was not wet or soiled.
-She did not know the resident was wearing 2 incontinence briefs.
-It was not normal for staff to use 2 incontinence briefs and she did not know why it was done.
-Resident #4 did not normally urinate excessively or in large amounts, but 4:30-5:00pm was her normal time to urinate.

Observations of Resident #4 on 09/07/23 from 8:15am until 10:00am revealed:
-She was sleeping in her bed with the bed alarm string clipped to her shoulder and her fall mat on the floor next to her bed from 8:15am until 9:38am.
-At 9:38am, she awoke, sat up and stood when the bed alarm string pulled the magnet from the alarm box and the bed alarm sounded.
-A PCA responded immediately and assisted the resident who was losing her balance by stepping on the fall mat.
-The back area of her night gown was wet from the mid back to the upper thigh area and across to both hips.
-Her bed had a disposable incontinence pad that

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was saturated and smelled of urine.
-The bed sheet underneath the disposable pad was wet at the center area of her bed.
-The resident walked away from the PCA several times as the PCA tried to help put her clothes on.
-A family member arrived and spoke into the resident's left ear and the resident responded with yes and no with the family member's prompts to dress and get ready for breakfast.

Interview with the second PCA on 09/07/23 at 9:38am revealed:
-She was coming up the hall from assisting another resident and heard Resident #4's bed alarm.
-Resident #4 was the 3rd of 7 residents on her assignment that day (09/07/23) that was soaked with urine and required a complete bed change because the bed was soaked with urine.
-One of the other residents was because the incontinence brief was not on properly, but the 2nd resident was because she was not changed by the previous shift.
-It was not a normal occurrence for residents not to have their incontinence briefs changed.
-Resident #4 was a challenge to help with eating, bathing, toileting, and dressing.
-The resident did not communicate verbally, tried to be very independent and did what she wanted to despite prompting gestures from staff.

Interview with Resident #4's family member on 09/07/23 at 10:07am revealed:
-There had been issues with staff providing personal care such as bathing, incontinence care and applying two incontinence briefs in the past due to staffing.
-Staffing levels improved over the last month and she thought the care had improved.
-Resident #4 was sent to the emergency room

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D 269	Continued From page 12 (ER) on 07/26/23 around 9:30am. -The nurse at the ER showed her how Resident #4's incontinence brief was so saturated with urine that there were beads of the briefing gelled and accumulated in the resident's groin area. -Another incident on returning from an ER visit at 10:00pm with Resident #4 she saw the resident's pajamas laid out on the bed with 2 incontinence briefs. -She talked to the medication aide (MA) who was on duty and was told one incontinence brief as for now and the second was for later. -She was visiting the resident last week (week of 08/28/23) at 11:30am and she saw that the resident did not have on her glasses to see, did not have shoes on her feet and the back of her pants were saturated with urine. -The staff were task oriented and did not know Resident #4 or what she needed. -She regularly communicated concerns to staff and the MCC. -She thought MCC addressed concerns but staffing and staff turnover made it difficult to maintain a consistent care environment. Telephone interview with the primary care provider (PCP) on 09/08/23 at 3:00pm revealed: -A resident should never have on more than one incontinence brief. -Sitting in urine for extended periods of time increases the risk for urinary tract infections (UTI) and skin breakdown. Interview with the MCC on 09/08/23 at 4:30pm revealed: -PCAs were responsible for providing toileting assistance and incontinence care every 2 hours and as needed. -PCAs were responsible for documenting assistance provided with incontinence care on the	D 269		

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activities of daily living (ADLs) electronic system.
-There were two electronic documentation systems and there were technical issues with user sign in and the staffs' ability to navigate the proper electronic system.
-The technical issues resulted in no documentation of care provided on electronic ADL record.
-She saw Resident #4's wet pants on 09/06/23, and was on the SCU until 8:00pm that day, but was not told by staff that the resident had 2 incontinence briefs on until the next day (09/07/23).
-It was not the policy to use 2 incontinence briefs at the same time.
-If Resident #4 was still in the bed at 9:38am on 09/07/23, that meant that third shift did not change her, or she would have been awake for breakfast.
-Oncoming PCA staff were responsible for checking each resident for cleanliness during the walking rounds completed with outgoing staff at shift change.
-PCAs were expected to pull covers back and check if residents were wet and/or soiled.
-The previous shift was responsible for staying and providing any needed care identified.
-PCAs were responsible for reporting any tasks not done by the previous shift to the MA on duty.
-For continued outstanding incomplete tasks, PCAs and MAs were responsible for reporting to her.
-She normally walked through the SCU daily on arrival.
-Normally all residents were awake, and housekeeping was changing bed linens.

Interview with the Administrator on 09/08/23 at 5:32pm revealed staff were expected to provide incontinence care every 2 hours using 1 brief with

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D 269	Continued From page 14 each change. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 269		
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 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 observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 3 of 5 sampled	D 280		

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residents (#1, #3, #4) included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident.

The findings are:

1. Review of Resident #3's current FL-2 dated 10/14/22 revealed:
-Diagnoses included infection and inflammatory reaction due to other internal joint prosthesis, methicillin resistant staphylococcus aureus, muscle weakness, rheumatoid arthritis, other persistent mood disorders, and essential hypertension.
-There was an order for thromboembolic deterrent (TED) hose on in the morning, off in the evening (TED hose are compression hose used to prevent blood clots).
-The resident was semi-ambulatory and used a wheelchair.

Review of Resident #3's Resident Register dated 06/20/20 revealed:
-The resident was admitted to the facility on 06/02/20.
-The resident required assistance with getting in/out of bed and toileting.

Review of Resident #3's physician's order dated 02/03/22 revealed an order for self-administration of Humira 40mg subcutaneously every other week. (Humira is used to treat rheumatoid arthritis.)

Review of Resident #3's signed physician orders dated 09/08/23 revealed:
-The resident had an order for Humira 40mg/0.4ml inject 0.4ml subcutaneously every 14 days for rheumatoid arthritis unsupervised

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self-administration.
-The resident had an order for compression stockings to apply in the morning and remove at bedtime as needed for swelling.

Observation of Resident #3 on 09/08/23 at 3:10pm revealed:
-The resident was sitting in and independently operating an electric wheelchair.
-The resident was not wearing TED hose.
-The resident's legs were not swollen.

Interview with Resident #3 on 09/08/23 at 3:15pm revealed:
-She administered the Humira injection for eight years to herself every other week.
-The staff ordered the medication from the facility's contracted pharmacy for her.
-She administered the Humira injection this morning in her right upper thigh.
-She was able to transfer without staff assistance from wheelchair to bed or chair.
-She was independent with her activities of daily living (ADLs) except for requiring assistance with changing incontinence briefs.
-She was able to apply and remove TED hose if she needed them and she had two pairs of TED hose in her room.

Review of Resident #3's current Licensed Health Professional Support (LHPS) review dated 08/30/23 revealed:
-The nurse checked transferring semi-ambulatory or non-ambulatory residents as personal care tasks currently present.
-There was no physical assessment documentation related to the LHPS tasks of applying and removing TED hose or medication through injection.
-Changes and follow up recommendations

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included requesting discontinue orders for self-administration medications and home health to administer IM (intramuscular) injections.
-The nurse noted LHPS personal care tasks provided included incontinence care at night every two hours, one person assistance with ADLs, and one person assistance with transfers at times.

Telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm revealed:
-When she completed the LHPS review for Resident #3 on 08/30/23, she observed the resident in her room for about an hour.
-She and the resident discussed the Humira injection and the resident told her that the Humira injection was intramuscular (IM).
-She was not aware Humira was a subcutaneous injection that the facility staff could administer.
-She was not aware the resident had TED hose because the facility staff and the resident told her the resident did not have any.
-After researching about LHPS reviews, she was aware the LHPS review for Resident #3 was incomplete and needed to be redone.

Refer to interview with the Administrator on 09/08/23 at 3:54pm.

Refer to telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm.

2. Review of Resident #1's current FL-2 dated 09/06/23 revealed:
-Diagnoses included vascular dementia without behavioral disturbance, cognitive communication deficiency, muscle wasting-atrophy, type 2 diabetes, chronic obstructive pulmonary disease

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(COPD), protein calorie malnutrition, and muscle weakness.
-The resident was non ambulatory.

Review of Resident #1's Resident Register dated 06/30/22 revealed:
-The resident was admitted to the facility on 06/30/22.
-The resident required assistance ambulation, feeding, positioning and turning.
-The resident used a walker, wheelchair, eyeglasses and hearing aids.

Review of Resident #1's Assessment and Care Plan dated 06/22/22 revealed:
-The resident was ambulatory with aide or device and needed a high back wheelchair.
-The resident was totally dependent with ambulation and transferring.
-The resident required supervision with eating.

Review of Resident #1's physician's order dated 08/25/23 revealed an order for oxygen at 2-5L via nasal cannula, to wear as needed for shortness of breath.

Observation of Resident #1 on 09/06/23 at 9:25am revealed:
-The resident was lying in bed.
-The resident's family member was feeding her.
-There were 3 oxygen tanks in the room.
-There was a high back wheelchair in the bathroom.

Telephone interview with Resident #1's family member on 09/07/23 at 12:05pm revealed the resident required assistance with transferring.

Review of Resident #1's current Licensed Health Professional Support (LHPS) review dated

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07/08/22 revealed:
-The nurse checked ambulation using assistive devices that require physical assistance and bowel or bladder training programs to regain continence as personal care tasks currently present.
-The nurse documented the resident had a high back wheelchair in the physical assessment section of the LHPS form.
-There was no physical assessment documentation related to the LHPS tasks of transferring semi-ambulatory or non-ambulatory residents.
-There were no notes in the changes and follow up recommendations section.
-The nurse documented LHPS personal care tasks provided included 2 person assist with transfers, toilet every 2 hours/incontinent care every 2 hours, oxygen as needed (PRN), total care with all ADLs, treatment to coccyx.

Review of Resident #1's record revealed there were no other quarterly LHPS reviews since 07/08/22.

Refer to interview with the Administrator on 09/08/23 at 3:54pm.

Refer to telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm.

3. Review of Resident #4's current FL-2 dated 10/19/22 revealed:
-Diagnoses included vascular dementia, psychotic disturbance, vitamin D deficiency, history of a hip fracture, history of cervical vertebrae fracture.
-Resident #4 required total personal care assistance.

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D 280	Continued From page 20 -There was an order for a pureed diet. Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 10/28/22. Review of Resident #4's primary care provider (PCP) visit note dated 07/04/23 revealed an order for compression socks for lower extremity edema. Review of Resident #4's current care plan dated 07/26/23 revealed she was on a pureed diet and required supervision with eating. Review of Resident #4's current Special Care Unit (SCU) Quarterly Profile dated 07/11/23 revealed there was no documentation indicating the level of assistance she required with eating. Review of Resident #4's hospice nurse (HN) visit note dated 07/31/23 revealed: -Resident #4 needed stand by assistance with ambulation due to an unsteady gait and fatigue over the last month (July 2023). -She had treatment for a urinary tract infection (UTI) and lost 3 pounds in the last month (July 2023). -She needed assistance with eating meals which was new since last month (June 2023). Review of Resident #4's electronic Progress Note dated 07/20/23 revealed the resident was refusing to eat dinner, holding food in her mouth, and then spitting it out. Review of Resident #4's electronic Progress Note dated 08/15/23 revealed: -She was aspirating when eating and needed to slow down while eating.	D 280		

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-She wanted to walk and leave the table before staff could finish assisting her to eat.

Review of Resident #4's electronic Progress Notes dated 08/21/23 and 08/25/23 revealed she refused to wear compression socks.

Review of Resident #4's licensed health professional support (LHPS) quarterly assessment and evaluation dated 08/23/23 revealed:
-LHPS tasks included feeding techniques for residents with swallowing problems.
-Applying and removing compression socks was not listed as an LHPS task.
-Review of health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care listed the following: staff assist resident with meals, enemas at times due to constipation and hospice services.
-The assessment did not include behaviors around eating meals, care plan interventions to manage behaviors and recommendations for any changes with meal assistance.
-Feeding techniques due to swallowing was the only LHPS task with staff competency validated documented, and was not marked yes or no.

Interview with the Memory Care Coordinator (MCC) on 09/07/23 at 11:53am revealed:
-A quarterly LHPS assessment and evaluation had not been done for Resident #4 prior to 08/23/23.
-She started as the MCC in March 2023.
-There were a lot of processes such as updated FL-2s, care plans and LHPS evaluations that had not been done.
-She started arranging to get groups of residents'

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LHPS assessments and evaluations completed around April - May 2023.
-Her process was to check electronic records for residents who needed to have an LHPS assessment and evaluation completed.
-She then took a group of residents' names and gave them to the Consultant Nurse when she was at the facility.

Telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm revealed:
-She had just started working as a contracted nurse at the facility in July 2023.
-She did not remember the residents that well and she could not recall Resident #4.
-If she was aware a resident required feeding assistance, she would observe the resident during feeding assistance for the LHPS review.
-If she had checked feeding assistance for a resident, it would be documented on the LHPS form.
-She was new at doing LHPS reviews and recently did some research on LHPS reviews.
-She was aware the LHPS reviews completed prior to September 2023 were done incorrectly and she needed to do those LHPS reviews again.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with the Administrator on 09/08/23 at 3:54pm.

Refer to telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm.

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Interview with the Administrator on 09/08/23 at

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3:54pm revealed:
-The nurse responsible for the LHPS reviews obtained information from the resident's medication administration record (MAR), talked with staff members, visited residents, and had access to resident's electronic health records.
-There was no system in place to check the accuracy of the LHPS reviews after they were completed by the nurse.

Telephone interview with the facility's current contracted LHPS nurse on 09/08/23 at 4:14pm revealed:
-She had been working part time at the facility, 3 days a week, since the end of July 2023.
-The Administrator asked her to do the LHPS reviews but she had never done them before.
-She did not usually have access to use the facility's computer system to access the residents' records.
-The Administrator gave her a laptop computer to use about 2 weeks ago but she was doing classes and training and did not have time to use the computer.
-She was not familiar with the LHPS rule and no one at the facility shared that information with her.
-She did some research after she completed LHPS reviews in August 2023 and realized she did not do them correctly.
-She needed to review the residents' records with all the notes to help with the LHPS reviews.
-She was aware the LHPS reviews she completed in August 2023 were incomplete and needed to be redone.

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10A NCAC 13F .0904(f)(2) Nutrition and Food Service

10A NCAC 13F .0904 Nutrition and Food Service

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(f) Individual Feeding Assistance in Adult Care Homes:
(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure there was staff available to provide feeding assistance when meals were served in an unhurried, respectful, and dignified manner for 3 of 4 sampled residents (#1, #8, #10) resulting in lack of prompting and delayed assistance with eating meals while sitting in the dining room with other residents eating the meal (#8, #10).

The findings are:

Interview with a personal care aide (PCA) on 09/06/23 at 12:18pm revealed:
-There were 3 PCAs, plus 1 PCA training and 1 medication aide (MA) on duty for 1st shift on 09/06/23 for 28-29 residents on the special care unit (SCU).
-The long table by the window was where they seated residents who required staff assistance to eat.
-She thought there were at least 6 residents who required staff assistance and sat at the long table.

1. Review of Resident #10's current FL-2 dated 10/27/22 revealed diagnoses included heart disease, hypothyroidism, anxiety, dementia, and hypertension.

Review of Resident #10's current diet order dated 08/17/23 revealed an order for a mechanical soft

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finger foods diet.

Interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm revealed:
-She did not have a care plan for Resident #10.
-The resident was admitted to the facility on 05/23/21 and should have had at least one completed.

Observations of the lunch meal on the SCU on 09/06/23 from 12:18pm until 12:41pm revealed:
-At 12:18pm, there were 18 residents in the dining room waiting for lunch to be served including Resident #10.
-Resident #10 was sitting in her geriatric chair at a table to the side of the long table.
-There were no other residents at the table with Resident #10.
-At 12:23pm, PCAs were serving lunch plates to residents.
-At 12:29pm, Resident #10 was staring at her lunch plate without eating.
-At 12:34pm, there were 3 PCAs assisting residents to eat at the long table.
-Resident #10 was not eating.
-Staff did not interact, encourage, or prompt her to eat.
-At 12:44pm, residents were leaving the dining room and going to the common area.
-Resident #10 started feeding herself but stopped eating and started dragging her bread across the table.
-At 1:04pm, the MA was seated next to Resident #10 and assisting her eat.

Observations during the breakfast meal on the SCU on 09/07/23 from 8:38am until 9:19am revealed:
-At 8:38am, 3 PCAs started serving residents seated (22) in the dining room.

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-Resident #10 was sitting in her geriatric chair at a table to the side of the long table.
-There were no other residents at the table with Resident #10.
-At 8:41am, the MCC talked to Resident #10 and encouraged her to eat her breakfast meal.

Interview with a PCA on 09/08/23 at 3:16pm revealed:
-Resident #10 sat by herself because did not like staff assisting her to eat.
-The resident would throw food at staff who tried to assist her with eating.

Interview with a MA on 09/07/23 at 4:21pm revealed staff had to assist Resident #10 because she made a mess and would throw food across the table.

Interview with the MCC on 09/08/23 at 4:30pm revealed she assisted in the dining room and common areas during meals when she was available.

Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable.

Refer to interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm.

Refer to interview with the Administrator on 09/08/23 at 5:32pm.

2. Review of Resident #8's current FL-2 dated 03/28/23 revealed diagnoses included dementia, hypertension, osteoporosis, hyperlipidemia, and physical disability.

Review of Resident #8's current diet order dated

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08/17/23 revealed an order for a no added salt mechanical soft diet.

Review of Resident #8's current care plan dated 01/17/23 revealed the resident required supervision with meals.

Observations during the initial tour of the special care unit (SCU) on 09/06/23 at 9:07am revealed:
-There were 7 residents in the dining room, 12 in the common area and 2 personal care aides (PCAs) going between the dining room and common area.
-Resident #8 was sitting upright in a geriatric chair at a dining room table.
-She was eating scrambled eggs, grits and a biscuit covered in gravy with her hands.
-Staff did not offer utensils or assistance.

Observations during the breakfast meal on the SCU on 09/07/23 from 8:38am until 9:19am revealed:
-At 8:38am, 3 PCAs started serving residents seated (22) in the dining room.
-Resident #8 was distracted and not eating her breakfast.
-At 8:45am, a PCA who was sitting next to another resident assisting that resident with eating, got up and stood next to Resident #8 who was seated across the table from the other resident.
-The PCA stood while assisting Resident #8 with eating for several bites before returning to sitting with the other resident.
-At 8:56am, Resident #8 attempted to get up from her wheelchair unassisted when the Memory Care Coordinator (MCC) assisted her with sitting in her wheelchair and to a recliner in the common area.

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Interview with a medication aide (MA) on 09/07/23 at 4:21pm revealed:
-There were 4 to 5 residents who were at the long table by the window in the dining room and required staff assistance to eat.
-There were 3 additional residents who sat at other tables in the dining room that needed prompting including Resident #8.
-Sometimes Resident #8 stopped eating and restarted using her fingers so staff tried to assist her with eating.

Interview with the MCC on 09/08/23 at 4:30pm revealed:
-There were 4-5 residents who required staff assistance to eat all meals in the dining room.
-Staff were not always aware to sit down while assisting residents to eat, engage with and prompt residents to eat .
-Newer staff might not know some residents needed prompting and assistance at times.
-She assisted in the dining room and common areas during meals when she was available.

Interview with the Administrator on 09/08/23 at 5:32pm revealed she expected one staff to sit between residents and provide assistance to 2-3 residents simultaneously.

Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.

Refer to interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm.

Refer to interview with the Administrator on 09/08/23 at 5:32pm.

3. Review of Resident #1's current FL-2 dated

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09/06/23 revealed:
-Diagnoses included vascular dementia without behavioral disturbance, cognitive communication deficiency, muscle wasting-atrophy, type 2 diabetes, chronic obstructive pulmonary disease (COPD), protein calorie malnutrition, and muscle weakness.
-The resident was non ambulatory.

Observation of Resident #1 on 09/06/23 from 12:15pm to 1:30pm during the lunch meal service revealed she was in her room and staff did not assist with her lunch meal and she did not eat during this time.

Interview with a dietary aide at 1:20pm revealed all residents had been fed and there was not a plate being held for any resident because all plates were in the rooms.

Interview with a personal care aide (PCA) at 1:25pm revealed:
-Resident #1's plate was on the counter in the dining room.
-The resident's son usually fed her a huge breakfast so she picked over her lunch.

Telephone interview with hospice nurse case manager on 09/07/23 at 12:30pm revealed Resident #1 fed herself sometimes and other times she would not feed herself and needed a lot of prompting.

Interview with a second PCA on 09/06/23 at 1:00pm revealed there were 6 residents that needed feeding assistance at the "feeder's table".

Intermittent observations made on 09/06/23 from 12:15pm until 1:25pm revealed Resident #1's lunch plate was never delivered to her room and

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she did not eat lunch and remained in bed.

Interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm revealed there were 2 residents who ate in their rooms.

Interview with the Administrator on 09/08/23 at 5:32pm revealed residents who stayed in their room were assisted with eating meals after the dining room meal was done.

Refer to interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm.

Refer to interview with the Administrator on 09/08/23 at 5:32pm.

____

Interview with the Memory Care Coordinator (MCC) on 09/08/23 at 4:30pm revealed:
-The number of residents that required assistance with eating varied each day depending on the ability of residents each day.
-There were some residents who might eat one meal independently, but needed staff to prompt them at the next meal (sometimes they would forget to eat) requiring staff to help them at the next.
-Sometimes staff were focused on getting tasks completed such as, serving plates and assisting residents to eat who were unable to eat on their own.
-Newer staff might not know some residents needed prompting and assistance at times.

Interview with the Administrator on 09/08/23 at 5:32pm revealed she knew there were more residents who required staff assistance to eat than there were staff to feed them.

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D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

10A NCAC 13F .0905 Activities Program
(d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided 14 hours of activities each week.

The findings are:

Review of the facility's monthly activities calendar on 09/06/23 at 9:00am revealed:
-There were at least 14 hours of scheduled activities weekly.
-There were five activities listed on the calendar for 09/06/23.
-The activity calendar that was posted in the facility had daily devotions scheduled at 9:00am, seniorcise scheduled at 10:00am, book reading scheduled at 10:30am, dine and music scheduled at 12:00pm, and bingo scheduled at 3:00pm.

Observation of activities on 09/06/23 at 9:00am, there was no daily devotions observed.

Observation of activities on 09/06/23 at 10:20am, seniorcise was observed.

Observation of activities on 09/06/23 at 10:30am, there was no book reading observed.

Observation of activities on 09/06/23 at 12:00pm, there was no dine with music observed.

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Observation of activities on 09/06/23 at 3:00am, bingo was observed.

Interview with a resident on 09/06/23 at 9:20am revealed:
-The facility had not been providing many activities.
-Most of the activities listed on the activity calendar were not offered to the residents.
-Staff occasionally took residents on an outing.

Interview with a second resident on 09/06/23 at 9:30am revealed:
-The only activities the facility offered was bingo and nail painting.
-The facility offered about two and a half hours of activities per week.

Interview with a third resident on 09/06/23 at 9:45am revealed:
-The facility had not been providing enough activities.
-Bingo was about the only activity that was provided.
-They used to have Sunday service but no longer did that.
-He would participate in activities if they offered any that interested him.

Interview with a fourth resident on 09/06/23 at 10:10am revealed:
-Bingo was the only activity provided.
-Sometimes people came into the facility and played music.

Interview with Activities Director (AD) on 09/06/23 at 12:30pm revealed:
-She was responsible for completing the monthly activities calendar and making sure activities

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were offered to residents.
-The Activities Assistant (AA) helped with activities on the memory care and assisted living side.
-The 9:00am activity that was posted on 09/06/23 was daily devotions and consisted of the television in the common area being turned to a religious channel, was not done because the activities assistant was taking a resident to an appointment.
-The 10:30am activity that was posted on 09/06/23 was book reading and was not done at this time because the 10:00am activity began late.
-The 12:00pm activity that was posted on 09/06/23 was dine with music and consisted of music playing during lunch, was not done because the activities assistant was taking a resident to an appointment. She did not know how to operate the speakers.
-The facility tried to offer two outings for residents monthly.

Interview with a personal care aide (PCA) on 09/06/23 at 1:00pm revealed:
-The AD was supposed to do activities.
-The AD did about two hours of activities each week.

Interview with a second PCA on 09/06/23 at 1:10pm revealed:
-The AD was supposed to do activities.
-The AD did about two hours of activities each week.

Interview with the Administrator on 09/08/23 at 9:50am revealed:
-The AD was responsible for completing the activities calendar and making sure activities were offered to residents.

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D 317	Continued From page 34 -She usually checked the activities calendar. -She had meetings with the AD each morning to make sure activities would be done each day. -Some of the activities that were on the calendar including: daily devotion, in the news and dine with music were not considered activities due to lack of interaction with residents.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a medication for constipation (#7) and medications for acid reflux, prevention of heart disease, Vitamin D deficiency, and Alzheimer's dementia (#6); and for 1 of 6 sampled residents (#6) who did not receive a medication for underactive thyroid disease as ordered. The findings are: 1. The medication error rate was 20% as	D 358		

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evidenced by 5 errors out of 25 opportunities during the 8:00am medication passes on 09/06/23 and 09/07/23.

a. Review of Resident #6's current FL-2 dated 11/29/22 revealed:
-Diagnoses included memory loss, hypertension, diabetes, and history of thyroid cancer with hypothyroidism.
-There was an order for Enteric Coated (EC) Aspirin 81mg 1 tablet once daily. (Aspirin is used for prevention of heart disease. EC Aspirin has a special coating to prevent stomach irritation and upset and reduce the risk of stomach bleeding. EC Aspirin should not be crushed or chewed to maintain the protective coating of the tablet.)

Review of Resident #6's physician's order dated 08/24/23 revealed an order for may crush medications and give with food/beverage to facilitate medication administration.

Observation of the 8:00am medication pass on 09/06/23 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one EC Aspirin 81mg tablet.
-The MA crushed all of Resident #6's oral medications, including the EC Aspirin, mixed them in vanilla pudding and administered them to the resident at 9:21am.

Observation of Resident #6's medications on hand on 09/06/23 at 2:12pm revealed:
-There was a supply of EC Aspirin 81mg tablets dispensed by a Veteran's Administration (VA) pharmacy.
-There was no information indicating if the medication could be crushed.

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Review of Resident #6's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg one time a day scheduled for 8:00am.
-Aspirin was documented as administered daily from 09/01/23 - 09/06/23.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Interview with Resident #6 on 09/06/23 at 1:26pm revealed:
-He thought he usually got him medications whole and he did not have problems swallowing them.
-He denied any current symptoms of stomach irritation or discomfort.

Interview with the MA on 09/06/23 at 2:12pm revealed:
-She usually crushed Resident #6's medications because the resident would pocket the medications on the side of his mouth or the top of his tongue.
-The resident would get choked if he tried to swallow the medications whole.
-She was unsure how she knew which medications could be crushed.
-She knew some medications like potassium supplements should not be crushed.
-She crushed the medications unless it was noted not to crush on the label or on the eMAR.
-She knew she could open capsules and empty them in the medication cup.
-She did not know if the facility had a "Do Not Crush" (DNC) list.
-She had worked at the facility for 5 months and had never seen a DNC list.
-She did not realize Resident #6's EC Aspirin should not be crushed.

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Observation of the MA on 09/06/23 at 2:12pm revealed she checked the controlled substance notebook on top of the medication cart and there was no DNC list available in the notebook.

Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 2:45pm revealed:
-Resident #6's medications were crushed because he held the medications in his mouth, not because he had trouble swallowing.
-The resident would forget how to swallow and just hold the medications in his mouth.
-The medication label should indicate whether a medication could be crushed.
-She thought there was a DNC list kept inside the controlled substance notebook on the medication carts.
-The MAs should refer to the medication label and the DNC list prior to crushing medications.
-If there was no DNC list, the MAs should notify her or the Administrator.
-Resident #6's EC Aspirin should not have been crushed.

Interview with the Administrator on 09/06/23 at 3:09pm revealed:
-There should be a DNC list from the pharmacy on the medication carts.
-The MAs should use the DNC list to determine which medications could be crushed.
-She was not aware there was no DNC list available for the MAs.
-She would check with the pharmacy and get one.

Review of the a Do Not Crush (DNC) medication list provided to the facility by the contracted pharmacy on 09/07/23 revealed EC Aspirin was included on the list as a medication that should not be crushed due to the enteric coating.

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Telephone interview with Resident #6's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #6's EC Aspirin should not be crushed.
-There was a potential for stomach irritation if the EC Aspirin was crushed.

b. Review of Resident #6's current FL-2 dated 11/29/22 revealed an order for Omeprazole DR (delayed release) 20mg take 1 capsule once daily. (Omeprazole DR is used to treat acid reflux. Omeprazole DR is a delayed release capsule that contains pellets inside the capsule. The capsule should be swallowed whole or the capsule may be opened and the pellets sprinkled on food. The pellets should not be crushed or chewed.)

Review of Resident #6's physician's order sheet dated 04/27/23 revealed an order or Esomeprazole DR 20mg 1 capsule daily. (Esomeprazole DR is used to treat acid reflux. Esomeprazole is a delayed release capsule that contains pellets inside the capsule. The capsule should be swallowed whole or the capsule may be opened and the pellets sprinkled on food. The pellets should not be crushed or chewed. Esomeprazole and Omeprazole are similar but are not the same medication.)

Review of Resident #6's physician's order dated 08/24/23 revealed an order for may crush medications and give with food/beverage to facilitate medication administration.

Observation of the 8:00am medication pass on 09/06/23 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one

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Omeprazole DR 20mg capsule.
-The MA opened the capsule and poured the pellets into a medication cup with all of the resident's other morning medications.
-The MA crushed all of Resident #6's oral medications, including the pellets of the Omeprazole DR 20mg capsule, mixed them in vanilla pudding and administered them to the resident at 9:21am.

Observation of Resident #6's medications on hand on 09/06/23 at 2:12pm revealed:
-There was a supply of Omeprazole 20mg capsules dispensed by a Veteran's Administration (VA) pharmacy on 07/19/23.
-There were instructions on the label that read, do not chew or crush before swallowing.
-There was no Esomeprazole available for administration.

Review of Resident #6's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Esomeprazole DR 20mg 1 capsule once a day for acid reflux scheduled for 8:00am.
-Esomeprazole was documented as administered daily from 09/01/23 - 09/06/23.
-There was no information noted on the eMAR to indicate the medication should not be crushed.
-There was no entry for Omeprazole and none was documented as administered.

Review of Resident #6's physician's orders revealed no documentation the orders for Omeprazole and Esomeprazole were clarified.

Interview with Resident #6 on 09/06/23 at 1:26pm revealed:
-He thought he usually got him medications whole

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and he did not have problems swallowing them.
-He usually got heartburn when he would overeat.
-He denied any current symptoms of heartburn or acid reflux.

Interview with the MA on 09/06/23 at 2:12pm revealed:
-She usually crushed Resident #6's medications because the resident would pocket the medications on the side of his mouth or the top of his tongue.
-The resident would get choked if he tried to swallow the medications whole.
-She was unsure how she knew which medications could be crushed.
-She knew some medications like potassium supplements should not be crushed.
-She crushed the medications unless it was noted not to crush on the label or on the eMAR.
-She knew she could open capsules and empty them in the medication cup.
-She did not know if the facility had a "Do Not Crush" (DNC) list.
-She had worked at the facility for 5 months and had never seen a DNC list.
-She did not realize the pellets in Resident #6's Omeprazole DR 20mg capsule should not be crushed.
-Resident #6 only had Omeprazole available for administration.
-She did not notice the eMAR had Esomeprazole listed instead of Omeprazole.
-She did not notice the label on the Omeprazole indicated not to crush and to swallow whole.

Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 2:45pm revealed:
-Resident #6's medications were crushed because he held the medications in his mouth, not because he had trouble swallowing.

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-The resident would forget how to swallow and just hold the medications in his mouth.
-The medication label should indicate whether a medication could be crushed.
-She thought there was a DNC list kept inside the controlled substance notebook on the medication carts.
-The MAs should refer to the medication label and the DNC list prior to crushing medications.
-If there was no DNC list, the MAs should notify her or the Administrator.
-If the medication label and the eMAR did not match, the MAs should notify her.

Interview with the Administrator on 09/06/23 at 3:09pm revealed:
-There should be a DNC list from the pharmacy on the medication carts.
-The MAs should use the DNC list to determine which medications could be crushed.
-She was not aware there was no DNC list available for the MAs.
-She would check with the pharmacy and get one.

Review of the facility's Do Not Crush (DNC) medication list provided to the facility by the contracted pharmacy revealed Omeprazole DR was included on the list as a medication that should not be crushed due being delayed release.

Review of Resident #6's clarification order dated 09/07/23 revealed:
-The resident was always on Omeprazole DR 20mg.
-The order was keyed into the eMAR system wrong.
-The resident was taking Omeprazole, not Esomeprazole.

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Telephone interview with Resident #6's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-The facility contacted her yesterday for clarification of Resident #6's Omeprazole.
-The Omeprazole capsule can be opened but the pellets should not be crushed.
-Crushing the Omeprazole pellets would prevent the medication from being delayed release and would decrease the benefits of the medication to the resident.
-This could result in untreated symptoms of acid reflux.

c. Review of Resident #6's current FL-2 dated 11/29/22 revealed an order for Vitamin D3 2000 units once a day, take with food. (Vitamin D3 is used to treat and prevent Vitamin D deficiency. Vitamin D3 Softgel capsules should be swallowed whole to ensure proper absorption and to ensure the full dosage is administered.)

Review of Resident #6's physician's order dated 08/24/23 revealed an order for may crush medications and give with food/beverage to facilitate medication administration.

Observation of the 8:00am medication pass on 09/06/23 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one Vitamin D3 2000 units Softgel capsule.
-The MA put the Vitamin D3 Softgel capsule in the plastic pouch and crushed it with all of the resident's other morning medications.
-The Vitamin D3 Softgel capsule ruptured and the liquid gel adhered to the inside lining of the plastic pouch.
-The MA did not attempt to get the liquid gel that adhered to the inside of the pouch.

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-The MA administered the crushed medications to the resident at 9:21am.
-The full dosage of Vitamin D3 was not administered.

Observation of Resident #6's medications on hand on 09/06/23 at 2:12pm revealed:
-There was an over-the-counter (OTC) bottle of Vitamin D3 2000 units Softgel capsules on had for Resident #6.
-There was no information indicating if the medication could be crushed.

Review of Resident #6's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin D3 2000 units 1 tablet once time a day for low Vitamin D scheduled for 8:00am.
-Vitamin D3 was documented as administered daily from 09/01/23 - 09/06/23.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Interview with Resident #6 on 09/06/23 at 1:26pm revealed:
-He thought he usually got him medications whole and he did not have problems swallowing them.
-He was unsure of all of the medications he was administered.

Interview with the MA on 09/06/23 at 2:12pm revealed:
-She usually crushed Resident #6's medications because the resident would pocket the medications on the side of his mouth or the top of his tongue.
-The resident would get choked if he tried to swallow the medications whole.
-She was unsure how she knew which

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medications could be crushed.
-She knew some medications like potassium supplements should not be crushed.
-She crushed the medications unless it was noted not to crush on the label or on the eMAR.
-She knew she could open capsules and empty them in the medication cup.
-She did not know if the facility had a "Do Not Crush" (DNC) list.
-She had worked at the facility for 5 months and had never seen a DNC list.
-She did not realize Resident #6's Vitamin D3 Softgel capsules should not be crushed.

Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 2:45pm revealed:
-Resident #6's medications were crushed because he held the medications in his mouth, not because he had trouble swallowing.
-The resident would forget how to swallow and just hold the medications in his mouth.
-The medication label should indicate whether a medication could be crushed.
-She thought there was a DNC list kept inside the controlled substance notebook on the medication carts.
-The MAs should refer to the medication label and the DNC list prior to crushing medications.
-If there was no DNC list, the MAs should notify her or the Administrator.
-Resident #6's Vitamin D3 Softgel capsules should not be crushed.
-Softgel capsules should be cut open and the liquid squeezed into the medication cup.

Interview with the Administrator on 09/06/23 at 3:09pm revealed:
-There should be a DNC list from the pharmacy on the medication carts.
-The MAs should use the DNC list to determine

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which medications could be crushed.
-She was not aware there was no DNC list available for the MAs.
-She would check with the pharmacy and get one.

Review of the facility's Do Not Crush (DNC) medication list provided to the facility by the contracted pharmacy revealed Vitamin D capsules were included on the list as a medication that should not be crushed.

Telephone interview with Resident #6's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #6's Vitamin D3 Softgel capsule should be not be crushed.
-It would be difficult to get the full dosage as the liquid gel would stick to the side of the plastic pouch.

d. Review of Resident #6's current FL-2 dated 11/29/22 revealed an order for Donepezil 10mg 1 tablet daily. (Donepezil is used to treat Alzheimer's dementia.)

Review of Resident #6's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Donepezil 10mg 1 tablet one time a day scheduled for 8:00am.
-Donepezil was documented as administered daily at 8:00am from 09/01/23 - 09/05/23.

Observation of the 8:00am medication pass on 09/06/23 revealed:
-The medication aide (MA) prepared and administered Resident #6's 8:00am medications at 9:21am.
-The MA did not administer Donepezil 10mg to

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Resident #6 when he received his other medications scheduled for 8:00am.

Interview with the MA on 09/06/23 at 9:21am revealed:
-She did not administer the Donepezil to Resident #6 this morning because the instructions on the medication label were to take it at night but the eMAR instructions were for 8:00am.
-The MA did not answer when asked what the procedure was if the label and eMAR did not match.

A second interview with the MA on 09/06/23 at 2:12pm revealed:
-Even though she had initialed she had administered Donepezil some mornings at 8:00am, she had actually not administered it.
-She should have documented it was not administered and wrote a note as to why.
-She reported the discrepancy to the Resident Care Coordinator (RCC) about a month ago.
-When there was discrepancy, she usually went by the medication label.
-She did not know if the resident was receiving Donepezil at night since she did not usually work at night.

Interview with the RCC on 09/06/23 at 2:45pm revealed:
-Resident #6 received his medications from a Veteran's Administration (VA) pharmacy.
-The most current order on file was for Donepezil to be administered daily.
-Daily medications were usually scheduled on the eMAR for 8:00am.
-Resident #6 should have received Donepezil at 8:00am on 09/06/23.
-The MAs should let her know if there as a discrepancy.

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-No one had notified her about Resident #6's Donepezil label and eMAR not matching.

e. Review of Resident #7's current FL-2 dated 10/14/22 revealed:
-Diagnoses included senile dementia and debility.
-There was an order for Miralax give 17 grams (g) by mouth once a day. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the cap. According to the manufacturer, Miralax powder should be dissolved in 4 to 8 ounces of beverage and drank. Ensure that the powder is fully dissolved before drinking. Do not drink if there are any clumps.)

Review of Resident #7's medication clarification order dated 03/16/23 revealed an order for Miralax mix 17g in 8 ounces of water or juice and give by mouth once daily for constipation.

Observation of the 8:00am medication pass on 09/06/23 revealed:
-The MA prepared 3 oral medications in a plastic medication cup for Resident #7.
-The MA then measured 17g of Miralax and poured the powder in the plastic medication cup with the oral solid medications.
-The MA put a couple of spoonfuls of vanilla pudding in the medication cup with the Miralax powder and the oral solid medications.
-The MA attempted to stir/mix the pudding with the Miralax powder but the powder did not dissolve and some of the powder spilled over the side of the medication cup.
-The MA then used the spoon to feed some of the pudding/powder mixture to the resident at 9:30am.

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-Resident #7 ate about half of the contents of the cup and motioned her hand and said "that's enough".
-The MA did not offer water to the resident.
-The resident coughed 3 times after eating about half of the powdery mixture.
-The MA then offered the resident some water at 9:32am.
-The MA then attempted to feed the resident the rest of the Miralax powder/pudding mixture with the 3 oral medications at the bottom of the cup.
-The resident ate most of the rest of the powdery mixture and spit out one of the pills and refused to take it.
-The Miralax was not dissolved and the resident did not receive the full amount.

Review of Resident #7's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax give 17g scoop by mouth one time a day for constipation scheduled for 8:00am.
-Miralax was documented as administered daily at 8:00am from 09/01/23 - 09/06/23.

Observation of Resident #7's medications on hand on 09/06/23 at 2:41pm revealed there was a bottle of Miralax powder with instructions to mix 1 capful (17g) in 8 ounces of liquid and take by mouth daily.

Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.

Interview with the MA on 09/06/23 at 2:12pm revealed:
-She typically put Resident #7's Miralax in applesauce but they were out of applesauce so

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she used the vanilla pudding.
-She usually put the resident's Miralax powder in the applesauce with her other medications to save time.
-Some days the resident would take the Miralax and some days, she would not take it.
-She was going by the eMAR instructions to take a 17g scoop once a day.
-She did not see the instructions on the medication label to mix in 8 ounces of water because she was rushing to get the medication pass done as she was running late administering medications.

Interview with the Resident Care Coordinator (RCC) on 09/06/23 at 2:45pm revealed:
-Miralax should always be mixed with liquid.
-The MAs were supposed to use the 9 ounce cups to mix the Miralax powder with 8 ounces of water.
-Resident #7 had difficulty swallowing medications and would hold them in her mouth.
-Resident #7 needed Miralax mixed in liquid to help her with swallowing the medication.

Interview with the Administrator on 09/06/23 at 3:09pm revealed:
-The MAs were supposed to mix Miralax powder in 8 ounces of water.
-The MAs were supposed to read the instructions on the medication labels and the eMARs when administering medications.

Telephone interview with Resident #7's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Miralax powder should be mixed with a liquid to ensure the medication is dissolved and the full amount is administered.
-The resident could have choked because of the

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D 358	Continued From page 50 texture of the unmixed and undissolved Miralax powder. 2. Review of Resident #6's current FL-2 dated 11/29/22 revealed: -Diagnoses included memory loss, hypertension, diabetes, and history of thyroid cancer with hypothyroidism. -There was an order for Levothyroxine 100mcg take 1 tablet daily before breakfast for thyroid, take on an empty stomach at least 30 minutes before breakfast. (Levothyroxine is used to treat underactive thyroid disease.) Review of Resident #6's physician's order dated 04/20/23 revealed an order to change Levothyroxine to 125mcg 1 tablet once a day. Review of Resident #6's physician's order dated 08/07/23 revealed: -There was an order to give three 75mcg Levothyroxine tablets (225mcg) now. -There was an order to give two 75mcg Levothyroxine tablets (150mcg) at 6:00am on 08/08/23. Review of Resident #6's verbal physician's order dated 08/09/23 revealed an order for Levothyroxine 112mcg 1 tablet in the morning for low thyroid hormone. Review of Resident #6's primary care provider (PCP) visit note dated 08/12/23 revealed: -The PCP noted the resident had not been getting his ordered Levothyroxine correctly which had exacerbated his hypothyroidism. -The PCP ordered labwork and made adjustments with the medication accordingly. -The resident had been out of his thyroid medication for over a week so the PCP ordered a	D 358		

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double dose of the existing medication to attempt to get him back on track.
-The PCP would monitor his thyroid stimulating hormone (TSH) levels closely over the next few weeks.

Review of Resident #6's thyroid labwork revealed:
-The resident's TSH level was 2.030 uIU/mL (reference range was 0.358 - 3.74) on 06/14/23.
-The resident's TSH level was 0.22 (reference range was 0.46 - 4.68) on 08/08/23.
-The resident's TSH level was 0.20 (reference range was 0.46 - 4.68) on 08/24/23.
-The resident's TSH level was 0.14 (reference range was 0.46 - 4.68) on 08/31/23.

Review of Resident #6's August 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Levothyroxine 125mcg 1 tablet one time a day for low thyroid hormone scheduled for 6:00am.
-Levothyroxine 125mcg was not documented as administered on 08/01/23, 08/09/23 - 08/17/23, 08/19/23, 08/20/23, and 08/23/23 due to the medication not being on the cart.
-There was an entry for Levothyroxine 75mcg take 3 tablets in the morning for thyroid for 1 day and it was documented as administered at 6:00am on 08/07/23.
-There was an entry for Levothyroxine 75mcg take 2 tablets in the morning for thyroid for 1 day and it was documented as administered at 6:00am on 08/08/23.
-There was an entry for Levothyroxine 112mcg 1 tablet in the morning for low thyroid hormone scheduled for 6:00am with a start date of 08/10/23.
-Levothyroxine 112mcg was documented as administered at 6:00am from 08/10/23 - 08/18/23.

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-There was a second entry for Levothyroxine 112mcg 1 tablet in the morning for low thyroid hormone scheduled for 8:00am with a start date of 08/19/23.
-Levothyroxine 112mcg was documented as administered at 8:00am from 08/19/23 - 08/31/23.

Review of Resident #6's September 2023 eMAR revealed:
-There was an entry for Levothyroxine 112mcg 1 tablet in the morning for low thyroid hormone scheduled for 8:00am.
-Levothyroxine 112mcg was documented as administered daily from 09/01/23 - 09/06/23.

Observation of Resident #6's medications on hand on 09/06/23 at 2:12pm revealed:
-There was a supply of Levothyroxine 112mcg tablets in a bottle dispensed by a VA pharmacy on 04/26/23.
-There was a second supply of Levothyroxine 112mcg tablets in a bottle dispensed by a VA pharmacy on 07/21/23.
-There was no Levothyroxine 125mcg tablets available.

Interview with Resident #6 on 09/06/23 at 1:26pm revealed:
-He received Levothyroxine for his thyroid but he was not sure what dosage he took.
-He felt okay today and denied any symptoms or side effects from his medications.

Interview with the Resident Care Coordinator (RCC) on 09/08/23 at 5:05pm revealed:
-Resident #6 ran out of Levothyroxine in August 2023.
-The medication aides (MAs) did not order the Levothyroxine in a timely manner and did not notify anyone that the resident was out of the

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medication.
-The MAs were responsible for ordering medications when there was a one week supply remaining.
-Resident #6's medications came from a Veteran's Administration (VA) pharmacy and the MAs were supposed to order them when there was a 10 to 15-day supply remaining because it took longer to get medications through the VA pharmacy.
-The resident's PCP had to double dose the resident after he missed the doses of Levothyroxine.
-The resident was taking Levothyroxine 125mcg but he ran out of them (could not recall date).
-The resident's family had some Levothyroxine 112mcg tablets so those were administered (could not recall date).
-Then, the PCP wrote an order for the resident to receive Levothyroxine 112mcg tablets since those were available and it took so long to get medications from the VA pharmacy.
-The resident was tired some days and did a lot of sleeping.

Telephone interviews with Resident #6's PCP on 09/07/23 at 6:36pm and 09/08/23 at 2:45pm revealed:
-When the resident first came to the facility, there was some confusion about his Levothyroxine because his medications came from a VA pharmacy.
-She checked his thyroid levels and he was on a lower dose of Levothyroxine than he needed so she increased the dosage.
-Then the resident had several missed doses of Levothyroxine and/or was administered the wrong strength in August 2023 so she had to do some dosing changes.
-The missed/incorrect doses of Levothyroxine

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could affect/exacerbate symptoms of hypothyroidism such as fatigue, loss of appetite, and weight loss.
-The resident was fatigued, confused, and was having weight loss which could be caused by the Levothyroxine not being administered as ordered.
-She also thought the resident's dementia was progressing which could also contribute to those symptoms.
-As of 08/09/23, the resident's correct dose of Levothyroxine was 112mcg daily, which was the dosage change she referenced in the PCP visit note dated 08/12/23.

Attempted telephone interview with Resident #6's VA pharmacy and VA care provider on 09/08/23 at 3:08pm was unsuccessful.

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The facility failed to administer medications as ordered to 2 of 3 residents observed during the medication passes on 09/06/23 and 09/07/23 resulting in a 20% medication error rate. Resident #7 was administered a powdered laxative without mixing and dissolving it in liquid putting the resident at risk for choking. Resident #6 had 3 medications crushed and administered that should not have been crushed putting the resident at risk of stomach irritation and acid reflux symptoms. Resident #6 who had a history of thyroid cancer missed doses and/or received the wrong dosage of his thyroid medication in August 2023, exacerbating symptoms of underactive thyroid such as fatigue, loss of appetite, and loss of weight. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/06/23 for

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D 358	Continued From page 55 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 4 of 4 residents observed (#8, #9, #10, #11) in the special care unit (SCU) and 3 of 3 residents observed (#5, #7, #12) on assisted living (AL) side of the facility on 09/07/23 resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness. The findings are: Review of the facility's Medication Administration Policies and Procedures with effective date of 10/01/20 revealed the facility would ensure that medications were administered to the residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.	D 364		

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Review of the facility's census report dated 09/06/23 revealed:
-The facility's current census was 71 residents.
-There were 41 residents in the assisted living (AL) side of the facility.
-There were 30 residents in the special care unit (SCU).

1. Observation of the special care unit (SCU) on 09/07/23 at 9:23am revealed a medication aide (MA) was administering medications on 300 hall.

Interview with the MA on 09/07/23 at 9:23am revealed:
-She was still administering the 8:00am medications to the residents on the 300 hall in the SCU.
-There was usually one MA assigned to administer medications to all residents in the SCU on first shift.
-She usually started administering medications at 7:00am and she usually finished around 9:30am.
-She still had eight residents to administer 8:00am medications to on the 300 hall in the SCU.

Observation of the SCU on 09/07/23 at 9:53am revealed the MA was still administering medications on 300 hall.

A second interview with the MA in the SCU on 09/07/23 at 9:53am revealed she still had to administer 8:00am medications to 4 residents on the 300 hall.

Observations in the SCU on 09/07/23 at 10:01am and 10:17am revealed the Memory Care Coordinator (MCC) walked to the common area and near the nurses' station where the MA was still administering morning medications without

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offering any assistance.

Observation on 09/07/23 revealed the MA in the SCU finished administering morning medications at 10:31am.

A third interview with the MA in the SCU on 09/07/23 at 10:32am revealed:
-About 1 to 2 months ago, they had 2 MAs administering morning medications in the SCU.
-When there were 2 MAs administering medications in the SCU, they usually finished the morning medications at 9:00am.
-It was her understanding the number of MAs was based on the resident census and now they only had 1 MA in the SCU on first shift.
-There was no procedure in place if she was running late with administering medications to her knowledge.
-The medications would show they were late on the electronic medication administration (eMAR) if not administered on time and the management staff saw them when they were administering medications late.
-No one offered to help except occasionally a Lead MA from the AL side would come and help.

Interview with the MCC on 09/07/23 at 12:36pm revealed:
-There was usually 1 MA and 3 personal care aides (PCAs) on first shift in the SCU.
-There was usually a Lead MA in the facility Monday - Friday from 9:00am - 5:00pm.
-The MA in the SCU should start administering medications at 7:00am and should be finished with morning medications no later than 9:00am or 9:30am.
-She thought the MA in the SCU finished administering medications around 9:45am this morning, 09/07/23.

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-There had been a few MAs that had run a little behind on the morning medication pass.
-If a MA was late administering medications in the SCU, if it was the MAs fault, like they were late for work, she gave them disciplinary action.
-If it was not the MAs fault, she would find out what happened.
-She had reached out to the facility's contracted pharmacy and regional nurse last month because some MAs said it was hard to administer the medications in the required timeframe.
-The facility's contracted pharmacy and regional nurse told her that she could change some of the administration times to help stagger the times.
-She had not changed any administration times on the eMAR because she was not comfortable changing the times.
-She was not aware the MA in the SCU did not finish administering morning medications that day, 09/07/23, until 10:31am.
-The MAs were supposed to let her, the Resident Care Coordinator (RCC), or the Administrator know if they were running late.

Review of the September 2023 electronic medication administration records (eMARs) for the 4 residents in the SCU who received late medications on 09/07/23 revealed:
-All four residents had morning medications scheduled for 8:00am.
-All four residents had medications ordered twice a day and/or 3 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

a. Review of Resident #8's current FL-2 dated 03/21/23 revealed diagnoses included dementia, hypertension, osteoporosis, hyperlipidemia, and physical disability.

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Observation of the MA in the SCU administering morning medications on 09/07/23 revealed the MA administered Resident #8's medications scheduled for 8:00am at 9:59am, 59 minutes beyond the allowed time frame.

Review of Resident #8's September 2023 electronic medication administration record (eMAR) revealed:
-There were 3 medications, Amlodipine (for heart and blood pressure), Macrobid (an antibiotic for infection), and Vitamin C (a vitamin supplement) scheduled once a day at 8:00am.
-Buspar (antidepressant) was scheduled twice a day at 8:00am and 8:00pm.
-Ferrous Sulfate (an iron supplement) and Lorazepam (a controlled substance for anxiety/agitation) were scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with Resident #8's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #8's medications should be administered on time to ensure therapeutic effectiveness.
-Receiving Lorazepam too close to the next dose could cause sedation, which could cause the resident to fall.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

b. Review of Resident #9's current FL-2 dated 03/21/23 revealed diagnosis included vascular dementia.

Observation of the MA in the SCU administering

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morning medications on 09/07/23 revealed the MA administered Resident #9's medications scheduled for 8:00am at 10:09am, 1 hour and 9 minutes beyond the allowed time frame.

Review of Resident #9's September 2023 electronic medication administration record (eMAR) revealed:
-There were 3 medications, Amlodipine and Losartan (for heart and blood pressure), and Carteolol Solution (eye drop for glaucoma) scheduled once a day at 8:00am.
-Depakote (for mood disorders) was scheduled twice a day at 8:00am and 4:00pm.
-Lotrisone cream was scheduled twice a day at 8:00am and 8:00pm.
-Acetaminophen (for pain and fever) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with Resident #9's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #9's medications should be administered on time to ensure therapeutic effectiveness.
-She was not as concerned about the medications ordered once or twice a day because of longer intervals between dosing times.
-For the Acetaminophen which was ordered 3 times a day, those intervals would be closer together if late but her main concern was the resident did not receive more than 3 grams of Acetaminophen in 24 hours.

Based on observations, interviews, and record reviews, it was determined that Resident #9 was not interviewable.

c. Review of Resident #10's current FL-2 dated

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10/27/22 revealed diagnoses included vascular dementia, atherosclerotic heart disease, anxiety disorder, and essential hypertension.

Observation of the MA in the SCU administering morning medications on 09/07/23 revealed the MA administered Resident #10's medications scheduled for 8:00am at 10:23am, 1 hour and 23 minutes beyond the allowed time frame.

Review of Resident #10's September 2023 electronic medication administration record (eMAR) revealed:
-There were 2 medications, Levothyroxine (for underactive thyroid) and Docusate Sodium (stool softener for constipation) scheduled once a day at 8:00am.
-Lorazepam (a controlled substance for anxiety/agitation), Depakote (for mood disorders), and Sinemet (for Parkinson's disease) were scheduled twice a day at 8:00am and 8:00pm.

Telephone interview with Resident #10's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #10's medications should be administered on time to ensure therapeutic effectiveness.
-Receiving Lorazepam too close to the next dose could cause sedation, which could cause the resident to fall.
-She was not as concerned about sedation with this resident because she had been on higher doses of Lorazepam in the past.
-Not receiving Sinemet on time could result in the resident have "freezing" symptoms related to her Parkinson's disease.

Based on observations, interviews, and record reviews, it was determined that Resident #10 was

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not interviewable.

d. Review of Resident #11's current FL-2 dated 08/30/23 revealed diagnoses included dementia, edema, hypertension, depression, irritable bowel syndrome with diarrhea, lower back pain, acid reflux, and right knee pain.

Observation of the MA in the SCU administering morning medications on 09/07/23 revealed the MA administered Resident #11's medications scheduled for 8:00am at 10:31am, 1 hour and 31 minutes beyond the allowed time frame.

Review of Resident #11's September 2023 electronic medication administration record (eMAR) revealed:
-There were 7 medications, Amlodipine and Olmesartan, (for heart and blood pressure), Aspirin (prevention of heart disease), Furosemide (diuretic for swelling), Sertraline (antidepressant), Miacalcin Nasal Spray (for osteoporosis), and Vitamin D3 (for Vitamin D deficiency) scheduled once a day at 8:00am.
-Klor-Con (a potassium supplement), IBgard (for stomach comfort), Ketoconazole Cream (for fungal infections of the skin), and Calcium Carbonate (calcium supplement) scheduled twice a day at 8:00am and 8:00pm.
-Dicyclomine (for irritable bowel syndrome) was scheduled 3 times a day at 8:00am, 2:00pm, and 8:00pm.

Attempted telephone call with Resident #11's primary care provider (PCP) on 09/08/23 at 2:57pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #11 was not interviewable.

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Refer to interview with the Administrator on 09/07/23 at 12:52pm.

2. Observation of the 100 hall on the assisted living (AL) side on 09/07/23 at 9:35am revealed a medication aide (MA) administering medications.

Interview with the MA on 09/07/23 at 9:35am revealed:
-She relieved another MA at 9:20am and still needed to administer 8:00am and 9:00am medications to eight residents on the 100 hall.
-There was usually one MA scheduled for the morning medication pass, sometimes two MAs on the AL side.
-If there were two MAs, she could usually finish one cart in 1.5 hours.
-If there was one MA scheduled for both carts, it was often 10:00am-10:30am before she could finish administering the medications scheduled for 8:00am.
-There were two MAs scheduled for this shift today, 09/07/23.

Interview with a second MA on 09/07/23 at 9:45am revealed:
-She was assigned to the 200 hall medication cart on the AL side for this shift.
-She finished administering medications on the 200 hall around 9:30am.
-She normally worked second shift, this was the first time she worked on first shift.
-Sometimes there were two MAs on first shift, sometimes there was one.
-There was usually one MA scheduled on second shift.
-There were more residents on the 100 hall and the medication pass took longer than the 200 hall.

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A second interview with the MA working on the 100 hall on the AL side on 09/07/23 at 10:03am revealed that she still needed to administer medications to three residents.

Observation of the 100 hall on the AL side on 09/07/23 revealed that the MA finished administering morning medications to residents on the 100 hall at 10:21am.

A third interview with the MA working on the 100 hall on the AL side on 09/07/23 at 11:00am revealed:
-She was late administering the medications scheduled for 8:00am.
-Medications were often late when the MA had both medication carts.
-She was responsible for one medication cart on the 100 hall for this shift.
-She was aware that late medications were considered a medication error.
-She had not reported being late with medication administration to the Resident Care Coordinator (RCC) or the Memory Care Coordinator (MCC).
-She felt that she could ask for help from the RCC or MCC if needed.
-Medication administration times had not been discussed in staff meetings.

Interview with the RCC on 09/07/23 at 12:23pm revealed:
-She was responsible for completing the schedule for the MAs and personal care aides (PCAs).
-There were one or two MAs scheduled depending on the number of PCAs scheduled in the AL side.
-The medication pass started at 7:00am.
-MAs should be finished with medication administration at 9:00am, but sometimes it was 10:00am or later before they were finished.

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-Medications were often administered after 9:00am; they were probably late every day.
-If two MAs are scheduled, they should be finished on time, but it was sometimes after 9:00am when they finished even with two MAs in the AL.
-She was unaware of a system for late medications.
-She had not received complaints from residents about medications being late in the morning but had received complaints about medications being late at night and the Administrator was notified of these complaints.
-There were two MAs administering medications in the AL side today, 09/07/23.
-One MA left today so another MA had to finish administering medications for that MA.
-She did not know what time the MAs in the AL finished administering morning medications today, 09/07/23.

Review of the September 2023 electronic medication administration records (eMARs) for the 3 residents in the AL who received late medications on 09/07/23 revealed all 3 residents had medications ordered twice a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

a. Review of Resident #5's current FL-2 dated 08/31/23 revealed diagnoses included metabolic encephalopathy, overactive bladder, insomnia, traumatic brain injury, constipation, and hyperlipidemia.

Observation of the medication aide (MA) administering morning medications on 09/07/23 revealed the MA administered Resident #5's medications scheduled for 8:00am at 10:04am, 1

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hour and 4 minutes beyond the allowed time frame.

Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed entries for Zonisamide 100mg (a medication for seizures) scheduled for 8:00am and Zonisamide 100mg (three capsules for 300mg dose) scheduled for 8:00pm.

Telephone interview with Resident #5's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #5's medications should be administered on time to ensure therapeutic effectiveness.
-She was not concerned with the Zonisamide being administered late on 09/07/23 since the next dose was not due until 8:00pm.

Based on observations, interviews, and record review, it was determined that Resident #5 was not interviewable.

b. Review of Resident #7's current FL-2 dated 10/14/22 revealed diagnoses included senile dementia, dementia, and debility.

Observation of the medication aide (MA) administering morning medications on 09/07/23 revealed the MA administered Resident #7's medications scheduled for 8:00am at 10:09am, 1 hour and 9 minutes beyond the allowed time frame.

Review of Resident #7's September 2023 electronic medication administration record (eMAR) revealed there was an entry for Omeprazole 40mg (a medication used to reduce stomach acid) scheduled for 8:00am and 8:00pm.

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Telephone interview with Resident #7's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #10's medications should be administered on time to ensure therapeutic effectiveness.
-Receiving Omeprazole late could cause the resident to experience acid reflux symptoms.

Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.

c. Review of Resident #12's FL-2 dated 06/09/22 revealed diagnoses included unspecified dementia without behavioral disturbance, unspecified mental disorder due to known physiological condition, metabolic encephalopathy, adult failure to thrive, occlusion and stenosis of right carotid artery, dilated cardiomyopathy, nonrheumatic aortic valve stenosis, and disorientation, unspecified.

Observation of the medication aide (MA) administering morning medications on 09/07/23 revealed the MA administered Resident #12's medications scheduled for 8:00am at 10:18am, 1 hour and 18 minutes beyond the allowed time frame, and the medication scheduled for 9:00am, 18 minutes beyond the allowed time frame.

Review of Resident #12's September 2023 electronic medication administration (eMAR) revealed:
-There was an entry for Mucinex DM Extended Release 12 hour 30-600mg (a medication used to treat cough and congestion) scheduled for 8:00am and 8:00pm.
-There was an entry for Nitrofurantoin

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Monohydrate 100mg (an antibiotic used to treat urinary tract infections) scheduled for 8:00am and 8:00pm.
-There was an entry for Docusate Sodium 100mg (a stool softener) scheduled for 9:00am and 9:00pm.
-There was an entry for Zyprexa 7.5mg (a medication used to regulate mood and behaviors) scheduled for 8:00am and 8:00pm.

Telephone interview with Resident #12's primary care provider (PCP) on 09/07/23 at 6:36pm revealed:
-Resident #12's medications should be administered on time to ensure therapeutic effectiveness.
-Resident #12's Nitrofurantoin Monohydrate needed to be administered on time to keep a steady state for it to exert the best therapeutic effect.

Based on observations, interviews, and record review, it was determined that Resident #12 was not interviewable.

Refer to interview with the Administrator on 09/07/23 at 12:52pm.

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Interview with the Administrator on 09/07/23 at 12:52pm revealed:
-The facility determined staffing according to the staffing chart in the regulations.
-They were required to have one MA and 20 hours of PCAs scheduled for the AL side for first shift.
-The facility staffed one MA and three PCAs in the special care unit (SCU) on first shift.
-A couple of MAs had reported it was "a tough med pass" and they had been late administering medications but she could not recall when.

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D 364	Continued From page 69 -They tried two MAs about a month ago in the AL but the PCAs complained they needed more help on the floor. -There was no system in place to monitor if medications were administered on time. -If MAs were late with medication administration, they should notify the RCC or MCC. -The RCC or MCC were expected to assist MAs if they needed assistance. -There were also Lead MAs that could assist with the medications if needed.	D 364		
D 456	10A NCAC 13F .1212(g) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (g) In the case of physical assault by a resident or whenever there is a risk that death or physical harm will occur due to the actions or behavior of a resident, the facility shall immediately: (1) seek the assistance of the local law enforcement authority; (2) provide additional supervision of the threatening resident to protect others from harm; (3) seek any needed emergency medical treatment; (4) make a referral to the Local Management Entity for Mental Health Services or mental health provider for emergency treatment of the threatening resident; and (5) cooperate with assessment personnel assigned to the case by the Local Management Entity for Mental Health Services or mental health provider to enable them to provide their earliest possible assessment. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 456		

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Based on record reviews and interviews the facility failed to seek the assistance of local law enforcement and emergency medical treatment when risk of physical harm was suspected to have occurred due to the actions or behaviors of another resident for 1 of 5 sampled residents (#5).

The findings include:

Review of Resident #5's current FL-2 dated 08/31/23 revealed:
-Diagnoses included metabolic encephalopathy, overactive bladder, insomnia, traumatic brain injury, constipation, and hyperlipidemia.
-Resident #5 was nonverbal.

Review of Resident #5's Resident Register revealed the resident was admitted to the assisted living side of the facility on 09/02/22.

Review of Resident #5's Care Plan dated 08/31/23 revealed:
-Resident #5 had limited range of motion and limited strength in her upper extremities.
-Resident #5 was totally dependent on the facility staff for toileting, bathing, dressing, grooming/personal hygiene and transferring.

Review of Resident #5's Progress Notes dated 08/06/23 revealed the resident complained of pain in her groin and vaginal area.

Review of Resident #5's Progress Notes dated 08/17/23 revealed:
-Resident #5 was found in her bed with her "brief tied in a knot and legs laid open."
-When asked had a man been in her room; Resident #5 answered "yes".

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-Resident #5 was very upset and uncomfortable during care to fix her brief and was not in the emotional state she was in prior to the incident.

Interview with a medication aide (MA) on 09/07/23 at 3:45pm revealed:
-Sometime in August 2023, a personal care aide (PCA) put Resident #5 to bed, in her clothes with the covers pulled up over her.
-Shortly after the PCA noticed a male resident in the hallway, the PCA went to check on Resident #5.
-When the PCA entered the room, Resident #5's brief had been undone, tied in a knot and the residents' legs were spread open.
-The PCA informed her and she went into Resident #5's room and saw the brief undone, tied in a knot and the residents' legs wide open.
-She checked Resident #5's private area and did not see any redness, bleeding or secretions.
-The MA filled out the referral form for Resident #5 to be seen by her primary care provider (PCP) for the reported pain in the resident's groin and vaginal area and reported the incident to the Resident Care Coordinator (RCC).

Interview with the RCC on 09/07/23 at 8:30am and on 09/07/23 at 10:22am revealed:
-After a male resident was reported to have entered Resident #5's room, Resident #5's room was moved closer to the nurse station to increase supervision.
-She did not know if the male resident had touched Resident #5 inappropriately.
-A cigarette was found in Resident #5's room and she did not smoke, the facility staff "put two and two together and concluded that the male resident had been in Resident #5's room."
-It was reported to her sometime in August 2023, after Resident #5 was moved closer to the

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nurse's station that the resident brief had been undone, pulled down and to the side.
-Resident #5 began to yell during personal care now and was not like that before.

Interview with Housekeeping staff on 09/07/23 at 12:00pm revealed:
-She had never witnessed the male resident going or coming out of Resident #5's bedroom.
-She found a cigarette on Resident #5's bedroom floor one morning and knew Resident #5 did not smoke.
-She assumed that the cigarette found on the floor may have been from the male resident because he smoked.
-Resident #5's door was locked at night and a camera was put in her room by a family member because of suspicion that the male resident had been going in her room.
-The male resident was put on 30-minute monitoring.

Telephone interview with Resident #5's family member on 09/07/23 at 12:17pm revealed:
-The family member visited Resident #5 at the facility 2 to 3 times a week.
-Resident #5's family member installed a camera in the resident's room after he was informed by some of the "girls who work with his wife" that an unauthorized male was seen coming out of the resident's room.
-The family member had not been told of any sexual, physical, or mental abuse towards Resident #5.
-The family member had not been informed that Resident #5 had changed behavior during personal care.
-The family member put the camera in Resident #5's room sometime around the end of August.

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Interview with another MA on 09/08/23 at 1:32pm revealed:
-Sometime in August 2023 when a PCA was performed patient care, Resident #5 said," intercourse it hurts".
-The MA called the Memory Care Director (MCD) to inform her what Resident #5 stated while patient care was performed.
-The MA asked if Resident #5 should be "sent to the local ED?"
-The MA was informed by the MCD to assess Resident #5's private area.
-The MA checked Resident #5's private area and saw redness in the creases of the resident's legs.
-Resident #5 was not sent to the local ED to be examined.
-The male resident continued to stand by Resident #5's room door but had not entered since the cameras had been installed.

Interview with another PCA on 09/08/23 at 1:55pm revealed, the male resident tried to get female residents to come into his room.

Interview with the male resident on 09/08/23 at 9:30am revealed:
-He had never wandered into another resident's bedroom.
-He was never in Resident #5's bedroom.
-He did not know why facility staff believed he entered Resident #5's bedroom.

Interview with Resident #5's Primary Care Provider (PCP) on 09/08/23 at 2:44pm revealed:
-She had a difficult time communicating with Resident #5.
-The PCP was notified by a MA that it was speculated that Resident #5 had been sexually assaulted by another resident sometime early August 2023.

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-After being notified, she examined Resident #5, two days later, on 08/21/23.
-Resident #5 informed her that a racoon came into her room and scratched her private area.

Interview with local law enforcement (LE) on 09/08/23 at 4:28pm revealed:
-If it were speculated a resident of the facility had been sexually assaulted LE would advise the two residents be separated and interviewed.
-Once all the information was gathered it would then be determined if the resident needed to be sent to the local ED to be examined by a doctor.

Interview with the Administrator on 09/08/23 at 10:33am revealed:
-Staff members voiced concerns to her about the male resident going into Resident #5's room at night.
-Resident #5 was moved closer to the nurse's station so the resident could be closely supervised.
-The male resident was placed on 30-minute monitoring on 8/08/23.
-Around 08/15/23, the male resident was seen in the hallway late that night going back to his room.
-The PCA on duty went into Resident #5's room and her "brief was not like it should have been", it was taped back poorly or tied.
-She had not informed Resident #5's family member that a male resident had been seen coming out the resident's room.
-Some of the other staff must have told Resident #5's family member of the incident and that was why the family member installed the camera in the resident's room.
-No staff member ever reported witnessing a male resident in Resident #5's bedroom.
-Law enforcement was never called because she did not believe the male resident guilty of abusing

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Resident #5.
-She did not complete a formal investigation.
-A 30-day discharge notice was given to the male resident's power of attorney on 08/16/23.

Attempted interview with Resident #5 on 08/21/23 at 2:00pm and on 09/08/23 was unsuccessful.

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The facility failed to immediately seek assistance from the local law enforcement authority and seek emergency medical treatment for a resident (#5) who was allegedly sexually abused by another resident. After the alleged incident, the resident began exhibiting behavioral changes when receiving personal care. This failure resulted in serious risk for neglect and constitutes an Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-2.16 on 09/08/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 8, 2023.