

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL032132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA RESERVE OF DURHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4523 HOPE VALLEY ROAD DURHAM, NC 27707</b>
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D 000	Initial Comments  The Adult Care Licensure Section and the Durham County Department of Social Services conducted an annual and follow-up survey from November 14, 2023 to November 16, 2023.	D 000		
D 125	<p>10A NCAC 13F .0403(a) Qualifications Of Medication Staff</p> <p>10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 3 of 5 staff sampled (B, C, and E) who administered medications had completed the state-approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required.</p> <p>The findings are:</p> <p>1. Review of Staff B's personnel record revealed: -Staff B worked for a staffing agency. -There was documentation of Staff B completing the medication administration clinical skills validation checklist on 08/21/23. -There was documentation of Staff B passing the MA written exam on 01/15/15. -There was no MA verification form for Staff B.</p>	D 125		

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

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D 125	<p>Continued From page 1</p> <p>-There was no documentation of Staff B completing the state-approved 5, 10, or 15-hour MA training courses.</p> <p>Review of a resident's September 2023, October 2023, and November 2023 electronic medication administration records (eMARs) revealed:                      -Staff B documented administering medications on 09/22/23, 09/25/23, 09/26/23, and 09/30/23.                      -Staff B documented administering medications on 10/07/23 and 10/09/23.                      -Staff B documented administering medications on 11/01/23, 11/08/23, and 11/10/23.</p> <p>Review of the clinical daily assignment sheet Staff B was listed at the MA for 11/16/23.</p> <p>Interview with Staff B on 11/16/23 at 5:10pm revealed:                      -She worked at the facility through a contracted staffing agency.                      -She administered medications to residents on her assigned medication cart when she worked.                      -She was required to have the approved 15 hours of medication aide training and passed the State's medication aide examination at an assisted living facility where worked several years ago.                      -She did not have documentation for completing the medication aide training available for review.</p> <p>Refer to the interview with the Administrator 11/16/23 at 2:27pm.</p> <p>Refer to the interview with the Director of the staffing agency on 11/17/23 at 9:20am.</p> <p>2. Review of Staff C's personnel record revealed:                      -Staff C worked for a staffing agency.                      -There was documentation of Staff C completing</p>	D 125		

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D 125	<p>Continued From page 2</p> <p>the medication administration clinical skills validation checklist on 07/27/23.</p> <ul style="list-style-type: none"> <li>-There was documentation of Staff C passing the MA written exam on 07/10/19.</li> <li>-There was no MA verification form for Staff C.</li> <li>-There was no documentation of Staff C completing the state-approved 5, 10, or 15-hour MA training courses.</li> </ul> <p>Review of the clinical daily assignment sheet Staff C was listed at the MA for daily from 11/14/23-11/16/23.</p> <p>Review of residents' September 2023, October 2023, and November 2023 electronic medication administration records (eMARs) revealed:</p> <ul style="list-style-type: none"> <li>-Staff C documented administering medications on 09/02/23, 09/03/23, 09/06/23, 09/07/23, 09/11/23, 09/15/23, 09/22/23, and 09/25/23.</li> <li>-Staff C documented administering medications on 10/01/23, 10/18/23, 10/25/23, 10/26/23, and 10/30/23.</li> <li>-Staff C documented administering medications on 11/01/23, 11/02/23, 11/06/23, 11/07/23, 1/11/23, and 11/13/23-11/15/23.</li> </ul> <p>Interview with Staff C on 11/16/23 at 4:51pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff C worked for a staffing agency.</li> <li>-She administered medications to the residents on the 300-hallway.</li> <li>-She had her medication aide (MA) training at another facility.</li> <li>-She took the MA test in July 2019 and she was listed on the North Carolina Registry.</li> <li>-She did not know what information was shared from the agency with the facility regarding her training.</li> </ul> <p>Refer to the interview with the Administrator</p>	D 125		

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D 125	<p>Continued From page 3</p> <p>11/16/23 at 2:27pm.</p> <p>Refer to the interview with the Director of the staffing agency on 11/17/23 at 9:20am.</p> <p>3. Review of Staff E's personnel record revealed: -Staff E worked for a staffing agency. -There was documentation of Staff E completing the medication administration clinical skills validation checklist on 08/10/23. -There was documentation of Staff E passing the MA written exam on 08/13/22. -There was no MA verification form for Staff E. -There was no documentation of Staff E completing the state-approved 5, 10, or 15-hour MA training courses.</p> <p>Review of the clinical daily assignment sheet Staff E was listed at the MA for 11/15/23.</p> <p>Review of residents' September 2023, October 2023, and November 2023 electronic medication administration records (eMARs) revealed Staff E documented administering medications on 11/10/23 and 11/12/23.</p> <p>Telephone interview with Staff E on 11/17/23 at 12:37pm revealed: -She had not had an MA class. -She used a study guide to study before taking the MA written exam, took and passed the exam. -She did not know she needed to take an MA class; she thought medication technicians had to have a class but she thought MAs only had to pass the state written exam.</p> <p>Refer to the interview with the Administrator 11/16/23 at 2:27pm.</p> <p>Refer to the interview with the Director of the</p>	D 125		

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D 125	<p>Continued From page 4</p> <p>staffing agency on 11/17/23 at 9:20am.</p> <p>Interview with the Administrator 11/16/23 at 2:27pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility had a contract with a named staffing agency to provide MAs.</li> <li>-The staffing agency was responsible for all required paperwork except the clinical skills checklist which was done at the facility before the MA administered medication.</li> </ul> <p>Interview with the Director of the staffing agency on 11/17/23 at 9:20am revealed:</p> <ul style="list-style-type: none"> <li>-Her agency ensured staff had passed the state MA exam but did not ensure the MA had completed a 5/10 or 15-hour training.</li> <li>-Her agency had never collected the certification for the 5/10 or 15-hour training.</li> <li>-The agency did not currently provide a 5/10 or 15-hour training class.</li> </ul>	D 125		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:</p> <ul style="list-style-type: none"> <li>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</li> <li>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</li> </ul> <p>This Rule is not met as evidenced by: Based on observations, interviews, and records reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#3 and #4) related to compression socks(#3) and thromboembolic</p>	D 276		

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D 276	<p>Continued From page 5</p> <p>deterrent (TED) hose (#4) .</p> <p>The findings are:</p> <p>1. Review of Resident #3's current FL2 dated 09/25/27 revealed: -Diagnoses included essential hypertension, and localized edema. -There was an order for compression socks every morning.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 09/25/23.</p> <p>Observation of Resident #3 on 11/15/23 at 12:00pm revealed Resident #3 was in the medication room, seated in her wheel chair, and was not wearing compression socks.</p> <p>Observation of Resident #3's chest of drawers with the facility Nurse on 11/16/23 at 10:20am revealed: -Resident #3 had one pair of beige knee-high open toe compression socks located in the top drawer of the chest. -Resident #3 had one pair of beige knee-high open toe compression socks located in the second from top drawer of the chest.</p> <p>Observation of Resident #3 on 11/16/23 at 4:45pm revealed: -Resident #3 was wearing no socks and strapped sandals. -There was visible swelling in both lower legs and ankles. -The sandal straps were causing slight indentures into the skin (pitting edema) around both feet and ankles. -The left ankle had more visible swelling with the ankle bones not visible due to swelling.</p>	D 276		

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D 276	<p>Continued From page 6</p> <p>Review of Resident #3's September, October, and November 2023 electronic medication administration records (eMARS) revealed: -Compression socks were not listed on the eMAR. -There was no documentation Resident #3 had compression socks applied daily as ordered on the current FL2 dated 09/27/23.</p> <p>Interview with Resident #3 on 11/15/23 at 12:03pm revealed: -She did not have any compression socks to wear. -Her feet swelled sometimes, like today.</p> <p>Telephone interview with the facility's primary care provider's (PCP) on 11/15/23 at 1:40pm revealed: -Resident #3 was recently admitted to the facility. -She had seen Resident #3 for examination post admission to the facility. -She did not recall if Resident #3 had orders for compression socks when she was admitted. -If Resident #3 had swelling in her ankles, the facility should have ensured her order for compression socks was implemented. -She did not recall processing an order for measurements for compression socks for Resident #3, but if she brought compression socks when she was admitted, the staff should be applying. -She expected the facility to administer treatments as ordered on the FL2 or subsequent orders.</p> <p>Telephone interview with Resident #3's family member on 11/16/23 at 9:31am revealed: -Resident #3 was in a rehabilitation facility prior to admission to the facility. -Resident #3 had swelling in her ankles in the</p>	D 276		

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D 276	<p>Continued From page 7</p> <p>past.</p> <ul style="list-style-type: none"> <li>-Resident #3 wore compression socks for swelling at the previous facility.</li> <li>-The family member packed 2 pairs of open-toe compression socks for the resident during the move to this facility.</li> <li>-She had not checked to see if Resident #3 was wearing the compression socks when she visited the resident.</li> <li>-She would buy more if Resident #3 needed more compression socks.</li> </ul> <p>Interview with the Director of Clinical Services (DCS) on 11/16/23 at 10:50am revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for processing FL2 orders for all new residents upon admission to the facility, including verification of orders entered by the contracted pharmacy into the eMAR system.</li> <li>-Subsequent physician orders were routinely entered by MA staff.</li> <li>-She had overlooked implementing Resident #3's order for compression socks by ensuring the socks were applied and documented because she was very new to processing FL2 orders in September 2023.</li> </ul> <p>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/16/23 at 11:10am revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy received Resident #3's FL2 dated 09/27/23 with an order for compression socks.</li> <li>-The pharmacy entered the order for compression socks on in the morning and off in the evening in their computer system and the order appeared on the resident's orders at the pharmacy.</li> <li>-There was no explanation for why the facility did not have compression socks on in the morning and off in the evening showing on Resident #3's facility eMAR.</li> </ul>	D 276		



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D 276	<p>Continued From page 8</p> <p>-The facility was responsible to contact the pharmacy if there was no where to document administration of medications or treatments.</p> <p>Interview with the medication aide (MA) on 11/16/23 at 12:10pm revealed: -She routinely reviewed residents' orders for medications and treatments on the eMAR daily when she was passing medications for residents. -She routinely helped enter residents' new physicians's orders but the nursing staff routinely entered the orders from the FL2 upon admission. -She had not seen Resident #3's original FL2 with the order for compression socks.</p> <p>Interview with the Administrator on 11/16/23 at 2:36pm revealed: -The pharmacy staff audited resident records quarterly. -The nurse from the pharmacy looked at orders to see they were being implemented. -The Corporate Nurse would do site visits and audit random records. -The DCS was responsible to ensure all orders for treatments were implemented.</p> <p>2. Review of Resident #4's current FL-2 dated 09/12/23 revealed: -Diagnoses included vascular dementia, idiopathic gout, hypothyroidism, irritable bowel syndrome, and malignant neoplasm of L. female breast. -The FL-2 was completed by hospital staff while during a recent hospitalization.</p> <p>Review of Resident #4's Primary Care Provider (PCP) order dated 08/07/23 revealed an order for a Thrombo-Embolic Deterrent (TED) hose, worn daily and removed at night.</p>	D 276		

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D 276	<p>Continued From page 9</p> <p>Review of Resident #4's care notes dated 09/01/2023-11/16/23 revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of Resident #4's TED hose being applied or removed.</li> <li>-August 2023 notes were not available to be reviewed due to the previous documentation tool used by the facility was no longer available for viewing by staff.</li> </ul> <p>Review of Resident #4's electronic medication administration records (eMARs) dated August 2023, September 2023, October 2023, and November 2023 from 11/01/23-11/16/23 revealed:</p> <ul style="list-style-type: none"> <li>-There was no entry to apply the TED hose every morning and remove them at bedtime.</li> <li>-There was no documentation on the eMAR indicating the order for TED hose was discontinued.</li> </ul> <p>Observation of Resident #4 on 11/14/23 at approximately 11:10am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 was wearing calf-length socks on her feet.</li> <li>-Resident #4 was not wearing compression stockings or TED hose.</li> </ul> <p>Second Observation of Resident #4 on 11/16/2023 at approximately 9:30am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 was wearing calf-length socks on her feet.</li> <li>-Resident #4 was not wearing compression stockings or TED hose.</li> </ul> <p>Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy was responsible for entering orders for the application and removal of the TED hose in the eMAR.</li> </ul>	D 276		

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D 276	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>-The order for the TED hose could only be entered into the MAR once the pharmacy received the measurements for the TED hose from the facility.</li> <li>-The pharmacy would send TED hose to the facility based on the measurements they received from the facility.</li> <li>-The facility faxed the order for Resident #4's TED hose to the pharmacy on 08/07/23.</li> <li>-The pharmacy faxed the facility a form to document Resident #4's measurements for TED hose on 08/07/23.</li> <li>-There was no documentation the facility completed and returned the measurement form; there were no measurements documented on the form.</li> <li>-Without measurements, the pharmacy was unable to enter the order for Resident #4's TED hose on the MAR.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 11/16/23 at approximately 1:52 pm revealed:</p> <ul style="list-style-type: none"> <li>-When a resident had an order for TED hose the order would be faxed to the pharmacy and the pharmacy would fax a sheet to document measurements on.</li> <li>-The medication aide (MA), the RCC, or the facility's Registered Nurse (RN) could measure residents for TED hose.</li> <li>-There was no documentation, the facility faxed the measurements to the pharmacy for Resident #4.</li> <li>-There was no documentation related to Resident #4's TED hose on the eMAR.</li> <li>-Resident #4 was wearing TED hose at one time, which was applied by staff; she did not recall when.</li> <li>-The TED hose was stopped due to Resident #4 not being comfortable in the TED hose.</li> </ul>	D 276		

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D 276	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-There was no discontinued order for Resident #4's TED hose.</li> <li>-No documentation was found documenting the use of the TED hose by Resident #4 or the reasoning for not following the order.</li> <li>-Resident #4 still had a standing order for the application of TED hose daily and for them to be removed in the evening.</li> </ul> <p>Interview with the Director of Clinical Services (DCS) on 11/16/23 at approximately 10:00 am revealed:</p> <ul style="list-style-type: none"> <li>-The use of TED hose was not on Resident #4's eMAR.</li> <li>-There was no discontinuation order for the TED hose in Resident #4's file.</li> <li>-She did not know why Resident #4 was not wearing TED hose as ordered.</li> <li>-When there was an order for TED hose, the order needed to be faxed to the pharmacy, and the measurements for the TED hose also needed to be faxed.</li> <li>-She did not know if the facility faxed Resident #4's measurements to the pharmacy.</li> </ul> <p>Interview with the Administrator on 11/15/23 at approximately 11:10 am revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy would enter the order for a resident's TED hose after they received the order and measurements from the facility.</li> <li>-The MA would be responsible for ensuring any new orders are sent to the pharmacy.</li> <li>-Resident #4 should have been measured for TED hose and measurements should have been sent to the pharmacy.</li> <li>-He expected all physician orders to be followed, including TED hose.</li> <li>-If clarification was needed, the MA or other staff should have obtained it.</li> <li>-If there was a reason for the discontinuation of</li> </ul>	D 276		

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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA RESERVE OF DURHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4523 HOPE VALLEY ROAD DURHAM, NC 27707</b>
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D 276	<p>Continued From page 12</p> <p>an order, the staff should have obtained an order. -He did not know if previous records (August 2023) documenting the use of the TED hose could be obtained.</p> <p>Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/16/23 at 2:32pm revealed: -She did not think Resident #4 needed TED hose. -She did not order TED hose for Resident #4.</p> <p>Attempted telephone interview with Resident #4 family member on 11/16/23 at 2:15 pm and on 11/20/2023 at 3:15 pm was unsuccessful.</p> <p>Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.</p>	D 276		
D 309	<p>10A NCAC 13F .0904(e)(3) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an accurate listing of residents with physician-ordered</p>	D 309		

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D 309	<p>Continued From page 13</p> <p>therapeutic diets was available for the guidance of the food service staff.</p> <p>The findings are:</p> <p>Observation of the facility's diet list on 11/15/23 at 10:34am revealed:</p> <ul style="list-style-type: none"> <li>-There was a picture of each resident with a typed label placed on each picture.</li> <li>-The label had the type of diet the residents were to be served.</li> <li>-The labels on the pictures were not dated.</li> <li>-The pictures were hung on a board above the steam table.</li> </ul> <p>Interview with the cook on 11/15/23 at 10:08am revealed:</p> <ul style="list-style-type: none"> <li>-The Director of Clinical Services would bring a copy of the diet order to the kitchen.</li> <li>-The Director of Clinical Services would give the diet order to the Dietary Manager (DM) or to the cook if the DM was not in the facility.</li> <li>-The copy of the diet order was shared with the staff and then placed in a notebook in the DM's office.</li> <li>-She was not sure who updated the labels on the pictures, and she did not know the last time they were updated.</li> <li>-She knew which diets the residents were ordered; she rarely referred to the pictures of the residents.</li> </ul> <p>Interview with the Director of Clinical Services on 11/15/23 at 3:12pm revealed:</p> <ul style="list-style-type: none"> <li>-She received new diet orders when they were written.</li> <li>-She would make a copy for herself and one for dietary.</li> <li>-She would give the dietary copy to the DM or a cook.</li> </ul>	D 309		

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D 309	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-The original diet order would be filed in the resident's record.</li> <li>-She did not know who updated the dietary list.</li> </ul> <p>Interview with the DM on 11/16/23 at 10:26am revealed:</p> <ul style="list-style-type: none"> <li>-There were pictures of the residents above the steam table and each picture was labeled with the type of diet each resident was ordered.</li> <li>-Diet orders were given to him by the MA's or the Director of Clinical Services.</li> <li>-He would show the kitchen staff the new diet order and file the order in a notebook in his office.</li> <li>-He did not update the pictures above the steam table.</li> <li>-He would ask the Activities Director to update the pictures since she had the label maker.</li> <li>-He did not know the last time the pictures were updated with a listing of the current diets.</li> </ul> <p>Interview with the Administrator on 11/16/23 at 4:38pm revealed the DM should update the dietary list to be accurate with the current diet orders for each resident.</p>	D 309		
D 310	<p>10A NCAC 13F .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve therapeutic diets and a supplement as ordered by the for 3 of 7 sampled residents (#2, #5, #7) who had an</p>	D 310		

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D 310	<p>Continued From page 15</p> <p>order for a supplement (#2); regular finger foods (#5); and a NCS, pureed, double portions (#7).</p> <p>The findings are:</p> <p>Review of the facility's regular menu for lunch dated 11/14/23 revealed:</p> <ul style="list-style-type: none"> <li>-The regular menu consisted of an 8-ounce ladle of chicken and noodles, a 4-ounce ladle of veggie blend, 1 cup of tossed salad, 1 roll, and 1 fresh baked cookie.</li> <li>-The alternate menu consisted of one polish sausage and au gratin potatoes.</li> </ul> <p>Review of the facility's therapeutic diet menu for lunch dated 11/14/23 revealed:</p> <ul style="list-style-type: none"> <li>-The mechanical soft diet consisted of 8-ounces of ground chicken and ground noodles with 2-ounces of gravy, shredded lettuce, or a ground polish sausage with 2-ounces of gravy.</li> <li>-The pureed diet consisted of pureed chicken and noodles, pureed veggie blend, pureed green beans, 2/3 pureed bread, or pureed sausage and au gratin potatoes.</li> <li>-The finger food diet consisted of a quartered chicken sandwich, 4-ounces of spoodle drained green beans, and a wedge of lettuce, or a polish sausage and 7 potatoes.</li> </ul> <p>Review of the facility's regular menu for breakfast dated 11/15/23 revealed a serving of a choice of cereal, one egg, 2 slices of Canadian bacon and one toasted English muffin.</p> <p>Review of the facility's therapeutic diet menu for breakfast dated 11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-The mechanical soft diet consisted of ground Canadian bacon with 1 ounce of gravy and a buttered English muffin.</li> <li>-The pureed diet consisted of pureed cereal,</li> </ul>	D 310		



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D 310	<p>Continued From page 16</p> <p>pureed egg, pureed Canadian bacon, and 2/3 slice of pureed bread.</p> <p>-The finger food diet consisted of one pop-tart and one hard-boiled egg.</p> <p>1. Review of Resident #5's current FL-2 dated 11/15/23 revealed:</p> <p>-Diagnoses included hyperlipidemia, anxiety disorder, Parkinson's Disease, hypertension, and depression.</p> <p>-There was a diet order for regular finger foods.</p> <p>Review of Resident #5's diet order sheet dated 7/18/23 revealed there was a diet order for regular finger foods. (Finger foods were foods that could be eaten easily with hands instead of cutlery.)</p> <p>Observation of Resident #5's lunch meal service on 11/14/23 at 12:32pm revealed:</p> <p>-Resident #5 was served a bowl of chicken and noodle soup, a shredded salad, and a roll.</p> <p>-Resident #5 did not receive a quartered chicken sandwich, green beans, or a wedge of lettuce.</p> <p>-Resident #5 fed herself with the assistance of staff.</p> <p>Observation of Resident #5's breakfast meal service on 11/15/23 at 7:33am revealed:</p> <p>-Resident #5 was served scrambled eggs, oatmeal, ground sausage, and a slice of white bread with the edges cut off and quartered.</p> <p>-Resident #5 was not served a hard-boiled egg or a pop-tart.</p> <p>-Resident #5 was observed feeding herself with the assistance of staff.</p> <p>Interview with the cook on 11/15/23 at 10:08am revealed:</p> <p>-Resident #5 was served a mechanical soft diet.</p>	D 310		

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D 310	<p>Continued From page 17</p> <p>-She did not know Resident #5 was ordered a finger food diet.</p> <p>Telephone interview with the Primary Care Provider (PCP) on 11/15/23 at 1:45pm revealed:</p> <p>-She did not know what diet Resident #7 was on.</p> <p>-Resident #7 did not participate in feeding.</p> <p>-She may have ordered a finger food diet, but she could not say without looking at her record.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/15/23 at 10:55am revealed:</p> <p>-Resident #5 received a mechanical soft diet.</p> <p>-The mechanical soft diet was ordered when Resident #5 returned from the hospital in July 2023.</p> <p>-She thought Resident #5 was ordered a mechanical soft diet.</p> <p>-She did not know Resident #5's diet order had changed to finger foods.</p> <p>Interview with the Dietary Manager (DM) on 11/16/23 at 10:26am revealed:</p> <p>-Resident #5 was served a mechanical soft diet.</p> <p>-He did not realize Resident #5 had an order for finger food.</p> <p>-The last order he received was for a mechanical soft diet.</p> <p>-He did not know how the diet order was missed.</p> <p>Refer to the interview with a personal care aide (PCA) on 11/15/23 at 8:04am.</p> <p>Refer to the interview with the cook on 11/15/23 at 10:08am revealed:</p> <p>Refer to the interview with the RCC on 11/15/23 at 10:55am.</p> <p>Refer to the interview with the DM on 11/16/23 at</p>	D 310		

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D 310	<p>Continued From page 18</p> <p>10:26am.</p> <p>Refer to the interview with the Administrator on 11/16/23 at 4:38pm.</p> <p>2. Review of Resident #7's current FL-2 dated 03/07/23 revealed: -Diagnoses of diabetes, hypertension, mild cognitive impairment, and mild renal insufficiency. -There was a diet order for no concentrated sweets (NCS).</p> <p>Review of Resident #7's diet order sheet dated 09/18/23 revealed there was a diet order for NCS, pureed, with double portions.</p> <p>Observation of Resident #7's lunch meal service on 11/14/23 at 12:29pm revealed: -Resident #7 was served a plate of pureed chicken and noodles. -Resident #7 did not receive pureed vegetables or bread.</p> <p>Observation of Resident #7's breakfast meal service on 11/15/23 at 7:30am revealed: -Resident #7 was served softened eggs, pureed sausage with smalls chunks of not pureed sausage visible, and pureed bread. -Resident #7 was not served pureed cereal.</p> <p>Interview with the cook on 11/15/23 at 10:08am revealed: -All of Resident #7's food should be pureed. -Resident received a bowl of pureed chicken and noodles for lunch on 11/14/23. -There were some vegetables already in the pureed chicken and noodle pureed. -She did not serve Resident #7 pureed salad or pureed bread. -Resident #7 did not receive pureed bread or</p>	D 310		

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D 310	<p>Continued From page 19</p> <p>pureed cereal for breakfast on 11/15/23. -She did not have a reason why Resident #7 did not get the salad and bread for lunch on 11/14/23 or the bread and cereal for breakfast on 11/15/23. -She did not serve double portions to Resident #7; she did not know Resident #7 was ordered double portions.</p> <p>Telephone interview with the Primary Care Provider (PCP) on 11/15/23 at 1:45pm revealed: -Resident #7 was on a pureed diet. -Resident #7 was not eating well, so she was changed to a pureed diet with double portions. -She expected all of Resident #7's meals to be pureed. -She did not know Resident #7 did not receive all foods listed on the menu and that she did not get double portions. -She did expect diets to be served as ordered.</p> <p>Interview with the Resident Care Coordinator (RCC) on 11/15/23 at 10:55am revealed: -She did not know Resident #7 was ordered double portions. -She did not know Resident #7 did not receive double portions and did not receive all the food listed on the menu.</p> <p>Interview with the Dietary Manager (DM) on 11/16/23 at 10:26am revealed: -Resident #7 was on a pureed diet with double portions. -He did not know Resident #7 did not get double portions during mealtime. -The staff was aware to serve double portions because they had been told. -Resident #7 was to receive the food items that were listed for the pureed diet. -Resident #7's food was to be pureed and not have any lumps in the food.</p>	D 310		

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D 310	<p>Continued From page 20</p> <p>Refer to the interview with a personal care aide (PCA) on 11/15/23 at 8:04am.</p> <p>Refer to the interview with the cook on 11/15/23 at 10:08am revealed:</p> <p>Refer to the interview with the RCC on 11/15/23 at 10:55am.</p> <p>Refer to the interview with the DM on 11/16/23 at 10:26am.</p> <p>Refer to the interview with the Administrator on 11/16/23 at 4:38pm.</p> <p>Interview with a personal care aide (PCA) on 11/15/23 at 8:04am revealed:</p> <ul style="list-style-type: none"> <li>-Residents plates were wrapped in saran wrap.</li> <li>-Their name was written on a sticker and the sticker was placed on the saran wrap.</li> <li>-The facility staff were able to easily identify which plate belonged to which resident.</li> </ul> <p>Interview with the cook on 11/15/23 at 10:08am revealed:</p> <ul style="list-style-type: none"> <li>-She was familiar with the therapeutic diet menu.</li> <li>-She knew the therapeutic menu was on a clipboard in a bind on the wall.</li> <li>-She did not refer to the therapeutic menu; she knew how to prepare the diets as ordered.</li> </ul> <p>Interview with the Resident Care Coordinator on 11/15/23 at 10:55am revealed:</p> <ul style="list-style-type: none"> <li>-There were pictures of each resident at the nurse's station and in the kitchen with a label that stated what type of diet each resident was on.</li> <li>-The plates are served from the kitchen with the resident name on each plate.</li> <li>-She observed the plates of food that each</li> </ul>	D 310		

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D 310	<p>Continued From page 21</p> <p>resident received to ensure the pureed plates and the mechanical soft plates were correct. -She did not notice any problems with the plates served the last couple of days. -She did not know some of the diets were not served as ordered.</p> <p>Interview with the Dietary Manager (DM) on 11/16/23 at 10:26am revealed: -The staff should look at the therapeutic diet menu before they start cooking and prepare the meal based on the menu. -The therapeutic menu was on a clipboard on the wall beside the serving table. -The kitchen staff could reference the therapeutic menu when they needed.</p> <p>Interview with the Administrator on 11/16/23 at 4:38pm revealed he expected diets to be served as ordered.</p> <p>2. Review of Resident #4's current FL-2 dated 09/12/23 revealed: -Diagnoses included vascular dementia, idiopathic gout, hypothyroidism, irritable bowel syndrome, and malignant neoplasm of L. female breast. -There was an order for health shakes.</p> <p>Review of Resident #4's September 2023, October 2023, and November 2023 from 11/01/23-11/11/16/23 electronic medication administration record (eMAR) revealed there was no entry for health shakes or documentation Resident #4 received health shakes.</p> <p>Interview with the cook on 11/14/23 at approximately 11:10 am revealed dietary did not provide liquid nutritional supplements with meals.</p> <p>Interview with the Administrator on 11/15/23 at</p>	D 310		

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D 310	<p>Continued From page 22</p> <p>11:15 am revealed:</p> <ul style="list-style-type: none"> <li>-She did not know Resident #4 had been ordered health shakes on the FL-2.</li> <li>-There was no documentation on the facility's provider notes advising the need for health shakes.</li> <li>-The facility follows the provider's recommendations and suggestions.</li> <li>-Resident #4 was not taking health shakes before going to the hospital; the health shakes were recommended by the hospital for Resident #4 when the resident returned to the facility.</li> <li>-The FL-2 should have been faxed to the facility pharmacy by the medication aide (MA).</li> <li>-The pharmacy provider would have entered the health shakes on the eMAR.</li> <li>-There was no order to discontinue Resident #4's health shakes.</li> <li>-Resident #4 was not receiving health shakes as entered on the FL-2 dated 09/12/2023.</li> </ul> <p>Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-FL-2 was received via fax which displayed health shakes for Resident #4.</li> <li>-Health shakes were not provided by the pharmacy unless requested by the facility.</li> <li>-Facilities could obtain health shakes on their own and not through the pharmacy.</li> <li>-No request was made by the facility for the pharmacy to provide health shakes for Resident #4.</li> </ul> <p>Interview with the Director of Clinical Services (DCS) on 11/16/23 at 10:00am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 was not receiving health shakes.</li> <li>-Resident #4's FL-2 should have been faxed to the facility pharmacy by the MA.</li> </ul>	D 310		

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D 310	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>-Clarification should have been obtained regarding the exact type of health shake being recommended for Resident #4.</li> <li>-The need for health shakes was not on Resident #4's eMAR.</li> <li>-The need for health shakes for Resident #4 was missed by the facility.</li> <li>-There was no order to discontinue health shakes for Resident #4.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 11/16/23 at approximately 2:00pm revealed:</p> <ul style="list-style-type: none"> <li>-Health shakes were not on Resident #4's eMAR.</li> <li>-There was no documentation that Resident #4 received any health shakes.</li> <li>-Clarification should have been obtained explaining the exact Health shakes being recommended.</li> <li>-Clarification could have been obtained by the MA.</li> </ul> <p>Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/16/23 at 2:32pm revealed:</p> <ul style="list-style-type: none"> <li>-She was not aware health shakes had been ordered for Resident #4 by a provider at the hospital.</li> <li>-She expected the facility staff to let her know of any changes in orders for a resident after a hospitalization/rehabilitation stay.</li> <li>-A health shake could be helpful for Resident #4.</li> </ul> <p>Attempted telephone interview with Resident #4 family member on 11/16/23 at 2:15 pm and on 11/20/2023 at 3:15 pm was unsuccessful.</p> <p>Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.</p>	D 310		



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D 344	<p>10A NCAC 13F .1002(a) Medication Orders</p> <p>10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#1) for medication used to treat mild pain.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 06/13/23 revealed diagnoses included gastroesophageal reflux disease (GERD), diabetes, hypothyroidism, hypertension, and normal pressure hydrocephalus with a shunt.</p> <p>Review of Resident #1's hospital emergency department after-visit summary dated 11/12/23 revealed: -Resident #1 was seen for a fall. -Resident #1 had a new rib fracture. -There was documentation to take the medication as directed for pain control. -There was an order for Acetaminophen (used to</p>	D 344		

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D 344	<p>Continued From page 25</p> <p>treat minor aches and pains) 500mg take one tablet by mouth every six hours for five days. -There was an order for Oxycodone 5mg take one tablet by mouth every six hours as needed for pain for up to three days.</p> <p>Review of Resident #1's November 2023 electronic medication administration record (eMAR) from 11/01/23-11/15/23 revealed: -There was no entry for Tylenol 500mg take one tablet every six hours for five days. -There was no documentation that Tylenol 500mg one tablet every six hours had been administered from 11/12/23-11/15/23. -There was an entry for Tylenol 500mg take two tablets as needed every 4-6 hours. -There was documentation that two tablets of Tylenol 500mg were administered on 11/02/23.</p> <p>Observation of Resident #2's medications on hand on 11/14/23 at 3:37pm revealed: -There was a punch card for Oxycodone 5mg with a dispensed date of 11/12/23. -There was no punch card for Tylenol 500mg with the directions to administer one tablet every six hours for five days. -There was a punch card for Tylenol 500mg with the directions to administer two tablets every 4-6 hours as needed; two tablets had been administered since it was dispensed on 10/12/23.</p> <p>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/15/23 at 9:20am revealed: -An electronic prescription was received on 11/12/23 for Resident #1's Tylenol 500mg and Oxycodone 5mg. -Oxycodone was dispensed to Resident #1 on 11/12/23. -Resident #1's order for Tylenol was not entered</p>	D 344		

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D 344	<p>Continued From page 26</p> <p>into the eMAR and not dispensed but he did not know why.</p> <ul style="list-style-type: none"> <li>-The facility should have had some PRN Tylenol on hand that could have been administered to Resident #1.</li> <li>-Tylenol was used for pain control and having the medication scheduled was trying to control pain without using Oxycodone.</li> </ul> <p>Interview with Resident #1 on 11/15/23 at 9:44am revealed:</p> <ul style="list-style-type: none"> <li>-She recently had a fall and hit her head.</li> <li>-She did not think she was getting Tylenol daily, but she had asked for it, she could not recall when, but it had been since she had her fall.</li> <li>-She had to ask for Tylenol; it helped with the pain she was having in her head.</li> <li>-Her head was hurting now but she had not asked for Tylenol.</li> </ul> <p>Telephone interview with Resident #1's family member on 11/16/23 at 11:17am revealed:</p> <ul style="list-style-type: none"> <li>-He had not talked to Resident #1 since she had her fall.</li> <li>-Resident #1 was "hit or miss" on asking for something for pain.</li> <li>-Resident #1 had told him she asked the MA for something, and the MA would tell him she had already administered the medication.</li> <li>-He thought Resident #1 was a poor historian.</li> </ul> <p>Telephone interview with Resident #1's PCP on 11/15/23 at 1:40pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a fall and hit her head.</li> <li>-She would have liked for Resident #1 to have received the scheduled Tylenol so the resident would not be in pain.</li> </ul> <p>Interview with a medication aide (MA) on 11/16/23 at 12:04pm revealed:</p>	D 344		

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D 344	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>-When a resident returned from the hospital, the hospital discharge papers should be reviewed for any new orders.</li> <li>-All new orders should then be processed and tracked using the new order tracking form.</li> <li>-Whoever accepted Resident #1 back from the hospital should have read over the discharge papers.</li> <li>-Resident #1 had not complained of any pain this week, the week of 11/13/23.</li> </ul> <p>Interview with the Administrator on 11/16/23 at 4:55pm revealed:</p> <ul style="list-style-type: none"> <li>-Hospital discharge papers were not considered orders unless they were electronically signed.</li> <li>-The MA or the Director of Clinical Services would have been responsible for having the discharge papers clarified.</li> </ul>	D 344		
D 358	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>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:</p> <ul style="list-style-type: none"> <li>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</li> <li>(2) rules in this Section and the facility's policies and procedures.</li> </ul> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #5) for an inhaler, a nasal spray,</p>	D 358		

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D 358	<p>Continued From page 28</p> <p>and a medication used to treat reflux (#1); and a blood pressure medication (#5).</p> <p>The findings are:</p> <p>Review of the facility's Medication Administration policy revealed:</p> <ul style="list-style-type: none"> <li>-There was no date on the policy.</li> <li>-Appropriately trained/licensed associates would administer medications following the specific state regulations and guidelines of; right resident, right medications, right dose, right time, right route, right documentation, and the right to refuse.</li> </ul> <p>1. Review of Resident #5's current FL-2 dated 11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included essential, primary hypertension and atherosclerotic heart disease of the coronary artery with angina pectoris.</li> <li>-There was an order for propranolol 10mg (used to treat high blood pressure) one tablet daily as needed for systolic blood pressure greater than 160.</li> </ul> <p>Review of Resident #5's signed physician orders dated 07/31/23 revealed there was an order for propranolol 10mg daily as needed for a systolic blood pressure greater than 160.</p> <p>Review of the Consultant Pharmacist's Medication Regimen review dated 06/05/23 revealed:</p> <ul style="list-style-type: none"> <li>-There was a recommendation to ensure staff were aware of Resident #5's "as needed" (PRN) order for propranolol for systolic blood pressure greater than 160.</li> <li>-There was no documentation that Resident #5's Primary Care Provider (PCP) had reviewed or signed the Pharmacist's recommendation.</li> </ul>	D 358		

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D 358	<p>Continued From page 29</p> <p>Review of Resident #5's vital sign history from 10/29/23 to 11/07/23 revealed:                      -There was documentation of a blood pressure reading on 10/29/23 at 3:49am of 204/77.                      -There was documentation of a blood pressure reading on 10/31/23 at 8:03pm of 182/76.                      -There was documentation of a blood pressure reading on 11/06/23 at 8:01am of 193/91.                      -There was documentation of a blood pressure reading on 11/07/23 at 8:16am of 165/74.</p> <p>Review of The American Heart Association guidelines revealed:                      -They recognized 5 blood pressure ranges.                      -Number 4 was hypertension stage 2 when the blood pressure consistently was 140/90 mmHg or higher.                      -Number 5 was hypertensive crisis when the blood pressure reading was greater than 180/120 mmHg requiring medical attention. -The Systolic blood pressure reading indicated how much pressure your blood exerts against the artery walls when the heart contracts.</p> <p>Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed:                      -There was an entry for propranolol 10mg daily PRN for a systolic blood pressure greater than 160.                      -There was no documentation propranolol was administered from 09/01/23 to 09/30/23.                      -There was no entry to obtain blood pressure readings.                      -There was no documentation of blood pressure readings from 09/01/23 to 09/30/23.</p> <p>Review of Resident #5's October 2023 eMAR revealed:</p>	D 358		

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D 358	<p>Continued From page 30</p> <ul style="list-style-type: none"> <li>-There was an entry for propranolol 10mg daily PRN for a systolic blood pressure greater than 160.</li> <li>-There was no documentation propranolol was administered from 10/01/23 to 10/31/23.</li> <li>-There was no entry to obtain blood pressure readings.</li> <li>-There was no documentation of blood pressure readings from 10/01/23 to 10/31/23.</li> </ul> <p>Review of Resident #5's November eMAR from 11/01/23 to 11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for propranolol 10mg daily PRN for a systolic blood pressure greater than 160.</li> <li>-There was no documentation propranolol was administered from 11/01/23 to 11/15/23.</li> <li>-There was an entry for blood pressure checks; there was no frequency noted.</li> <li>-There was documentation of blood pressure readings on 11/04/23 at 8:23am of 142/76, on 11/05/23 at 8:21am of 148/76, on 11/06/23 at 8:01am of 193/91, and on 11/07/23 at 8:16am of 165/74.</li> </ul> <p>Observation of medication on hand for Resident #5 on 11/15/23 at 11:37am revealed:</p> <ul style="list-style-type: none"> <li>-There was a blister pack of propranolol 10mg dispensed on 01/27/23 on the medication cart.</li> <li>-There were 16 of 30 propranolol remaining and available for administration.</li> <li>-The directions on the blister pack were to administer 1 daily as needed for systolic blood pressure greater than 160.</li> </ul> <p>Review of Resident #5's radiology report dated 11/01/23 revealed:</p> <ul style="list-style-type: none"> <li>-The x-ray was done at the facility.</li> <li>-There was stable left pleural effusion with associated consolidation of the left lower lobe.</li> </ul>	D 358		

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D 358	<p>Continued From page 31</p> <p>-The lungs were mildly congested.</p> <p>Review of the Resident #5's Primary Care Physician's (PCP) visit summary dated 11/06/23 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5's recent chest x-ray showed extra fluid, which was indicative of congestive heart failure.</li> <li>-Resident #5's lungs were clear upon auscultation today.</li> <li>-Resident #5 received a diuretic for 3 days to help manage the extra fluid.</li> <li>-Resident #5's blood pressure was noted to be elevated at 138/62 today.</li> <li>-The plan was to continue to monitor Resident #5's blood pressure closely.</li> </ul> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/16/23 at 9:53am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5 had an order for propranolol 10mg daily for a systolic blood pressure greater than 160.</li> <li>-Propranolol was used to lower blood pressure.</li> <li>-If the blood pressure was not taken, the facility staff would not know if the propranolol was needed.</li> <li>-The pharmacy had a new computer system, and the look back date was April 2023.</li> <li>-No propranolol 10mg had been dispensed since April 2023 for Resident #5.</li> </ul> <p>Interview with a medication aide (MA) on 11/16/23 at 3:51pm revealed:</p> <ul style="list-style-type: none"> <li>-If a resident's blood pressure needed to be taken, it would "pop-up" on the eMAR and the blood pressure reading would be entered in the eMAR.</li> <li>-Resident #5 did not have an order for blood pressure readings daily.</li> </ul>	D 358		



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D 358	<p>Continued From page 32</p> <ul style="list-style-type: none"> <li>-She did not know Resident #5 had an order for a PRN medication based on the blood pressure readings.</li> <li>-The PRN orders did not "pop-up" on the eMAR; she would have to click on the PRN tab on the eMAR to see the PRN orders.</li> <li>-Resident #5 had not complained of headaches or dizziness.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 11/16/23 at 3:59pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5's blood pressure was checked monthly.</li> <li>-Resident #5's PCP would review Resident #5's blood pressure readings when the PCP visited the resident.</li> <li>-She did not know Resident #5 had a PRN order for a blood pressure medication if the systolic blood pressure was greater than 160.</li> <li>-Resident #5's blood pressure should be checked daily to see if the PRN blood pressure medication was needed, but there was no order to check Resident #5's blood pressure daily.</li> <li>-She had not audited medication carts as the RCC.</li> <li>-The RCC and the Director of Clinical Services were responsible for weekly cart audits.</li> <li>-She and the Director of Clinical Services were new to their positions and weekly cart audits were not being done.</li> </ul> <p>Telephone interview with Resident #5's PCP on 11/16/23 at 1:24pm revealed:</p> <ul style="list-style-type: none"> <li>-Propranolol was ordered for Resident #5 to treat high blood pressure.</li> <li>-She checked Resident #5's blood pressure with each visit and the systolic blood pressure was lower than 160.</li> <li>-She had not been informed of any systolic blood pressure readings greater than 160.</li> </ul>	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>-She was not made aware of the elevated blood pressure readings on 10/29/23 at 3:49am of 204/77, on 10/31/23 at 8:03pm of 182/76, on 11/06/23 at 8:01am of 193/91, and on 11/07/23 at 8:16am of 165/74.</li> <li>-Resident #5 should have had an extra dose of propranolol on the four days the systolic blood pressure was greater than 160.</li> <li>-Resident #5 could have had a heart attack or a stroke with blood pressure readings that high.</li> </ul> <p>Interviews with the Administrator on 11/16/23 at 2:36pm and 5:19pm revealed:</p> <ul style="list-style-type: none"> <li>-The MAs should know about the PRN order to administer propranolol to Resident #5 when her systolic blood pressure was greater than 160.</li> <li>-However, the PRN medications did not "pop-up" on the eMAR screen like the scheduled medications, so they would have to click on the PRN tab to see the order.</li> <li>-The PRN order for Resident #5's propranolol should be entered on the eMAR with Resident #5's scheduled dosage of propranolol.</li> <li>-The facility checked residents' blood pressures monthly unless ordered differently from the PCP.</li> <li>-The Director of Clinical Services received the pharmacy recommendations from the Pharmacist.</li> <li>-The Director of Clinical Services was responsible for giving the recommendations to the PCP for review.</li> <li>-He did not know why the Director of Clinical Services did not follow up on the pharmacy recommendation from June 2023.</li> </ul> <p>Refer to the interview with the Administrator on 11/16/23 at 2:36pm.</p> <p>2. Review of Resident #1's current FL2 dated 06/13/23 revealed diagnoses included</p>	D 358		

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D 358	<p>Continued From page 34</p> <p>gastro-esophageal reflux disease (GERD), diabetes, hypothyroidism, hypertension, and normal pressure hydrocephalus with shunt.</p> <p>a. Review of Resident #1's FL2 dated 06/13/23 revealed an order for Omeprazole (used to treat GERD) 40mg take one capsule daily.</p> <p>Review of Resident #1's physician order dated 07/21/23 revealed an order to hold Omeprazole for 7 days during antibiotic treatment, due to medication interaction.</p> <p>Review of Resident #1's physician's order dated 07/31/23 revealed an order for Omeprazole 40mg one capsule daily.</p> <p>Review of Resident #1's Primary Care Provider (PCP) after-visit summary dated 10/09/23 revealed: -Resident #1 had a productive cough with inspiratory and expiratory rales throughout all lung fields. -Resident #1 was started on an antibiotic, and an inhaler, and a chest x-ray was ordered.</p> <p>Review of Resident #1's PCP after-visit summary dated 10/20/23 revealed: -Resident #1 had a cough for several months. -Resident #1 had been treated with an antibiotic and a scheduled inhaler. -Chest x-ray results showed no pneumonia. -Per chart, Resident #1's O2 sats were within the normal limit on room air. -It was unclear if the cough was due to either a medication such as Enalapril (an ACE inhibitor medication used to treat high blood pressure, diabetic kidney disease, and heart failure) or reflux or postnasal drip. -Would consider changing/discontinuing the ACE</p>	D 358		

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D 358	<p>Continued From page 35</p> <p>inhibitor if possible.</p> <p>-Would consider having a hospital bed that could help with raising the head of the bed for possible reflux given it was worse at night.</p> <p>Review of Resident #1's PCP after-visit summary dated 10/23/23 revealed:</p> <p>-Resident #1 was being seen for cough, fall, and hypothyroidism.</p> <p>-Resident #1 continued to have a productive cough.</p> <p>-Resident #1 was treated with an antibiotic and an inhaler.</p> <p>-Resident #1 reported overall she felt like her cough was getting better though it was lingering.</p> <p>-Resident #1 had been using her PRN (as needed) medication to help with the symptoms.</p> <p>Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for Omeprazole 40mg take one capsule daily with a scheduled administration time of 6:30am.</p> <p>-There was documentation that the medication was on hold from 09/01/23-09/31/23.</p> <p>Review of Resident #1's October 2023 eMAR revealed:</p> <p>-There was an entry for Omeprazole 40mg take one capsule daily with a scheduled administration time of 6:30am.</p> <p>-There was documentation that the medication was on hold from 10/01/23-10/31/23.</p> <p>Review of Resident #1's November 2023 eMAR from 11/01/23-11/15/23 revealed:</p> <p>-There was an entry for Omeprazole 40mg take one capsule daily with a scheduled administration time of 6:30am.</p>	D 358		

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D 358	<p>Continued From page 36</p> <p>-There was documentation that the medication was on hold from 11/01/23-11/15/23.</p> <p>Observation of Resident #1's medications on hand on 11/14/23 at 3:34pm revealed there was a punch card with 22 of 31 omeprazole capsules dispensed on 08/14/23.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/15/23 at 9:20am revealed:</p> <p>-Omeprazole 40mg, administer one tablet daily, was a current order for Resident #1.</p> <p>-They did not have a current hold order for Resident #1's Omeprazole.</p> <p>-Resident #1's Omeprazole was cycle-filled and was dispensed on 08/14/23, 09/14/23, and 10/17/23.</p> <p>-The Omeprazole dispensed on 09/14/23 and 10/14/23 had been returned to the pharmacy; there was no documentation as to why the medication had been returned.</p> <p>-Omeprazole was used to treat GERD, heartburn, and/or reflux.</p> <p>-If Resident #1's Omeprazole was not administered as ordered, the resident could experience indigestion, heartburn, and a cough from irritation from reflux.</p> <p>Interview with Resident #1 on 11/15/23 at 9:44am revealed:</p> <p>-Her cough was "still here" but it was better than it had been.</p> <p>-She had not had any problems with heartburn that she recalled.</p> <p>-She did not know what medications she took or when she was last administered Omeprazole.</p> <p>Telephone interview with Resident #1's family member on 11/16/23 at 11:17am revealed:</p>	D 358		

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D 358	<p>Continued From page 37</p> <ul style="list-style-type: none"> <li>-Resident #1 was a poor historian.</li> <li>-Resident #1 intermittently had problems with an upset stomach related to GI problems but no problems with GERD that he was aware of.</li> </ul> <p>Telephone interview with Resident #1's PCP on 11/15/23 at 1:40pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a current order for Omeprazole 40mg to be administered at 6:30am; the medication should not be on hold.</li> <li>-Resident #1 had been ordered Omeprazole because of problems with reflux.</li> <li>-She expected medication to be administered as ordered.</li> </ul> <p>Interview with a medication aide (MA) on 11/16/23 at 12:04pm revealed:</p> <ul style="list-style-type: none"> <li>-New orders were sent to the pharmacy to be filled and entered into the eMAR system and were then approved by a facility staff member.</li> <li>-Whoever approved the order to hold Resident #1's Omeprazole could have entered the hold for seven days in the eMAR system.</li> <li>-She did not know why Resident #1's Omeprazole had been on hold since 07/21/23.</li> <li>-Resident #1's Omeprazole was administered by the third shift MA so she would not have known the medication had been on hold.</li> <li>-Resident #1 had not complained of any symptoms of reflux that she was aware of.</li> </ul> <p>Interview with the Administrator on 11/16/23 at 2:49pm revealed:</p> <ul style="list-style-type: none"> <li>-If Resident #1's Omeprazole had been put on hold for seven days, then medication should have only been held for seven days.</li> <li>-The pharmacy staff entered new orders into the eMAR system, and it was then approved by a MA.</li> <li>-The MA should have verified the hold time when</li> </ul>	D 358		

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D 358	<p>Continued From page 38</p> <p>the entry was approved.</p> <p>Attempted telephone interview with a third shift MA on 11/16/23 at 11:41am was unsuccessful.</p> <p>Refer to the interview with the Administrator on 11/16/23 at 2:36pm.</p> <p>b. Review of Resident #1's physician's order dated 10/09/23 revealed an order for Albuterol (used to treat or prevent bronchospasm) 90mcg four puffs every four hours while awake for three days; then Albuterol 90mcg every 6 hours as needed for shortness of breath.</p> <p>Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Albuterol 90mcg four puffs every four hours for three days with a scheduled administration time of 9:00am, 1:00pm, 5:00pm, and 9:00pm.</li> <li>-There was documentation Albuterol 90mcg was administered four times daily from 10/12/23-10/31/23.</li> </ul> <p>Review of Resident #1's November 2023 eMAR from 11/01/23-11/15/23 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Albuterol 90mcg four puffs every four hours for three days with a scheduled administration time of 9:00am, 1:00pm, 5:00pm, and 9:00pm.</li> <li>-There was documentation Albuterol 90mcg was administered four times daily from 11/01/23-11/06/23 and twice on 11/07/23.</li> </ul> <p>Observation of Resident #1's medications on hand on 11/14/23 at 3:34pm revealed there was an Albuterol inhaler dispensed on 10/13/23 with the directions to administer every 6 hours as</p>	D 358		

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D 358	<p>Continued From page 39</p> <p>needed for shortness of breath starting 10/13/23; the inhaler had not been used.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/15/23 at 9:20am revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy dispensed one inhaler with 200 metered inhalations on 10/09/23</li> <li>-A second Albuterol inhaler for as-needed usage was dispensed on 10/13/23.</li> <li>-Resident #1 had an order for Albuterol four inhalations four times per day for three days that was received on 10/09/23.</li> <li>-Albuterol at that dosage was meant to be for short-term use.</li> <li>-If Resident #1 was administered Albuterol long term at that dosage, the resident ran the risk of an increased heart rate, palpitations, and high blood pressure.</li> </ul> <p>Review of Resident #1's PCP after-visit summary dated 10/09/23 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 had a productive cough with inspiratory and expiratory rales throughout all lung fields.</li> <li>-Resident #1 was started on an antibiotic, and an inhaler, and a chest x-ray was ordered.</li> </ul> <p>Review of Resident #1's PCP after-visit summary dated 10/23/23 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was being seen for cough, fall, and hypothyroidism.</li> <li>-Resident #1's continued to have a productive cough.</li> <li>-Resident #1 was treated with an antibiotic and an inhaler.</li> <li>-Resident #1 reported overall she felt like her cough was getting better though it was lingering.</li> <li>-Resident #1 had been using her PRN (as needed) medication to help with the symptoms.</li> </ul>	D 358		



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D 358	<p>Continued From page 40</p> <p>Interview with Resident #1 on 11/15/23 at 9:44am revealed: -Her cough was "still here" but it was better than it had been. -She used her inhaler every day. -The MAs did not ask her if she needed the Albuterol inhaler, "they just gave it." -She did not feel any different after using the inhaler.</p> <p>Telephone interview with Resident #1's family member on 11/16/23 at 11:17am revealed: -Resident #1 was a poor historian. -Resident #1 had recently been treated for an upper respiratory infection and was prescribed an inhaler. -Resident #1 had not expressed any problems with feeling anxious.</p> <p>Telephone interview with Resident #1's PCP on 11/15/23 at 1:40pm revealed: -She did not want Resident #1 to be administered Albuterol four times per day for longer than ordered. -If Resident #1 was administered Albuterol four times per day for longer than three days it could cause Resident #1 to be more anxious and not sleep well.</p> <p>Interview with a MA on 11/16/23 at 12:04pm revealed: -She could see in the eMAR system Resident #1's Albuterol was started on 10/12/23 and stopped on 11/07/23. -She did not know why Resident #1's Albuterol was not stopped after three days. -When the medication was put in the eMAR system, there should have been a stop date; the MA or the Pharmacy staff should have put a stop</p>	D 358		

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D 358	<p>Continued From page 41</p> <p>date.</p> <p>-When the order was approved the MA should have made sure there was a stop date.</p> <p>-She did not recall Resident #1 being more anxious while taking the Albuterol.</p> <p>Interview with the Administrator on 11/16/23 at 2:49pm revealed he expected Resident #1 to have received her Albuterol inhaler as ordered and was concerned she received the medication longer than she should have based on the order.</p> <p>Refer to the interview with the Administrator on 11/16/23 at 2:36pm.</p> <p>c. Review of Resident #1's FL2 dated 06/13/23 revealed an order for Fluticasone (used to treat rhinosinusitis) 50mcg, one spray in each nostril twice daily.</p> <p>Review of Resident #1's physician's after-visit summary dated 01/10/23 revealed Resident #1 had a nighttime cough, suspected allergic rhinitis; not getting Flonase regularly.</p> <p>Review of Resident #1's PCP after-visit summary dated 10/09/23 revealed: -Resident #1 had a productive cough with inspiratory and expiratory rales throughout all lung fields. -Resident #1 was started on an antibiotic, and an inhaler, and a chest x-ray was ordered.</p> <p>Review of Resident #1's PCP after-visit summary dated 10/20/23 revealed: -Resident #1 had a cough for several months. -Resident #1 had been treated with an antibiotic and a scheduled inhaler. -Chest x-ray results showed no pneumonia. -It was unclear if the cough was due to either a</p>	D 358		

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D 358	<p>Continued From page 42</p> <p>medication such as Enalapril (an ACE inhibitor medication used to treat high blood pressure, diabetic kidney disease, and heart failure) or reflux or postnasal drip.</p> <p>Review of Resident #1's PCP after-visit summary dated 10/23/23 revealed: -Resident #1 was being seen for cough, fall, and hypothyroid. -Resident #1 continued to have a productive cough. -Resident #1 was treated with an antibiotic and an inhaler. -Resident #1 reported overall she felt like her cough was getting better though it was lingering. -Resident #1 had been using her PRN (as needed) medication to help with the symptoms.</p> <p>Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Fluticasone one spray in each nostril twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation Fluticasone was administered twice daily from 09/01/23-09/31/23.</p> <p>Review of Resident #1's October 2023 eMAR revealed: -There was an entry for Fluticasone one spray in each nostril twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation Fluticasone was administered twice daily from 10/01/23-10/31/23.</p> <p>Review of Resident #1's November 2023 eMAR from 11/01/23-11/15/23 revealed: -There was an entry for Fluticasone one spray in each nostril twice daily with a scheduled administration time of 9:00am and 9:00pm.</p>	D 358		

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D 358	<p>Continued From page 43</p> <p>-There was documentation Fluticasone was administered twice daily from 11/01/23-11/15/23.</p> <p>Observation of Resident #1's medications on hand on 11/14/23 at 3:34pm revealed there was a bottle of Fluticasone 50mcg dispensed on 05/30/23 with the directions to place one spray in each nostril twice daily; there was medication remaining in the bottle.</p> <p>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/15/23 at 9:20am revealed:</p> <p>-Resident #1's current order was for Fluticasone one spray in each nostril twice daily.</p> <p>-Fluticasone was not cycle-filled and refills had to be requested.</p> <p>-Resident #1's Fluticasone was last filled on 05/30/23 and a request had come in on 11/14/23 for a refill.</p> <p>-Based on Resident #1's order, the Fluticasone dispensed on 05/30/23 would last for 30-days.</p> <p>-Fluticasone was used to treat allergies and nasal congestion.</p> <p>-If Resident #1's Fluticasone was not administered as ordered the resident could experience a stuffy nose, allergy symptoms, and congestion.</p> <p>Interview with Resident #1 on 11/15/23 at 9:44am revealed:</p> <p>-Her cough was "still here" but it was better than it had been.</p> <p>-She received nasal spray four times daily.</p> <p>Telephone interview with Resident #1's family member on 11/16/23 at 11:17am revealed:</p> <p>-Resident #1 was a poor historian.</p> <p>-Resident #1 had recently been treated for an upper respiratory infection and had experienced a</p>	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL032132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA RESERVE OF DURHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4523 HOPE VALLEY ROAD DURHAM, NC 27707</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 44</p> <p>cough and runny nose that had improved.</p> <p>Telephone interview with Resident #1's PCP on 11/15/23 at 1:40pm revealed: -Resident #1 had a current order for Fluticasone one spray in each nostril twice daily. -She expected Resident #1's Fluticasone to be administered as ordered.</p> <p>Interview with a MA on 11/16/23 at 12:04pm revealed: -Resident #1 had complained of a runny nose over the past couple of months. -She did not know why Resident #1's Fluticasone dispensed on 05/30/23 had medication remaining in the bottle. -Resident #1 had not refused Fluticasone for her.</p> <p>Interview with the Administrator on 11/16/23 at 2:49pm revealed he expected the MAs to follow the order as written for Resident #1's Fluticasone.</p> <p>Refer to the interview with the Administrator on 11/16/23 at 2:36pm.</p> <p>Interview with the Administrator on 11/16/23 at 2:36pm revealed: -The pharmacy staff audited resident records quarterly. -The nurse from the pharmacy looked at orders to see they were being followed. -The corporate nurse would do site visits and audit random charts.</p> <p>The facility failed to ensure medications were administered as ordered for 2 sample residents, including a resident who was not receiving propranolol as needed for a systolic blood pressure greater than 160 when the systolic blood pressure was greater than 160 four times from</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL032132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CAROLINA RESERVE OF DURHAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4523 HOPE VALLEY ROAD DURHAM, NC 27707</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	<p>Continued From page 45</p> <p>10/29/23 to 11/07/23, there were no recordings of daily blood pressure checks to see if propranolol should have been administered, and resident was treated for pneumonia and increase in fluid (#5), and Resident #1 was not administered her reflux medication for four months and was administered an Albuterol inhaler four puffs four times daily more than three days when the medication should have been changed to every six hours as needed after three days. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on November 16, 2023.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2023.</p>	D 358		