STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R-C 11/20/2023

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and Mecklenburg County Department of Social Services conducted a follow-up survey on November 14th through November 20, 2023.	{D 000}		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues and the previous Type B Violation was not abated. Based on interviews and record reviews the facility failed to ensure 3 of 6 sampled medication aides (MA) (Staff D, E and F) completed a medication administration clinical skills validation prior to the administration of resident's medication. The findings are: 1. Review of Staff D's MA personnel record on revealed: -Staff D's hire date was 08/19/23.	D 125		

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-There was documentation of a virtual medication administration clinical skills validation dated 08/20/23.

Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff D administered medications 150 times from 10/11/23 through 10/31/23.

Review of a resident's November 2023 eMAR revealed there was documentation Staff D administered medications 84 times from 11/01/23 through 11/16/23.

Telephone interview with Staff D on 11/16/23 at 2:15pm revealed:
-She was employed by the facility's contracted staffing agency.
-She had been working at the facility as a MA since August 2023.
-She began working in the Special Care Unit (SCU) on 11/15/23.
-Her MA duties included administering medications.
-On 08/20/23, she was provided a virtual medication administration clinical skills orientation by a contracted Registered Nurse (RN).
-She had not received any additional medication administration clinical skills validation in the facility.
-She did not notice that Resident #5's levothyroxine sodium on the medication cart did not match the eMAR orders.
-The MAs were supposed to compare medications on the medication cart to the eMAR orders but she did not.
-If there was an incorrect dose of medication on the medication cart, the MA should have documented in the progress notes and notified

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the pharmacy as well as the resident's PCP.

Refer to telephone interview with a MA on 11/17/23 at 3:30pm.

Refer to interview with the Business Office Manager (BOM) on 11/20/23 at 10:46am.

Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm.

Refer to interview with the Administrator on 11/20/23 at 4:40pm.

2. Review of Staff E's MA personnel record revealed:
-Staff E's hire date was 10/17/23.
-There was no documentation of a medication administration clinical skills validation.

Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff E administered medications 8 times from 10/11/23 through 10/31/23.

Review of a resident's November 2023 eMAR revealed there was documentation Staff E administered medications 25 times from 11/01/23 through 11/16/23.

Interview with Staff E on 11/16/23 at 11:10am revealed:
-She was employed through the facility's contracted staffing agency.
-She had been working at the facility as a MA since October 2023.
-She had not performed a medication administration clinical skills validation prior to performing medication administration tasks in the

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D 125	Continued From page 3 facility. Refer to telephone interview with a MA on 11/17/23 at 3:30pm. Refer to interview with the BOM on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm. 3. Review of Staff F's MA personnel record revealed: -Staff F's hire date was 10/24/23. -There was no documentation of a medication administration clinical skills validation Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff F administered medications 6 times from 10/11/23 through 10/31/23. Review of a resident's November 2023 eMAR revealed there was documentation Staff F administered medications 54 times from 11/01/23 through 11/15/23. Telephone interview with Staff F on 11/16/23 at 2:00pm revealed: -She was employed through the facility's contracted staffing agency. -She had been working at the facility as a MA since October 2023. -She had not performed a medication administration clinical skills validation prior to performing medication administration tasks.	D 125		

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D 125	Continued From page 4 Refer to telephone interview with a MA on 11/17/23 at 3:30pm. Refer to interview with the BOM on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm. _____ Telephone interview with a MA on 11/17/23 at 3:30pm revealed -From 09/11/23 to 11/14/23 the MAs completed required training classes. -These classes did not include agency staff. -The Administrator was responsible for scheduling agency staff for required trainings, and their required skills validation. Interview with the BOM on 11/20/23 at 10:46am revealed: -She was responsible for auditing facility staff training records weekly. -The facility utilized staffing agency staff since August 2023. -She was not responsible for auditing the staff records for the facility's agency staff training records. -She was responsible for communicating staff training needs to the facility's compliance nurse. -She was not aware the facility's contracted agency staff were required to perform a medication clinical skills validation in the facility prior to administration of resident's medications. Interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm revealed:	D 125		

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D 125	Continued From page 5 -She was responsible for providing clinical training for staff, including medication administration clinical skills validation for the facility's contracted facility staff. -A medication administration clinical skills validation was to be performed with each MA in-person, in the facility prior to the MA performing medication administration tasks. -The BOM was responsible for notifying her of any staff requiring medication administration clinical skills validation. -She was not aware Staff D, Staff E, or Staff F did not have a medication administration clinical skills validation. Interview with the Administrator on 11/20/23 at 4:40pm revealed: -The BOM was responsible for auditing facility staff training records. -The BOM was responsible for notifying the facility's Compliance Nurse of any MA needing the medication administration clinical skills validation prior to performing medication administration tasks. -The facility utilized staffing agency staff since August 2023. -She was aware staffing agency staff were required to have the same training requirements as facility staff. -She was aware a medication administration clinical skills validation was to be performed in the facility with each MA prior to the MA performing any medication administration tasks. -The BOM did not maintain staff training records for staffing agency staff. -She was not aware Staff D had been provided a virtual medication administration clinical skills validation on 08/20/23 by facility staff. -A virtual medication administration clinical skills validation was not permitted.	D 125		

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D 125	Continued From page 6 -The facility had not ensured staffing agency MA staff had a valid medication administration clinical skills validation prior to performing medication administration tasks. _____ The facility failed to ensure 3 of 6 sampled MA staff completed a medication administration clinical skills validation prior to performing medication administration tasks, resulting in staff being unable to have the knowledge needed to administer resident's medications. The facility's failure was detrimental to the health, safety, and well-being of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2024.	D 125		
{D 164}	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action;	{D 164}		

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{D 164}	Continued From page 7 (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was not abated. Non-compliance continues. Based on interviews and record reviews the facility failed to ensure 3 of 6 sampled medication aides (MA) (Staff D, E and F) completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff D's MA personnel record revealed: -Staff D's hire date was 08/19/23. -There was no documentation of training on diabetic care for residents. Review of a resident's October 2023 electronic medication administration record (eMAR) revealed there was documentation Staff D checked resident's finger stick blood sugar	{D 164}		

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{D 164}	Continued From page 8 (FSBS) 15 times and administered insulin 13 times from 10/27/23 through 10/31/23. Review of a resident's November 2023 eMAR revealed there was documentation Staff D checked resident's FSBS 17 times and administered insulin 14 times from 11/01/23 through 11/16/23. Telephone interview with Staff D on 11/16/23 at 2:15pm revealed: -She was employed by the facility's contracted staffing agency. -She had been working at the facility as a MA since August 2023. -Her MA duties included administering insulin when needed and checking residents' FSBS as ordered. -Since she started working at the facility, she had not received any training related to care of diabetic residents. Refer to interview with the Business Office Manager (BOM) on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm. 2. Review of Staff E's MA personnel record revealed: -Staff E's hire date was 10/17/23. -There was no documentation of training on diabetic care for residents. Review of a resident's November 2023 electronic medication administration record (eMAR) revealed there was documentation Staff E	{D 164}		

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{D 164}	Continued From page 9	{D 164}		

checked resident's FSBS 2 times and administered insulin 2 times from 11/01/23 through 11/16/23.

Interview with Staff E on 11/16/23 at 11:10am revealed:
-She was employed by the facility's contracted staffing agency.
-She had been working at the facility as a MA since October 2023.
-Her MA duties included administering insulin when needed and checking residents' FSBS as ordered.
-Since she started working at the facility, she had not received any training related to care of diabetic residents.

Refer to interview with the BOM on 11/20/23 at 10:46am.

Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm.

Refer to interview with the Administrator on 11/20/23 at 4:40pm.

3. Review of Staff F's MA personnel record revealed:
-Staff F's hire date was 10/24/23.
-There was no documentation of training on diabetic care for residents.

Review of a resident's November 2023 electronic medication administration record (eMAR) revealed there was documentation Staff F checked resident's FSBS 9 times and administered insulin 8 times from 11/01/23 through 11/16/23.

Telephone interview with Staff F on 11/16/23 at

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{D 164}	Continued From page 10 2:00pm revealed: -She was employed by the facility's contracted staffing agency. -She had been working at the facility as a MA since October 2023. -Her MA duties included administering insulin when needed and checking residents' FSBS as ordered. -Since she started working at the facility, she had not received any training related to care of diabetic residents. Refer to interview with the BOM on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm. _____ Interview with the BOM on 11/20/23 at 10:46am revealed: -She was responsible for auditing facility staff training records weekly. -The facility utilized staffing agency staff since August 2023. -She was not responsible for auditing the facility's contracted agency staff training records. -She did not maintain any of the facility's contracted staff training records. -She was responsible for communicating staff training needs to the facility's Compliance Nurse. Interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm revealed: -She was responsible for providing clinical training for staff, including training on the care of diabetic residents. -The BOM was responsible for notifying her of	{D 164}		

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{D 164}	Continued From page 11 any staff requiring clinical training prior to the employee providing diabetic care of residents. -She was not aware Staff D, Staff E, or Staff F did not have diabetic training prior to providing diabetic care of residents. Interview with the Administrator on 11/20/23 at 4:40pm revealed: -The BOM was responsible for auditing the facility's staff training records. -The BOM was responsible for notifying the facility's Compliance Nurse of any staff training needs prior to the staff working in the facility. -The facility utilized a contracted staffing agency staff since August 2023. -She was aware all agency staff were required to have the same training requirements as facility staff. -The BOM did not maintain staff training records for staffing agency staff. -The facility had "overlooked auditing the contracted agency staff training records". _____ The facility failed to ensure 3 of 6 sampled MA staff completed diabetic training on the care of residents with diabetes, resulting in staff being unable to have the knowledge need to care for residents with a diagnosis of diabetes. The facility's failure was detrimental to the health, safety, and well-being of the residents, which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/16/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2024.	{D 164}		

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D 271	Continued From page 12	D 271		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 5 sampled residents (Resident #4) who was observed by staff exhibiting signs of pain and injury to her right arm that staff failed to seek any treatment leading to the family finding the resident in severe pain the next morning. The findings are: Review of the facility's Incident Reports- Falls and Mobility Management Policy dated 10/01/20 revealed: -It is the policy of the facility to ensure residents are systematically assessed to determine their risk for falls and appropriate interventions to identify any potential issues and determine	D 271		

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procedures to be implemented to decrease fall and/or minimize injuries.
-Upon move in, with significant change in condition, every 6 months, annually and after every fall episode, the nurse will assess the resident to determine their risk for falls or repeat falls.
-A report will be submitted to the County Department of Social Services my mail, fax, email, or in person within 48 hours of the initial discovery or knowledge of the accident or incident.
-The Executive Director or Health Services Director will assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the any injury of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from time of initial discover or knowledge of the injury by staff and documented in the resident's file.
-Should a resident fall, the community must show documentation of an analysis of the circumstances of the fall and interventions that were initiated to prevent or reduce the risk of subsequent falls.

Review of Resident #4's current FL2 dated 09/22/23 revealed:
-Diagnoses included Alzheimer's dementia.
-Resident #4 was constantly disoriented.
-Resident #4's level of care was Special Care Unit (SCU).

Review of Resident #4's Pre-admission Screening dated 07/27/22 revealed:
-Resident #4 had a history of wandering behaviors.
-Resident #4 required assistance with dressing,

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bathing, and toileting.
-Resident #4 was able to feed self but required verbal cues.

Review of Resident #4's Care Plan dated 2/20/23 revealed:
-Resident #4 had a history of wandering.
-Resident #4 required supervision with bathing.
-Resident #4 was independent with ambulation and use of upper extremities.

Review of Resident #4's record on 11/15/23 and on revealed:
-There was no documentation of Resident #4 seeing an outside provider.
-There was no documentation of an Accident or Incident report.
-There was documentation of fall/injury risk assessment.

Review of Resident #4's hourly checks dated 11/11/23 revealed:
-There was documentation Resident #4 was checked on from 7:00am to 1:00pm.
-There was documentation at 10:00am Resident #4 complained her arm hurt and medication aides (MA's) were told/call family member.
-There was documentation Resident #4 went with her family member to the doctor's office after lunch.
-There was documentation Resident #4 was out of the facility at 2:00pm and 3:00pm.
-There were no other documentation hourly checks were completed.

Telephone interview with Resident #4's family member on 11/15/23 at 11:52am revealed:
-Resident #4's family came to visit her on 11/12/23.
-Resident #4's family member stated Resident #4

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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was holding her right arm and appeared to be in excruciating pain.
-Resident #4's family member took Resident #4 to an orthopedic urgent care facility where she was diagnosed with a right fractured elbow.
-The family member reported fracture to the facility.
-The family member was not notified of Resident #4 having a fall or of any an accident or incident where Resident #4 sustained an elbow fracture.
-The family member stated no one at the facility knew how Resident #4 fractured her elbow.

Review of Resident #4's 24-hour report dated 11/11/23 revealed Resident #4 complained about arm told MA's and to call the family member.

Review of Resident #4's progress note dated 11/13/23 revealed the Special Care Unit Coordinator (SCC) had spoken with Resident #4's family member who was to bring in doctor orders for the care of Resident #4's arm and sling and staff informed.

Interview with a personal care aide (PCA) on 11/17/23 at 12:00pm revealed:
-She worked first shift on 11/11/23.
-She had noticed that Resident #4's arm was hurting and reported it to the two MA's.
-She said that one of the MA's put a cream on Resident #4's arm.
-She did document Resident #4 complained of pain on the hourly checks and 24-hour report.

Interview with a MA on 11/17/23 at 1:30pm revealed:
-She was the assigned MA for Resident #4 on 11/11/23.
-She did know that Resident #4's arm was hurting.

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D 271	Continued From page 16 -She said the other MA working in the SCU on 11/11/23 applied diclofenac (used to treat aches, pains and problems with joints, muscles, and bones) to Resident #4's right arm. -She does not recall Resident #4 having a fall or being told Resident # 4 had fallen. -She did not document that Resident #4 had right arm pain. -She did not know if the other MA had documented Resident #2 having right arm pain. -She did not complete a skin assessment on Resident #4. -She did not report it to the following shift or to Resident #4's Primary Care Provider (PCP) of right arm pain. -She did not call Resident #4's family because she stated Resident #4 told her not to call her family member. Interview with a second MA on 11/20/23 at 3:18pm revealed: -She worked on 11/11/23 but was not assigned to Resident #4. -She did not recall the PCA telling her and the other MA working in the SCU on 11/11/23 that Resident #4 had right arm pain. -She knew Resident #4 very well, knew Resident #4 had an order for diclofenac gel (used to treat pain and other symptoms of arthritis of the joints such as inflammation, swelling, stiffness, and joint pain) and applied it to Resident #4's right arm. -She did not document that Resident #4 was having right arm pain. -She did not know if Resident #4's assigned MA documented resident having right arm pain. Attempted telephone interview with a third MA on 11/17/23 at 3:46pm was unsuccessful.	D 271		

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D 271	Continued From page 17 Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: -Resident #4 presented with right elbow pain. -The family member was unsure of a specific fall. -Resident #4 had a right nondisplaced radial neck fracture. -Resident #4 was placed in a posterior splint and given a sling. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was responsible for reviewing all 24-hour communication logs, including weekend logs, every morning, Monday through Friday. -The MA was responsible for adding progress note documentation if there was documentation on Resident #4's 24-hour communication log. -The MA was responsible for following up with the PCP regarding Resident #4's pain. Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She was unaware that Resident #4 had a fractured elbow. -The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow. -She expected the facility to notify her immediately of any resident accident or incident. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23. -The MA or SCC should have notified Resident #4's PCP when pain was reported. _____ The facility failed to immediately respond and provide care for Resident #4 after she was	D 271		

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D 271	Continued From page 18 observed by staff complaining of pain to her right elbow and staff did not seek immediate care for the injury of unknow origin resulting in the resident experiencing prolonged pain that was recognized by her family member the next day, which resulted in the resident being treated for a fractured right elbow. This failure placed all residents at substantial risk for physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on November 15, 2023, in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 20, 2023.	D 271		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Non-compliance continues with an increase in severity resulting in serious physical harm. THIS IS A TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 5 sampled residents (Resident #4 and #5) regarding failure to obtain orders and instructions	{D 273}		

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{D 273}	Continued From page 19 related to the care and treatment of fractures (#4 and #5). The findings are: Review of the facility's Health Care Referral and Follow-up training roster for medication aides (MA) from 10/12/23 to 11/13/23 revealed there was no documentation of training completed. 1. Review of Resident #4's current FL2 dated 09/22/23 revealed: -Diagnoses included Alzheimer's dementia. -Resident #4 was constantly disoriented. -Resident #4's level of care was Special Care Unit (SCU). Observation of Resident #4 on 11/14/23 at 9:55am revealed: -She was in the SCU sitting in a chair in the day room. -Her left arm was not in a sling that was hanging off of her shoulder and her left arm was hanging down straight. -The medication aide (MA) put her left arm back in the sling and tightened it up so that her left arm was comfortable across her abdomen and resting in the sling. Review of Resident #4's record on 11/15/23 revealed: -There was no documentation or doctor orders related to Resident #4's arm or sling. -There was no documentation of Resident #4 seeing an outside provider. Telephone interview with Resident #4's family member on 11/15/23 at 11:52am revealed: -Resident #4's family came to visit her on 11/12/23.	{D 273}		

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{D 273}	Continued From page 20 -Resident #4's family member stated Resident #4 "was holding her right arm and was in excruciating pain". -Resident #4's family member took Resident #4 to an orthopedic urgent care facility where she was diagnosed with a right fractured elbow. -Resident #4 was fitted for a splint and sling. -The family member reported fracture to the facility. -The family member did not give the facility any paperwork from the orthopedic provider. -The family member was not notified of Resident #4 having a fall or of any an accident or incident where Resident #4 could have sustained an elbow fracture. -The family member stated no one at the facility knew how Resident #4 fractured her elbow. -The family member took Resident #4 to an orthopedic care facility on 11/14/23 due to Resident #4 having swelling in her right hand. -Resident #4 returned to the facility on 11/14/23 without the splint due to the splint causing hand swelling. Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: -Resident #4 presented with right elbow pain. -The family member was unsure of a specific fall. -Resident #4 had a right nondisplaced radial neck fracture. -Resident #4 was placed in a posterior splint and given a sling. Review of Resident #4's orthopedic visit note dated 11/15/23 revealed: -Resident #4 was brought in by her family member due to swelling of her hand. -The provider discontinued Resident #4's splint only with sling still needing to be utilized.	{D 273}		

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{D 273}	Continued From page 21 Review of the facility's Stand-Up Meeting minutes dated 11/13/23 revealed there was documentation of Resident #4's fall and discussions with the family and to contact hospital discharge paperwork from visit on 11/12/23. Review of Resident #4's record on 11/16/23 revealed the facility did obtain Resident #4's physician progress notes from the orthopedic provider on 11/15/23 at 4:52pm. Interview with a personal care aide (PCA) on 11/17/23 at 12:00pm revealed: -She assisted Resident #4 with dressing on 11/17/23. -She assisted Resident #4 with putting on her sling. -She did not ask nor receive any instructions regarding the care and application of Resident #4's elbow sling. Interview with a MA on 11/17/23 at 1:30pm revealed she did not receive any instructions regarding the care and application of Resident #4's elbow sling and should have asked the other MA for instruction. Attempted telephone interview with a night shift MA on 11/17/23 at 3:46pm was unsuccessful. Interview with the Special Care Coordinator (SCC) on 11/20/23 at 1:20pm revealed: -She was aware on 11/13/23 that Resident #4 did not have any discharge instructions from the orthopedic provider to address care of Resident #4's splint and sling. -She did ask the family member to bring discharge instructions to the facility on 11/13/23. -She did not attempt to contact anyone regarding discharge paperwork for Resident #4's fracture	{D 273}		

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{D 273}	Continued From page 22 because she did not know where the family member had taken Resident #4. -She did not notify Resident #4's primary care provider (PCP) of Resident #4's fracture. -She did not contact Resident #4's PCP to obtain instructions to care for Resident #4's fracture. -It was her responsibility to ensure all appropriate paperwork was obtained from outside providers for the facility to follow physician orders. Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed: -She did not know Resident #4 had a fractured elbow. -The facility did not notify her or her practice that Resident #4 had complained of arm pain nor of her fractured elbow. -She expected the facility to notify her immediately. -The facility did not contact her regarding instructions related to fractured elbow and use of the splint or sling. -If the facility notified her related to the fracture, then Resident #4 could have increased pain due to not wearing a splint or it could be because of a change with the fracture as in worsening of the fracture. -She would have told the staff to watch for signs of worsening symptoms with a fracture such as increased swelling, increased pain and numbness/tingling in the arm and hand, all of which would have required an evaluation by a physician. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23. -She was not aware that Resident #4 did have any discharge instruction from the orthopedic	{D 273}		

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provider addressing care or Resident #4's splint and sling.
-The SCC was responsible to ensure all appropriate paperwork was obtained from outside providers for the facility to follow physician orders.
-If the facility did not have the appropriate paperwork to ensure care for the resident's, she expected the SCC to contact the resident's PCP.

2. Review of Resident #5's current FL2 dated 04/21/23 revealed:
-Diagnoses included vascular dementia with behavioral disturbance.
-Resident #5 was constantly disorientated.
-Resident #5's level of care was SCU.

Review of Resident #5's Accident and Incident report dated 11/10/23 revealed:
-Resident #5 was sitting upright in a chair at approximately 11:30pm, he reached over the left side of the chair to pick something up off the floor he fell over with the chair getting stuck between his legs.
-Staff removed the chair, assessed resident then noticed his lips turning blue with vomiting a few moments later.
-Staff called 911.
-There was documentation of no injuries observed at time of incident.
-Resident's family member was notified of the incident at 12:43am.
-There was no documentation of the facility notifying Resident #5's PCP.

Observation of Resident #5 on 11/15/23 at 11:07am revealed Resident sitting in a chair in the dinning room with a splint partially covered by his sock on his left lower extremity.

Review of Resident #5's record on 11/15/23

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revealed:
-There were no instructions related to the care of Resident #5's splint.
-There was no discharge summary or emergency department visit notes.
-There was a copy of emergency department paperwork that listed Resident #5's current medications, a picture of a left foot/ankle but did not have any instructions or physician orders documented.

Review of Resident #5's progress note dated 11/10/23 revealed:
-Late entry documented and progress note was entered on 11/14/23 at 12:22pm.
-Resident #5 was sitting upright in a chair at approximately 11:30pm, he reached over the left side of the chair to pick something up off the floor he fell over with the chair getting stuck between his legs.
-Staff removed the chair, assessed resident then noticed his lips turning blue with vomiting a few moments later.
-Staff called 911.

Telephone interview with Resident #5's family member on 11/16/23 at 3:47pm revealed:
-The family member was notified that Resident #5 had fallen out of a chair and was sent to the emergency department, 45 minutes after Resident #5's fall.
-The family member went to the emergency department where they informed her that Resident #5 had a fractured left ankle.
-The family member transported Resident #5 back to the facility and gave staff the emergency department paperwork.

Review of the facility's Stand-Up Meeting minutes dated 11/13/23 revealed there was

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{D 273}	Continued From page 25 documentation Resident #5 fell on 11/10/23. Interview with a MA on 11/15/23 at 11:00am revealed she did not receive any training on referral and follow-up related to resident's issues/concerns from 10/01/23 through 11/14/23. Interview with a MA on 11/15/23 at 2:05pm revealed: -She was aware that Resident #5 had fallen and fractured his left ankle. -A night shift MA had placed splint on Resident #5. -She was not aware of any instructions for Resident #5's splint. Attempted telephone interview with a night shift MA on 11/17/23 at 3:46pm was unsuccessful. Telephone interview with Resident #5's PCP on 11/16/23 at 8:45am and on 11/20/23 at 12:40pm revealed: -She did not know Resident #5 had a fractured ankle prior to speaking with a surveyor. -She expected the facility to notify her immediately. -If the fracture had been reported to her by the facility, she would have seen Resident #5 during facility rounds on 11/14/23. -She was not contacted regarding care of Resident #5's left ankle fracture. -If the facility notified her related to the fracture, then Resident #5 could have increased pain due to not wearing a splint or it could be because of a change with the fracture as in worsening of the fracture. -She would have told the staff to watch for signs of worsening symptoms with a fracture such as increased swelling, increased pain and numbness/tingling in the foot, all of which would	{D 273}		

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have required an evaluation by a physician.
-On 11/17/23, Resident #5's family member did contact her regarding fall with ankle fracture and a Hospice referral.

Interview with the SCC on 11/16/23 at 10:25am and 11/20/23 at 1:20pm revealed:
-She first started as the SCC one month ago.
-She was not aware Resident #5 did not have any discharge instructions from the emergency department to address care of his left ankle fracture prior to 11/15/23.
-She did not notify Resident #5's PCP of his fractured ankle.
-She did not contact Resident #5's PCP to obtain instructions to care for his fractured ankle.
-She was responsible for obtaining and reviewing the 24 hour and the 72 hour reports.
-She did not receive additional in-services related to notification to the physician from 10/11/23 through 11/14/23.
-It was her responsibility to ensure all appropriate paperwork was obtained from outside providers for the facility to follow physician orders.

Interview with the facility's Compliance Nurse on 11/15/23 at 11:07am and 11/20/23 at 3:34pm revealed:
-She was a Registered Nurse who began working at the facility about a month ago.
-She did not receive an in-service related to notification of the physician or follow up.
-The SCC/RCC was responsible for reviewing the 24 hour and 72 hour reports, prior to the morning stand ups.
-The SCC/RCC was responsible for notifying the physician about any injuries sustained by a resident.
-She would then be responsible for making sure those referrals were taken care of and assist if

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{D 273}	Continued From page 27 the SCC/RCC needed help. -She was not aware of any injuries that required a follow-up with the physician therefore she could not follow-up with anything. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She was not aware that Resident #5 had any discharge instructions or physician orders from his visit to the emergency department on 11/10/23 addressing care for his fractured ankle/splint. -It was the SCC's responsibility to ensure all appropriate paperwork was obtained from outside providers for the facility to follow physician instructions/orders. -If the facility did not have the appropriate paperwork to ensure care for the residents, she expected the SCC to contact the resident's PCP. -The SCC/RCC was responsible for reviewing the 24 hour and 72 hour reports prior to the morning stand up meetings. -This was a process issue meaning, checks were put in place for the SCC/RCC to report to the Compliance Nurse to assist them with it. -There were two additional nurses hired to assist the Compliance Nurse when needed to fill in for the SCC or RCC when they had to complete other duties such as filling in for a MA or if they were out of the facility for any reason. -When the SCC/RCC did not complete their checks and report to the Compliance Nurse, then the Compliance Nurse could not assist with issues and use the other two nurses for help. -The SCC, RCC, Compliance Nurse, and herself reviewed and discussed residents during the daily stand-up meetings and expected issues to be corrected by the next day. _____	{D 273}		

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{D 273}	Continued From page 28 The facility failed to ensure referral and follow-up for 2 of 5 sampled residents (Resident #4 and #5) regarding failure to follow up with the provider to obtain physician orders and instructions related to the care and treatment of a right nondisplaced radial neck fracture due to an unwitnessed fall (#4) and failure to follow up with the provider to obtain physician orders and instructions related to the care and treatment of a resident with a left ankle fracture (#5). This failure resulted in serious neglect and injury which constitutes a Type A1 Violation. _____ The facility provided a plan of protection on November 17, 2023 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 20, 2023.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased	{D 358}		

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{D 358}	Continued From page 29 severity resulting in residents placed at substantial risk that serious physical harm will occur. THIS IS A TYPE A2 VIOLATION. Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (Resident #7 and #6) observed during the medication pass on 11/15/23 at 7:30am, for medications to lower blood pressure and to treat anemia (#7), and missed medications for blood pressure and edema (#6), and 2 of 5 sampled residents (Resident #2 and #5) related to missed medications for high cholesterol and cellulitis (#2), and a medication to treat hypothyroidism (#5). The findings are: Review of the facility's undated morning routine policy revealed: -The Special Care Unit Coordinator (SCC) and the Resident Care Coordinator (RCC) was responsible for printing and reviewing the Medication Audit Report every morning before the stand up meeting. -The Medication Audit Report contained missed medications. -The SCC/RCC were responsible for obtaining the 24 hour and the 72 hour report, for the exceptions on medications and review the progress notes. -The SCC/RCC were responsible for follow-up with the pharmacy related to the status of the medications missing. -The SCC/RCC were responsible for notification to the Primary Care Provider (PCP) and Power of Attorney (POA).	{D 358}		

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{D 358}	Continued From page 30	{D 358}		

-The SCC/RCC were responsible for discussing the missed medications with the Administration in the morning stand up meetings.

1. Review of Resident #7's current FL2 dated 11/09/23 revealed diagnoses included hypertension, atherosclerotic heart disease, coronary artery disease without angina, a right bundle branch block (a condition that causes irregular heartbeat) and anemia (lack of healthy blood cells).

a. Review of Resident #7's current FL2 dated 11/09/23 revealed there was an order for amlodipine besylate 10 mg (used to treat high blood pressure) every day.

Review of Resident #7's previous order dated 08/19/23 revealed an order for amlodipine besylate 10mg every day.

Observation of the medication pass on 11/08/23 at 7:32am revealed:
-The medication aide (MA) was administering Resident #7's morning medications.
-Resident #7's amlodipine besylate 10mg was not available to administer to Resident #7.

Review of Resident #7's October 2023 electronic Medication Administration Record (eMAR) revealed.
-There was an entry dated 08/19/23 for amlodipine besylate 10mg, one tablet daily.
-Resident #7's amlodipine besylate 10mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 10/01/23, and 10/02/23.

Review of Resident #7's progress notes revealed Resident #7's amlodipine besylate was not

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administered on 10/01/23 and 10/02/23 due to the medication not being available.

Review of Resident #7's November 2023 eMAR revealed.
-There was an entry dated 08/19/23 for amlodipine besylate 10mg, one tablet daily.
-Resident #7's amlodipine besylate 10mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 11/03/23, 11/06/23, 11/10/23 through 11/15/23.

Review of Resident #7's progress notes revealed:
-Resident #7's amlodipine besylate was not administered on 11/03/23 due to needing the medication.
-Resident #7's amlodipine besylate was not administered on 11/06/23, 11/10/23, through 11/15/23 due to the medication unavailable.

Observation of Resident #7's medications available for administration on 11/15/23 at 7:32am revealed there was no amlodipine besylate available for administration.

Review of Resident #7's blood pressures (BP) revealed:
-On 10/25/23, his BP was documented as 134/88 (normal BP was less than 120/80).
-On 11/02/23, his BP was documented as 142/84.

Telephone interview with a representative with the facility's contracted pharmacy on 11/15/23 at 10:15am revealed:
-There was an order for amlodipine besylate 10mg, one tablet daily dated 08/18/23 documented for Resident #7.
-On 08/18/23, there were 30 doses of amlodipine besylate 10mg dispensed to the facility for

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{D 358}	Continued From page 32 Resident #7. -On 09/22/23, there were 28 doses of amlodipine besylate 10mg dispensed to the facility for Resident #7. -The cycle fill pharmacy technician attempted to notify the facility a few days prior to the end of the cycle to obtain a new refill of the amlodipine 10mg but the facility did not follow up with the refill prescription of the amlodipine besylate 10mg every day. -On 10/20/23 the amlodipine besylate was not dispensed to the facility on a 28-day cycle because the facility did not provide a refill prescription of the amlodipine besylate 10mg every day. -On 11/15/23, the facility requested a refill of Resident #7's amlodipine besylate 10mg but there was no refill left. -They did not receive Resident #7's signed physician's order written on the FL2 dated 11/09/23. -The amlodipine besylate was not refilled since 09/22/23 and he would have been out of amlodipine besylate on 10/20/23. -Resident #7 required 26 more doses of amlodipine besylate, from 10/20/23 to 11/15/23, to follow the PCP's order. Interview with a MA on 11/15/23 at 11:00am revealed: -On 11/06/23 during her medication pass was the first time she noticed Resident #7 did not have any amlodipine besylate 10mg to administer, so she documented the amlodipine besylate as "medication unavailable" and notified the lead MA of the missing amlodipine. -On 11/10/23 during her medication pass was the next time she noticed Resident #7 did not have any amlodipine besylate 10mg to administer, so she documented the amlodipine besylate as	{D 358}		

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"medication unavailable" and notified the lead MA of the missing amlodipine.
-The lead MA was to notify the SCC about the missing medications.

Interview with Resident #7's Primary Care Physician (PCP) on 11/15/23 at 9:25am revealed:
-She was not notified Resident #7 was not receiving his amlodipine besylate or that the pharmacy required a refill prescription.
-It was the responsibility of the facility to notify her about Resident #7 was out of his amlodipine and that a refill prescription was required by the pharmacy.
-Resident #7's ongoing elevated blood pressures could be a result of not receiving the amlodipine.
-Amlodipine was used to decrease Resident #7's blood pressure by relaxing the blood vessels so the heart did not have to work so hard and decrease damage to his heart.
-Resident #7 not receiving his amlodipine besylate could cause damage to his heart and increase the risk of a heart attack, heart failure or stroke.

Interview with the facility Compliance Nurse on 11/15/23 at 11:07am revealed:
-She was a Registered Nurse who began working at the facility about a month ago.
-She was not aware Resident #7 did not have amlodipine to administer and was out of the medication for over a week.

Interview with the SCC on 11/16/23 at 10:25am revealed:
-On 11/12/23 she administered Resident #7's morning medications, and the amlodipine besylate was not on the medication cart for administration.
-She reported the amlodipine besylate missing in

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the morning stand up meeting around 9:30am but did not notify the pharmacy because she forgot due to passing medications that day and other duties.

Interview with the Administrator on 11/20/23 at 4:38pm revealed she was not aware Resident #7's amlodipine was missing and that it was not re-ordered and not administered to Resident #7.

b. Review of Resident #7's current FL2 dated 11/09/23 revealed there was an order for ferrous sulfate (a type of iron used to treat anemia) 325mg every day.

Review of Resident #7's previous order dated 10/12/23 revealed an order for ferrous sulfate 325mg every 12 hours.

Review of Resident #7's previous order dated 10/19/22 revealed an order for ferrous sulfate 325mg every day.

Observation of the medication pass on 11/15/23 at 7:32am revealed:
-The MA was administering Resident #7's morning medications.
-Resident #7's ferrous sulfate 325mg was not available to administer to Resident #7.

Review of Resident #7's October 2023 eMAR revealed.
-There was an entry dated 10/12/23 for ferrous sulfate 325mg, every 12 hours.
-Resident #7's ferrous sulfate 325mg was documented not administered with the exception code "09" indicating "other/see nurse notes" on 10/13/23, 10/14/23, 10/15/2310/18/23 at 9:00am and 10/14/23 and 10/17/23 at 9:00pm.
-There was an entry dated 10/19/23 for ferrous

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sulfate 325mg one tablet daily.
-Resident #7's ferrous sulfate 325mg was documented not administered with the exception code "09" indicating "other/see nurse notes" on 10/19/23.

Review of Resident #7's progress notes revealed Resident #7's ferrous sulfate was not administered on 10/11/23, 10/13/23, 10/14/23,10/15/23, 10/17/23, 10/18/23, and 10/19/23 due to the medication not being available.

Review of Resident #7's November 2023 eMAR revealed.
-There was an entry dated 10/19/23 for ferrous sulfate 325mg, one tablet daily.
-Resident #7's ferrous sulfate 325mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 11/06/23, 11/10/23 through 11/15/23.

Review of Resident #7's progress notes revealed Resident #7's ferrous sulfate was not administered on 11/06/23, 11/10/23, through 11/15/23 due to the medication unavailable.

Review of the facility's contracted pharmacy medication to medication cart audit dated 10/18/23 revealed Resident #7's ferrous sulfate 325mg was not available for administration.

Telephone interview with a representative with the facility's contracted pharmacy on 11/15/23 at 10:15am revealed:
-Resident #7 had an order for ferrous sulfate 325mg, one tablet daily dated 10/18/23.
-On 10/19/23, there were 12 doses of ferrous sulfate 325mg dispensed to the facility for Resident #7.

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{D 358}	Continued From page 36 -On 11/15/23, the facility requested a refill of Resident #7's ferrous sulfate 325mg but there was no refill left so the remaining 26 doses from the 10/18/23 refill was dispensed to the facility for Resident #7. -The cycle fill pharmacy technician attempted to notify the facility a few days prior to the end of the cycle to obtain a new refill of the ferrous sulfate 325mg but the facility did not follow up with the refill prescription of the ferrous sulfate 325mg every day. -On 11/01/23 the ferrous sulfate was not dispensed to the facility on a 28-day cycle because the facility did not provide a refill prescription of the ferrous sulfate 325mg every day. -They did not receive Resident #7's order from the FL2 dated 11/09/23. -The ferrous sulfate was not refilled since 10/18/23 and would have been out on 11/01/23. -Resident #7 required 15 more doses of amlodipine, on 11/01/23 to 11/15/23, to follow the PCP's order. Interview with a MA on 11/15/23 at 11:00am revealed: -On 11/06/23 during her medication pass was the first time she noticed Resident #7 did not have any ferrous sulfate 325mg to administer, documented the ferrous sulfate as "medication unavailable" and notified the lead MA of the missing ferrous sulfate. -On 11/10/23 during her medication pass was the next time she noticed Resident #7 did not have ferrous sulfate 325mg to administer, documented the ferrous sulfate as "medication unavailable" and notified the lead MA of the missing ferrous sulfate. Interview with Resident #7's Primary Care	{D 358}		

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{D 358}	Continued From page 37 Physician (PCP) on 11/15/23 at 9:25am revealed: -She was not notified Resident #7 missed doses of his ferrous sulfate and required a refill prescription. -Resident #7 was anemic and required ferrous sulfate using iron to make healthy blood cells which were used to carry oxygen through the body to help prevent a heart attack or stroke. -Not getting the ferrous sulfate put Resident #7 at a higher risk of a heart attack or stroke. Interview with the facility Compliance Nurse on 11/15/23 at 11:07am revealed: -She was a Registered Nurse who began working at the facility about a month ago. -She was not aware Resident #7 did not have ferrous sulfate to administer and was out of the medication for over a week. Interview with the SCC on 11/16/23 at 10:25am revealed: -On 11/12/23 she administered Resident #7's morning medications, and the ferrous sulfate was not on the medication cart for administration. -She reported the ferrous sulfate missing in the morning stand up meeting around 9:30am but did not notify the pharmacy because she forgot due to passing medications that day and other duties. Interview with the Administrator on 11/20/23 at 4:38pm revealed she was not aware Resident #7's ferrous sulfate was missing and that it was not re-ordered and not administered to Resident #7. Refer to interview with a MA on 11/15/23 at 11:00am. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am.	{D 358}		

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{D 358}	Continued From page 38 Refer to interview with the SCC on 11/16/23 at 10:25am. Refer to interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm Refer to interview with the Administrator on 11/20/23 at 4:45pm. 2. Review of Resident #6's current FL2 dated 11/09/23 revealed: -Diagnoses included hypertension, mild cognitive impairment, and hyperlipidemia. -There was an order for hydrochlorothiazide 12.5mg (used to treat high blood pressure and edem (swelling) one tablet by mouth daily. Review of Resident #6's FL2 dated 04/03/23 revealed there was an order for hydrochlorothiazide 12.5mg one tablet by mouth daily. Review of Resident #6's signed physician order sheet dated 07/14/23 revealed: -There was an order for hydrochlorothiazide 12.5mg one tablet by mouth daily. -The original order date was 04/07/23. Review of Resident #6's Resident Register revealed an admission date of 04/07/23. Observation of the medication pass on 11/15/23 at 7:30am revealed: -The medication aide (MA) administered Resident #6's morning medications. -Resident #6's hydrochlorothiazide 12.5mg was	{D 358}		

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{D 358}	Continued From page 39 not available to administer. Interview with a MA on 11/15/23 at 12:05pm revealed: -Resident #6's responsible party (RP) delivered medications to the facility that were filled at her preferred pharmacy. -In the past, the MAs had to wait for the RP to bring the medications to the facility. -Resident #6 was currently out of hydrochlorothiazide. -She had requested a new order today from the primary care provider (PCP) and will fax it to the pharmacy once obtained. Review of Resident #6's October 2023 electronic medication administration record (eMAR) revealed. -There was an entry for hydrochlorothiazide 12.5mg daily. -Resident #6's hydrochlorothiazide 12.5mg was documented as administered from 10/01/23 to 10/31/23 at 8:00am. Review of Resident #6's November 2023 eMAR revealed. -There was an entry for hydrochlorothiazide 12.5mg, daily. -Resident #6's hydrochlorothiazide 12.5mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 11/06/23, 11/07/23, 11/10/23, 11/11/23 and 11/16/23 at 8:00am. -Resident #6's hydrochlorothiazide 12.5mg was documented as administered on 11/01/23 to 11/05/23, 11/08/23, 11/09/23, and 11/12/23 to 11/14/23. Review of Resident #6's progress notes from 10/27/23 to 11/16/23 revealed:	{D 358}		

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WICKSHIRE STEELE CREEK	13600 S TRYON ST CHARLOTTE, NC 28278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 40 -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/06/23, 11/07/23, and 11/10/23, due to "awaiting pharmacy". -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/11/23 and 11/16/23, due to "medication unavailable". -There was no documentation related to medications documented as administered on 11/08/23, 11/09/23, and 11/12/23 to 11/14/23 when there was no hydrochlorothiazide available on the medication cart. Review of Resident #6's progress notes from 11/06/23 to 11/14/23 revealed hydrochlorothiazide was not administered on 4 occasions due to the medication not being available. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/15/23 at 10:32am revealed: -They entered Resident #6's medications to be listed on the eMAR. -They never filled medications for Resident #6 because she used an outside pharmacy Telephone interview with the pharmacist at Resident #6's preferred pharmacy on 11/15/23 at 11:02am revealed: -There was an active order for hydrochlorothiazide 12.5mg, take one tablet daily for Resident #6. -Hydrochlorothiazide 12.5mg was dispensed on 01/16/23 for a quantity of 90 tablets and again on 02/02/23 for a quantity of 90 tablets for Resident #6. -This medication was dispensed to Resident #6 when she lived in another state (prior to her admission to the facility). -There was one refill left for hydrochlorothiazide. -The pharmacy had not received any orders for	{D 358}		

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{D 358}	Continued From page 41 hydrochlorothiazide and had not dispensed any hydrochlorothiazide for Resident #6 since 02/02/23. Telephone interview with Resident #6's RP on 11/16/23 at 11:10am and 2:28pm revealed: -When Resident #6 was admitted to the facility she brought all medications that were filled prior to Resident #6's admission on 04/07/23. -She always tried to get 90-day supplies and brought refills before Resident #6 ran out of medications. -She found out today (11/16/23) that the hydrochlorothiazide was last filled by Resident #6's preferred pharmacy on 02/04/23. -The facility did notify her when medication refills were needed, but she was not notified of the hydrochlorothiazide doses that were missed in November 2023. Telephone interview with a MA on 11/17/23 at 3:30pm revealed: -On 11/15/23, during the medication pass, Resident #6 did not have any hydrochlorothiazide 12.5mg to administer. -Resident #6 was out of her hydrochlorothiazide for one to two weeks. -Resident #6 could borrow the medication from her spouse who was also a resident in the facility. -The MA called Resident #6's RP on 11/15/23 and 11/16/23 to get refills from the preferred pharmacy. -The RP told her that the resident didn't have any medications to be filled. -The MA faxed over the 6 month signed physician orders dated 07/14/23 to the preferred pharmacy. -The RCC had the fax confirmation. -She did not know if there were any faxes sent for hydrochlorothiazide before this week.	{D 358}		

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{D 358}	Continued From page 42 Interview with Resident #6's PCP on 11/16/23 at 8:40am revealed: -She had sent an electronic prescription in June 2023 for hydrochlorothiazide with 11 refills to Resident #6's preferred pharmacy. -Resident #6 was taking hydrochlorothiazide to treat high blood pressure and edema. -Not taking hydrochlorothiazide could affect the Resident's blood pressure and edema. -The resident lived out of state prior to her admission to the facility. -She believed Resident #6 had used the facility's contracted pharmacy initially and then switched over to a preferred pharmacy. -She was not notified that the hydrochlorothiazide was not available until June 2023. -This was the only time staff notified her of missing medications. Interview with the RCC on 11/20/23 at 12:33pm revealed: -He had not had any issues with receiving Resident #6's medications. -Resident #6 was possibly out of her medication since the middle of July 2023. -There was no way to tell what medications were received for Resident #6 upon admission, or from Resident 6's preferred pharmacy. -Resident #6's RP brought in her medication from her preferred pharmacy. -He could not verify if hydrochlorothiazide was dispensed between July 2023 to present. -He was not aware that she was out of hydrochlorothiazide and not sure how long she was out of the medication Interview with the facility's Compliance Nurse on 11/20/23 at 3:35pm revealed: -She was not aware of missing hydrochlorothiazide for Resident #6 until	{D 358}		

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{D 358}	Continued From page 43 11/15/23, when surveyors brought it to her attention. -She expected medications to be on the cart for Resident #6. Interview with the Administrator on 11/20/23 at 4:45pm revealed: -She was not aware of any issues with Resident #6's medications. -She was not aware that staff were documenting "09" code for Resident #6 and then documenting a medication was administered when they were clearly unavailable. -She expected the MA and RCC to notify the PCP of any missed medications. -She did not know if the backup pharmacy was ever contacted for Resident #6. -She was not aware that Resident #6 was out of hydrochlorothiazide. Refer to interview with a MA on 11/15/23 at 11:00am. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am. Refer to interview with the SCC on 11/16/23 at 10:25am. Refer to interview with the Resident RCC on 11/20/23 at 12:33pm. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm Refer to interview with the Administrator on 11/20/23 at 4:45pm. 3. Review of Resident #2's current FL2 dated 04/03/23 revealed diagnoses included chronic	{D 358}		

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{D 358}	Continued From page 44 obstructive pulmonary disease, hyperlipidemia and hypertension. a. Review of Resident #2's current FL2 dated 04/03/23 revealed there was an order for atorvastatin (a medication used to treat abnormal lipid levels) 80mg daily. Review of Resident #2's Primary Care Provider's (PCP) order dated 09/07/23 revealed an order for atorvastatin 80mg daily. Observation of the medication cart on 11/15/23 at 9:40am revealed Resident #2's atorvastatin 80mg was not available for administration. Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 04/12/23 for atorvastatin 80mg, one tablet daily. -Resident #2's atorvastatin 80mg was documented as administered daily between 10/27/23 and 10/31/23. Review of Resident #2's October 2023 progress notes revealed there was no documentation related to Resident #2's atorvastatin 80mg. Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 04/12/23 for atorvastatin 80mg, one tablet daily. -Resident #2's atorvastatin 80mg was documented as administered daily between 11/01/23 and 11/13/23. Review of Resident #2's November 2023 progress notes revealed there was no	{D 358}		

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{D 358}	Continued From page 45 documentation related to Resident #2's atorvastatin 80mg. Interview with Resident #2 on 11/14/23 between 10:00am and 11:30am revealed: -He was prescribed numerous medications and did not recall most of medications or what they were used to treat. -His daily medications were stored by the facility and administered daily by MAs. Interview with a first shift MA on 11/17/23 at 3:30pm revealed: -Resident #2 was prescribed atorvastatin 80mg daily. -Upon Resident #2's admission to the facility, there was no documentation of Resident #2's atorvastatin 80mg being brought to the facility by Resident #2's RP. -Resident #2 utilized a local pharmacy for his medication refills. -Resident #2's RP was responsible to request Resident #2's atorvastatin 80mg refills. -Resident #2's RP was responsible to deliver Resident #2's atorvastatin 80mg to the facility. -Resident #2's RP was not aware Resident #2's atorvastatin 80mg was not on the medication cart. -If Resident #2's atorvastatin 80mg was not available for administration, the facility was to request a refill from the facility's contracted pharmacy until Resident #2's RP delivered Resident #2's atorvastatin 80mg from Resident #2's local pharmacy. Telephone interview with the facility's contracted pharmacist on 11/15/23 at 10:29am revealed: -The pharmacy maintained a profile for Resident #2's medications. -Resident #2 did not utilize the pharmacy for medication refills.	{D 358}		

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{D 358}	Continued From page 46 -The facility had not requested a refill of Resident #2's atorvastatin 80mg. Telephone interview with the pharmacist at Resident #2's preferred pharmacy on 11/15/23 at 2:48pm revealed: -Resident #2 utilized the pharmacy for atorvastatin 80mg one tablet daily refills. -Resident #2's atorvastatin 80mg was last filled on 01/16/23 for 90 doses. -The facility or Resident #2's RP were responsible to request refills of Resident #2's atorvastatin 80mg. -There were no additional refill requests for Resident #2's atorvastatin 80mg. -Resident #2's RP was responsible for delivery of Resident #2's medications to the facility. -Atorvastatin 80mg was used to treat high cholesterol to prevent myocardial infarctions and cerebrovascular accidents. Telephone interview with Resident #2's RP on 11/16/23 at 3:17pm revealed: -Resident #2 was admitted to the facility on 04/07/23. -Upon Resident #2's admission on 04/07/23, she brought any medications Resident #2 had to the facility but did not recall if Resident #2's atorvastatin 80mg was brought to the facility. -She or the facility were responsible to request Resident #2's medication refills. -The facility was responsible to notify her when Resident #2's medication refills were called into Resident #2's local pharmacy. -She was responsible to deliver Resident #2's medications to the facility. -She had no record of Resident #2's atorvastatin 80mg being requested since Resident #2's admission to the facility.	{D 358}		

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Telephone interview with Resident #2's PCP on 11/16/23 at 8:45am revealed:
-Resident #2 was prescribed atorvastatin 80mg daily to treat Resident #2's cholesterol.
-She expected the facility to ensure Resident #2's atorvastatin 80mg was administered as prescribed.
-She expected the facility to request Resident #2's atorvastatin 80mg refills in accordance with the facility's refill policy, usually within one-week of the last dose.
-She expected the facility to notify her if Resident #2's atorvastatin 80mg was not available for administration.
-She was not aware Resident #2's atorvastatin 80mg daily was not available for administration.
-Resident #2 was at risk of a myocardial infarction or cerebrovascular accident if his atorvastatin 80mg was not administered as order.

Interview with the facility's Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed:
-MAs were responsible to request refills of resident's medications within the last seven doses.
-The facility was responsible to request Resident #2's refills from Resident #2's local pharmacy.
-Resident #2's RP was responsible to deliver Resident #2's medications to the facility.
-He was not aware Resident #2's atorvastatin 80mg daily was unavailable for administration.

Interview with the facility's Registered Nurse (RN) on 04/20/23 at 3:33pm revealed she was not aware Resident #2's atorvastatin 80mg daily was not available for administration.

Interview with the facility Administration on 04/20/23 at 4:20pm revealed she was not aware

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{D 358}	Continued From page 48 Resident #2's atorvastatin 80mg daily was not available for administration. b. Review of Resident #2's current FL2 dated 04/03/23 revealed there was an order for doxycycline (a medication used to treat and prevent infection) 100mg daily. Review of Resident #2's Primary Care Provider's (PCP) order dated 09/07/23 revealed an order for doxycycline 100mg twice daily. Observation of the medication cart on 11/15/23 at 9:40am revealed Resident #2's doxycycline 100mg twice daily was filled on 11/03/23 for 60 doses. Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 04/25/23 for doxycycline 100mg twice daily at 6:00am and 8:00pm for wound healing. -Doxycycline 100mg twice daily was documented with the exception code "09" indicating 'other/see nurse note" for two doses on 10/27/23, for one dose on 10/28/23, for two doses on 10/29/23, and for one dose on 10/30/23. Review of Resident #2's October 2023 progress notes revealed: -There was an entry on 10/27/23 at 5:51am which documented "medication unavailable, RCC aware." -There was an entry on 10/27/23 at 8:23pm which documented doxycycline 100mg was on order. -There was an entry on 10/28/23 at 6:33am which documented doxycycline 100mg was on order. -There was an entry on 10/28/23 at 5:58pm which documented doxycycline 100mg was not	{D 358}		

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available.
-There was an entry on 10/29/23 at 7:58pm which documented doxycycline 100mg "family is supposed to supply."
-There was an entry on 10/30/23 at 7:56pm which documented "medication unavailable, RCC aware, family aware."
-There were no additional entries related to doxycycline 100mg twice daily.

Review of Resident #2's November 2023 eMAR revealed:
-There was an entry dated 04/25/23 for doxycycline 100mg twice daily at 6:00am and 8:00pm.
-Doxycycline 100mg twice daily was documented with the exception code "09" indicating 'other/see nurse note" for two doses on 11/01/23, 11/02/23, 11/03/23, and for one dose on 11/04/23.

Review of Resident #2's November 2023 progress notes revealed:
-There was an entry on 11/01/23 at 7:59pm which documented doxycycline 100mg was not administered because the medication was not available.
-There was an entry on 11/02/23 at 5:56am which documented "medication unavailable."
-There was an entry on 11/02/23 at 8:43pm which documented doxycycline 100mg was "unavailable."
-There was an entry on 11/03/23 at 6:09am which documented doxycycline 100mg was "unavailable."
-There was an entry on 11/03/23 at 6:09am which documented "medication unavailable, RCC and physician aware."
-There was an entry on 11/04/23 at 5:49am which documented "medication unavailable, RCC and physician aware, waiting on family to delivery

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{D 358}	Continued From page 50 medication." Interview with Resident #2 on 11/14/23 between 10:00am and 11:30am revealed: -He was prescribed an antibiotic to treat his leg wounds to prevent infection. -His daily medications were stored by the facility and administered by MAs. -In October 2023, the MAs occasional did not administer his antibiotic because it was not available. -In early November 2023, he notified his RP to refill his antibiotic. -He was administered his antibiotic on 11/14/23. Telephone interview with a second shift MA on 11/16/23 at 4:35pm revealed: -Resident #2 was prescribed doxycycline 100mg twice daily. -In late October 2023 and early November 2023, she documented in Resident #2's progress notes related to Resident #2's doxycycline 100mg medication not available for administration. -In late October 2023 and early November 2023, Resident #2's doxycycline 100mg was the only medication she documented as not being available for administration. -Resident #2's RP was responsible to request Resident #2's doxycycline 100mg for refill and to delivery Resident #2's doxycycline 100mg to the facility. -In late October 2023 and early November 2023, she had documented notifying Resident #2's PCP and the RCC related to Resident #2's doxycycline 100mg but may not have communicated with the PCP or RCC. -She was not responsible for requesting a refill for Resident #2's doxycycline 100mg from the facility's contracted pharmacy if the medication was not available for administration.	{D 358}		

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{D 358}	Continued From page 51 Interview with a first shift MA on 11/17/23 at 3:30pm revealed: -Resident #2 was prescribed doxycycline 100mg twice daily. -Resident #2 utilized a local pharmacy for his medication refills. -Resident #2's RP was responsible to request Resident #2's doxycycline 100mg refills. -Resident #2's RP was responsible to deliver Resident #2's doxycycline 100mg to the facility. -In late October 2023 and early November 2023, she was aware Resident #2's doxycycline 100mg was not on the medication cart and the facility was waiting on Resident #2's RP to fill and delivery Resident #2's doxycycline 100mg. -In late October 2023 and early November 2023, a second shift MA had notified her related to Resident #2's doxycycline 100mg not being available for administration. -If Resident #2's doxycycline 100mg was not available for administration, the facility was to request a refill from the facility's contracted pharmacy until Resident #2's RP delivered doxycycline 100mg. -The facility had not requested a refill of Resident #2's doxycycline 100mg from the facility's contracted pharmacy in October 2023 or November 2023. Telephone interview with the facility's contracted pharmacist on 11/15/23 at 10:29am revealed: -The pharmacy maintained a profile for Resident #2's medications. -Resident #2 did not utilize the pharmacy for medication refills. -Resident #2's doxycycline 100mg medication was not filled by the pharmacy in October 2023 or November 2023.	{D 358}		

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{D 358}	Continued From page 52 Telephone interview with the pharmacist at Resident #2's preferred pharmacy on 11/15/23 at 2:48pm revealed: -Resident #2 utilized the pharmacy for doxycycline 100mg refills. -Resident #2's doxycycline 100mg required a request for refill every 30 days. -Resident #2's doxycycline 100mg twice daily was filled on 10/07/23 for 60 doses. -Resident #2's doxycycline 100mg twice daily was dispensed to Resident #2's RP on 10/07/23. -Resident #2's doxycycline 100mg twice daily was filled on 11/03/23 for 60 doses. -Resident #2's doxycycline 100mg twice daily was dispensed to Resident #2's RP on 11/04/23. -The facility or Resident #2's RP were responsible to request refills of Resident #2's doxycycline 100mg. -Resident #2's RP was responsible for delivery of Resident #2's medications to the facility. -Doxycycline 100mg twice daily was used to treat infections. -If Doxycycline 100mg was not administered as order, antibiotic resistance could occur or onset of infection. Telephone interview with Resident #2's RP on 11/16/23 at 3:17pm revealed: -She or the facility were responsible to request Resident #2's medication refills. -The facility was responsible to notify her when Resident #2's medication refills were called into Resident #2's local pharmacy. -She was responsible to deliver Resident #2's medications to the facility. -In early November 2023, Resident #2 notified her that his doxycycline 100mg had not been administered for a few days. -On 11/03/23, she requested a refill of Resident #2's doxycycline 100mg from Resident #2's local	{D 358}		

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pharmacy and delivered Resident #2's doxycycline 100mg to the facility during second shift on 11/04/23.

Telephone interview with Resident #2's PCP on 11/16/23 at 8:45am revealed:
-Resident #2 was prescribed doxycycline 100mg twice daily to treat Resident #2's bilateral leg chronic cellulitis.
-She expected the facility to ensure Resident #2's doxycycline 100mg twice daily was administered as prescribed.
-She expected the facility to request Resident #2's doxycycline 100mg refills in accordance with the facility's refill policy, usually within one-week of the last dose.
-She expected the facility to notify her if Resident #2's doxycycline 100mg was not available for administration.
-She was not aware Resident #2's doxycycline 100mg twice daily was not available for administration between 10/27/23 and 11/04/23.
-Resident #2's legs were not currently exhibiting evidence of infection.
-Resident #2 'was at risk of the likelihood of infection which could lead to hospitalization for cellulitis' if his doxycycline 100mg twice daily was not administered as order.

Interview with the facility's Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed:
-MAs were responsible to request refills of resident's medications within the last seven doses.
-The facility was responsible to request Resident #2's refills from Resident #2's preferred pharmacy.
-Resident #2's RP was responsible to deliver Resident #2's medications from Resident #2's

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preferred pharmacy.
-He was not aware Resident #2's doxycycline 100mg twice daily was unavailable for administration in late October 2023 or early November 2023.

Interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm revealed she was not aware Resident #2's doxycycline 100mg twice daily was not available for administration in late October 2023 and early November 2023.

Interview with the facility Administration on 11/20/23 at 4:20pm revealed she was not aware Resident #2's doxycycline 100mg twice daily was not available for administration in late October 2023 and early November 2023.

Refer to interview with a MA on 11/15/23 at 11:00am.

Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am.

Refer to interview with the SCC on 11/16/23 at 10:25am.

Refer to interview with the RCC on 11/20/23 at 12:33pm.

Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm

Refer to interview with the Administrator on 11/20/23 at 4:45pm.

4. Review of Resident #5's current FL2 dated 04/21/23 revealed:
-Diagnoses included Vascular dementia with behavioral disturbance, benign prostatic

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hyperplasia, and hypothyroidism.
-Resident #5 was constantly disorientated.
-Resident #5's level of care was SCU.
-There was an order for levothyroxine sodium (used to treat underactive thyroid gland) 137mcg by mouth daily.

Review of Resident #5's physician orders dated 09/07/23 revealed an order for levothyroxine sodium 150mcg by mouth daily.

Review of Resident #5's physician orders dated 10/12/23 revealed an order for levothyroxine sodium 175mcg by mouth daily.

Review of Resident #5's October 2023 eMAR revealed:
-There was an entry dated 10/12/23 for levothyroxine sodium 175 mcg by mouth daily.
-Levothyroxine sodium 175 mcg by mouth daily was documented as not administered with the exception code of 02 indicating resident refusal on 10/12/23.
-Resident #5's levothyroxine sodium 175 mcg by mouth daily was documented as being administered 10/13/23 through 10/31/23.

Review of Resident #5's November 2023 eMAR revealed:
-There was an entry for levothyroxine sodium 175 mcg by mouth daily.
-Resident #5's levothyroxine sodium 175mcg by mouth daily was documented as not being administered with the exception code of 09 indicating, other/see nurses notes on 11/13/23.

Review of Resident #5's progress notes revealed Resident #5's levothyroxine sodium was not administered on 11/13/23 due to the medication not being available.

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{D 358}	Continued From page 56 Observation of Resident #5's medications available for administration on 11/15/23 at 10:42am revealed levothyroxine sodium 137mcg in a bubble pack with a dispense date of 06/30/23 with 21 remaining capsules available for administration. Telephone interview with a representative with the facility's contracted pharmacy on 11/16/23 at 10:18am revealed: -Levothyroxine sodium 137mcg by mouth daily was last filled and dispensed to the facility on 06/30/23, for 28 doses. -Resident #5 had an order for levothyroxine sodium 150mcg by mouth daily dated 07/06/23 that was last filled and dispensed to the facility on 09/27/23, for 28 doses. -Resident #5 had an order for levothyroxine sodium 175mcg by mouth daily dated 10/11/23 that was last filled and dispensed to the facility on 10/11/23, for 14 doses. Interview with the MA on 11/15/23 at 10:45am revealed: -She did not notice that Resident #5's levothyroxine sodium on the medication cart did not match the eMAR orders. -The MAs were to compare medications on the medication cart to the eMAR orders but she did not. -If there was an incorrect dose of medication on the medication cart, the MA should document in the progress notes, notify the resident's PCP and pharmacy, and not administer the medication. Interview with Resident #5's PCP on 11/16/23 at 8:45am revealed: -She was not notified that Resident #5 was receiving the incorrect dose of levothyroxine	{D 358}		

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{D 358}	Continued From page 57 sodium. -She had gradually increased Resident #5's levothyroxine sodium due to thyroid levels being low. -Not receiving the correct dose of levothyroxine sodium, Resident #5 could become tired, sleeping more with possible weakness which could lead to falls. -She expected the facility to follow medications orders as prescribed. Interview with the facility Compliance Nurse on 11/20/23 at 3:38pm revealed: -She was a Registered Nurse who began working at the facility about a month ago. -She did not know Resident #5 had been receiving the incorrect dose of levothyroxine sodium. Interview with the special care coordinator (SCC) on 11/20/23 at 1:20pm revealed: -She did not know Resident #5 had been receiving the incorrect dose of levothyroxine sodium. -She was responsible for reviewing the 24 hour reports that identified medications that were missing from the medication carts but did not remember any issues with Resident #5's medications. -She did not complete a medication cart audit since she started as the SCC 30 days ago because of other duties that required her attention. -She was responsible for completing a weekly medication cart audit that matched the eMAR with the medication on the medication cart and the physician order but had not. -It was her responsibility to notify the pharmacy and the PCP if there was an issue with medications.	{D 358}		

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{D 358}	Continued From page 58 Interview with the Administrator on 11/20/23 at 4:38pm revealed: -She did not know Resident #5 had been receiving the incorrect dose of levothyroxine sodium. -The MAs are responsible for comparing the medications on the cart to the eMAR before administering a medication to a resident. -If a resident was given the incorrect dose of a medications, the SCC or MA were responsible for calling the pharmacy and PCP. -The MAs or the SCC were responsible for documenting incorrect doses of medications or if medications were not available on a progress note and on the 24 hour report. -The SCC was responsible for completing a weekly medication cart audit that matched the medications on the cart to the eMAR and the physician order. -She was not aware the medication cart audits were not completed. -The SCC was responsible for reviewing the 24 hour reports that identified medications that were missing from the medication carts. -She did not know the SCC had not completed any medication cart audits. Refer to interview with a MA on 11/15/23 at 11:00am. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am. Refer to interview with the SCC on 11/16/23 at 10:25am. Refer to interview with the RCC on 11/20/23 at 12:33pm.	{D 358}		

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{D 358}	Continued From page 59 Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm Refer to interview with the Administrator on 11/20/23 at 4:45pm. _____ Interview with the facility's Compliance Nurse on 11/15/23 at 11:07am revealed: -She was a Registered Nurse who began working at the facility about a month ago. -The SCC/RCC were responsible for completing weekly medication cart audits that would reveal any missing medications, and medications that do not have an order or do not match the order. -The SCC/RCC were responsible for reviewing the 24 hour and 72 hour report, the medication audit report and and medication cart audit prior to the morning stand ups and report any issues or concerns with medications for the residents, such as missing medications and medication order issues to her. -The morning stand ups were Monday through Friday. -She would then be responsible for making sure those issues were taken care of and assist if the SCC/RCC needed help. -She was not aware of any medication issues since she started at the facility since nothing was reported to her in the morning stand up meetings and therefore she could not follow up with anything. -She was not aware the medication cart audits were not completed and she did not check to see if the SCC/RCC completed the medication cart audits because she was still learning her duties at the facility. Interview with the SCC on 11/16/23 at 10:25am revealed:	{D 358}		

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{D 358}	Continued From page 60 -She first started as the SCC 30 days ago. -It was her responsibility before the stand-up meeting at 9:30am every morning, to complete/obtain the Medication Audit report which contained medications that were left blank on the eMAR. -She was also responsible for obtaining and reviewing the 24 hour and the 72 hour reports which contained medications that were missing off the medication cart. -She was also responsible for completing a weekly medication cart audit that matched the eMAR with the medication on the medication cart and the physician orders. -The medication cart audit would catch a missing medication, or a medication not being administered as ordered. -It was her responsibility to notify the pharmacy and physician when there was an issue with missing medications. -She did not complete a medication cart audit since she started as the SCC 30 days ago because of other duties that required her attention. -On 10/11/23, she received an inservice by the VP of Clinical Services on how to enter orders into the eMAR system. -She did not receive additional inservices related to medication administration from 10/11/23 through 11/14/23. Interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed: -He started working for the facility 3 weeks ago as the RCC. -When a medication was not available on the medication cart it was the resident's responsibility of the RCC and the MAs to reach out to the pharmacy for a refill. -If the resident used an outside pharmacy, it was	{D 358}		

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the responsibility of the residents' responsible party to pick up and deliver the medication to the facility.
-Medication cart audits were to be completed once a week.
-He assigned them to the MAs, but he had not been doing them.
-The MAs did the cart audits weekly and the facility's contracted pharmacy performed a full cart audit on 10/18/23.
-If there was no medication available, he would call the pharmacy and request a new order if a prescription was needed.
-The MA or RCC would call the pharmacy once they realized a resident was out of medications.
-The medications should be refilled when there was a 7-day supply left in the bottle or bubble pack.
-When a resident had missed a dose or if medications were unavailable, the MA would notify the PCP and family if they were out of medications after the first occurrence.
-Notification to the PCP and family should be documented on the progress note.
-When a medication was listed on the progress note with no detailed information, then it was considered not available for administration.
-The "09" code meant a medication was not administered and the in between times documented as administered were not administered, because the medication was not available.
-The MAs were just "being dishonest" by checking that a medication was administered when it was not available on the cart.
-The "09" code does not trigger a missed medication on the missed medication report, the report only showed when a box on the eMAR was left blank.
-The facility only audited the blanks on the eMAR,

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{D 358}	Continued From page 62 not the "09" codes which meant someone was out of a medication. -The in-house MAs were responsible to perform medication cart audits. -The agency MA staff did not perform cart audits, but were also responsible to ensure medications were available on the cart. Interview with the facility's Compliance Nurse on 11/20/23 at 3:34pm revealed: -She received an inservice from the Vice President of Clinical Services on 10/11/23 related to entering orders into the eMAR system, but did not know of any inservices related to medication administration for the MAs. -The MAs were responsible for notification to the pharmacy related to any medications not available for administration or a medication with 7 doses left requiring a refill. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -The MAs were responsible for notification of missed medications, missing medications, and medication order issues to the SCC/RCC by documentation the issues on the 24 hour report. -The SCC/RCC was responsible for performing cart audits once a week and to notify the Compliance Nurse when there were medication issues. -The last medication cart audit was performed by the facility's contracted pharmacy on 10/18/23. -During the daily stand-up meetings, exception reports (progress notes), missed medication reports (holes in eMAR), variance reports (actual time of administration of medications) were reviewed. -These 3 reports were discussed every day and issues were expected to be corrected by the next day.	{D 358}		

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{D 358}	Continued From page 63 -Most of the time the reports have been blank when they were reviewed. -The SCC/RCC was responsible for the medication cart audits once a week on Thursdays related to the 3 reports discussed during the stand-up meetings. -The SCC/RCC should have ensured medications were filled the same way for all residents no matter which pharmacy was used. -She was not aware the medication cart audits were not completed. -This was a process issue meaning, checks were put in place for the SCC/RCC to report to the Compliance Nurse to assist with. -There were two additional nurses hired to assist the Compliance Nurse when needed to fill in for the SCC/RCC when they had to complete other duties such as filling in for a MA or if they were out of the facility for any reason. -When the SCC/RCC did not complete their checks and report to the Compliance Nurse, then the Compliance Nurse could not assist with issues and use the other two nurses for help. _____ The facility failed to ensure 4 of 7 residents' (Resident #2, #5, #6, and #7) medications were administrated as ordered which included medications to prevent high blood pressure and anemia (#7), medications for high blood pressure and edema (#6), medications for high cholesterol and cellulitis (#2), and medications for benign prostatic hyperplasia and hyperthyroidism (#5). Failure to administer medications as ordered placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection on November 15, 2023 in accordance with G.S. 131D-34 for this violation.	{D 358}		

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{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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues and the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or after the prescribed time for 4 of 5 sampled residents resulting in some medications with multiple administration times being administered too close to the next scheduled administration time (Residents #3, #4, #5, and #1). The findings are: Review of the facility's policy on Medication Administration dated 10/01/20 revealed the community will ensure that medications were to be administered to the residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. 1. Review of Resident #3's current FL2 dated 02/20/23 revealed diagnoses included multiple myeloma (disease of bone marrow) in relapse, type 2 diabetes mellitus (non-insulin dependent high blood sugar), chronic kidney disease stage 3 (moderate kidney damage and noticeable loss of	{D 364}		

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kidney function), obstructive and reflux uropathy (a disease of the urinary or urogenital organs), hyperlipidemia (the presence of excess fat or lipids in the blood), and essential hypertension (a common form of hypertension that occurs in the absence of any evident cause).

Review of Resident #3's resident register revealed an admission date of 02/22/23.

a. Review of Resident #3's Primary Care Provider's (PCP) orders dated 06/14/23 revealed there was an order for metformin (used to treat diabetes) 500mg by mouth twice daily.

Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed there was an entry for metformin 500mg by mouth twice daily at 8:00am and at 4:00pm with documentation of administration at 4:00pm on 10/27/23.

Review of Resident #3's October 2023 Medication Administration Audit Report revealed metformin was administered outside of the one hour before/after time frame 1 out of 5 opportunities on 10/27/23 at 5:40pm.

Review of Resident #3's November 2023 eMAR revealed there was an entry for metformin 500mg by mouth twice daily at 8:00am and at 4:00pm with documentation of administration at 8:00am on 11/02/23, 11/12/23 and 11/13/23, at 4:00pm on 11/02/23, 11/03/23 and 11/11/23.

Review of Resident #3's November 2023 Medication Administration Audit Report revealed metformin was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 364}	Continued From page 66 on 11/02/23 at 6:21pm. Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed metformin was used to treat Resident #3's blood sugar and if the medication was administered too close together, then the medication could not cause the desired effect and could possibly have issues with Resident #3's blood sugar. b. Review of Resident #3's PCP orders dated 06/14/23 revealed there was an order for apixaban (used to prevent blood clots and stroke) 2.5mg by mouth twice daily. Review of Resident #3's October 2023 eMAR revealed there was an entry for apixaban 2.5mg by mouth twice daily 4:00pm with documentation of administration at 4:00pm on 10/27/23. Review of Resident #3's October 2023 Medication Administration Audit Report revealed apixaban was administered outside of the one hour before/after time frame 1 out of 5 opportunities on 10/27/23 at 5:40pm. Review of Resident #3's November 2023 eMAR revealed there was an entry for apixaban 2.5mg by mouth twice daily at 8:00am and 4:00pm with documentation of administration at 8:00am on 11/02/23, 11/12/23 and 11/13/23, at 4:00pm on 11/02/23, 11/03/23 and 11/11/23. Review of Resident #3's November 2023 Medication Administration Audit Report revealed apixaban was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being on 11/02/23 at 6:21pm.	{D 364}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 364}	Continued From page 67 Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed apixaban was used as a blood thinner and if the medication was administered too close together, then the medication could not cause the desired effect of keeping the blood thinned. c. Review of Resident #3's PCP orders dated 06/14/23 revealed there was an order for insulin aspart solution pen-injector (used to help lower blood sugars spikes) 100 units/1ml, inject subcutaneously (SQ) per sliding scale before meals and at bedtime. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for insulin aspart solution pen-injector 100 units/1ml, inject SQ per sliding scale before meals at 7:30am, 11:30am, 5:30pm and at bedtime at 8:00pm with documentation of administration on 11/02/23, 11/05/23, 11/06/23, 11/11/23, 11/12/23, and 11/13/23 at 7:30am, and on 11/11/23 at 11:30am. -On 11/02/23 at 7:30am the finger stick blood sugar (FSBS) was 146, and at 11:30am was documented as 109. -On 11/05/23 at 7:30am the FSBS was 113 and at 11:30am was documented as 105. -On 11/06/23 at 7:30am the FSBS was 139 and at 11:30am was documented as 121. -On 11/11/23 at 7:30am the FSBS was 127, 11:30am was 138, and at 5:30pm was 134. -On 11/12/23 at 7:30am the FSBS was 134 and at 11:30am was 108. -On 11/13/23 at 7:30am the FSBS was 129 and at 11:30am was 133. Review of Resident #3's November 2023 Medication Administration Audit Report revealed insulin aspart was administered outside of the	{D 364}		

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one hour before/after time frame 7 out of 16 opportunities with the latest administration being on 11/11/23 at 1:57pm.

Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed:
-The insulin aspart was used to treat Resident #3's blood sugars and if the medication was administered too close together, then the medication could not decrease Resident #3's blood sugars.
-The insulin aspart should be administered according to the blood sugar results obtained 30 minutes before meals and at bedtime.
-The insulin aspart does not lower the blood sugar until about 1 to 1.5 hours after receiving the insulin.
-If Resident #3 received the insulin after the blood sugar was obtained and then ate food then the blood sugar would stay high longer and could cause symptoms of high blood sugar such as tiredness and blurred vision.

d. Review of Resident #3's PCP orders dated 06/14/23 revealed there was an order for acyclovir (used to treat pyelonephritis) 400mg by mouth daily.

Review of Resident #3's November 2023 eMAR revealed there was an entry for acyclovir 400mg by mouth daily at 8:00am with documentation of administration at 8:00am on 11/02/23, 11/12/23 and 11/13/23.

Review of Resident #3's November 2023 Medication Administration Audit Report revealed acyclovir was administered outside of the one hour before/after time frame 3 out of 16 opportunities with the latest administration being on 11/12/23 at 9:56am.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 364}	Continued From page 69 Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed acyclovir was used to treat pyelonephritis, and when not given at the same time each day, then the medication could not cause the desired effect to treat infection. e. Review of Resident #3's PCP orders dated 06/14/23 revealed there was an order for Flomax (used to treat benign prostatic hyperplasia) 0.4mg by mouth daily. Review of Resident #3's November 2023 eMAR revealed there was an entry for Flomax 0.4mg by mouth daily at 8:00am with documentation of administration at 8:00am on 11/02/23, 11/12/23 and 11/13/23. Review of Resident #3's November 2023 Medication Administration Audit Report revealed Flomax was administered outside of the one hour before/after time frame 3 out of 16 opportunities with the latest administration being on 11/12/23 at 9:56am. Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed Flomax was used to treat benign prostatic hyperplasia, and when not given at the same time each day, then the medication could not cause the desired effect of improved urine flow. f. Review of Resident #3's PCP orders dated 06/14/23 revealed there was an order for empagliflozin (used to treat diabetes) 25mg by mouth daily. Review of Resident #3's November 2023 eMAR revealed there was an entry for empagliflozin 25mg by mouth daily 8:00am with documentation	{D 364}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 364}	Continued From page 70 of administration at 8:00am on 11/02/23, 11/12/23 and 11/13/23. Review of Resident #3's November 2023 Medication Administration Audit Report revealed empagliflozin was administered outside of the one hour before/after time frame 3 out of 16 opportunities with the latest administration being on 11/12/23 at 9:36am. Telephone interview with Resident #3's PCP on 11/20/23 at 12:30pm revealed empagliflozin was used to treat diabetes, and when not given at the same time each day, could not cause the desired effect and could possibly have issues with Resident #3's blood sugar. Telephone interview with a first shift medication aide (MA) on 11/17/23 at 3:30pm revealed no one in management asked her why Resident #3's medications were late according to the Medication Administration Audit Report. Interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed he was not aware Resident #3 had received medications late 30 times from 10/27/23 to 11/13/23. Attempted telephone interview with Resident #3's responsible party (RP) on 11/20/23 at 3:42pm was unsuccessful. Interview with the Administrator on 11/20/23 at 4:45pm revealed: -During the daily stand-up meetings, staff and management reviewed the Medication Administration Audit Reports which show the actual time medications were administered. -We review and discuss this report every day and expect issues to be corrected by the next day.	{D 364}		

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-She was not aware of any issues with Resident #3's medications.
-She expected the MA and RCC to notify the PCP of any late medications.

Refer to interview with a MA on 11/17/23 at 12:19pm.

Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am.

Refer to interview with the SCC on 11/16/23 at 10:25am

Refer to interview with the RCC on 11/16/23 at 10:25am.

Refer to interview with the Administrator on 11/20/23 at 4:38pm.

2. Review of Resident #4's current FL2 dated 09/22/23 revealed diagnoses included Alzheimer's dementia, degenerative disc disease, and hypertension.

a. Review of Resident #4's Primary Care Provider's (PCP) orders dated 09/22/23 revealed there was an order for amlodipine besylate (used to treat high blood pressure) 5mg by mouth daily.

Review of Resident #4's October 2023 electronic medication administration record (eMAR) revealed there was an entry for amlodipine besylate 5mg by mouth daily at 7:00am with documentation of administration at 7:00am on 10/27/23, 10/28/23, 10/29/23 and 10/31/23.

Review of Resident #4's October 2023 Medication Administration Audit Report revealed amlodipine besylate was administered outside of

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the one hour before/after time frame 4 out of 5 opportunities with the latest administration being on 10/31/23 at 8:58am.

Review of Resident #4's November 2023 eMAR revealed there was an entry for amlodipine besylate 5mg by mouth daily at 7:00am with documentation of administration at 7:00am on 11/01/23 - 11/02/23, 11/06/23 - 11/11/23, and 11/13/23 -11/16/23.

Review of Resident #4's November 2023 Medication Administration Audit Report revealed amlodipine besylate was administered outside of the one hour before/after time frame 12 out of 16 opportunities with the latest administration being on 11/15/23 9:01am.

Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the amlodipine besylate was used to treat Resident #4's blood pressure and if the medication was administered too close together, then the medication could cause the blood pressure to drop more than intended.

b. Review of Resident #4's PCP orders dated 09/22/23 revealed there was an order for vitamin D3 (used to treat bone diseases) 25mcg by mouth daily.

Review of Resident #4's November 2023 eMAR revealed there was an entry for vitamin D3, 25mcg by mouth daily with documentation of administration at 8:00am on 11/11/23 and 11/14/23.

Review of Resident #4's November 2023 Medication Administration Audit Report revealed vitamin D3 was administered outside of the one

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hour before/after time frame 2 out of 16 opportunities with the latest administration being on 11/14/23 at 9:43am.

Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the vitamin D was used to treat Resident #4's bone loss and if administered too close together then there would not be a constant level of the medication in the blood to work effectively.

c. Review of Resident #4's PCP orders dated 09/22/23 revealed: there was an order for memantine HCL (used to treat memory loss) 10mg by mouth twice daily.

Review of Resident #4's November 2023 eMAR revealed there was an entry for memantine HCL 10 mg by mouth twice daily with a documentation of administration at 8:00am on 11/11/23 and 11/14/23.

Review of Resident #4's November 2023 Medication Administration Audit Report revealed memantine HCL was administered outside of the one hour before/after time frame 2 out of 16 opportunities with the latest administration being on 11/11/23 at 9:42am.

Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the memantine HCL was used to treat Resident #4's memory loss due to dementia and if administered too close together then there would not be a constant level of the medication in the blood to work effectively.

d. Review of Resident #4's PCP orders dated 09/22/23 revealed there was an order for fish oil (used to prevent heart disease and stroke)

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{D 364}	Continued From page 74 1000mg by mouth daily. Review of Resident #4's November 2023 eMAR revealed there was an entry for fish oil 1000mg by mouth daily with a documentation of administration at 8:00am on 11/11/23 and 11/14/23. Review of Resident #4's November 2023 Medication Administration Audit Report revealed fish oil was administered outside of the one hour before/after time frame 2 out of 16 opportunities with the latest administration being on 11/11/23 at 9:42am. Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the fish oil was used to treat Resident #4's heart disease and prevent stroke and if administered too close together then there would not be a constant level of the medication in the blood to work effectively. e. Review of Resident #4's PCP orders dated 09/22/23 revealed there was an order for montelukast sodium (to treat allergy symptoms) 10mg by mouth daily. Review of Resident #4's November 2023 eMAR revealed there was an entry for montelukast sodium 10mg by mouth daily with a documentation of administration at 8:00am on 11/11/23 and 11/14/23. Review of Resident #4's November 2023 Medication Administration Audit Report revealed montelukast sodium was administered outside of the one hour before/after time frame 2 out of 16 opportunities with the latest administration being on 11/11/23 at 9:42am.	{D 364}		

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{D 364}	Continued From page 75 Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the montelukast sodium was used to treat Resident #4's allergies and if administered too close together then there would not be a constant level of the medication in the blood to work effectively. f. Review of Resident #4's PCP orders dated 09/22/23 revealed there was an order for losartan potassium (used to treat hypertension) 25mg by mouth daily. Review of Resident #4's November 2023 eMAR revealed there was an entry for losartan potassium 25mg by mouth daily at 8:00am with documentation of administration at 8:00am on 11/11/23 and 11/14/23. Review of Resident #4's November 2023 Medication Administration Audit Report revealed losartan potassium was administered outside of the one hour before/after time frame 2 out of 16 opportunities with the latest administration being on 11/14/23 at 9:42am. Telephone interview with Resident #4's PCP on 11/20/23 at 12:30pm revealed the losartan potassium was used to treat Resident #4's blood pressure and if the medication was administered too close together, then the medication could cause the blood pressure to drop more than intended. Refer to interview with a MA on 11/17/23 at 12:19pm. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am. Refer to interview with the SCC on 11/16/23 at	{D 364}		

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{D 364}	Continued From page 76 10:25am Refer to interview with the RCC on 11/16/23 at 10:25am. Refer to interview with the Administrator on 11/20/23 at 4:38pm. 3. Review of Resident #5's current FL2 dated 04/21/23 revealed diagnoses included vascular dementia with behavioral disturbance, benign prostatic hyperplasia, and hypothyroidism. a. Review of Resident #5's Primary Care Provider (PCP) orders dated 09/07/23 revealed there was an order for levothyroxine sodium (used to treat an under active thyroid gland) 150mcg by mouth daily. Review of Resident #5's PCP orders dated 10/11/23 revealed an order for levothyroxine sodium (used to treat benign prostatic hyperplasia) 175mcg by mouth daily. Review of Resident #5's October 2023 eMAR revealed there was an entry for levothyroxine sodium 150mcg by mouth daily at 7:00am with documentation of administration at 7:00am on 10/29/23, 10/30/23 and 10/31/23. Review of Resident #5's October 2023 Medication Administration Audit Report revealed levothyroxine sodium was administered outside of the one hour before/after time frame 3 occurrences out of 5 opportunities with the latest administration being on 10/30/23 at 9:14am. Review of Resident #5's November 2023 eMAR revealed there was an entry for levothyroxine sodium 150mcg by mouth daily at 7:00am with	{D 364}		

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documentation of administration at 7:00am on 11/02/23 - 11/03/23, 11/05/23 - 11/07/23, 11/09/23 - 11/16/23.

Review of Resident #5's November 2023 Medication Administration Audit Report revealed levothyroxine sodium was administered outside of the one hour before/after time frame 13 out of 16 opportunities with the latest administration being on 11/13/23 10:35am.

Telephone interview with Resident #5's PCP on 11/20/23 at 12:30pm revealed the levothyroxine sodium was used to treat Resident #5's hypothyroidism and if administered too close together then there would not be a constant level of the medication in the blood to work effectively.

b. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for quetiapine fumarate (used to treat depressive and manic episodes) 25mg by mouth twice daily.

Review of Resident #5's October 2023 eMAR revealed there was an entry for quetiapine fumarate 25mg by mouth twice daily at 9:00am and 2:00pm with documentation of administration at 2:00pm on 10/30/23.

Review of Resident #5's October 2023 Medication Administration Audit Report revealed quetiapine fumarate was administered outside of the one hour before/after time frame 1 occurrences out of 5 opportunities on 10/30/23 at 3:59pm.

Review of Resident #5's November 2023 eMAR revealed there was an entry for quetiapine fumarate 25mg by mouth twice daily at 9:00am and 2:00pm with documentation of administration

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{D 364}	Continued From page 78 at 9:00am on 11/13/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed quetiapine fumarate was administered outside of the one hour before/after time frame 1 out of 16 opportunities on 11/13/23 10:34am. Telephone interview with Resident #5's previous PCP on 11/20/23 at 12:30pm revealed quetiapine fumarate was used to treat Resident #5's major depressive disorders and if administered too close together then there would not be a constant level of the medication in the blood to work effectively. c. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for divalproex sodium (used to treat mental/mood condition) 125mg by mouth twice daily. Review of Resident #5's November 2023 eMAR revealed there was an entry for divalproex sodium 125mg by mouth twice daily at 8:00am and 6:00pm with documentation of administration at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed divalproex sodium was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being for the scheduled dose at 8:00am on 11/13/23 at 10:33am. Telephone interview with Resident #5's previous PCP on 11/20/23 at 12:30pm revealed divalproex was used to treat Resident #5's mood disorders and if administered too close together then there	{D 364}		

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{D 364}	Continued From page 79 would not be a constant level of the medication in the blood to work effectively. d. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for triamcinolone acetonide cream (used to treat itching, redness, rash, dryness, and scaling) 0.1% apply to both legs daily Review of Resident #5's November 2023 eMAR revealed there was an entry for triamcinolone acetonide cream 0.1% apply to both legs daily at 8:00am with documentation of administration at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed triamcinolone acetonide was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being on 11/13/23 at 10:35am. Telephone interview with Resident #5's previous PCP on 11/20/23 at 12:30pm revealed triamcinolone acetonide was used to treat Resident #5's skin issues and if administered too close together then there would not be a constant level of the medication on the skin to work effectively. e. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for memantine (used to treat memory loss) 5mg by mouth twice daily. Review of Resident #5's November 2023 eMAR revealed there was an entry for memantine 5mg by mouth twice daily at 8:00am and 6:00 with documentation of administration on 5mg by	{D 364}		

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{D 364}	Continued From page 80 mouth twice daily at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed memantine was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being for the scheduled dose at 8:00am on 11/13/23 at 10:33am. Telephone interview with Resident #5's PCP on 11/20/23 at 12:30pm revealed the memantine HCL was used to treat Resident #5's memory loss due to dementia and if administered too close together then there would not be a constant level of the medication in the blood to work effectively. f. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for clotrimazole betamethasone (used to treat fungal infections and rash) 1-0.05% apply topically to face twice daily. Review of Resident #5's November 2023 eMAR revealed there was an entry for clotrimazole betamethasone 1-0.05% apply topically to face twice daily at 8:00am and 6:00pm with documentation of administration at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed clotrimazole betamethasone was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being for the dose scheduled at 8:00am on 11/13/23 at 10:32am.	{D 364}		

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{D 364}	Continued From page 81 Telephone interview with Resident #5's PCP on 11/20/23 at 12:30pm revealed the clotrimazole betamethasone was used to treat Resident #5's fungal infection and if the medication was administered too close together, then the medication could not cause the desired effect and the infection could not be controlled. g. Review of Resident #5's PCP orders dated 09/07/23 revealed there was an order for losartan potassium (used to treat hypertension) 25mg by mouth daily. Review of Resident #5's November 2023 eMAR revealed there was an entry for losartan potassium 25mg by mouth daily at 8:00am with documentation of administration at 8:00am on 11/07/23, 11/10/23 - 11/13/23 and 11/15/23. Review of Resident #5's November 2023 Medication Administration Audit Report revealed losartan potassium was administered outside of the one hour before/after time frame 6 out of 16 opportunities with the latest administration being on 11/13/23 at 10:34am. Telephone interview with Resident #5's PCP on 11/20/23 at 12:30pm revealed the losartan potassium was used to treat Resident #5's blood pressure and if the medication was administered too close together, then the medication could cause the blood pressure to drop more than intended. Refer to interview with a MA on 11/17/23 at 12:19pm. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am.	{D 364}		

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Refer to interview with the SCC on 11/16/23 at 10:25am

Refer to interview with the RCC on 11/16/23 at 10:25am.

Refer to interview with the Administrator on 11/20/23 at 4:38pm.

4. Review of Resident #1's FL2 dated 02/13/23 revealed diagnoses included late onset Alzheimer's Dementia, coronary artery disease, history of colon cancer with metastasis, chronic pain and B-12 deficiency.

a. Review of Resident #1's FL2 dated 02/13/23 revealed an order for refresh tears solution (a medication used for dry eyes) 1.4-0.6%, instill one drop in both eyes four times a day.

Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed.
-There was an entry for refresh tears solution 1.4-0.6%, instill one drop in both eyes scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The entry was documented as administered at 8:00am, 12:00pm, 4:00pm and 8:00pm from 11/01/23 to 11/15/23.

Review of Resident #1's November 2023 Medication Administration Audit Report revealed the refresh tears solution was administered outside of the one hour before/after time frame on 2 occurrences out of 60 opportunities with the latest administration being on 11/11/23 at 10:15am for the 8:00am dose.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 11/20/23 at 12:30pm

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revealed refresh tears solution was used to treat Resident #1's dry eyes and if the medication was administered too close together, then the medication could not cause the desired effect and eyes could remain dry causing irritation to the eyes.

b. Review of Resident #1's FL2 dated 02/13/23 revealed an order for acetaminophen extended release (ER) 650mg (a medication used for pain), one tablet three times a day.

Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed.
-There was an entry for acetaminophen ER 650mg, one tablet three times a day.
-The acetaminophen was documented as administered at 8:00am, 2:00pm and 8:00pm from 11/01/23 to 11/15/23.

Review of Resident #1's November 2023 Medication Administration Audit Report revealed the acetaminophen ER was administered outside of the one hour before/after time frame on 2 occurrences out of 45 opportunities with the latest administration being on 11/11/23 at 10:15am for the 8:00am dose.

Telephone interview with Resident #1's PCP on 11/20/23 at 12:30pm revealed acetaminophen ER was used to treat Resident #1's pain and if the medication was administered too close together, then the medication could not control his pain because there needed to be a constant level of the medication in his blood to control his pain.

c. Review of Resident #1's FL2 dated 02/13/23 revealed an order for diclofenac sodium (a medication used for pain) 1%, apply one gram to

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{D 364}	Continued From page 84 both knees topically four times a day. Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed. -There was an entry for diclofenac sodium 1% apply one gram to both knees topically four times a day. -The diclofenac was documented as administered at 8:00am, 12:00pm, 4:00pm and 8:00pm from 11/01/23 to 11/15/23. Review of Resident #1's November 2023 Medication Administration Audit Report revealed the diclofenac sodium was administered outside of the one hour before/after time frame on 2 occurrences out of 60 opportunities with the latest administration being on 11/11/23 at 10:15am for the 8:00am dose. Telephone interview with Resident #1's PCP on 11/20/23 at 12:30pm revealed diclofenac sodium was used to treat Resident #1's pain and if the medication was administered too close together, then the medication could not control his pain because there needed to be a constant level of the medication in his body to control the pain. d. Review of Resident #1's FL2 dated 02/13/23 revealed an order for oxcarbazepine (a medication used for seizures) 150mg two times a day. Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed. -There was an entry for oxcarbazepine, 150mg two times a day. -The entry was documented as administered at 8:00am and 8:00pm from 11/01/23 to 11/15/23.	{D 364}		

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{D 364}	Continued From page 85 Review of Resident #1's November 2023 Medication Administration Audit Report revealed the oxcarbazepine sodium was administered outside of the one hour before/after time frame on 2 occurrences out of 30 opportunities with the latest administration being on 11/11/23 at 10:15am for the 8:00am dose. Telephone interview with Resident #1's PCP on 11/20/23 at 12:30pm revealed oxcarbazepine sodium was used to treat Resident #1's seizures and if the medication was administered too close together, then the medication could increase the risk of a seizure due to not having a constant amount in the blood to control the seizures. Refer to interview with a MA on 11/17/23 at 12:19pm. Refer to interview with the facility's Compliance Nurse on 11/15/23 at 11:07am. Refer to interview with the SCC on 11/16/23 at 10:25am Refer to interview with the RCC on 11/16/23 at 10:25am. Refer to interview with the Administrator on 11/20/23 at 4:38pm. _____ Interview with a MA on 11/17/23 at 12:19pm revealed: -All medications were to be administered one hour before to one hour after the administration time. -On 11/11/23, she administered the 8:00am medication over an hour late in the SCU because	{D 364}		

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{D 364}	Continued From page 86 she was administering medications on the AL side first and she began over on the AL around 7:00am. -There were too many residents to administer medications to that were due at 8:00am. -She did not receive any new training on medication administration times since she hired about 5 months ago. Interview with the facility Compliance Nurse on 11/15/23 at 11:07am revealed: -She was a Registered Nurse who began working at the facility about a month ago. -The SCC/RCC were responsible for completing the Medication Administration Audit Report and reviewing it every morning. -The Medication Audit Report contained medication administration times. -The SCC/RCC could then see the actual medication administration times and then could address the issues with the MAs responsible for administering medications outside the one hour before and one hour after. Interview with the SCC on 11/16/23 at 10:25am revealed: -She first started as the SCC 30 days ago. -It was her responsibility before the stand-up meeting at 9:30am every morning, to complete/obtain the Medication Administration Audit Report which contained medication administration times. -She was responsible for reviewing the Medication Administration Audit report and meeting with the MA responsible for administering medication outside of the one hour before and one hour after rule. -She did not review the Medication Administration Audit reports since she started as the SCC, 30 days ago because of other duties that required	{D 364}		

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{D 364}	Continued From page 87 her attention. Interview with the RCC on 11/16/23 at 10:25am revealed: -He first started as the RCC, 30 days ago. -It was his responsibility before the stand-up meeting at 9:30am every morning, to complete/obtain the Medication Administration Audit Report which contained medication administration times. -He was responsible for reviewing the Medication Administration Audit report and meeting with the MA responsible for administering medications outside of the one hour before and one hour after rule. -He did not review the Medication Administration Audit Reports since he started as the RCC, 30 days ago because of other duties that required his attention. Interview with the Administrator on 11/20/23 at 4:38pm revealed: -The MAs were responsible to administer mediations within the one hour before to one hour after the scheduled medication administration time. -It was the responsibility of the SCC/RCC to review the Medication Administration Audit report every day and speak to the MAs responsible for administering medications outside that time frame. -She was aware that on some occasions a MA was responsible for administering medications in the AL and in the SCU at the same time, which would make medications late for some residents on a different unit. -This was a process issue meaning, checks were put in place for the SCC/RCC to report to the Compliance Nurse to assist with. -There were two additional nurses hired to assist	{D 364}		

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{D 364}	Continued From page 88 the Compliance Nurse when needed to fill in for the SCC/RCC when they had to complete other duties such as filling in for a MA or if they were out of the facility for any reason. -When the SCC/RCC did not complete their checks and report to the Compliance Nurse, then the Compliance Nurse could not assist with issues and use the other two nurses for help. -There was no new training on medication administration times after October 2023 because of getting staff in their new roles. _____ The facility failed to ensure 4 of 5 sampled residents' (#3, #4, #5 and #1) medications were administrated within one hour before or one hour after after the prescribed time, resulting in Resident #3 receiving medications late on 30 occasions for blood pressure medications twice daily, an oral diabetic medication once daily, sliding scale insulin before meals, an oral diabetic medication twice daily, and a medication used to treat edema daily, Resident #4 receiving medications late for two daily blood pressure medications, Resident #5's daily medications to treat blood pressure and hypothyroidism being administered too close together or too far apart, and Resident #1's pain medications administered three and four times daily and a seizure medication twice daily. Failure to administer the medications timely was detrimental to the health and safety of the residents and constitutes a Type Unabated B Violation. _____ The facility provided a plan of protection on November 17, 2023 in accordance with G.S. 131D-34 for this violation.	{D 364}		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 3 of 7 residents (Resident #7, #6, and #2) including inaccurate documentation of a blood pressure medication and a medication used to treat anemia (#7), medications for blood pressure and edema (#6), and medications for high cholesterol and cellulitis (#2). The findings are: Review of the facility's Medication Administration	D 367		

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Policy dated 10/01/20 revealed the recording on the administration of the medication administration record shall be by the staff who administered the medication immediately following administration of the medication to the resident.

1. Review of Resident #7's current FL2 dated 11/09/23 revealed diagnoses included hypertension, atherosclerotic heart disease, coronary artery disease without angina, a right bundle branch block (a condition that causes irregular heartbeat) and anemia (lack of healthy blood cells).

a. Review of Resident #7's current FL2 dated 11/09/23 revealed there was an order for amlodipine besylate (used to treat high blood pressure)10 mg every day.

Review of Resident #7's October 2023 electronic Medication Administration Record (eMAR) revealed.
-There was an entry for amlodipine besylate 10mg, one tablet daily.
-Resident #7's amlodipine besylate 10mg was documented as administered from 10/03/23 through 10/31/23.

Review of Resident #7's November 2023 eMAR revealed.
-There was an entry for amlodipine besylate 10mg, one tablet daily.
-Resident #7's amlodipine besylate 10mg was documented as administered 11/01/23, 11/02/23, 11/04/23, 11/05/23, 11/07/23, and 11/08/23.

Observation of Resident #7's medications available for administration on 11/15/23 at 7:32am revealed there was no amlodipine

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D 367	Continued From page 91 besylate available. Telephone interview with a representative with the facility's contracted pharmacy on 11/15/23 at 10:15am revealed: -There was an order for amlodipine besylate 10mg, one tablet daily dated 08/18/23 documented for Resident #7. -On 08/18/23, there were 30 doses of amlodipine besylate 10mg dispensed to the facility for Resident #7. -On 09/22/23, there were 28 doses of amlodipine besylate 10mg dispensed to the facility for Resident #7. -The amlodipine besylate was not dispensed since 09/22/23 and would have been out of amlodipine besylate on 10/20/23. -Resident #7 required 26 more doses of amlodipine besylate, on 10/20/23 to 11/15/23, to follow the PCP's order. Interview with a medication aide (MA) on 11/17/23 at 12:33pm revealed: -She administered amlodipine besylate to Resident #7 on 11/04/23, 11/07/23 and 11/08/23. -She did not know the previous MA documented the amlodipine as waiting for the pharmacy to dispense the amlodipine. -She must have marked the amlodipine besylate as administered by accident. b. Review of Resident #7's current FL2 dated 11/09/23 revealed there was an order for ferrous sulfate (a type of iron used to treat anemia) 325mg every day. Review of Resident #7's primary care provider's (PCP's) order dated 10/12/23 revealed an order for ferrous sulfate 325mg every 12 hours.	D 367		

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D 367	Continued From page 92 Observation of the medication pass on 11/15/23 at 7:32am revealed Resident #7's ferrous sulfate 325mg was not available to administer. Review of Resident #7's October 2023 eMAR revealed. -There was an entry dated 10/12/23 for ferrous sulfate 325mg, every 12 hours. -Resident #7's ferrous sulfate 325mg was documented as administered at 9:00am on 10/03/23 to 10/05/23, 10/07/23 to 10/10/23, 10/12/23, 10/16/23, 10/17/23 and at 9:00pm at 10/01/23 to 10/13/23 and 10/15/23 to 10/16/23. -There was an entry dated 10/19/23 for ferrous sulfate 325mg one tablet daily. -Resident #7's ferrous sulfate 325mg was documented as administered on 10/20/23 to 10/31/23. Review of Resident #7's November 2023 eMAR revealed. -There was an entry dated 10/19/23 for ferrous sulfate 325mg, one tablet daily. -Resident #7's ferrous sulfate 325mg was documented as not administered on 11/01/23 to 11/05/23, and 11/07/23 to 11/09/23. Observation of Resident #7's medications available for administration on 11/15/23 at 7:32am revealed there was no ferrous sulfate available. Telephone interview with a representative with the facility's contracted pharmacy on 11/15/23 at 10:15am revealed: -Resident #7 had an order for ferrous sulfate 325mg, one tablet daily dated 10/18/23. -On 10/19/23, there were 12 doses of ferrous sulfate 325mg dispensed to the facility for Resident #7.	D 367		

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D 367	Continued From page 93 -On 11/15/23, the facility requested a refill of Resident #7's ferrous sulfate but there was no refill left so the remaining 26 doses from the 10/18/23 refill was dispensed to the facility for Resident #7. -The ferrous sulfate was not refilled since 10/18/23 and would have been out on 11/01/23. -Resident #7 required 15 more doses of ferrous sulfate on 11/01/23 to 11/15/23, to follow the PCP's order. Interview with a medication aide (MA) on 11/17/23 at 12:33pm revealed: -She administered ferrous sulfate to Resident #7 on 11/04/23, 11/07/23 and 11/08/23. -She did not know the previous MA documented the ferrous sulfate as awaiting for the pharmacy to dispense the ferrous sulfate. -She must have marked the ferrous sulfate as administered by accident. Refer to interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm. Refer to interview with the Administrator on 11/20/23 at 4:38pm. 2. Review of Resident #6's current FL2 dated 11/09/23 revealed: -Diagnoses included hypertension, mild cognitive impairment, and hyperlipidemia. -There was an order for hydrochlorothiazide 12.5mg (used to treat high blood pressure and swelling) one tablet by mouth daily. Review of Resident #6's FL2 dated 04/03/23 revealed there was an order for hydrochlorothiazide 12.5mg one tablet by mouth daily.	D 367		

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D 367	Continued From page 94 Review of Resident #6's signed physician order sheet dated 07/14/23 revealed: -There was an order for hydrochlorothiazide 12.5mg one tablet by mouth daily. -The original order date was 04/07/23. Review of Resident #6's Resident Register revealed an admission date of 04/07/23. Observation of the medication pass on 11/15/23 at 7:30am revealed: -The medication aide (MA) administered Resident #6's morning medications. -Resident #6's hydrochlorothiazide 12.5mg was not available to administer. Observation of Resident #6's medications available for administration on 11/15/23 at 7:30am revealed there was no hydrochlorothiazide 12.5mg tablets available for administration. Interview with a MA on 11/15/23 at 12:05pm revealed: -Resident #6's responsible party (RP) delivered medications to the facility that were filled at a local pharmacy. -In the past, the MAs had to wait for the RP to bring the medications to the facility. -Resident #6 was currently out of hydrochlorothiazide. Review of Resident #6's October 2023 electronic medication administration record (eMAR) revealed. -There was an entry for hydrochlorothiazide 12.5mg daily. -Resident #6's hydrochlorothiazide 12.5mg was documented as administered from 10/01/23 to 10/31/23 at 8:00am.	D 367		

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D 367	Continued From page 95 Review of Resident #6's November 2023 eMAR revealed. -There was an entry for hydrochlorothiazide 12.5mg daily. -Resident #6's hydrochlorothiazide 12.5mg was documented as not administered with the exception code "09" indicating "other/see nurse notes" on 11/06/23, 11/07/23, 11/10/23, 11/11/23 and 11/16/23 at 8:00am. -Resident #6's hydrochlorothiazide 12.5mg was documented as administered on 11/01/23 to 11/05/23, 11/08/23, 11/09/23, and 11/12/23 to 11/15/23. Telephone interview with a MA on 11/17/23 at 3:30pm revealed: -On 11/15/23, during the medication pass, Resident #6 did not have any hydrochlorothiazide 12.5mg available to administer. -Resident #6 was out of her hydrochlorothiazide for one to two weeks. -Resident #6 could borrow the medication from her spouse who was also a resident in the facility. Review of Resident #6's progress notes from 10/27/23 to 11/16/23 revealed: -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/06/23, 11/07/23, and 11/10/23, due to "awaiting pharmacy". -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/11/23 and 11/16/23, due to "medication unavailable". -Resident #6's hydrochlorothiazide 12.5mg was not administered on 11/15/23 due to needing a prescription from the physician's assistant (PA). -There was no documentation related to medications documented as administered on 11/08/23, 11/09/23, and 11/12/23 to 11/15/23 when there was no hydrochlorothiazide available	D 367		

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D 367	Continued From page 96 on the medication cart. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/15/23 at 10:32am revealed: -They only entered her medications to be listed on the eMAR. -They had never filled medications for Resident #6 because she used an outside pharmacy Telephone interview with the pharmacist at Resident #6's preferred pharmacy on 11/15/23 at 11:02am revealed: -There was an active order for hydrochlorothiazide 12.5mg, take one tablet daily for Resident #6. -Hydrochlorothiazide 12.5mg was dispensed on 01/16/23 for a quantity of 90 tablets and again on 02/02/23 for a quantity of 90 tablets for Resident #6. -This medication was dispensed to Resident #6 when she lived in another state (prior to her admission to the facility). -There was one refill left for hydrochlorothiazide. -The pharmacy had not received any orders for hydrochlorothiazide and had not dispensed any hydrochlorothiazide for Resident #6 since 02/02/23. Review of the facility's Compliance Nurse's medication cart audit dated 11/16/23 to 11/17/23 revealed the hydrochlorothiazide 12.5mg quantity 90 was on the cart as of 11/17/23. Telephone interview with Resident #6's RP on 11/16/23 at 11:10am and 2:28pm revealed: -When Resident #6 was admitted to the facility she brought all medications that were filled prior to Resident #6's admission on 04/07/23. -The facility did notify her when medication refills	D 367		

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were needed, but she was not notified of the hydrochlorothiazide doses that were missed in November 2023.
-She always tried to get 90-day supplies and brought refills before Resident #6 ran out of medications.
-She found out today that Resident #6's hydrochlorothiazide was last filled on 02/04/23.
-She was supposed to pick up resident #6's medications today from a local pharmacy.
-The RP was instructed to call the pharmacy today (11/16/23) to see if hydrochlorothiazide 12.5mg daily could be filled.
-She was not aware, until today (11/16/23) this was the last time hydrochlorothiazide was filled.

Interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed:
-He had not had any issues with receiving Resident #6's medications.
-Resident #6 was possibly out of her medication since the middle of July 2023.
-There was no way to tell what medications were received for Resident #6 upon admission, or from the local pharmacy.
-Resident #6's RP brought in her medication from a local pharmacy.
-He could not verify if hydrochlorothiazide was dispensed between mid-July and 11/16/23.
-He was not aware that she was out of hydrochlorothiazide and not sure how long she was out of the medication

Interview with the facility's Compliance Nurse on 11/20/23 at 3:35pm revealed:
-When the MA entered the 09 code on the eMAR, they were responsible to call the pharmacy and/or their PCP on the first occurrence.
-When an outside pharmacy was used, the time frame for requesting a refill was when there was a

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seven-day supply left in the bottle or in the bubble pack.
-Some of the MAs have been allowed to transcribe orders into point click care in the past.
-The medication orders need to be approved and compared to dispensed medication prior to administration.

Interview with the Administrator on 11/20/23 at 4:45 PM revealed:
-She was not aware that staff were documenting "09" code for Resident #6 and then documenting a medication was administered when they were clearly unavailable.
-She expected the MA and RCC to notify the PCP of any missed medications.
-She was not aware that Resident 6's eMAR was inaccurate.
-She did not know if the backup pharmacy was ever contacted for Resident #6.
-She was not aware that Resident #6 was out of hydrochlorothiazide.

Refer to interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm.

Refer to interview with the Administrator on 11/20/23 at 4:38pm.

3. Review of Resident #2's current FL2 dated 04/03/23 revealed:
-Diagnoses included asthma, anemia, anxiety, chronic obstructive pulmonary disease, hypertension, hyperlipidemia, hypothyroidism, diabetes mellitus, neuropathy, depression, osteoarthritis, chronic kidney disease, benign prostatic hyperplasia, and leukopenia.
-An order for atorvastatin 80mg (a medication used to treat abnormal lipid levels) tablet daily at bedtime.

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D 367	Continued From page 99 Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 04/07/23. Review of Resident #2's Primary Care Provider's (PCP) order dated 09/07/23 revealed an order for atorvastatin 80mg tablet daily at bedtime. Review of Resident #2's October 2023 eMAR revealed: -There was an entry dated 04/12/23 for atorvastatin 80mg tablet daily scheduled for 8:00pm. -Atorvastatin 80mg was documented as administered daily between 10/11/23 and 10/31/23. Review of Resident #2's October 2023 progress notes revealed there was no documentation which indicated atorvastatin 80mg was unavailable for administration. Review of Resident #2's November 2023 eMAR revealed: -There was an entry dated 04/12/23 for atorvastatin 80mg tablet daily scheduled for 8:00pm. -Atorvastatin 80mg was documented as administered daily between 11/01/23 and 11/13/23. Review of Resident #2's November 2023 progress notes revealed there was no documentation which indicated atorvastatin 80mg was unavailable for administration. Observation of the medication cart on 11/15/23 at 9:40am revealed Resident #2's atorvastatin 80mg was not available for administration.	D 367		

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D 367	Continued From page 100 Telephone interview with a pharmacist at Resident #2's preferred pharmacy on 11/15/23 at 2:48pm revealed: -Resident #2 utilized the pharmacy to dispense atorvastatin 80mg one tablet daily refills. -The atorvastatin 80mg was not dispensed since 01/16/23 and would have been out of atorvastatin 80mg on 04/16/23. -There were no additional refill requests for Resident #2's atorvastatin 80mg. -Resident #2's responsible party was responsible for delivery of Resident #2's medications to the facility. Telephone interview with a second shift MA on 11/16/23 at 4:35pm revealed: -She documented administration of Resident #2's atorvastatin 80mg on 11/03/23, 11/04/23, 11/05/23, and 11/11/23. -She did not recall if Resident #2's atorvastatin 80mg was on the medication cart in November 2023. -She may have marked the atorvastatin 80mg as administered in error if the medication was last dispensed on 01/16/23. -MAs were not permitted to borrow medications from other residents. Refer to interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm. Refer to interview with the Administrator on 11/20/23 at 4:38pm. _____ Interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm revealed: -When a medication was not available on the medication cart it was the responsibility of the	D 367		

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D 367	Continued From page 101 RCC and the MAs to reach out to the pharmacy for a refill. -If the resident used an outside pharmacy, it was the responsibility of the RP to pick up and deliver the medication to the facility. -Medication cart audits were to be completed once a week. -He assigned them to the MAs, but he had not been doing them. -The MAs did the cart audits weekly and the facility's contracted pharmacy performed a full cart audit on 10/18/23. -If there was no medication available, he would call the pharmacy and request a new order if a prescription was needed. -When a medication was listed on the progress note with no detailed information, then it was considered not available for administration. -The "09" code meant a medication was not administered and the in between times documented as administered were not administered, because the medication was not available. -The MAs were just "being dishonest" by checking that a medication was administered when it was not available on the cart. -The "09" code does not trigger a missed medication on the missed medication report, the report only showed when a box on the eMAR was left blank. -The facility only audited the blanks on the eMAR, not the "09" codes which meant someone was out of a medication. -The in-house MAs were responsible to perform medication cart audits. -The agency MA staff did not perform cart audits, but were also responsible to ensure medications were available on the cart. Interview with the Administrator on 11/20/23 at	D 367		

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D 367	Continued From page 102 4:38pm revealed: -The MAs were responsible for administering the medications that were in the residents' eMAR, and then documenting that the medication was administered. -If the medication was not in the medication cart or the medication was not labled as the order in the eMAR, then the MA was not to administer the medication or document the medication as administered. -The SCC/RCC were responsible for weekly medication cart audits where they would find missing medications, medication order issues and medications that were not to be on the medication cart. -Following the cart audits, the SCC/RCC should notify the Compliance Nurse when there were medication issues. -When the SCC/RCC did not complete their checks and report to the Compliance Nurse, then the Compliance Nurse could not assist with issues and use the other two nurses for help.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24	D 438		

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hours of knowledge of resident injuries for 1 of 5 sampled residents (Resident #4) who had injuries of unknown origin that resulted in a fracture for her right arm.

The findings are:

Review of Resident #4's current FL2 dated 09/22/23 revealed:
-Diagnoses included Alzheimer's dementia.
-Resident #4 was constantly disoriented.
-Resident #4 was ambulatory.
-Resident #4's level of care was Special Care Unit (SCU).

Review of Resident #4's Pre-admission Screening dated 07/27/22 revealed:
-Resident #4 had a history of wandering behaviors.
-Resident #4 required assistance with dressing, bathing, and toileting.
-Resident #4 was able to feed self but required verbal cues.

Review of Resident #4's Care Plan dated 2/20/23 revealed:
-Resident #4 had a history of wandering.
-Resident #4 required supervision with bathing.
-Resident #4 was independent with ambulation and use of upper extremities.

Telephone interview with Resident #4's family member on 11/15/23 at 11:52am revealed:
-Resident #4's family came to visit her on 11/12/23.
-She stated Resident #4 was holding her right arm and seemed to be and excruciating pain.
-She took Resident #4 to an orthopedic urgent care facility where she was diagnosed with a right fractured elbow.

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D 438	Continued From page 104 -The family member reported fracture to the facility. -The family member was not notified of Resident #4 having a fall or of any an accident or incident where Resident #4 sustained an elbow fracture. -The family member stated no one at the facility knew how Resident #4 fractured her elbow. Interview with a personal care assistant (PCA) on 11/17/23 at 12:00pm revealed: -She worked first shift on 11/11/23. -She had noticed that Resident #4's arm was hurting and reported it to the two medication aides (MA). -She said that one of the MA's had put a cream on Resident #4's arm. -She did document Resident #4 complained of pain on the hourly checks and 24-hour report. Review of Resident #4's hourly checks dated 11/11/23 revealed there was documentation at 10:00am Resident #4 complained her arm hurt and for the medication aides (MA's) to call Resident #4's family member. Interview with a MA on 11/17/23 at 1:30pm revealed: -She was the assigned MA for Resident #4 on 11/11/23. -She did know that Resident #4's arm was hurting. -She did not recall Resident #4 having a fall or being told Resident # 4 had fallen. -She did not document that Resident #4 had right arm pain. -She did not know if the other MA had documented Resident #2 having right arm pain. -She did not complete a skin assessment on Resident #4. -She did not report to the oncoming shift or to	D 438		

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Resident #4's PCP about Resident #4's right arm pain.
-She did not call Resident #4's family because she stated Resident #4 told her not to call her family member.

Attempted telephone interview with another MA on 11/17/23 at 3:46pm was unsuccessful.

Review of Resident #4's orthopedic visit note dated 11/12/23 revealed:
-Resident #4 presented with right elbow pain.
-The family member was unsure of a specific fall.
-Resident #4 had a right nondisplaced radial neck fracture.
-Resident #4 was placed in a posterior splint and given a sling.

Review of Resident #4's record on 11/17/23 revealed that the facility had submitted an Accident and Incident report to the Department of Social Services on 11/16/23 at 2:05pm.

Interview with the Special Care Coordinator (SCC) on 11/20/23 at 1:20pm revealed:
-She worked as a MA on 11/12/23 when Resident #4's family member took her to the urgent care orthopedic provider.
-She did not document that Resident #4 family member took her out of the facility on 11/12/23 but should have.
-She did not know Resident #4 had a fractured elbow until the following day.
-She reported the incident to the Administrator on 11/13/23.
-She did not document that Resident #4 had a fractured elbow but should have.
-She documented on 11/13/23 she spoke with Resident #4's family member and asked the family member to bring doctor orders for the care

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D 438	Continued From page 106	D 438		

of Resident #4's arm and sling.
-She did not followup with staff to make sure Resident #4's Primary Care Provider (PCP) was notified of her right elbow fracture.
-She did not followup with staff to make sure there was an incident and accident report completed for Resident #4.
-She stated the MA should have notified Resident #4's PCP of her right elbow fracture and completed an incident and accident report.
-She did not complete an accident and incident report for Resident #4 until 11/16/23.
-She did not report the incident to the Healthcare Personnel Registry (HCPR) because this was the facility's Compliance Nurse responsibility to report to the HCRP within 24-hours.
-She did not notify the Department of Social Services.
-She was responsible for reviewing all 24-hour communication logs, including the weekend logs that she reviewed every morning, Monday through Friday.
-The MA was responsible for adding progress note documentation if there was documentation on Resident #4's 24-hour communication log.
-The MA was responsible for following up with the PCP regarding Resident #4's pain.

Telephone interview with Resident #4's PCP on 11/17/23 at 4:02pm revealed:
-She was unaware that Resident #4 had a fractured elbow.
-The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow.
-She expected the facility to notify her immediately of any resident accident or incident.

Interview with the Administrator on 11/20/23 at 4:38pm revealed:

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D 438	Continued From page 107 -She was out of the facility when she was notified of Resident #4's fractured elbow on 11/12/23 and did not return to the facility until today (11/20/23). -The Administrator was responsible for reporting and resident injury's of unknown origin to the HCPR but if absent from the facility, the SCC was responsible for reporting to the HCPR and begin an investigation that was to be started within 24-hours of the incident and completed within five days. _____ The facility failed to ensure an injury of unknown origin was reported to the HCPR for Resident #4 who sustained a fracture of her arm. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection on November 15, 2023 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 4, 2023.	D 438		
{D 451}	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	{D 451}		

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{D 451}	Continued From page 108 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 1 of 5 sampled residents (Resident #4) who sustained an injury of unknown origin that resulted in a fracture of her right arm. The finding are: Review of the facility's Incident Reports - Falls and Mobility Management Policy dated 10/01/20 revealed: -Upon move in, with significant change in condition, every 6 months, annually and after every fall episode, the nurse will assess the resident to determine their risk for falls or repeat falls. -The Executive Director or Health Services Director will assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the any injury of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from time of initial discover or knowledge of the injury by staff and documented in the resident's file. -Should a resident fall, the community must show documentation of an analysis of the circumstances of the fall and interventions that were initiated to prevent or reduce the risk of subsequent falls. Review of Resident #4's current FL2 dated 09/22/23 revealed: -Diagnoses included Alzheimer's dementia. -Resident #4 was constantly disoriented. -Resident #4's level of care was Special Care Unit (SCU).	{D 451}		

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{D 451}	Continued From page 109 Review of Resident #4's Pre-admission Screening dated 07/27/22 revealed: -Resident #4 had a history of wandering behaviors. -Resident #4 required assistance with dressing, bathing, and toileting. -Resident #4 was able to feed self but required verbal cues. Review of Resident #4's Care Plan dated 2/20/23 revealed: -Resident #4 had a history of wandering behaviors. -Resident #4 required supervision with bathing. -Resident #4 was independent with ambulation and use of upper extremities. Review of Resident #4's Incident and Accident report on 11/17/23 revealed the facility did not submit an Accident and Incident report to the Department of Social Services until 11/16/23 at 2:05pm. Review of Resident #4's orthopedic visit note dated 11/12/23 revealed: -Resident #4 presented with right elbow pain. -The family member was unsure of a specific fall. -Resident #4 had a right nondisplaced radial neck fracture. -Resident #4 was placed in a posterior splint and given a sling. Interview with the Special Care Coordinator (SCC) on 11/20/23 at 1:20pm revealed: -She worked as a MA on 11/12/23 when Resident #4's family member took her to the urgent care orthopedic provider. -She did not document that Resident #4 family member took her out of the facility on 11/12/23	{D 451}		

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{D 451}	Continued From page 110	{D 451}		

but should have.
-She did not know Resident #4 had a fractured elbow until the following day (11/13/23).
-She reported the incident to the Administrator on 11/13/23.
-She documented on 11/13/23 she spoke with Resident #4's family member.
-She did not document in Resident #4's progress note that the resident has a fractured elbow.
-She stated the MA should have notified Resident #4's PCP of her right elbow fracture and completed an incident and accident report when fracture was reported.
-It was her responsibility to followup with to make sure Resident #4's PCP was notified of her right elbow fracture but she did not.
-It was her responsibility to followup with staff to make sure there was an incident and accident report completed for Resident #4 but she did not.
-She did not complete an accident and incident report for Resident #4 until 11/16/23.
-She did not notify the Department of Social Services until 11/16/23.
-She was responsible for reviewing all 24-hour communication logs, including the weekend logs that she reviewed every morning, Monday through Friday.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/17/23 at 4:02pm revealed:
-She was unaware that Resident #4 had a fractured elbow.
-The facility did not notify her or her practice that Resident #4 had complained of arm pain nor her fractured elbow.
-She expected the facility to notify her immediately of any resident accident or incident.

Interview with the Administrator on 11/20/23 at

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{D 451}	Continued From page 111 4:38pm revealed: -She was notified of Resident #4's fractured elbow on 11/12/23. -She was not aware that Resident #4 did not have an accident and incident report filled out until 11/16/23. -The SCC was responsible for completing accident and incident reports and was responsible for notifying the Department of Social Services. -She was not aware the SCC did not notify the Department of Social Services. -She expected the SCC to complete all Accident and Incident reports and to notify the Department of Social Services.	{D 451}		
{D 459}	10A NCAC 13F .1302 Special Care Unit Disclosure 10A NCAC 13F .1302 Special Care Unit Disclosure (a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders. (b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to disclose the form of care and treatment provided for residents in the Special Care Unit (SCU) for 3 of 3 residents (Residents #1, #4 and #5).	{D 459}		

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{D 459}	Continued From page 112 The findings are: 1.Review of Resident #1's current FL2 dated 02/13/23 revealed: -Diagnoses included late onset Alzheimer's Dementia. -Resident #1's level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 12/10/20. Review of Resident #1's record on 11/14/23 revealed there was not a signed SCU disclosure statement. Refer to interview with the Business Office Manager (BOM) on 11/20/23 at 10:48am. Refer to interview with the Special Care Coordinator (SCC) on 11/20/23 at 1:20pm. Refer to interview with the Administrator on 11/20/23 at 4:38. 2. Review of Resident #4's current FL2 dated 09/22/23 revealed: -Diagnoses included Alzheimer's dementia. -Resident #4's level of care was SCU. Review of Resident #4's Resident Register revealed an admission date of 07/26/21. Review of Resident #4's record on 11/15/23 revealed there was not a signed SCU disclosure statement. Telephone interview with Resident #4's family member on 11/15/23 at 11:52am revealed she did	{D 459}		

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{D 459}	Continued From page 113 sign and complete admission paperwork that was given to her but did not recall if the disclosure statement was part of the admission paperwork. Refer to interview with the BOM on 11/20/23 at 10:48am. Refer to interview with the SCC on 11/20/23 at 1:20pm. Refer to interview with the Administrator on 11/20/23 at 4:38. 3. Review of Resident #5's current FL2 dated 04/21/23 revealed: -Diagnoses included vascular dementia with behavioral disturbance. -Resident #5's level of care was SCU. Review of Resident #5's Resident Register revealed an admission date of 12/29/20. Review of Resident #5's record on 11/14/23 revealed there was not a signed SCU disclosure statement. Telephone interview with Resident #5's family member on 11/16/23 at 3:47pm revealed she did remember signing admission paperwork but was uncertain if she specifically signed a resident disclosure statement. Refer to interview with the BOM on 11/20/23 at 10:48am. Refer to interview with the SCC on 11/20/23 at 1:20pm. Refer to interview with the Administrator on 11/20/23 at 4:38.	{D 459}		

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{D 459}	Continued From page 114 Interview with the BOM on 11/20/23 at 10:48am revealed: -She was responsible for obtaining the signature on the SCU Disclosure Statement during the admission process. -She complied the admission paperwork which included the SCU Disclosure Statement and gave the admission packet to the SCC for the resident's record. -There were not any new admissions for her to obtain the SCU Disclosure Statements. Interview with the SCC on 11/20/23 at 1:20pm revealed: -She was hired about 30 days ago and there were not any new admissions to the SCU. -She had not completed any audits of the SCU resident's records for the Disclosure Statement. Interview with the Administrator on 11/20/23 at 4:38 revealed: -The SCC was responsible for auditing the resident's record in the SCU to make sure the Disclosure Statements were there and signed. -She was not aware the audit was not completed. -The BOM was responsible for ensuring the SCU disclosure was reviewed and signed upon admission to the SCU.	{D 459}		
{D 468}	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and	{D 468}		

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{D 468}	Continued From page 115 training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues and the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure that 3 of 6 sampled staff, (Staff D, Staff E, Staff F) completed 6 hours of orientation on the nature and needs for the residents of the Special Care Unit (SCU) within the first week of employment. The findings are:	{D 468}		

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{D 468}	Continued From page 116 Review of the facility's current license dated 01/01/23 revealed the facility was licensed as an Alzheimer's/Dementia SCU with a capacity of 48 residents. Review of the facility's current census tracking log revealed the SCU census on 11/14/23 was 40 residents. 1. Review of Staff D's medication aide (MA) personnel record revealed: -Staff D's hire date was 08/19/23. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff D. Review of Staff D's schedule for 10/27/23 through 11/12/23 revealed Staff D worked in the SCU on 10/29/23, 10/30/23, 10/31/23, 11/01/23, 11/02/23, 11/07/23, 11/05/23, 11/06/23, 11/07/23, and 11/08/23. Telephone interview with Staff D on 11/16/23 at 2:15pm revealed: -She was employed through a staffing agency. -She had been working in the facility's SCU as a MA since August 2023. -Since she started working at the facility, she had not received any training related to SCU orientation and care needs of the SCU residents. Refer to interview with the Resident Care Coordinator (RCC) on 11/20/23 at 12:33pm. Refer to interview with the Business Office Manager (BOM) on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm.	{D 468}		

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{D 468}	Continued From page 117 Refer to interview with the Administrator on 11/20/23 at 4:40pm. 2. Review of Staff E's MA personnel record revealed: -Staff E's hire date was 10/17/23. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff E. Review of the employee schedule for 10/27/23 through 11/12/23 revealed Staff E worked in the SCU on 11/01/23, 11/03/23, 11/04/23, 11/05/23, 11/08/23, and 11/09/23. Interview with Staff E on 11/16/23 at 11:10am revealed: -She was employed through the facility's contracted staffing agency. -She had been working at the facility as a MA since October 2023. -She was occasionally scheduled to work in the SCU. -On 11/16/23, she was scheduled to work in the SCU. -Since she started working at the facility, she had not received any training related to SCU orientation and care needs of the SCU residents. -She had to ask the facility staff to help her visually verify residents in the SCU, because she did not know the residents. Refer to interview with the RCC on 11/20/23 at 12:33pm. Refer to interview with the BOM on 11/20/23 at 10:46am. Refer to interview with the facility's Compliance	{D 468}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060166	A. BUILDING: _____ B. WING _____	R-C 11/20/2023

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{D 468}	Continued From page 118 Nurse on 11/20/23 at 3:33pm. Refer to interview with the Administrator on 11/20/23 at 4:40pm. 3. Review of Staff F's MA personnel record revealed: -Staff F's hire date was 10/24/23. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff F. Review of the employee schedule for 10/27/23 through 11/12/23 revealed Staff F worked in the SCU on 10/31/23, 11/03/23, 11/10/23, and 11/12/23. Telephone interview with Staff F on 11/16/23 at 2:00pm revealed: -She was employed by the facility's contracted staffing agency. -She had been working at the facility as a MA since October 2023. -She was frequently scheduled to work in the SCU. -Since she started working at the facility, she had not received any training related to SCU orientation and the care needs of the SCU residents. Telephone interview with the facility's contracted staffing agency owner on 11/16/23 at 11:40am revealed: -The facility had contracted with the staffing agency to provide staff for the facility's SCU. -The facility was responsible for providing any necessary training to the staffing agency staff upon being scheduled to work in the facility. -She had offered the facility a complimentary 1-hour in-facility orientation for each staffing	{D 468}		

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{D 468}	Continued From page 119 agency staff prior to each staff's first shift in the SCU. -The facility never requested the staffing agency orientation opportunity. -Between August 2023 and November 2023, numerous staffing agency staff which were scheduled to work in the facility's SCU had expressed concern for a lack of orientation to the residents. Interview with the RCC on 11/20/23 at 12:33pm revealed: -He was responsible to schedule staff to work in the SCU. -He was not responsible for any training requirements for staff. -The contracted staffing agency and the facility's Compliance Nurse were responsible for training agency staff. -The Administrator was responsible to keep agency staff personnel records. Interview with the BOM on 11/20/23 at 10:46am revealed: -She was not aware staff scheduled to work in the SCU required a minimum of 6 hours of facility specific orientation, on the nature and needs for the residents of the SCU, within the first week of employment. -The Administrator made her aware of the 6 hour SCU training requirements within the past week. -The facility's Compliance Nurse was responsible for all staff training requirements. -She kept training sign-in sheets in a binder for facility staff training. -Individual staff training certificates were the responsibility of the trainer and should be kept in personnel records. -She was responsible for auditing facility staff training records weekly.	{D 468}		

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{D 468}	Continued From page 120 -The facility utilized staffing agency staff since August 2023. -She did not maintain or audit agency staff training records. Interview with the facility's Compliance Nurse on 11/20/23 at 3:33pm revealed: -She was responsible to provide training for staff. -The BOM was responsible for notifying her of any staff requiring training. -She was not aware of the 6 hours of orientation on the nature and needs of the residents of the SCU for staff scheduled to work in the SCU. -She had not provided any training to staff related to the 6 hours of orientation to SCU residents. Interview with the Administrator on 11/20/23 at 4:40pm revealed: -The BOM was responsible to audit facility staff training records. -The BOM was responsible for notifying the facility's Compliance Nurse of any training needs. -The BOM did not maintain staff training records for staffing agency staff. -The facility utilized staffing agency staff since August 2023. -Staff D was frequently scheduled to work in the SCU. -She was not familiar with Staff E or Staff F's schedules. -She was aware staffing agency staff were required to have a minimum of 6 hours of SCU orientation within the first week of employment. -The facility had overlooked auditing of staffing agency staff training records related to a minimum of 6 hours of orientation on the nature and needs for the residents of the SCU within the first week of employment. _____	{D 468}		

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{D 468}	Continued From page 121 The facility failed to ensure 3 of 6 sampled staff completed 6 hours of orientation training on the nature and needs for the residents of a SCU within the first week of employment, resulting in staff being unable to have the basic knowledge needed to care for residents in the SCU with a diagnoses of Alzheimer's dementia and vascular dementia with behavioral disturbances. Agency staff had not received any SCU training related to orientation and care needs of the SCU residents, or there was a lack of orientation provided regarding the SCU residents, agency staff asked facility staff to help visually verify residents, because agency staff did not know the residents. The facility's failure was detrimental to the health, safety, and well-being of the residents, which constitutes a Type Unabated B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/17/23 for this violation. CORRECTION DATE FOR THE TYPE UNABATED B VIOLATION SHALL NOT EXCEED JANUARY 4, 2024.	{D 468}		