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D 000	Initial Comments The Adult Care Licensure Section and New Hanover County Department of Social Services conducted an annual survey and complaint investigation on October 17-19, 2023. The complaint investigation was initiated by the New Hanover County Department of Social Services on September 15, 2023.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) as evidenced by 7 of 16 fixtures with hot water temperatures from 118 to 123 degrees F. The findings are: Observations of hot water temperatures on the special care unit (SCU) on 10/17/23 at 10:40am revealed: -The hot water temperature in the bathroom sink of resident room 224 was 120 degrees F. -The hot water temperature in the bathroom sink of resident room 225 was 118 degrees F. -The hot water temperature in the bathroom sink	D 113		

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of resident room 226 was 118 degrees F.
-The hot water temperature in the bathroom sink of resident room 227 was 119 degrees F.
-There were no signs posted in the bathrooms of rooms 224, 225, 226 and 227 to caution on increased hot water temperatures.

Review of the facility's county environmental health inspection dated 09/01/23 revealed:
-The facility's overall score was 94 with 6 total demerits.
-There was 1.5 demerits for hot water being outside the parameters of 100 and 116 degrees F.
-There was a comment that hot water temperatures were observed above 116 degrees F throughout the facility in shared employee/resident restrooms and resident rooms.
-Resident rooms and actual temperatures were unspecified.

Review of the facility's Weekly Water Temperature Log dated 08/23/23 revealed:
-There were hot water temperatures documented for 10 resident rooms ranging from 110 to 116 degrees F dated 08/23/23.
-There were no hot water temperatures documented for any other dates.

Review of the facility's Weekly Water Temperature Log dated 10/12/23 revealed:
-There were hot water temperatures documented for 8 resident rooms, the laundry room and the kitchen ranging from 110 to 116 degrees F in resident rooms dated 10/12/23.
-The hot water temperature for the laundry room was 122 degrees F and the kitchen was 125 degrees F.
-There were no hot water temperatures documented for any other dates.

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D 113	Continued From page 2 Interview with a medication aide (MA) on 10/17/23 at 10:49pm revealed: -Sometimes the hot water ran too hot. -The hot water was off one day last week (10/10/23). -There had been a few hot water shutdowns since then for 1-2 hours while maintenance worked on the boiler. -The maintenance person monitored hot water temperatures. Interview with the maintenance assistant on 10/17/23 at 10:53am and 11:24am revealed: -The hot water heater thermatic mixer temperature was adjusted last Thursday (10/12/23) after the mixing valve was replaced. -He had not checked hot water temperatures since last week because his thermometer was broken. -He would adjust the thermostat and it would take approximately half a day for the hot water to be regulated. Observations of hot water temperatures checked by the maintenance person on 10/17/23 at 11:16am revealed: -The hot water temperature in the bathroom sink of resident room 226 was 123 degrees F. -The hot water temperature in the bathroom sink of resident room 227 was 120 degrees F. -The hot water temperature in the bathroom sink of resident room 218 was 119 degrees F. -The hot water temperature in the bathroom sink of resident room 107 was 120 degrees F. -There were no signs posted in the bathrooms of rooms 107, 118, 226 and 227 to caution on increased hot water temperatures. Interview with the Administrator on 10/17/23 at	D 113		

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2:55pm revealed:
-They had not had a Maintenance Director since July 2023.
-The Maintenance Director was responsible for ensuring the hot water temperatures were monitored and maintained between 100 and 116 degrees F.
-She did not know if there were hot water temperature logs.
-The maintenance assistant should have been monitoring hot water temperatures weekly.
-The maintenance assistant might have monitored the hot water temperatures monthly because the facility had changed from monthly to weekly monitoring a few weeks ago.

Interview with the maintenance assistant on 10/17/23 at 3:22pm revealed:
-The previous Maintenance Director instructed him to check hot water temperatures monthly.
-Hot water temperature monitoring changed to weekly last week, so he was just starting weekly hot water temperature monitoring.

Interview with the Administrator on 10/17/23 at 4:00pm revealed:
-She was not aware of the hot water temperatures above 116 degrees F documented in the county environmental health inspection dated 09/01/23.
-She was not in the facility when the county environmental health inspection was done.
-The report probably prompted the maintenance assistant to initiate the hot water heater repairs.
-The delay from 09/01/23 to 10/12/23 was due to waiting for parts to complete the repairs.

Interview with the maintenance assistant on 10/19/23 at 10:55am revealed:
-He could not remember if he saw the county

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D 113	Continued From page 4 environmental health inspection dated 09/01/23. -The inspection reports usually went to the Maintenance Director. -09/01/23 was around the time he became aware of problems with the hot water heater. -He called a plumbing company and there was a delay because the part had to be ordered -He told the Administrator about the needed repairs for the hot water heater. Interview with the Administrator on 10/19/23 at 5:44pm revealed: -The maintenance assistant told her about elevated hot water temperatures in early September 2023 unrelated to the environmental health inspection report. -She was responsible for making residents aware of the elevated hot water temperatures. -She sent an electronic mail notification to residents and family and family members of the work that was done on the hot water system.	D 113		
D 183	10A NCAC 13F .0603(a) Management of Facilities With A Capacity Or 10A NCAC 13F .0603 Management of Facilities with a Capacity or Census of 81 or More Residents (a) An adult care home with a capacity or census of 81 or more residents shall be under the direct control of an administrator, who shall be responsible for the operation, administration, management and supervision of the facility on a full-time basis to assure that all care and services to residents are provided in accordance with all applicable local, state and federal regulations and codes. The administrator shall be on duty in the facility at least eight hours per day, five days per week and shall not serve simultaneously as a	D 183		

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personal care aide supervisor or other staff to meet staffing requirements while on duty as an administrator or be an administrator for another adult care home except as follows. If there is more than one facility on a contiguous parcel of land or campus setting, and the combined licensed capacity of the facilities is 200 beds or less, there may be one administrator on duty for all the facilities on the campus. The administrator shall not serve simultaneously as a personal care aide supervisor in this campus setting. For staffing chart, see Rule .0606 of this Subchapter.

This Rule is not met as evidenced by:
Based on observations and interviews the Administrator failed to ensure all care and services to residents were provided in accordance with state rules and regulations related to other requirements, tuberculosis tests, medical exam and immunizations, personal care and supervision, nutrition and food services, and medication administration.

The findings are:

Review of the facility's current license effective 01/01/23 through 12/31/23 revealed the facility had a licensed capacity of 101 beds with 28 special care unit (SCU) beds.

Review of the facility's census report dated 10/17/23 revealed there were 75 residents in the facility.

Interview with the Business Office Manager (BOM) on 10/17/23 at 8:55am revealed:

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-The Administrator was out of the area.
-She and all other managers on duty would be in charge in the absence of the Administrator.
-There were 86 residents in the facility.

Telephone interview with the Administrator on 10/17/23 at 9:00am revealed:
-She would be away from the facility until that afternoon (10/17/23).
-The Director of Resident Care (DRC) would be her point person in her absence.
-The DRC was newly hired to that role on 10/13/23.
-She was available by phone.

Telephone interview with a family member on 10/17/23 at 4:30pm revealed:
-No one from the facility had contacted her after her family member died on 09/02/23 at the facility after being there for one week.
-She had questions that no one took the time to answer.
-No one called to explain what happened or did not happen.

Telephone interview with a personal care aide (PCA) on 10/19/23 at 6:05am revealed:
-There was no communication for what each resident needed such as fall risks, coming back from the hospital, and what they could and could not eat.
-There was no consistency in care assignments, so it was hard to learn about each resident.
-She would find out new residents were admitted to the facility when they used their call pendant.
-She did not make a habit of checking previously empty rooms routinely.
-When she asked the MAs about the needs of residents, they only had a list of medications.
-No one knew the chain of command.

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-PCAs were responsible for reporting to the MA and then there was the Business Office Manager (BOM) and the Administrator.
-The BOM was responsible for a lot of things but there was no structure or system for resident care.
-There were staffing issues related to staff coming one and half hours late for their shift, 1 PCA and 1 MA for the entire first floor and staff with bad attitudes.

Telephone interview with a medication aide (MA) on 10/19/23 at 5:49am revealed:
-He was the third shift MA on duty for the assisted living (AL) side.
-He did not think there was a PCA by [name listed on schedule] who worked at the facility.
-After looking at the schedule, he saw she was working on the second floor AL.

Interview with a medication aide (MA) on 10/19/23 at 10:15am revealed:
-She was responsible for reporting to the new Director of Resident Care (DRC).
-Prior to this week (10/16/23) she reported to the Assistant DRC who was formerly the special care unit (SCU) Director.
-She did not know a resident was out of the facility on 10/19/23 with a family member because no one told her.

Interview with a personal care aide (PCA) on 10/19/23 at 10:30am revealed:
-She did not know Resident #6 was out of the facility.
-No one told her.
-There was a lack of communication about resident care at the facility.

Interview with the Assistant Director of Resident

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Care (DRC) on 10/19/23 at 5:29pm revealed:
-She was the SCU Director until she became the Assistant DRC 2-3 weeks ago.
-For the last 2-3 weeks she had been going back and forth between both roles.
-She tried to check the SCU every 2 hours if she could, it depended on what was going on in the building.
-She was last on the SCU at 3:34pm on 10/19/23.

Telephone interview with the former DRC on 10/19/23 at 6:16pm revealed:
-She worked at the facility from June 2023 to September 2023.
-She was responsible for resident assessments, new hire training, FL-2s, and care plans.
-She and the former Assistant DRC were responsible for processing orders.
-She was not comfortable with MAs processing orders.
-She had concerns working at the facility about staffing and the medication process.
-She did not want to discuss specific concerns.
-Resident needs identified during assessments were verbally communicated to staff on duty at shift change.
-Staff were responsible for communicating to the next shift during shift change report.
-Staff had access to electronic assessments and care plans.

Interview with the current Director of Resident Care (DRC) on 10/19/23 at 11:07am revealed:
-She was responsible for overseeing the SCU since 10/13/23.
-She and the Assistant DRC were responsible for overseeing the entire facility including all the assisted living (AL) and SCU halls.
-PCAs reported to MAs, MAs reported to the Wellness Secretary which was a new position as

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of 10/16/23, the Assistant DRC and her.
-She thought staff lacked a sense of direction prior to 10/13/23.

Interview with the Administrator on 10/19/23 at 5:44pm revealed:
-She had been the Administrator for one year and was working to resolve staffing and related issues since the pandemic.
-The facility had been without a Maintenance Director since July 2023.
-The former DRC and Assistant DRC left the first week of September 2023.
-She was continuously hiring and training PCAs and MAs.
-She was responsible to be in the facility and ensure resident care and safety.
-She walked around the facility daily and spent time in the dining rooms to observe and help with serving meals.

Noncompliance was identified in the following areas:

1. Based on interviews and record reviews, the facility failed to supervise 1 of 5 sampled residents (#5) for a resident who required special services according to the facility's pre-admission assessment including visual checks, hourly checks, night checks, additional safety monitoring and additional health monitoring. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care & Supervision Type A1 Violation]

2. Based on observations, interviews and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) as evidenced by 7 of 16 fixtures with hot water temperatures from 118 to 123 degrees F. [Refer to Tag 113, 10A NCAC

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D 183	Continued From page 10 13F .0311(d) Other Requirements] 3. Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#2) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. [Refer to Tag 234, 10A NCAC 13F .0703(a)Tuberculosis Tests, Medical Examination & Immunizations] 4. Based on observations, interviews and record reviews, the facility failed to ensure personal care assistance for 2 of 6 sampled residents (#2 and #6) who required assistance with indwelling catheter care (#2) and toileting and incontinence care #6. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision] 5. Based on observations and interviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. [Refer to Tag 286, 10A NCAC 13F .0904(b)(1) Nutrition & Food Service] 6. Based on observations and interviews the facility failed to ensure snacks were offered to all residents between meals. [Refer to Tag 299, 10A NCAC 13F .0904(d) Nutrition & Food Service] 7. Based on observations, interviews, and record reviews, the facility failed to ensure residents, who required assistance with eating, were assisted upon receipt of the meal and the assistance was provided in a manner which maintained and enhanced each resident's dignity and respect for 1 of 1 sampled resident (#8), who required feeding assistance. [Refer to Tag 312, 10A NCAC 13F .0904(f)(2) Nutrition & Food Service]	D 183		

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D 183	Continued From page 11 8. Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#2 and #9) observed during the morning medication pass including a hormone replacement and laxative (#9), and a stool softener (#2); and for 2 of 5 sampled residents for record review including narcotic pain and blood clot prevention medications, (#2) and corticosteroid medication (#4). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration] 9. Based on observations, interviews and record reviews, the facility failed to ensure medications prepared in advance for 3 of 8 sampled residents (#10, #11 and #12) were kept in a sealed package where the medications were identified and protected from contamination and spillage up to the point of administration. [Refer to Tag 363, 10A NCAC 13F .1004(f) Medication Administration] 10. Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#1) including inaccurate documentation for two medications used to treat infections. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration]	D 183		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted	D 234		

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by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#2) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health.

The findings are:

Review of Resident #2's current FL-2 dated 03/23/23 revealed diagnosis included generalized weakness.

Review of Resident #2's Resident Register revealed he was admitted to the facility on 03/23/23.

Review of Resident #2's record revealed:
-There was a report of tuberculosis (TB) screening evaluation dated 03/22/23.
-The report showed the 1st tuberculin skin test was 03/22/23 .
-There was no record of the results of the test being read.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

Interview with the Executive Director on 10/17/23 at 4:24pm revealed:
-The facility nurse who was responsible for

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D 234	Continued From page 13 ensuring that TB skin tests were done for residents upon admission along with the 2nd step no longer worked with the facility. -She audited the residents' record in April 2023 for care plans and licensed health professional task (LHPS) (not sure of exact date) after the nurse left but she did not audit TB skin test. -She was not aware Resident #2 needed a TB skin test.	D 234		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure personal care assistance for 2 of 6 sampled residents (#2 and #6) who required assistance with indwelling catheter care (#2) and toileting and incontinence care #6. The findings are: 1. Review of Resident #6's current FL-2 dated 10/18/23 revealed: -Diagnoses included dementia, rash, hypertension, chronic obstructive pulmonary disease, history of lung cancer and insomnia. -The resident was constantly disoriented and required assistance with bathing and dressing.	D 269		

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Review of Resident #6's current Care Plan dated 10/11/23 revealed she was dependent on staff for incontinence care every 1-2 hours.

Upon request on 10/18/23 and 10/19/23, documentation of Resident #6's assistance provided with activities of daily living (ADLs) was not provided for review.

Observation of Resident #6 on 10/17/23 at 9:57am revealed:
-She was lying in her bed with her eyes closed with a wheelchair next to her bed.
-There was a strong urine odor in her room.
-There was a wet mark on the bed sheet underneath her from her upper thigh to her lower back.
-The mark was surrounded by a larger dried yellow stain approximately 2 inches from where she was laying.

Observation of Resident #6 on 10/17/23 at 11:14am revealed:
-She was still lying in her bed with her eyes closed.
-The wet mark had spread to approximately 4 inches from her and covered the former dried yellow staining.

Interview with a personal care aide (PCA) on 10/17/23 at 4:10pm revealed:
-Resident #6 was sitting in her wheelchair in the TV room.
-The resident required standby assistance with bathing and toileting.
-The resident required toileting reminders because she did not remember to use the toilet.
-Her room normally smelled like urine.

Interview with a second PCA on 10/18/23 at

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D 269	Continued From page 15 9:06am revealed: -Residents were checked for incontinence care and toileting needs every 2 hours. -She was not assigned to Resident #6 by herself. -PCAs worked together on the special care unit (SCU) to provide personal care assistance such as toileting and incontinence care. -The PCAs knew which residents had been changed and toileted because they talked to each other and let each other know. -Resident #6 should have been checked and changed 3 times since the start of first shift at 6:00am on 10/17/23. -She did not know Resident #6 was wet because it was not communicated to her. -There were 3 PCAs on duty for first shift on 10/17/23, she was not the only one responsible for providing assistance to Resident #6. Interview with a third PCA on 10/18/23 at 9:11am revealed: -PCAs worked together to care for residents in the SCU. -PCAs let each other know who had been changed. -She checked Resident #6 that morning (10/17/23) and the resident was not wet. -She did not know Resident #6 was wet and needed to be changed. -She and another PCA got Resident #6 up before lunch and assisted her with a shower and changed her bed linens because she was "soaked". Interview with a medication aide (MA) on 10/19/23 at 10:15am revealed: -Sometimes Resident #6 did not get up for breakfast. -PCAs were responsible for checking and changing residents every 2 hours even if the	D 269		

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resident was not up for breakfast.
-Resident #6 and her bed should have been changed before 10:30am on 10/17/23.
-All residents should be checked and changed every 2 hours to make sure they were safe, had not fallen, did not need anything and to prevent skin breakdown.
-MAs were responsible for making sure residents were cared for by PCAs.
-She checked residents with medication passes and at each meal.
-It was possible to check behind PCAs when there were 3 MAs on duty in the building.
-It was not always possible to check behind PCAs when there were only 2 MAs on duty in the building.

Interview with the Assistant Director of Resident Care (DRC) on 10/19/23 at 5:29pm revealed:
-PCAs were responsible for checking residents every 2 hours for toileting needs and changing if soiled.
-She did not know Resident #6 was lying in her bed soaked in urine at 10:30am and 11:15 am on 10/17/23.
-She had found residents soiled and needing to be changed on previous occasions.
-She had discussions with staff about ensuring every 2 hour changes.

Interview with the DRC on 10/19/23 at 11:07am revealed:
-Any staff (MAs and PCAs) who saw Resident #6 were responsible for cleaning her; we can all smell when someone needed incontinence care.
-PCAs were primarily responsible for checking and changing residents every 2 hours and as needed.

Interview with the Administrator on 10/19/23 at

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D 269	Continued From page 17 5:44pm revealed: -The DRC told her about Resident #6 being found soaked in urine on 10/17/23. -It should not have happened. -PCAs preferred to work together over having assignments, however not having assignments was contributed to Resident #6 not being changed. 2. Review of Resident #2's current FL-2 dated 03/23/23 revealed diagnosis included generalized weakness. Review of Resident #2's Resident Register revealed he was admitted to the facility on 03/23/23. Review of a picture provided by the family of Resident #2 on 10/17/23 revealed the foley catheter leg bag was secured to his knee. Interview with Resident #2's family member on 10/17/23 at 2:51pm revealed: -The resident called her on 10/15/23 at 6:35am complaining that the staff put his foley leg bag on wrong by placing it on his knee. -He told the staff the bag did not belong on his knee. -He has had several urinary tract infections (UTI) since being admitted to the facility. Interview with the hospice nurse on 10/17/23 at 10:01am revealed: -She had never been to the facility and witnessed the foley catheter leg bag on wrong. -A family member showed her a picture of the foley catheter leg bag placed on Resident #2's knee. -The foley catheter leg bag should be placed around Resident #2's ankle.	D 269		

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D 269	Continued From page 18 -If the foley catheter leg bag was placed incorrectly it could prevent gravity and cause the urine not to drain and go back up to the bladder. -If the urine did not drain correctly and went back up to the bladder it could cause a UTI or bladder infection which could lead to sepsis of another 'bad 'infection. Interview with the Director of Resident Care (DRC) on 10/19/23 at 10:07am revealed: -She provided training to the staff on how to change the tubing and switch the night bag to the foley catheter leg bag for Resident #2. -She demonstrated to staff how to disconnect the tubing to prevent infection. -The foley catheter leg bag should be placed slightly below the knee around the calf. -The foley catheter leg bag should not be placed on the knee, to prevent improper drainage. Interview with the Assistant Director of Resident Care on 10/19/23 at 10:52am revealed: -She changed Resident #2's foley catheter leg bag tubing. -The bag should not be placed on resident's knee, to prevent urine drainage and possibly urine backing up into the bladder, which could cause an infection or other issues. Interview with the Executive Director on 10/19/23 at 12:02pm revealed she was not aware of any concerns or issues with Resident #2 because the family never discussed anything with her.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 270		

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D 270	Continued From page 19 (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to supervise 1 of 5 sampled residents (#5) for a resident who required special services according to the facility's pre-admission assessment including visual checks, hourly checks, night checks, additional safety monitoring and additional health monitoring. The findings are: Review of Resident #5's current FL-2 dated 08/23/23 revealed: -Diagnoses included cerebral infarction, left dominant side hemiparesis, cardiomyopathies, congestive heart failure, hyperlipidemia, gastro-esophageal reflux disease, and prediabetes. -He was intermittently disoriented, semi-ambulatory, and required assistance with bathing and dressing. Review of Resident #5's pre-admission assessment dated 08/18/23 revealed: -He had mild confusion. -He was non-ambulatory, required staff assistance with transfers and used a wheelchair for mobility. -He required staff assistance with toileting, bathing, and dressing. -He required special services including visual	D 270		

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checks, hourly checks, night checks, additional safety monitoring and additional health monitoring.

Review of Resident #5's physical therapy (PT) evaluation dated 08/28/23 revealed he had deficits in gait, balance and left upper and lower extremity strength and coordination.

Review of Resident #5's electronic progress notes dated 08/25/23 through 09/02/23 revealed:
-He moved into the facility on 08/25/23.
-There were no progress note entries from 08/25/23 until 09/02/23.
-Staff documented he was deceased at 1:34pm on 09/02/23.

Review of Resident #5's Emergency Medical Services (EMS) Report dated 09/02/23 revealed:
-EMS was called at 6:28am and arrived at the facility at 6:39am.
-EMS found the resident at 6:41am with obvious signs of death.
-His skin was cold and dry with dilated pupils.
-There was an absence of rise and fall in his chest.
-There was rigor (mortis) in his upper and lower extremities. (Rigor mortis is a stiffening of the joints and muscles of the body.)

According to the National Institute of Health dated 05/23/23, rigor mortis appears approximately 2 hours after death in the muscles of the face, progressing to the limbs over the next few hours, completing between 6 to 8 hours after death.

Telephone interview with Resident #5's family member on 10/17/23 at 4:30pm revealed:
-Resident #5 moved into the facility one week before he died.

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D 270	Continued From page 21 -She saw him every day that he was at the facility. -His breathing was "a little off" that week (08/28/23). -She spoke with the former Director of Resident Care (DRC) on 08/30/23 and asked for a review of his medications. -His breathing was the same on that Thursday (08/31/23) and Friday (09/01/23), it was "a little heavy". -He had been able to participate in PT each day that week (08/28/23). -That Friday (09/01/23), Resident #5 asked her to take him to the bank and to the market. -He was fine that day. -She brought him back to the facility that evening (09/01/23) at about 5:30pm. -She assisted him into his bed, put a blanket over him and set his wheelchair next to his bed. -The next thing she heard was a call from a medication aide (MA) at 6:35am that Saturday (09/02/23) that they had found Resident #5 unresponsive in his wheelchair with a towel over his head. -She went to the facility immediately that morning (09/02/23). -The former DRC arrived and gave her condolences. -Staff (uncertain who) took Resident #5 out of his wheelchair (after he was deceased) and put him in his bed before she saw him. -Resident #5 was wearing the same clothing he had on that Friday (09/01/23). -Staff (uncertain who) had covered him with a blanket, but his shoes were still on the bed. -Resident #5's room was only 2 or 3 doors down from the nursing station -Once Resident #5 was placed in the bed, his legs were stiff and folded as if he was sitting in the wheelchair. -He was lying on his side facing the wall.	D 270		

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-She found the call pendant given to Resident #5 in the bathroom hanging in the shower.
-The MA called her later that day (09/02/23) to tell her a staff checked on Resident #5 at 4:00am on 09/02/23.
-She did not understand why the MA would call her to just say that.
-The facility gave their word he would be checked on every 2 hours when he was admitted.
-The facility said he had the call pendant to call staff if he needed anything else.
-She brought the pendant to the front desk person and told her she had found it hanging in the shower in the resident's bathroom.

Interview with a personal care aide (PCA) on 10/18/23 at 4:34pm revealed:
-She worked the evening of 09/01/23 and was assigned to Resident #5's hall.
-There was nothing out of the ordinary that evening.
-Resident #5 did not eat dinner in the dining room that evening (09/01/23).
-She delivered his meal to his room.
-She removed the plate on her last rounds "between 9:17pm and 9:40pm".
-He ate the full meal.
-She knew the exact time because she had to take the trash to the dumpster before the end of her shift.
-She helped Resident #5 change into sweatpants and a white tee shirt before bedtime that evening.
-She checked residents every 2 hours and whenever they used their call pendant.
-Staff did not document every 2 hour checks.
-When she checked residents, she asked if they needed anything and some, she knew their normal evening routine, so she was able to anticipate their needs.
-Resident #5 was in his bed at the end of her shift

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D 270	Continued From page 23 (10:00pm) on 09/01/23. Interview with a second PCA on 10/18/23 at 4:29pm revealed: -She was working the evening of 09/01/23. -Resident #5 seemed okay that evening. -She assisted him in his wheelchair to the dining room where he ate dinner. -The family member told her Resident #5 was recovering from a recent stroke. -Resident #5 was able to stand but not walk. -Resident #5 required help with toileting and showering. -She was not assigned to his hall, so she did not see him anymore after dinner that evening (09/01/23). Telephone interview with a MA on 10/19/23 at 3:07pm revealed: -She was the MA on duty from 6:00pm on 09/01/23 until 6:00am on 09/02/23. -She gave Resident #5 his evening medications while he sat on the edge of his bed. -Resident #5 took his medications without any problems. -Resident #5 had asked her for some applesauce, and she brought it back to him after administering his medications. -Those were the only interactions she had with Resident #5 that evening (09/01/23). -There was one PCA for the first floor from 10:00pm on 09/01/23 until 6:00am on 09/02/23. -There were 36 to 38 residents on the first floor. -She was on one side (hall) and the PCA was on the other hall. -You could not see one hall from the other on the first floor because it was a large square with a large courtyard in the center. -She did not know if the PCA checked every resident every 2 hours because she could not see	D 270		

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the PCA.
-Every time she saw the PCA that night, the PCA was in and out of resident rooms.
-It was normal to have 1 PCA and 1 MA on the first floor for the third shift and it was usually busy especially if there were incidents.
-At approximately 2:00am on 09/02/23, another resident who was taking blood thinners fell and was bleeding from her mouth.
-The PCA had to stay with the other resident while she gathered paperwork and unlocked the front door for emergency medical services (EMS).
-That incident tied her and the PCA up for approximately 45 minutes.
-The other resident refused to go to the emergency room (ER) so she (MA) had to stay on that hall and monitor that resident.
-She kept the resident's door open so she could walk by and see her frequently.
-The other resident was not on the same hall as Resident #5.
-Additionally, the pharmacy came that night with a medication delivery.
-She had to check all the medications packed with the packing list and sign for the delivery.
-She had to separate the first and second floor medications.
-The second floor MA put the medications on the second floor carts and she took care of putting away the first floor medications.
-Managing the pharmacy delivery took about 30 to 45 minutes.

Review of Resident #5's September 2023 electronic medication administration record (eMAR) revealed a topical cream was applied at 8:06pm.

Telephone interview with a third PCA on 10/19/23 at 6:05am revealed:

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D 270	Continued From page 25 -She was working third shift on 09/01/23 to 09/02/23. -She was the only PCA working that night on the first floor. -Residents were supposed to be checked every 2 hours. -She went in residents' rooms and checked to make sure they were breathing. -The last checks were usually around 5:30am. -She had a hard time remembering Resident #5. -She did not remember the last time she checked on Resident #5 that night (09/01/23 - 09/02/23). -Resident #5 was in his chair and breathing when she checked on him. -That night was her first time working on the first floor. -There was a MA on duty who was responsible for working the floor and medications for 2 medication carts. -There were many residents on the first floor who were not able to get up by themselves and required assistance to the bathroom. -There was no communication for what each resident needed such as fall risks, coming back from the hospital, and what they could and could not eat. -There was no consistency in care assignments, so it was difficult to learn about each resident. -She would find out new residents were admitted to the facility when they used their call pendant. -It was not routine to check empty rooms. -When she asked the MAs about the needs of residents, they only had a list of medications. Interview with a fourth PCA on 10/19/23 at 1:47pm revealed: -She was working the first shift on 09/02/23. -Between 6:15am and 6:30am she knocked on Resident #5's door for breakfast. -Resident #5 did not respond when she called to	D 270		

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him from the door.
-She saw him sitting in his wheelchair but was not moving.
-Resident #5 did not have a shirt on and was cold when she touched him.
-He was laying over his bedside table with his head over his arms.
-He was not wearing any pants, he only had on a pair of boxers.
-She went to the resident's door and motioned for the MA to come to the room.

Telephone interview with a second MA on 10/19/23 at 12:26pm revealed:
-He was working the first shift on 09/02/23.
-He was called to Resident #5's room shortly after the start of the shift (6:00am) by the PCA.
-Resident #5 was sitting in his wheelchair with no shirt or tee shirt on.
-The resident had dark colored shorts pulled up to his thighs.
-There was a dark colored shirt on the sink which made him think the resident was in the process of getting dressed.
-He put the shirt on Resident #5.
-Resident #5 was a full code but he could not get the resident out of his wheelchair to initiate CPR.
-When he tried to straighten Resident #5, his legs came up with the top of his body.
-The resident was bent forward in his wheelchair with his hands between his legs touching the floor.
-He was on the phone with 911 at the same time he was trying to get Resident #5 out of his wheelchair.
-Emergency medical services (EMS) paramedics arrived at the facility in what felt like less than 5 minutes.
-The paramedic helped him to get Resident #5 from his wheelchair into his bed.

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-He covered Resident #5 with the dark colored shirt and pulled the dark colored shorts up.
-The paramedic told him Resident #5 was in full rigor mortis.
-Resident #5's call pendant was on the nightstand next to the resident.
-The resident's night clothes were on the floor beside the toilet in the bathroom.
-He talked to the DRC and the Administrator that day (09/02/23) about what happened.

Telephone interview with the paramedic on 10/19/23 at 2:12pm revealed:
-He found Resident #5 sitting upright in his wheelchair.
-He could not recall if the resident was wearing any clothing.
-Resident #5 was in full whole body rigor mortis which meant a stiffening of his joints and muscles.
-The resident was showing obvious signs of death and CPR was futile.
-Rigor mortis usually started to set in within a couple of hours of death.
-He was not a physician and could not say how long it took for the whole body to develop rigor mortis.

Interview with the Kitchen Manager on 10/18/23 at 4:13pm revealed:
-He was the manager on duty that day (09/0223).
-He saw Resident #5 after he was found by staff a little after 6:00am.
-The resident had on a dark colored shirt and his bottom half was naked.
-He thought the resident was in the process of getting dressed.
-Resident #5 was sitting in the wheelchair leaning forward.
-He called the Administrator and the DRC.

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D 270	Continued From page 28 Telephone interview with the former DRC on 10/19/23 at 6:16pm revealed: -The MA on duty called on the morning of 09/02/23 and told her Resident #5 died at the facility. -She arrived at the facility around 9:00am. -EMS and local law enforcement had already been and gone from the facility. -She saw Resident #5 in his bed. -He only had a shirt on, but she could not remember what kind of shirt. -She was not at the facility to find out if an investigation surrounding the events of Resident #5's death was done. -She had concerns but could not elaborate without having done an investigation. -She assessed Resident #5 at a rehabilitation facility prior to admission. -He was an atypical, assisted living resident due to complex medical diagnoses and being under age 65. -She was concerned about staff being able to meet the medical needs of Resident #5. -She could not remember the exact needs and diagnoses that concerned her. -She had made a home health nursing referral for nursing oversight of his cardiac diagnoses. -Resident #5 was newly admitted to the facility (08/25/23) and had not seen the primary care provider (PCP). -She did not know if recommendations had been reviewed and written as orders by the PCP. Interview with the Administrator on 10/19/23 at 5:44pm revealed: -She was out of the facility the entire week Resident #5 was at the facility. -The former DRC was at the facility every day that week (08/28/23).	D 270		

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D 270	Continued From page 29 -She talked to the MA and PCA that were on duty on the first shift on 09/02/23 about what happened with Resident #5. -She did not talk to the third shift staff on duty (09/01/23 to 09/02/23). -Resident #5 was found in full rigor mortis which meant he had probably not been checked on for a while. -The MA on duty for first shift on 09/02/23 told her the resident was checked on by third shift staff the night of 09/01/23 - 09/02/23. -PCAs were primarily responsible for checking and changing residents every 2 hours and as needed. -Staff did not document every 2 hour checks. _____ The facility failed to provide supervision for one resident who was newly admitted to the facility and required special services according to the facility's pre-admission assessment including visual checks, hourly checks, night checks, additional safety monitoring and additional health monitoring. Resident #5 was found at approximately 6:15am seated in his wheelchair in full rigor mortis which appears approximately 2 hours after death completing between 6 to 8 hours after death resulting in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/19/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 18, 2023.	D 270		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service	D 286		

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D 286	Continued From page 30 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime table service included a non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage container. The findings are: Observation of the breakfast meal service in the memory care dining room on 10/19/23, from 7:35am to 8:30am, revealed: -There were place settings that consisted of a napkin, plastic spoon, plastic fork, plastic knife and a styrofoam cup. -There were 16 residents present for the meal at various times. -The breakfast meal was served to the residents on styrofoam plates. Observation of the lunch meal service in the memory care dining room on 10/19/223, from 11:45am to 12:55pm, revealed: -There were place settings that consisted of a napkin, plastic spoon, plastic fork, plastic knife and a styrofoam cup.	D 286		

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D 286	Continued From page 31 -There were 16 residents present for the meal at various times. Interview with a Personal Care Aide (PCA) in the memory care dining room on 10/19/23 at 12:40pm revealed: -Plastic utensils and styrofoam cups and were the normal place setting at meals. -Place settings were provided by the kitchen, so that is what staff used. Interview with the Kitchen Manager on 10/19/23 at 1:00pm revealed: -Plastic utensils and styrofoam cups were the normal place setting at the meals. -He was not aware the kitchen could not use disposable place setting until the facility's Executive Director informed him on 10/19/2023. Interview with the Executive Director on 10/19/23 at 11:47am revealed: -Disposables were used because the kitchen did not have enough plate covers. -She was not aware the kitchen could not use disposables.	D 286		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure snacks were offered to all residents between meals.

The findings are:

Observation of the Assisted Living Unit snack areas on 10/17/23 between 10:19am- 10:42am revealed:
-There were two snack counters. One located in the front of the facility in the hallway, and another located in the back area in the parlor.
-There was a beverage dispenser filled with water and infused with fruit on the counter in both snack areas.
-There was a sign on the snack counter in front of the facility that read, 'please help yourself to a drink and a snack.'
-There were no snacks on the counters.

Observation of the Assisted Living Unit on 10/17/23 at 3:35pm revealed:
-There was a beverage dispenser filled with water and infused with fruit on the counter in both snack areas.
-There was a sign on the snack counter in front of the facility that read, 'please help yourself to a drink and a snack.'
-There were no snacks on the counters.

Observation of the Assisted Living Unit on 10/18/23 at 10:43am, 11:17, 1:43pm, and 3:11pm revealed:
-There was a beverage dispenser filled with water

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and infused with fruit on the counter in both snack areas.
-There was a sign on the snack counter in front of the facility that read, 'please help yourself to a drink and a snack.'
-There were no snacks on the counters.

Interview with a resident on 10/17/23 at 9:30am revealed:
-She would like to have snacks between meals, but they were not offered.
-Snacks were supposed to be on the counter in the front entrance to the right in the facility.
-There was coffee on the counter.

Interview with a second resident on 10/17/23 at 9:46am revealed the facility provided snacks sometimes but his daughter purchased his snacks.

Interview with a third resident on 10/17/23 at 9:54am revealed:
-The facility did not provide snacks between meals.
-He was told the facility did not provide snacks anymore because the kitchen was short staffed, and they did not have time to put out snacks.
-He felt snacks should be offered every day.

Interview with the Dietary Manager (DM) on 10/18/23 revealed:
-Snacks were not put out on 10/17/23 and 10/18/23 because dietary staff did not put them out.
-He did not put snacks out because the residents would take 3 or 4 to their rooms and hoard them.
-When the kitchen was short staffed, they did not put snacks out.
-He was aware snacks were to be available to residents three times per day.

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D 298	Continued From page 34 Interview with the Executive Director on 10/18/23 at 4:16pm revealed: -Per licensure the facility should offer snacks three times per day. -The facility should provide snacks 10:00am, 2:00pm and 8:00pm. -The dietary manager was responsible for ensuring snacks were available daily. -She was not aware snacks were not being put out daily.	D 298		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents, who required assistance with eating, were assisted upon receipt of the meal and the assistance was provided in a manner which maintained and enhanced each resident's dignity and respect for 1 of 1 sampled resident (#8), who required feeding assistance. The findings are: Review of Resident #8's current FL-2 dated 07/13/23 revealed: -The resident's diagnoses included Alzheimer's	D 312		

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Dementia and mild depression.
-The resident was intermittently confused.

Review of the Resident Evaluation for Resident #8, dated 10/05/23, revealed:
-The resident required verbal cues/reminders to attend meals.
-The resident required assistance with menu selection.
-Tee resident required assistance to open "containers, packet etc.".

a. Observations of Resident #8 during the breakfast meal on 10/19/23 from 7:36am to 8:15am revealed:
-The resident was seated at a table with three other residents.
-There was an empty bottle of water and empty styrofoam beverage cup on the table in front of Resident #8.
-The resident attempted to drink from the empty drink cup on six occasions between 7:36am and 8:13am.
-The resident did not initiate requesting a beverage refill and staff did not check the resident's drink cup or offer any additional fluids.
-The resident was seated with her arms crossed when the breakfast meal of eggs, toast and ground sausage was served.
-The resident did not eat any of the breakfast meal from 7:36 to 7:53am.
-At 7:53am, a personal care aide (PCA) asked the resident if she would like a peanut butter and jelly sandwich instead of the meal served, the resident accepted.
-At 7:57am, another PCA cleared Resident #8's untouched breakfast plate and plastic utensils, the PCA did not speak to the resident.
-At 8:04am, the PCA returned with the peanut butter and jelly sandwich and placed it on a paper

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towel in front of Resident #8.
-The resident finished eating 100% of the peanut butter and jelly sandwich at 8:13am.
-At 8:15am, a PCA cleared Resident #8's place setting of the paper towel and empty beverage cup, the PCA did not speak to the resident.

Interview with a PCA on 10/19/23 at 8:22am revealed:
-Resident #8 could verbalize her needs but did not usually initiate making her needs known.
-Resident #8 did not usually eat much breakfast but she did eat better at lunch and she would usually accept a peanut butter jelly sandwich if she was asked.
-The PCA usually checked on the resident two times during the meal to see if she was eating, after the second time she offered the resident a peanut butter and jelly sandwich.
-All residents were provided with a bottled water at the beginning of each meal and staff provided additional beverages during meals at the residents' request.
-Resident #8 would not normally initiate asking staff for liquids so the PCA offered Resident #8 liquids at least three times per shift in addition to meals.

Interview with the medication aide (MA) at 12:55pm revealed:
-Resident #8 needed cues and encouragement to eat for most meals.
-Resident #8 would usually accept a peanut butter and jelly sandwich if she was not interested in the meal.

Interview with the Executive Director (ED) on 10/19/23 at 5:43pm revealed the ED's expectations were for staff to provide feeding assistance at meals, including cues,

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encouragement and alternate food options and beverages if residents needed assistance.

b. Observation of Resident #8 on 10/17/23 at 10:27am revealed:
-She was awake and sitting up in her bed.
-There was a Styrofoam plate on the seat of a rollator next to her bed.
-The plate was uncovered with uneaten scrambled eggs, oatmeal, bacon, and toast.
-She was repeating, "I don't know" while smiling.

Interview with a PCA on 10/18/23 at 9:06am revealed:
-Breakfast was served at 7:00am to residents on the special care unit (SCU).
-Uneaten meal plates were normally removed when residents were checked (every 2 hours).
-She was not assigned to Resident #8 by herself.
-PCAs worked together on the SCU to provide personal care assistance such as feeding assistance.
-The PCAs knew which residents had been fed because they talked to each other and let each other know.
-Normally Resident #8 did not get up for breakfast, PCAs got her up for lunch.
-There were 3 PCAs on duty for first shift on 10/17/23, she was not the only one responsible for providing assistance to Resident #8.

Interview with a second PCA on 10/18/23 at 9:11am revealed:
-PCAs worked together to care for residents in the SCU.
-PCAs let each other know who had been fed.
-She went and checked Resident #8, and the resident said she was going to eat her breakfast, so she left the plate in the room.
-She thought she removed the uneaten plate at

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10:45am on 10/17/23.
-When a resident said they were going to eat she left the plate in the room for a while.
-PCAs tried to get Resident #8 up before lunch daily.

Interview with a MA on 10/19/23 at 10:15am revealed:
-PCAs took breakfast to residents' rooms for residents who were not in the dining room after the dining room meal was done.
-PCAs were responsible for picking up meal plates from residents' rooms within the hour.
-Resident #8 needed more help with eating than the resident was aware she needed.
-Resident #8 was depressed, had chronic pain, and would stay in her bed all day without encouragement and prompting.
-Prompting and encouragement helped Resident #8 to eat.

Interview with the Assistant Director of Resident Care (DRC) on 10/19/23 at 5:29pm revealed:
-A breakfast plate should have been removed from Resident #8's room before 10:45am.
-Resident #8 required some standby assistance and cueing with meals.
-The PCA delivering the plate should have told the resident, 'here is your breakfast, let's eat."

Interview with the DRC on 10/19/23 at 11:07am revealed:
-Staff were responsible for assisting all residents in the SCU to the dining room for meals.
-Resident #8 must not have gone to the dining room and staff brought breakfast to her on 10/17/23 to offer an opportunity to eat.
-Breakfast was served at 7:00am in the SCU.
-Staff should have offered assistance and if Resident #8 did not want to eat, then staff should

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D 312	Continued From page 39 have thrown the plate away. -All residents in the SCU required prompting with meals; if the resident was not eating, prompting was expected. -She would expect staff to encourage eating and if a resident did not want to eat at that time, cover the plate and try back later. -If there were 3 PCAs on duty on the SCU, 1 PCA should have stayed with Resident #8 in room while she ate breakfast. Interview with the Administrator on 10/19/23 at 5:44pm revealed: -The DRC told her about Resident #8 having an uneaten breakfast plate at bedside at 10:30am on 10/17/23. -It should not have happened. -PCAs preferred to work together over having assignments, however not having assignments contributed to Resident #8 being left unassisted with breakfast. -She walked around the facility daily and spent time in the dining rooms to observe and help with serving meals. Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.	D 312		
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	D 358		

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D 358	Continued From page 40 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 2 of 5 residents (#2 and #9) observed during the morning medication pass including a hormone replacement and laxative (#9), and a stool softener (#2); and for 2 of 5 sampled residents for record review including narcotic pain and blood clot prevention medications, (#2) and corticosteroid medication (#4). The findings are: The medication error rate was 24% as evidenced by 6 errors out of 25 opportunities observed during the morning medication pass on 09/21/23. 1. Review of Resident #9's current FL-2 dated 08/14/23 revealed diagnoses included Alzheimer's disease, hypercholesterolemia, carotid artery disease, and abnormal weight gain. a. Review of Resident #9's current FL-2 dated 08/14/23 revealed an order for Miralax 17gm - mix one capful in 8 ounces of water daily. (Miralax is a used to treat constipation.) Observation during the morning medication pass on 10/18/23 from 8:38am until 8:50am revealed: -The medication aide (MA) removed Resident #9's bottle of Miralax from the medication cart drawer. -The bottle was approximately 1/3 full and the pharmacy label indicated it was dispensed on 11/15/22 and was opened on 12/01 (year not specified).	D 358		

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D 358	Continued From page 41 -Resident #9 had 2 additional near full bottles of Miralax in the medication cart drawer. -The pharmacy label indicated one was dispensed on 08/23/23 and the second was dispensed on 10/05/23. -There were no open dates on the 2 additional bottles. -The MA searched for measurement conversions on her cellular phone. -She poured Miralax powder into a plastic medication cup. -After prompting to review measuring instructions on the bottle, the MA transferred the Miralax powder into the bottle cap. -The MA filled the Miralax bottle cap halfway and when prompted announced she could not see the arrow to the top of the white inner measuring cup. -The MA mixed a capful of Miralax in 8 ounces of water and administered the cup to Resident #9 in the dining room at 8:50am. -The MA observed the resident drink the entire amount of Miralax mixed in water. Review of Resident #9's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17gm mixed in 4-8 ounces of fluid daily at 8:00am. -There was documentation Miralax was administered to Resident #9 daily 10/01/23 through 10/18/23. Interview with the MA on 10/18/23 from 8:38am until 8:50am revealed: -That day was her first day working on the special care unit (SCU). -She did not know there were measuring instructions on the Miralax bottle. -She did not know there was an arrow indicating the fill line on the inside of the cap.	D 358		

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-She administered Miralax before using the plastic medication cup.
-She did not know why Resident #9 had 3 bottles of Miralax.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/19/23 at 12:57pm revealed:
-Resident #9 had an order dated 08/14/23 for Miralax 17gm daily.
-The pharmacy dispensed 1 bottle which was a 30-day supply on 08/23/23 and 10/05/23.
-08/23/23 and 10/05/23 were the most recent dispenses; dispensing prior to 08/23/23 was remote.
-The facility was not on monthly cycle fills; staff were responsible for requesting refills.

b. Review of Resident #9's current FL-2 dated 08/14/23 revealed an order for levothyroxine 25mcg daily. (Levothyroxine is used as a thyroid hormone supplement.)

Observation during the morning medication pass on 10/18/23 from 8:38am until 8:50am revealed:
-At 8:38am, the medication aide (MA) searched the medication cart but could not find the bubble pack for Resident #9's levothyroxine 25mcg.
-The MA did not administer levothyroxine 25mcg to Resident #9.

Review of Resident #9's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for levothyroxine 25mcg daily at 6:30am.
-There was documentation levothyroxine was administered daily from 10/01/23 through 10/17/23 except 10/08/23, 10/10/23, 10/15/23 and 10/18/23.

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-The reason levothyroxine was not administered was not documented on the eMAR.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/19/23 at 12:57pm revealed:
-Resident #9 had an order dated 08/14/23 for levothyroxine 25mcg.
-The pharmacy dispensed 30 tablets on 06/19/23, 07/18/23, 08/11/23 and 08/15/23.
-There was an unexplained duplicate dispensing in August which equaled a 2-month supply.

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

2. Review of Resident #2's current FL-2 dated 03/23/23 revealed diagnoses included generalized weakness.

a. Observation during the morning medication pass on 10/18/23 from 9:25am until 9:35am revealed:
-At 9:25am the medication aide (MA) removed a Colace 100mg capsule from a bubble pack with Resident #2's name on the pharmacy label. (Colace is used to soften body excretions.)
-The pharmacy label included instructions to puncture one capsule and squirt it into the resident's left ear twice daily.
-The pharmacy label indicated 14 capsules were dispensed on 10/05/23 and there were 8 capsules remaining.
-There was an underlined handwritten entry on the type right corner of the bubble pack in large capital letters: "PLEASE READ INSTRUCTIONS".
-The Colace capsule was in the plastic medication cup with 3- and one-half tablets when

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the MA handed the cup to the resident at 9:31am.
-After prompting the MA took the medication cup back from the resident.
-The MA announced, "How am I supposed to put this in his ear?"
-The MA left the resident's room with the medication cup and reviewed the instructions on the Colace pharmacy label.
-She cut the end of the capsule and returned to Resident #2.
-At 9:34am, the MA squeezed the content of the Colace capsule in the Resident's left ear after he removed his hearing aide.

Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Colace 100mg enterally twice daily for ear wax squirt into left ear twice daily for 5 days and 9:00am and 9:00pm.
-There was documentation the Colace was administered into Resident #2's left ear at 9:00pm on 10/03/23 and at 9:00am and 9:00pm 10/04/23 through 10/18/23.

Interview with the MA on 10/18/23 from 9:25am until 9:35am revealed:
-She was worried about getting behind in her medication pass.
-She did not take the time to review the instructions for the Colace.

Interview with a representative at the local pharmacy on 10/19/23 at 5:44pm revealed:
-On 10/05/23, the pharmacy received an order for Colace 100mg twice daily for 5 days.
-The pharmacy dispensed 14 Colace 100mg capsules which was a 7 day supply.

Upon Request on 10/17/23, 10/18/23 and

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D 358	Continued From page 45 10/19/23, Resident #2's physician's order for Colace was not provided for review. b. Review of Resident #2's physician's order dated 10/12/23 revealed there was an order for Aspirin 81mg 1 tablet every day. (Aspirin is used to prevent blood clots). Observation during the morning medication pass on 10/18/23 at 9:35am revealed: -The medication aide (MA) prepared Resident #2's oral medications for administration from bubble packs with pharmacy labels which included the resident's name and medication instructions. -There was no bubble pack with Resident #2's aspirin. -There were 4 capsules or tablets in a plastic medication cup the MA handed to Resident #2 at 9:35am. -There was no aspirin tablet in the medication cup. Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for aspirin 81mg daily at 9:00am. -There was documentation aspirin was administered to Resident #2 on 10/13/23, 10/14/23, and 10/15/23. -There was documentation aspirin was not administered to Resident #2 on 10/16/23, 10/17/23 and 10/18/23. c. Review of Resident #2's FL-2 dated 03/23/23 revealed an order for cholecalciferol 50mcg daily. (Cholecalciferol 50mcg is used as a vitamin D supplement.)	D 358		

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Observation during the morning medication pass on 10/18/23 at 9:35am revealed:
-The medication aide (MA) prepared Resident #2's oral medications for administration from bubble packs with pharmacy labels which included the resident's name and medication instructions.
-There was no bubble pack with Resident #2's cholecalciferol.
-There were 4 capsules or tablets in a plastic medication cup the MA handed to Resident #2 at 9:35am.
-There was no cholecalciferol 50mcg tablet in the medication cup.

Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for cholecalciferol 50mcg daily at 9:00am.
-There was documentation cholecalciferol was administered to Resident #2 from 10/01/23 through 10/15/23.
-There was documentation cholecalciferol was not administered to Resident #2 on 10/16/23, 10/17/23 and 10/18/23.

d. Review of Resident #2's physician's order dated 10/16/23 revealed there was an order for Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day and Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours as needed (PRN) for pain. (Hydrocodone-Acetaminophen is a narcotic used to treat moderate to severe pain.)

Observation during the morning medication pass on 10/18/23 at 9:35am revealed:
-The medication aide (MA) prepared Resident #2's oral medications for administration from

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bubble packs with pharmacy labels which included the resident's name and medication instructions.
-There was no bubble pack with Resident #2's hydrocodone.
-There were 4 capsules or tablets in a plastic medication cup the MA handed to Resident #2 at 9:35am.
-There was no hydrocodone tablet in the medication cup.

Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone-acetaminophen 5-325mg twice daily at 8:00am and 8:00pm dated 10/16/23.
-There were no doses of hydrocodone-acetaminophen documented as administered to Resident #2 on 10/16/23, 10/17/23 and 10/18/23.

Interview with the MA on 10/18/23 from 9:25am until 9:35am revealed:
-The missing medications for Resident #2 were new medications ordered by hospice.
-The medications were not received from the pharmacy.
-The Director of Resident Care (DRC) was going to follow up with the hospice nurse (HN).

Interview with a representative at the local pharmacy on 10/19/23 at 5:44pm revealed:
-On 10/17/23, the pharmacy received an order for Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day for pain and Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours PRN for pain.
-The Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day was not

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dispensed because they considered it a duplicate order.
- Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours PRN for pain was filled but they were told by someone who called (not sure who) not to send the medication because Resident #2 was being discharged from the facility.

Interview with the DRC on 10/18/23 at 11:30am revealed:
-She was made aware of Resident #2's missing medications that morning (10/18/23).
-She had spoken to the HN on 10/17/23 regarding the hydrocodone because it was a new order.
-The HN told her the prescription was sent to the pharmacy on 10/17/23, but the pharmacy told her they did not receive the electronic prescription.
-She left a voice message for the HN on 10/18/23.

Interview with the Administrator on 10/19/23 at 5:44pm revealed:
-MAs were expected to administer the right medication, right dose, right route, at the right time to the right resident.
-MAs were responsible for weekly medication cart audits.
-A Regional Nurse completed medication cart audits in September.
-The pharmacy also audited medication carts quarterly.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 10/19/23 at 3:22pm was unsuccessful.

3. Review of Resident #2's FL-2 dated 03/23/23 revealed a diagnosis of generalized weakness.

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D 358	Continued From page 49 Review of Resident #2's physician's order dated 10/16/23 revealed there was an order for Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day and Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours as needed (PRN) for pain. Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day for pain scheduled for 8:00am and 10:00pm. -On 10/17/23, the Hydrocodone-Acetaminophen tablet 5-325mg scheduled for 8:00am and 10:00pm was documented as absent from community without medications. -On 10/18/23, the Hydrocodone-Acetaminophen tablet 5-325mg scheduled for 8:00am and 10:00pm was documented as other/see progress note for 8:00am and documented on paper MAR for 10:00pm. Review of Resident #2's medication leave form on 10/19/23 at 4:00pm revealed there was no Hydrocodone-Acetaminophen tablet 5-325mg available for administration. Interview with a medication aide on 10/19/23 at 5:29pm revealed: -She did not know there were missing medications for Resident #2 before he was discharged. -When there were missing medications, she would have contacted her supervisor. Interview with a representative at the local pharmacy on 10/19/23 at 5:44pm revealed:	D 358		

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D 358	Continued From page 50 -On 10/17/23, the pharmacy received an order for Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day for pain and Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours as needed (PRN) for pain. -The Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet 2 times a day was not dispensed because they considered it a duplicate order. - Hydrocodone-Acetaminophen tablet 5-325mg 1 tablet every 6 hours as needed (PRN) for pain was filled but they were told by someone who called (not sure who) not to send the medication because Resident #2 was being discharged from the facility. Interview with the Assistant Director of Resident Care on 10/19/23 at 10:31am revealed she was not aware the medication was not available. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 10/19/23 at 3:22pm was unsuccessful. b. Review of Resident #2's physician's order dated 10/12/23 revealed there was an order for Aspirin 81mg 1 tablet every day. (Aspirin 81mg is used to prevent heart attack or stroke). Review of Resident #2's October 2023 electronic medication administration record (eMAR) revealed there was no entry for Aspirin 81mg 1 tablet every day. Review of Resident #2's medication leave form on 10/19/23 at 4:00pm revealed there was no Aspirin 81mg 1 tablet every day available for administration. Interview with a medication aide on 10/19/23 at	D 358		

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5:29pm revealed:
-She did not know if there were missing medications for Resident #2 before he was discharged.
-When there were missing medications, she would have contacted her supervisor.

Interview with a representative at the local pharmacy on 10/19/23 at 5:44pm revealed:
-On 10/13/23 the pharmacy received an order for Aspirin 81mg 1 tablet daily.
-The order for Aspirin 81mg 1 tablet daily was not filled because it was still available at the pharmacy.

Interview with the Assistant Director of Resident Care on 10/19/23 at 10:31am revealed:
-She and the nurse were responsible to put resident's orders in to the eMAR system.
-She was not aware the medication was not available.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 10/19/23 at 3:22pm was unsuccessful.

4. Review of Resident #1's current FL-2 dated 12/28/22 revealed diagnoses included hypertension, hyperlipidemia, congestive heart failure, urge incontinence of urine, renal insufficiency, uncontrolled type 2 diabetes mellitus, morbid obesity, and bilateral edema.

Review of Resident #1's physician order sheet dated 07/14/23 revealed an order for Prednisone 1mg take 3 tablets by mouth every day. (Prednisone is a corticosteroid used to decrease inflammation.)

Review of Resident #1's Primary Care Provider

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D 358	Continued From page 52 (PCP) order dated 07/19/23 revealed an order for Prednisone 1mg take 2 tablets by mouth daily. Review of a subsequent order for Resident #1 dated 08/25/23 revealed an order to discontinue Prednisone orders and to start Prednisone 1mg tab take 1 tab by mouth daily times 30 days then discontinue. Review of Resident #1's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 1mg give 2 tablets by mouth in the morning for inflammation. Reduce daily Prednisone by 1 mg every month scheduled at 8:00am. -Prednisone was documented as administered from 08/01/23 (8:00am)- 08/25/23 (8:00am). -There was no documentation that Prednisone was administered after 08/25/23. Review of Resident #1's September 2023 eMAR revealed there was no entry for Prednisone for scheduled administration. Observation of Resident #1's medications on hand on 10/19/23 at 9:10am revealed: -There was a bubble card of Prednisone 1mg take one tablet by mouth every day times 30 days dispensed on 08/25/23 with 30 of 30 tablets remaining. Review of Resident #1's Pharmacy Medication Review dated 09/26/23 revealed: -The resident had an order written 08/25/23 for Prednisone 1mg daily times 30 days then discontinue, which was not entered into the electronic MAR system and therefore the resident did not get the final 30 days of the Prednisone taper.	D 358		

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D 358	Continued From page 53 -The category was identified as an administration error. -The pharmacist noted to report medication error to provider and review with staff. Review of facility medication incident form for Resident #1 dated 10/18/23 revealed: -The date of the incident was 08/25/23. -The description of incident was medication was omitted from the Medication Administration Record (MAR). -The medication aide (MA) was the former Assistant Resident Care Director (ARCD), who was no longer employed at the facility. -Resident #1 had no adverse reactions from missed doses. -The medication incident form was signed by the Administrator. Review of physician communication form dated 10/18/23 for Resident #1 revealed: -There was an order given on 08/25/23 for Prednisone 1mg daily times 30 days then discontinue. -The order was not entered into the electronic MAR system. -The resident was not administered the 30-day Prednisone taper. -The PCP discontinued the Prednisone order on 10/18/23. Telephone interview with the facility's pharmacy technician on 10/19/23 at 12:02pm revealed: -The pharmacy received an order for Resident #1 on 08/25/23 for Prednisone 1mg 1 tablet by mouth daily for 30 days then discontinue. -The pharmacy dispensed 30 tablets of Prednisone 1mg to the facility on 08/25/23 for Resident #1. -The Prednisone order would have automatically	D 358		

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dropped off the eMAR after 09/25/23.
-If the 08/25/23 order for Prednisone 1mg 1 tablet by mouth daily for 30 days then discontinue order was not on Resident #1's August 2023 and September 2023 eMAR, the facility could have called the pharmacy to add the order to the eMAR.

Telephone interview with Resident #1's PCP on 10/19/23 at 12:57pm revealed:
-Resident #1 was on Prednisone for inflammatory arthritis.
-On 08/25/23 she discontinued Resident #1's Prednisone orders and ordered Prednisone 1mg tablet take 1 by mouth daily times 30 days then discontinue.
-She was informed by the facility on 10/18/23 that Resident #1 had not received the 08/25/23 order for Prednisone.
-Resident #1 came off Prednisone "cold turkey," as she did not receive medication as ordered on 08/25/23.
-Prednisone was medication that needed to be tapered due to risk of causing increased pain by coming off too fast.
-She would have expected medication to be administered as ordered.

Interview with the RCD on 10/19/23 at 11:04am revealed:
-She was previously the facility nurse consultant but started in the RCD position on 10/13/23.
-She was in the process of reviewing the 09/26/23 pharmacy reviews but had not reviewed Resident #1's pharmacy review prior to 10/18/23.
-She was not aware Resident #1 had not received the 08/25/23 Prednisone order until 10/18/23, when she reviewed the 08/25/23 order, the 09/26/23 pharmacy review, and the August 2023 and September 2023 eMARs.

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D 358	Continued From page 55 -As the RCD, she would expect medications to be administered as ordered. Interview with the Administrator on 10/19/23 at 8:15am revealed: -On 08/25/23, Resident #1 had order to discontinue Prednisone orders and to start Prednisone 1mg 1 tablet by mouth daily times 30 days then discontinue. -When former ARCD discontinued Prednisone order on 08/25/23 in PCC, she did not add new 08/25/23 order for Prednisone in PCC for 1mg 1 table by mouth daily times 30 days then discontinue. -The Prednisone order had to be added into PCC for order to added to August 2023 and September 2023 eMAR. -She was not aware Resident #1 had not received Prednisone as ordered on 08/25/23 until 10/18/23 when asked about medication error report from the 09/26/23 pharmacy review. -The RCD started in role of RCD on 10/13/23 as she was previously the nurse consultant who filled in to assist facility until position was filled. -The RCD was in the process of reviewing the 09/26/23 pharmacy review and following up on any recommendations. -Resident #1's PCP was notified on 10/18/23 that the resident had not received Prednisone as ordered on 08/25/23. -She completed medication error report for Resident #1 on 10/23/23, as the resident had not received Prednisone as ordered on 08/25/23. -She would expect medications to be administered as ordered.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration	D 363		

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D 363	Continued From page 56 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications	D 363		

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prepared in advance for 3 of 8 sampled residents (#10, #11 and #12) were kept in a sealed package where the medications were identified and protected from contamination and spillage up to the point of administration.

The findings are:

1. Review of Resident #10's current FL-2 dated 04/27/23 revealed:
-Diagnoses included hypertension, hypothyroidism, anxiety, and major depression.
-Medication orders included metamucil 0.52gm capsule twice daily (dietary fiber), chlorthalidone 25mg daily (antihypertensive), wellbutrin (antidepressant), labetalol 200mg twice daily (antihypertensive), vitamin D 25mcg daily (supplement), losartan 100mg daily (antihypertensive), and pravastatin 20mg daily (cholesterol lowering).

Review of Resident #10's physician order dated 05/19/23 revealed an order for vitamin B12 1000mcg daily (supplement).

Observation of the morning medication pass on 10/17/23 at 9:28am revealed:
-The medication aide (MA) was walking from the desk area on Hall 1 toward resident rooms.
-She had plastic medication cups in her hand.
-She knocked on the door of a resident room across from room 116 and announced she had medications.
-She came back out of the room and went to a light-colored medication cart in the hall.
-She set a plastic medication cup with I capsule and 7 tablets on the medication cart.
-She took the plastic medication cup to Resident #10's room.
-The MA handed Resident #10 the plastic cup of

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D 363	Continued From page 58 pills and a cup of water. Review of Resident #10's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for chlorthalidone 25mg daily at 9:00am with documentation the dose was administered on 10/17/23. -There was an entry for vitamin B12 1000mcg daily at 9:00am with documentation the dose was administered on 10/17/23. -There was an entry for losartan 100mg daily at 9:00am with documentation the dose was administered on 10/17/23. -There was an entry for pravastatin 20mg daily at 9:00am with documentation the dose was administered on 10/17/23. -There was an entry for vitamin D 25mcg daily at 9:00am with documentation the dose was administered on 10/17/23. -There was an entry for wellbutrin 100mg twice daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am. -There was an entry for labetalol 200mg twice daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am. -There was an entry for metamucil 0.52gm twice daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am. Interview with the MA on 10/17/23 at 9:28am revealed: -She had medications for two residents prepared. -Those residents' medications were kept in the medication cart (brown wooden color) that was near the desk. -She prepared their medications from the brown	D 363		

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wooden medication cart and brought them with her because she was switching to the light-colored medication cart.
-One medication cart stored medications for one group of resident rooms and the other for another group of resident rooms.

Refer to interview with the Director of Resident Care (DRC) on 10/17/23 at 1:11pm.

Refer to interview with the Administrator on 10/19/23 at 5:44pm.

2. Observation on 10/17/23 at 9:39am revealed:
-There were 2 plastic medication cups in the top drawer of the brown wooden medication cart.
-There were markings of identification or covering on the plastic medication cups.
-One cup had 4 tablets and the second cup had 8 tablets.

Interview with the MA on 10/17/23 at 9:39am and 1:10pm revealed:
-She prepared the medications to administer but the residents were not ready when she went to administer the medication to them.
-One resident was using the bathroom and the other was getting washed.
-She usually labeled the medication cups with the resident's name.
-She did not know the medications should be identified and the container covered.
-The medication cups in the drawer of the medication cart (brown wooden color) belonged to Resident #11 and Resident #12.

a. Review of Resident #11's current FL-2 dated 03/31/23 revealed:
-Diagnoses included reduced mobility, overactive bladder, protein calorie malnutrition, atrial

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fibrillation, hypertension, depression, anxiety, chronic obstructive pulmonary disease, chronic kidney disease, and gastro-esophageal reflux disease.
-Medication orders included montelukast 10mg daily (decongestant), buspirone 5mg three times daily (antianxiety), ferrous gluconate 324mg daily (supplement), nebivolol 5mg daily (antihypertensive), apixaban 2.5mg twice daily (blood thinner), oxybutynin 5mg daily (bladder relaxant), and protonix 40mg twice daily (anti-reflux).

Review of Resident #11's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for ferrous gluconate 324mg daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for montelukast 10mg daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for nebivolol 5mg daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for oxybutynin 5mg daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for apixaban 2.5mg twice daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am.
-There was an entry for protonix 40mg twice daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am.
-There was an entry for ciprofloxacin 250mg every 12 hours at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am.
-There was an entry for buspirone 10mg three

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times daily at 9:00am and 9:00pm with documentation the dose was administered on 10/17/23 at 9:00am.

Refer to interview with the Director of Resident Care (DRC) on 10/17/23 at 1:11pm.

Refer to interview with the Administrator on 10/19/23 at 5:44pm.

b. Review of Resident #12's current FL-2 dated 10/28/23 revealed:
-Diagnoses included chronic atrial fibrillation, congestive heart failure, hypertension, Graves disease, and endocrine, nutritional, and metabolic disease.
-Medication orders included potassium chloride 10mEq daily (supplement), furosemide 20-60mg daily (diuretic), and Valsartan 40mg daily (antihypertensive).

Review of Resident #12's physician order dated 10/18/23 revealed an order clarification for Lasix 20mg 3 tabs (60mg) daily.

Review of Resident #12's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for furosemide 20mg 3 tablets (60mg) daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for potassium chloride 10mEq daily at 9:00am with documentation the dose was administered on 10/17/23.
-There was an entry for Valsartan 40mg daily at 9:00am with documentation the dose was administered on 10/17/23.

Refer to interview with the Director of Resident

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D 363	Continued From page 62 Care (DRC) on 10/17/23 at 1:11pm. Refer to interview with the Administrator on 10/19/23 at 5:44pm. _____ Interview with the Director of Resident Care (DRC) on 10/17/23 at 1:11pm revealed: -She was new to the DRC position as of 10/13/23 and did not train the MAs working at the facility. -MAs were responsible to bring the medication cart to the resident's room at the time of preparing the medications. -MAs should check with the resident prior to preparing medication to see if the resident needed any pain medication. -The resident might also want to know what medications were being administered. -It was hard to remember the names of 10 pills. Interview with the Administrator on 10/19/23 at 5:44pm revealed: -MAs should not have been pre-pouring residents' medications. -MAs were expected to administer the right medication, right dose, right route, at the right time to the right resident. -MAs were responsible for preparing medications immediately before administering the medications to the resident.	D 363		
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;	D 367		

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D 367	Continued From page 63 (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 1 of 5 sampled residents (#1) including inaccurate documentation for two medications used to treat infections. The findings are: a. Review of Resident #1's current FL-2 dated 12/28/22 revealed diagnoses included hypertension, hyperlipidemia, congestive heart failure, urge incontinence of urine, renal insufficiency, uncontrolled type 2 diabetes mellitus, morbid obesity, and bilateral edema. Review of an Emergency Room (ER) Summary report for Resident #1 on 09/06/23 revealed the resident was seen in the ER for altered mental status. Review of a subsequent order for Resident #1	D 367		

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dated 09/06/23 revealed an order for Cefdinir 300mg take 1 capsule by mouth two times daily for 10 days. (Cefdinir is used to treat infections caused by bacteria).

Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Cefdinir 300mg give 300mg by mouth two times a day for urinary tract infection (UTI) with scheduled administration times at 9:00am and 9:00pm.
-The first dose of Cefdinir was administered on 09/08/23 at 9:00pm and the last dose was documented as administered on 09/23/23 at 9:00am.

Review of Resident #1's Pharmacy Medication Review dated 09/26/23 revealed Cefdinir was ordered times 10 days and added to electronic MAR system with no stop date and therefore charted times 15 days.

Telephone interview with the facility's pharmacy technician on 10/19/23 at 12:02pm revealed:
-The pharmacy received an order for Resident #1 on 09/07/23 for Cefdinir 300mg by mouth two times daily for 10 day.
-The pharmacy dispensed 20 capsules of Cefdinir 300mg to the facility on 09/08/23.

Interview with the RCD on 10/19/23 at 11:04am revealed:
-She was previously the facility nurse consultant but started in the RCD position on 10/13/23.
-She was not aware Resident #1's Cefdinir was documented as administered beyond the order.

Interview with the Administrator on 10/19/23 at 8:15am revealed she would expect administration

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of medications to be documented correctly on eMAR according to the medication order.

b. Review of a subsequent order for Resident #1 dated 09/15/23 revealed an order for Diflucan 100mg take 1 tablet by mouth every 72 hours times 4 doses. (Diflucan is used to treat fungal or yeast infections).

Review of Resident #1's September 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Diflucan 100mg give 100mg by mouth every 72 hours for yeast infection times 4 doses with scheduled administration times every 72 hours.
-Diflucan was documented as administered on 09/16/23, 09/19/23, 09/22/23, and 09/27/23.

Observations of Resident #1's medications on hand on 10/19/23 at 9:10am revealed there was no Diflucan and Cefdinir observed on the medication cart.

Review of Resident #1's Pharmacy Medication Review dated 09/26/23 revealed Diflucan order had no stop date.

Telephone interview with the facility's pharmacy technician on 10/19/23 at 12:02pm revealed:
-The pharmacy received an order for Resident #1 on 09/15/23 for Diflucan 100mg give one every 72 hours times 4 doses.
-The pharmacy dispensed 4 tablets of Diflucan to the facility on 09/15/23.

Interview with the RCD on 10/19/23 at 11:04am revealed:
-She was previously the facility nurse consultant but started in the RCD position on 10/13/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

(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 367	Continued From page 66 -She was not aware Resident #1's Diflucan was documented as administered beyond the order date. Interview with the Administrator on 10/19/23 at 8:15am revealed she would expect administration of medications to be documented correctly on eMAR according to the medication order.	D 367		