STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056006	A. BUILDING: _____ B. WING _____	R 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN HOUSE	186 ONE CENTER STREET FRANKLIN, NC 28734

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D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a follow-up survey and complaint investigation with an onsite visit from 12/05/23-12/08/23 and 12/11/23, and a desk review with a telephone exit on 12/12/23.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure the residents' rooms were free of hazards related to bed bugs for 2 of 2 sampled residents (Resident #5 and Resident #7) who shared a room. The findings are: Observation of the previous room Resident #5 and Resident #7 shared as spouses on 12/07/23 at 10:11am revealed: -The beds were stripped. -There was a large clear trash bag with bed linens in them and tied closed. -There were two large trash bags with clothing items in them and tied closed and a empty laundry basket with clothes hangers in the basket. -There were several unidentifiable brown bug	D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings It is the intent of the Community to be free of all obstructions and hazards including hazards related to bed bugs. Pest control protocol for bed bugs will be followed according to company policy. 01/26/2024 Inservice training was provided to the ED and Care Manager's on company pest control protocol. 12/14/2023 ED, Care Manager's and Maintenance Tech will complete a walk through of the Community no less than 1x weekly to ensure that the Community is free of all obstructions and hazards. 01/26/2024	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Utall NP, ED — TITLE — (X6) DATE: 1/26/24

Reviewed and acknowledged Julie Grooms, RN 01/29/24

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D 079	Continued From page 1 carcases in various places throughout the room. Interview with Resident #5 on 12/08/23 at 1:49pm revealed: -He had to change rooms because of the bugs. -He could not recall when there was bugs or what the bugs were. -He stated to talk with his daughter because she knew what the type of bugs were. Interview with a housekeeper on 12/11/23 at 11:00am revealed: -Resident #5 and Resident #7 were no longer in their room because "bed bugs" had been observed in their room. -The room had been locked several weeks ago and no one could go into the room. -She had not been told to clean the room and had not been informed of anything she was supposed to do to the room. Interview with the Administrator on 12/11/23 at 12:00pm revealed on 11/24/23 she called the Regional Director of Operations (RDO) and informed her of the "bug" situation and the RDO reported the situation to the Regional Maintenance Director. Interview with the Special Care Coordinator (SCC) on 12/11/23 at 1:00pm revealed: -She was made aware of the bed bugs following a fall in which Resident #5 was sent to the hospital and Resident #5's family member showed her pictures of "bugs" found on Resident #5 when he was admitted to the hospital. -Staff did a skin assessment and did not find any bites on Resident #5 or Resident #7 around 12/2/23 when Resident #5 returned from the hospital.. -She did not observe any bugs.	D 079		

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D 079	Continued From page 2 -She notified the Administrator and the Maintenance Director after speaking to the family member. Telephone interview with a personal care aide (PCA) on 12/12/23 at 10:16am revealed: -On 11/23/23 she saw bed bugs on Resident #5, his pillow and 3 on his bed and 1 fell off his shirt onto his bed as she was changing his shirt and 1 on his chest. -There was another PCA who was assisting her with Resident #5 who also saw the bed bugs. Telephone interview with a second PCA on 12/12/23 at 12:56pm revealed: -She had observed bed bugs on Resident #5 on more than one occasion. -She was assisting Resident #5 around the end of November just before he went to the hospital when she observed bed bugs on his sheets, his shirt and chest. -She only observed the bed bugs on Resident #5's side of the room. -She reported the bed bugs to the Maintenance Director but he no longer worked for the facility. -She was not aware of anyone previously treating or currently treating the bed bugs. Telephone interview with a third PCA on 12/12/23 at 10:16am revealed: -On 11/23/23 she observed bed bugs in Resident #7's room. - She informed the Maintenance Director in November when the incident occurred.. Telephone interview with a fourth PCA on 12/12/23 at 12:56pm revealed: -She observed bed bugs on Resident #5 on more than one occasion. -She assisted Resident #5 around the end of	D 079		

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D 079	Continued From page 3 November 2023 just before he went to the hospital when she observed bed bugs on his sheets, his shirt and chest. -She had only observed the bed bugs on Resident #5's side of the room. Telephone interview with the Corporate Maintenance Director on 12/12/23 at 10:05am revealed: -No one had told him there were bed bugs in the facility. -The facility had not been treated for bed bugs since 2022. -The contracted pest control company's last visit was 11/19/23 for a general pest control visit but did not include treating bed bugs. -The local pest control company only treated with chemicals. -He expected the facility maintenance director or the facility Administrator to notify him of the concerns with bed bugs. Telephone interview with the Regional Director of Operations (RDO) on 12/12/23 at 3:30pm revealed: -The Administrator notified her on 11/24/23 of the bed bugs found in Resident #5's room and on Resident #5 after the bed bugs were discovered when Resident #5 was previously sent to the hospital. -She notified the Corporate Maintenance Director and told him to get Resident #5's room treated for bed bugs since the facility no longer had a Maintenance Director. -She did not know why the Corporate Maintenance Director said he was not notified of the bed bugs in Resident #5's room because she personally notified him. Based on observations, interviews and record	D 079		

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D 079	Continued From page 4 reviews it was determined Resident #7 was not interviewable.	D 079		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C; (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting; (c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; or (d) be certified as an Activity Director by the National Certification Council for Activity Professionals.	D 129	10A NCAC 13F .0404 (2) Qualifications of Activity Director Inservice training provided for ED and Care Manager's that there is to be a dedicated Activity Coordinator on premises for no less than 14 hours a week to ensure that activities are available to all residents A certified Activity Coordinator will be available for no less than 14 hours a week to ensure that activities are available to all residents	12/14/2023 01/26/2024

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D 129	Continued From page 5 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have a qualified Activity Director (AD). The findings are: Observation of the December 2023 activities calendar posted in the main hallway on 12/05/23 at 11:16am revealed: -There were various activities listed on the calendar with no beginning or end times. -The only days with any activities scheduled with a time were the activities that were provided by members of the community. -There was one activity scheduled on 12/19/23 from 10:30am-11:00am for the local elementary school students to sing for the residents. -A volunteer from the community was scheduled for 6 of 31 days to provide an activity for the residents with a beginning time listed but no end time. -Every Saturday on the calendar was scheduled resident rest and relaxation typed in each box with no beginning or ending time. Interview with the Resident Care Coordinator (RCC) on 12/06/23 at 11:20am revealed: -They did not have an AD or anyone designated to lead activities for the residents. -The staff tried to do what was posted on the activities calendar provided by the corporation, but it was not always possible because they were taking care of the residents. -There had been no AD since approximately the first of November 2023. Interview with the Administrator on 12/07/23 at 12:29pm revealed:	D 129		

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D 129	Continued From page 6 -The previous AD position ended on 11/09/23 or 11/10/23 and corporate management would not let her hire another AD until at least January 2024. -The company's management had a corporate certified AD and the AD prefilled out an activities calendar for each month and sent the calendar to the facility. -The facility staff and a volunteer provided activities for the residents. -Multiple residents told her they wanted a new AD because they missed doing activities but she informed them she was not able to hire an AD at this time.	D 129		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure implementation of an activities program that promoted active involvement by the residents. The findings are:	D 315	10A NCAC 13F .0905 (a & b) Activites Program Inservice training provided for ED and Care Coordinator to ensure that activities are avalable to all residents. A designated Activity Director will be available for no less than 14 hours a week to promote the residents' active involvement with each other, their families, and the community. ED and/or Care Coordinators will review the daily planned activities at Stand Up meeting to ensure activites are made available and posted correctly.	12/14/2023 01/26/2024 01/26/2024

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D 315	Continued From page 7 Observation of the facility's December 2023 activities calendar in the main hallway of the Assisted Living Unit (AL) and in the main hallway of the Special Care Unit (SCU) on 12/05/23 at 1:16pm revealed: -There was documentation of church service streaming scheduled every Sunday with no time listed. -There was documentation of morning exercise class with no time listed scheduled three times. -There was documentation of Resident Rest &Relaxation with no time listed scheduled every Saturday. -There was documentation of chair yoga with no times listed scheduled three times. -There was documentation of gingerbread houses with no time listed scheduled two times. -There was documentation of bingo at 1:30pm scheduled five times and documentation of bingo scheduled seven times with no time listed. -There was documentation of Sunday school at 1:30pm scheduled every Friday. -There was documentation of candlelight service at 6:30pm scheduled on 10/10/23. -There was documentation of holiday themed trivia with no time listed and documentation of men's challenge at 11:30am with no end time scheduled on 10/11/23. -There was documentation of crafts/ornaments from the Auxiliary at 10:30am scheduled on 12/13/23. -There was documentation of ugly sweater contest with no time listed scheduled on 10/14/23. -There was documentation of elementary school carols and gifts scheduled at 10:30am-11:00am and piano music scheduled at 1:00pm. -There was documentation of holiday movie matinee with no time listed scheduled on	D 315		

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D 315	Continued From page 8 12/20/23. -There was documentation of cookie decorating with no time listed on scheduled on 12/21/23. -There was documentation of Christmas day brunch and gift exchange with no time listed scheduled on 12/24/23. -There was documentation of a holiday game night with no time listed scheduled on 12/28/23. -There was documentation of New Year celebration on 12/31/23 with no time listed. -There was documentation of any activities scheduled on 12/04/23 and 12/07/23. Interview with a resident on 12/05/23 at 10:00am during the initial tour revealed: -The facility offered activities at times but she wished there was more to do. -She was "sad and bored" by not having anything to do. Interview with a second resident on 12/05/23 at 10:35am during the initial tour revealed: -She was upset the facility no longer had an Activity Director (AD) who provided activities for herself and the other residents. -It was lonely and depressing to sit around with nothing to look forward too. -She went home several times a week now to have something to do, but she could not go home to live. -She said she felt lonely and sad now living at the facility. Interview with a third resident on 12/06/23 at 8:35am revealed: -The facility "let go" the AD about 1 ½ -2 months ago. -The facility did not offer any activities. -There was a volunteer that visited the facility twice weekly and provided bible study one day	D 315		

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and played bingo with them the other day and a female resident would gather some of the residents to do exercises in the dining room.
-She was bored and would keep herself busy by making her bed, reading, or watching television.
-She missed playing games with the other residents or making crafts provided by the former AD.

Interview with a fourth resident on 12/06/23 at 11:38am revealed:
-The facility had not offered any activities for at least a month.
-She had nothing to do except watch television and read her bible.
-Having no activities offered by the facility made her depressed with nothing to look forward to and she felt like she was "one step away from being in the morgue".
-A volunteer came twice a week and would either play bingo with some of the residents or conduct a bible study.
-It made her sad because there were no crafts being offered and she wanted to make decorations for Christmas.

Interview with a family member on 12/06/23 at 11:50 am revealed:
-The facility offered very little in the way of activities and the activities were sporadic.
-The facility did not have an AD to provide activities on a regular basis.
-The resident of the family member was not brought down to activities when there was an activity.

Telephone interview with a second family member on 12/11/23 at 9:00am revealed:
-Her family member was on the special care unit (SCU) and was unable to remember when the

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facility provided activities.
-The resident was told at times the facility was providing an activity "in 15 minutes" but the resident was not able to remember being told 15 minutes later.
-Staff did not return to get the resident for the activity.
-The resident stayed in their room, sitting in a chair with no radio or television.
-The resident voiced concerns to her that the resident was depressed and did not have anything to do but sit in her room all day.

Interview with the Resident Care Coordinator (RCC) on 12/06/23 at 11:20am revealed:
-They did not have an AD or anyone designated to lead activities for the residents.
-The staff tried to do what was posted on the activities calendar provided by the corporation, but it was not always possible because they were taking care of the residents.

Interview with the Administrator on 12/07/23 at 12:29pm revealed:
-The previous AD position ended on 11/09/23 or 11/10/23 and corporate management would not let her hire another AD until at least January 2024.
-As soon as she was instructed by management that it was okay to post the AD position, she would interview applicants, but she was informed it would be at least January 2024.
-The company's management had a corporate certified AD and the AD prefilled out an activities calendar for each month and sent the calendar to the facility.
-The facility staff and a volunteer provided activities for the residents.
-Multiple residents told her they wanted a new AD because they missed doing activities but she

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D 315	Continued From page 11 informed them she was not able to hire an AD at this time. The facility failed to provide activities designed to promote the residents' active involvement with each other causing some of the residents to become depressed and one resident felt like she had nothing to look forward to and was waiting on death to occur. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/07/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2023.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the residents' rooms and belongings were free of hazards for 2 of 2 sampled resident (Resident #5 and Resident #7) related to bed bugs. The findings are:	D 338	10A NCAC 13F .0909 Resident Rights It is the intent of the Community to ensure that the rights of all residents are maintained and may be exercised without hindrance. Inservice training provided to Community on Resident Rights by ACD/RN Pest Control services were provided by a licensed Pest Control company. ED, Care Coordinators and Maintenance will complete walk through of Community no less than 1x weekly to ensure that Community is free of all obstructions and hazards. ED and/or Care Coordinators will ensure belongings are treated as needed and returned to residents within 48 hrs of completed treatement.	01/09/2024 12/15/2023 01/26/2024 01/26/2024

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D 338	Continued From page 12 Observation of the previous room Resident #5 and Resident #7's shared as spouses on 12/07/23 at 10:11am revealed: -The beds were stripped. -There was a large clear trash bag with bed linens in them and tied closed. -There were two large trash bags with clothing items in them and tied closed and a empty laundry basket with clothes hangers in the basket. -There were several unidentifiable brown bug carcases, food particles,dirt and bits of paper in various places throughout the room. -There was a wheel chair with a cushion sitting in the right corner of the room and a straight chair behind the wheelchair. -There was a small table beside the wheel chair with a open package of briefs on the table. -There was a television and refrigerator with a dirty Kleenex on top of the refrigerator on the table on the far side of the room that had not been cleaned. -There were personal pictures and calendars and personal items throughout both sides of the room. Review of Resident #5's current FL2 dated 10/25/23 revealed diagnoses included vascular dementia, chronic kidney disease, cerebrovascular disease, dysphagia, hyperlipidemia. Review of Resident #7's current FL2 dated 11/04/23 for revealed diagnoses included dementia, diabetes, hypertension and arthritis. Interview with a family member on 12/06/23 at 11:50am revealed: -Resident #5 and Resident #7 were married and shared a room.	D 338		

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D 338	Continued From page 13 -She was made aware of the bed bugs after a fall where Resident #5 went to the hospital and the hospital staff at the hospital gave her a bottle with a bed bug they had reportedly found in Resident #5's brief. -The hospital staff told her to bring it to the facility and let the facility the facility know so the facility would be aware. -The hospital placed Resident #5 on isolation precautions during his hospital stay due to the "bed bug" that were found. -The family alerted the facility and facility staff moved Resident #5 and Resident #7 into another room. -Resident #5's and Resident #7's previous room was not cleaned nor treated and all of their belongings were left in the previous room. Interview with Resident #5 on 12/08/23 at 1:49pm revealed: -He had to change room because of the bugs. -He could not recall when there was bugs or what the bugs were. Interview with a housekeeper on 12/11/23 at 11:00am revealed: -Resident #5 and Resident #7 were no longer in their previous room because "bed bugs" had been observed in the room. -The room had been locked several weeks ago and no one could go into the room. -Resident #5 and Resident #7 did not have any of their personal items in the new room; all of their belongings were still in the previous room. Interview with the Administrator on 12/11/23 at 12:00pm revealed: -She received a telephone call from Resident #5's family member concerning "a bug" found on Resident #5 in the emergency department.	D 338		

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D 338	Continued From page 14 -They moved Resident #5 and Resident #7 to a different room, put the clothes in the dryer and bagged them up, contacted maintenance. -She did not direct staff to clean the room because she was waiting on directions from the corporate Maintenance Director. Interview with the Special Care Coordinator (SCC) on 12/11/23 at 1:00pm revealed: -The residents clothes were put in the dryer and then bagged. -The residents belongings had to be contained for a period of time and would get their belongings after that but she did not state when that would be. -She had notified the Administrator and the Maintenance Director at that time. Telephone interview with a PCA on 12/12/23 at 10:16am revealed on 11/23/23 she observed bed bugs on Resident #5, his pillow and 3 on his bed and 1 fell off his shirt onto his bed as she was changing his shirt and 1 on his chest. Telephone interview with a second PCA on 12/12/23 at 12:56pm revealed: -She was off for a few days and when she came back to work Resident #5 and Resident #7 were moved across the hall but all of their belongings were still in their previous room and the door was locked. -Resident #5 was unable to use his personal wheelchair because it was still in his previous room and could not be removed from the room due to the bed bugs in the room. -She had no idea when Resident #5 would be able to use his own wheelchair. Telephone interview with the Corporate Maintenance Director on 12/12/23 at 10:05am	D 338		

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D 338	Continued From page 15 revealed: -No one had told him there were bed bugs in the facility. -The facility had not been treated for bed bugs since 2022. -The contracted pest control last visit was 11/19/23 for a general pest control visit but nothing to do with bed bugs. -The local pest control company only treated with chemicals, if the room needed to be heat treated they would have to call another company. -Staff should start to clean the room, the linens needed to be heat treated and they would also have the dog come in to verify there was bed bugs. -He expected the facility maintenance man or the facility Administrator to notify him of the concerns with bed bugs. -He stated there was obviously dropped communication. Telephone interview with the Regional Director of Operations (RDO) on 12/12/23 at 3:30pm revealed: -The Administrator notified her on 11/24/23 of the bed bugs found in Resident #5's room on and on Resident #5 after the bed bugs were discovered when Resident #5 was previously sent to the hospital. -She notified the Corporate Maintenance Director and told him to get Resident #5's room treated for bed bugs since the facility no longer had a Maintenance Director. -She did not know why the Corporate Maintenance Director said he was not notified of the bed bugs in Resident #5's room because she personally notified him. Telephone interview with the Administrator on 12/12/23 at 4:45pm during the exit revealed:	D 338		

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D 338	Continued From page 16 -Resident #5 and Resident #7 had been returned to their previous room on 12/12/23 after the staff had cleaned the room but not treated it. - They were following their policy. Based on observations, interviews and record reviews it was determined Resident #7 was not interviewable. The failure of the facility to ensure resident rooms were free of hazards related to bed bugs by not having resident rooms professionally treated or following their policies and procedures which resulted in two residents (#5, #7) being removed from their rooms and then being returned to the same room without that room being treatment. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection on 12/12/23 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 26, 2024.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358	10A NCAC .1004(a) Medication Administration Inservice training provided by ACD/RN on Medication Administration to ensure that medication is being administered to residents as the prescribing physician has written the medications to be taken and as often as it is written to be taken. Inservice training provided by ACD/RN on documentation when medication are being delivered to the Community.	01/09/2024 01/09/2024

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D 358	Continued From page 17 and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record review, and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to a medication used to treat bipolar disorder and an observation during the morning medication pass including errors with an incorrect dosage for a medication used to treat an oral yeast infection and not administering a medication used to treat seasonal allergies. The findings are: Review of the facility's policies and procedures for medication administration dated November 2018 revealed: -The 5 medication rights (resident, drug, dose, route, and time) are used by the medication aide (MA) for each medication being administered with a triple check of the 5 rights while preparing each medication when the medication is selected, when the dose is removed from the container, and just after the dose is prepared and the medication was put away. -The medication is compared to the electronic medication administration record (eMAR) for accuracy by reviewing the 5 medication rights. -The dosage of the medication was verified against the label and the eMAR by reviewing the 5 rights. -If any dosage was questioned, the physician's orders were checked for the correct dosage	D 358	ED, Care Coordinator and/or designee will perform a cart to MAR audit of medication no less than 1x week for no less than 60 day to ensure that medications are being given appropriately. Audits will be kept in a binder in the ED's office for review by the RDO, ACD and/or DVPO during site visit. ACD/RN will provide training to Medication Aides, ED and Care Managers on documentation of when medication are delivered to the Community by both the in-house and any outside pharmacy. Documentation of delivery will be kept in binder for review by ACD, RDO and/or DVPO during site visit	01/26/2024 01/26/2024 01/09/2024 01/26/2024

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D 358	Continued From page 18	D 358		

schedule.
-If a medication with a current active order cannot be located, the pharmacy was contacted.
-Medications are administered in accordance with written orders of the prescriber.

1. Review of Resident #1's current FL2 dated 10/10/23 revealed diagnoses included mild cognitive impairment, bipolar disorder, and seasonal allergies.

a. Review of Resident #1's physician's orders dated 10/10/23 revealed an order for divalproex (used to treat bipolar disorder) 250mg take 1 tablet daily.

Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex 250mg take 1 tablet daily at 9:00am.
-There was documentation divalproex 250mg was administered daily from 10/01/23-10/31/23.

Review of Resident #1's November 2023 eMAR revealed:
-There was an entry for divalproex 250mg take 1 tablet daily at 9:00am.
-There was documentation divalproex 250mg was administered daily from 11/01/23-11/30/23.

Review of Resident #1's 12/01/23-12/05/23 eMAR revealed:
-There was an entry for divalproex 250mg take 1 tablet daily at 9:00am.
-There was documentation divalproex 250mg was administered daily from 12/01/23-12/05/23.

Observation of Resident #1's medications on hand on 12/11/23 at 10:13am revealed there was

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D 358	Continued From page 19 a pill bottle of divalproex 250mg with a dispense date of 12/01/23 in the quantity of 30 tablets with 19 tablets available for administration. Interview with Resident #1 upon initial tour on 12/05/23 at 10:40am revealed: -Sometimes the facility ran out of some of her medications. -She had to go without divalproex for at least 4 days that she knew of the last week in November 2023. -The missed doses of divalproex caused her to have tremors, her whole-body shook "really bad" to where she could not even hold a cup of coffee, and she had trouble walking causing her to be unsteady. -She told a medication aide (MA) that she needed the divalproex when she realized the MAs were not administering it to her and the MA told her that she left a note for another MA to request a refill for the medication since she would not be working for a few days. -She called a local pharmacy herself and requested a refill for the divalproex and her family member picked up the medication and delivered it to the facility on 12/01/23. Telephone interview with Resident #1's family member on 12/08/23 at 10:24am revealed: -Resident #1 called her sometime the last week in November 2023 and said the facility ran out of her divalproex and she was not administered the medication for at least a few days. -Resident #1 told her she called the primary care provider (PCP) to see if a new prescription was needed to get the divalproex dispensed by the local pharmacy. -She received a text message on 12/01/23 from a local pharmacy that Resident #1's divalproex was ready for pick up and she picked up the	D 358		

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D 358	Continued From page 20 medication and took it to the facility. -The facility was supposed to call Resident #1's pharmacy to request refills for medications when medications were in low supply, and she picked up the medications when they were dispensed and took them to the facility. -The last time the facility ran out of Resident #1's divalproex in July 2023, Resident #1 was shaking and jerking so bad that a MA called her, and she told the MA to send Resident #1 to the local hospital emergency room (ER) for an evaluation. -Resident #1 chose to use a local pharmacy instead of the facility's contracted pharmacy in another state because when Resident #1 ran out of medication, it took too long to get the medication dispensed and delivered to the facility. Telephone interview with a pharmacy technician at a local pharmacy on 12/11/23 at 10:40am revealed: -Resident #1's divalproex was last dispensed on 10/05/23 in the quantity of 30 tablets and would last for 30 days if it was administered as ordered. -A new prescription was faxed to the pharmacy on 12/04/23 but it was not filled because Resident #1's insurance rejected the refill, and a comment was added to the rejection documenting the divalproex was last dispensed on 12/01/23 so the divalproex must have been filled by another pharmacy. -The facility normally called the pharmacy to request medication refills but there were no refill requests for Resident #1's divalproex between 11/05/23-12/04/23 made by the facility. Telephone interview with a pharmacy technician from a second local pharmacy on 12/11/23 at 1:31pm revealed: -Resident #1's divalproex was last dispensed on 12/01/23 in the quantity of 30 tablets.	D 358		

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D 358	Continued From page 21 -There were no other previous dispenses for Resident #1's divalproex from the pharmacy. Interview with a MA on 12/11/23 at 11:13am revealed: -She remembered Resident #1's divalproex supply was getting "low" about a month ago, but she left a note for the oncoming shift MA because she was going to be off a few days from work. -She denied Resident #1's divalproex was unavailable for administration when she administered Resident #1's medications on 11/14/23, 11/16/23-11/19/23, and 11/28/23. -She did not know if Resident #1 ran out of divalproex before the medication was dispensed by the pharmacy on 12/01/23. -Resident #1's divalproex was available when she administered Resident #1's medications. Interview with a second MA on 12/11/23 at 12:59pm revealed: -She documented Resident #1's divalproex as administered on 11/29/23 and 11/30/23 so she must have administered the medication. -She did not know how there was enough of Resident #1's divalproex to administer when the medication would have run out on 11/05/23 if the medication was administered as ordered. Interview with the RCC on 12/07/23 at 12:12pm revealed: -She was not aware Resident #1 was not administered divalproex from 11/05/23-12/01/23. -The MAs were responsible for requesting medication refills from the resident's pharmacy when medications were in low supply. -If the medication was not eligible for a refill, the MA was supposed to contact the PCP for a new prescription or let her know and she would contact the PCP.	D 358		

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D 358	Continued From page 22 -The MAs should have documented on the eMAR that Resident #1's divalproex was not administered if it was unavailable and added a comment to the notes section the reason why the medication was not administered. Interview with the Administrator on 12/07/23 at 12:29pm revealed: -She did not know Resident #1 did not have enough divalproex to administer from 11/05/23-12/01/23. -Resident #1 used a local pharmacy instead of the facility's contracted pharmacy and Resident #1's family member picked up the medication and delivered it to the facility. -The MAs were responsible to call the pharmacy for medication refill request when a medication was unavailable to administer or low in supply. -The MAs were taught to administer medications as ordered and document accurately on the eMAR if the medication was administered or not administered with a reason why the medication was not given. -She expected the MAs to follow the facility's policies and procedures for medication administration and administer medications as ordered, notify the PCP of any missed doses, and accurately document the administration or non-administration on the eMAR. Attempted telephone interview with Resident #1's PCP on 12/12/23 at 10:08am was unsuccessful. b. The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the morning medication pass on 12/05/23. Review of Resident #1's physician's orders dated 10/04/23 revealed there was an order to	D 358		

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D 358	Continued From page 23 discontinue fluticasone (a medication used to treat seasonal allergies) 50mcg instill 1 spray each nostril daily. Review of Resident #1's physician's orders dated 10/10/23 revealed there was an order for fluticasone 50mcg instill 1 spray each nostril daily. Observation of the medication pass for Resident #1 on 12/05/23 at 10:19am revealed there was no fluticasone nasal spray administered to Resident #1. Review of Resident #1's 11/09/23-11/30/23 electronic medication administration record (eMAR) revealed: -There was no entry for fluticasone 50mcg instill 1 spray each nostril daily. -There was no documentation fluticasone was administered. Review of Resident #1's 12/01/23-12/05/23 eMAR revealed: -There was no entry for fluticasone 50mcg instill 1 spray each nostril daily. -There was no documentation fluticasone was administered. Observation of Resident #1's medications on hand on 12/11/23 at 10:13am revealed there was no fluticasone available to administer. Telephone interview with a pharmacy technician at a local pharmacy on 12/11/23 at 10:40am revealed: -Resident #1's fluticasone spray was last dispensed on 08/22/23 in the quantity of 144 metered sprays and would last for 72 days if administered as ordered. -The facility did not request a refill for Resident	D 358		

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D 358	Continued From page 24 #1's fluticasone since it was last dispensed on 08/22/23. Interview with a medication aide (MA) on 12/05/23 at 11:18am revealed Resident #1 did not have fluticasone available to administer because it was discontinued on 10/04/23. Interview with Resident #1 on 12/05/23 at 11:38am revealed: -Sometimes the facility ran out of some of her medications. -She did not know when the facility last administered fluticasone to her. -She used another over-the-counter medication a couple of times every day to help with sinus congestion caused by allergies. Interview with the Resident Care Coordinator (RCC) on 12/06/23 at 11:20am revealed: -Resident #1's fluticasone was discontinued by the primary care provider (PCP) on 10/04/23. -She did not know Resident #1's fluticasone was reordered by the PCP on 10/10/23. -She was responsible for reviewing all new physician's orders and making sure the orders were faxed to the pharmacy and added to the eMARs correctly. -She missed the new order for Resident #1's fluticasone spray because she was behind on her job duties because she was working on the floor administering medications to the residents lately. -She was responsible for calling the PCP to clarify any questionable medication orders. -She did not call Resident #1's PCP to clarify if the fluticasone was meant to be reordered. Telephone interview with Resident #1's PCP medical assistant on 12/08/23 at 1:46pm revealed:	D 358		

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D 358	Continued From page 25 -Resident #1's PCP was sent a message and he responded to the message that the fluticasone was ordered on 10/10/23 due to Resident #1's history of allergies and sinus congestion. -Resident #1 would not need to self-administer an over-the-counter medication that was not ordered if the fluticasone was administered as ordered. -By Resident #1 not receiving the fluticasone as ordered it could cause increased sinus congestion and pain. -He expected the facility to call and clarify any medication orders that were unclear or if the facility had any questions about the medications ordered for Resident #1. Interview with the Administrator on 12/07/23 at 12:29pm revealed: -She did not know Resident #5 was not administered the ordered fluticasone from 10/10/23-12/05/23. -If Resident #1's fluticasone was discontinued on 10/04/23 and reordered on 10/10/23 and there were any questions about the ordered medication, the RCC should have contacted Resident #1's PCP to clarify the medication order. -The RCC was responsible for checking all new medication orders, making sure the orders were faxed to the pharmacy, and added to the eMARs. -Since Resident #1 used a local pharmacy, the RCC should have faxed the order to the facility's contracted pharmacy so the fluticasone could be added to the eMAR. -The MAs would not know to administer the fluticasone to Resident #1 if it was not added to the eMAR. -She did not know why the medication order for Resident #1's fluticasone was missed. c. The medication error rate was 7% as evidenced by the observation of 2 errors out of 26	D 358		

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D 358	Continued From page 26 opportunities during the morning medication pass on 12/05/23. Review of Resident #1's physician's orders dated 10/10/23 revealed there was an order for nystatin (a medication used to treat a yeast or fungal infection in the mouth) swish and spit 4ml twice daily. Observation of the medication pass for Resident #1 on 12/05/23 at 10:19am revealed: -The medication aide (MA) poured 15ml of nystatin liquid into a plastic medication cup for Resident #1. -The label with printed directions on Resident #1's nystatin bottle read to administer 4ml, swish and spit twice daily. -The MA prepared Resident #1's other morning medications, locked the medication cart and started to walk to Resident #1's room. -The MA was stopped and after being prompted by the surveyor, she repoured Resident #1's nystatin liquid to the 4ml line on the medication cup. Interview with a MA on 12/05/23 at 10:34am revealed: -When asked how much nystatin was ordered to administer to Resident #1, she stated she "over poured" the nystatin while preparing the medication. -Resident #1 was supposed to be administered 4ml of nystatin. -Resident #1 always wanted more nystatin than what was ordered. Review of Resident #1's 12/05/23 electronic medication administration record (eMAR) revealed there was an entry for nystatin 1000 units/ml swish and spit 4ml by mouth twice daily	D 358		

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D 358	Continued From page 27 at 9:00am and 9:00pm. Telephone interview with a pharmacy technician at a local pharmacy on 12/11/23 at 10:40am revealed Resident #1's nystatin was last dispensed on 11/20/23 and would last 30 days if administered as ordered. Interview with the Resident Care Coordinator (RCC) on 12/06/23 at 11:20am revealed: -MAs were trained by other MAs and managers and taught to administer medications as ordered. -The MAs were not allowed to administer extra doses of nystatin to Resident #1 even if Resident #1 asked for a larger dose. -The MA was responsible to call Resident #1's primary care provider (PCP) if there were any questions about Resident #1's medications. Interview with the Administrator on 12/07/23 at 12:29pm revealed: -She did not know why the MA administered almost 15ml nystatin to Resident #1 instead of the ordered 4ml. -The MAs were not allowed to administer more of a medication when a resident asked for more. -The MA should have prepared and administered Resident #1's nystatin by using the 5 rights of medication administration per the facility's policies and procedures for medication administration. Attempted telephone interview with Resident #1's PCP on 12/12/23 at 10:08am was unsuccessful. The facility failed to administer medications as ordered for Resident #1 who was not administered 25 doses of a medication to treat bipolar disorder causing Resident #1 to experience tremors, severe jerking, and difficulty walking. This failure was detrimental to the health	D 358		

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D 358	Continued From page 28 and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/12/23 for this violation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) was accurate for 1 of 5 sampled residents (Resident #1) related to a medication used to treat bipolar	D 367	10A NCAC 13F .1004(j) Medication Administration Inservice training provided by ACD/RN on Medication Administration to ensure that medication is being administered to residents as the prescribing physician has written the medications to be taken and as often as it is written to be taken. ED, Care Coordinator, and/or designee will perform a cart to MAR audit of medication no less than 1x week for no less than 60 days to ensure that medications are being given appropriately. Audits will be kept in a binder in the ED's office for review by the RDO, ACD, and/or DVPO during the site visit.	01/09/2024 01/26/2024 01/26/2024

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D 367	Continued From page 29 disorder. The findings are: Review of the facility's policies and procedures for Medication Administration dated September 2021 revealed missed medications were documented on the resident's medication administration record. Review of Resident #1's current FL2 dated 10/10/23 revealed: -Diagnoses included mild cognitive impairment and bipolar disorder. -There was no information documented for orientation. Review of Resident #1's physician's orders dated 10/10/23 revealed an order for divalproex (used to treat bipolar disorder) 250mg take 1 tablet daily. Interview with Resident #1 upon initial tour on 12/05/23 at 10:40am revealed: -The facility sometimes ran out of some of her medications. -She did not have any divalproex for at least 4 days that she knew of the last week in November 2023. -The missed doses of divalproex caused her to have tremors, her whole-body shook jerking "really bad" to where she could not even hold a cup of coffee, and she had trouble walking causing her to be unsteady. -She told a medication aide (MA) she needed the divalproex when she realized the MAs were not administering it to her and the MA told her that she left a note for another MA to request a refill for the medication since she would not be working for a few days.	D 367		

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D 367	Continued From page 30 -She called a local pharmacy herself and requested a refill for the divalproex and her family member picked up the medication and delivered it to the facility on 12/01/23. Review of Resident #1's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for divalproex 250mg take 1 tablet daily at 9:00am. -There was documentation divalproex 250mg was administered daily from 10/01/23-10/31/23. Review of Resident #1's November 2023 eMAR revealed: -There was an entry for divalproex 250mg take 1 tablet daily at 9:00am. -There was documentation divalproex 250mg was administered daily from 11/01/23-11/30/23. Review of Resident #1's 12/01/23-12/05/23 eMAR revealed: -There was an entry for divalproex 250mg take 1 tablet daily at 9:00am. -There was documentation divalproex 250mg was administered daily from 12/01/23-12/05/23. Observation of Resident #1's medications on hand on 12/11/23 at 10:13am revealed divalproex 250mg with a dispense date of 12/01/23 in the quantity of 30 tablets with 19 tablets available for administration. Telephone interview with a pharmacy technician at a local pharmacy on 12/11/23 at 10:40am revealed: -Resident #1's divalproex was last dispensed on 10/05/23 in the quantity of 30 tablets and would last for 30 days if it was administered as ordered. -A new prescription was faxed to the pharmacy	D 367		

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D 367	Continued From page 31	D 367		

on 12/04/23 but it was not filled because Resident #1's insurance rejected the refill, and a comment was added to the rejection documenting the divalproex was last dispensed on 12/01/23 so the divalproex must have been filled by another pharmacy.
-The facility normally called the pharmacy to request medication refills but there were no refill requests for Resident #1's divalproex between 11/05/23-12/04/23 made by the facility.

Telephone interview with a pharmacy technician from a second local pharmacy on 12/11/23 at 1:31pm revealed:
-Resident #1's divalproex was last dispensed on 12/01/23 in the quantity of 30 tablets.
-There were no other previous dispenses for Resident #1's divalproex from the pharmacy.

Interview with a MA on 12/11/23 at 11:13am revealed she was taught to document the administration of medications on the eMAR as administered or not administered if the medication was unavailable or if the resident refused.

Interview with a second MA on 12/11/23 at 12:59pm revealed:
-She documented Resident #1's divalproex as administered on 11/29/23 and 11/30/23 so she must have administered the medication.
-She did not know how there was enough of a supply of Resident #1's divalproex to administer when the medication would have run out on 11/05/23 if the medication was administered as ordered.

Interview with the Administrator on 12/07/23 at 12:29pm revealed:
-She did not know Resident #1 did not have

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D 367	Continued From page 32 enough divalproex to administer from 11/05/23-12/01/23 and staff documented the divalproex as administered. -The MAs were taught to administer medications as ordered and document accurately on the eMAR if the medication was administered or not administered with a reason why the medication was not given. -She expected the MAs to follow the facility's policies and procedures for medication administration and administer medications as ordered, notify the PCP of any missed doses, and accurately document the administration or non-administration on the eMAR.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure 1 of 1 sampled resident (#1) had a physician's order to	D 375	10A 13F .1005(a) Self-Administration of Medications Inservice training provided by ACD/RN on medication left in rooms by family and that all medications must be removed without an order by the prescribing physician for the resident to self-administer. ED, Care Coordinator and/or designee will check rooms daily for medications left in rooms without proper documentation in place. ED and/or Care Coordinator will review MARS for self-administer orders and assessments completed for any resident that has a self-administer order and Care Plans will be updated as needed.	01/09/2024 01/26/2024 01/26/2024

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D 375	Continued From page 33 self-administer medications related to medications used to treat sinus congestion and an anti-inflammatory medication. The findings are: Review of the facility's policies and procedures for self-administration of medications dated September 2021 revealed: -The Resident Care Coordinator (RCC) or designee will ensure there is a physician's order in place that indicates the resident is able to store and self-administer his/her medications. -For residents who self-administer medications, medications require a label with specific instructions for administration. -Resident's with a diagnosis of memory impairment will not be permitted to self-manage their medications. -All medications must be kept in a secure environment that is accessible only to the resident and the facility staff. -Locked storage is maintained in the resident's room to prevent access by other residents. Review of Resident #1's current FL2 dated 10/10/23 revealed: -Diagnoses included mild cognitive impairment, hypertension, and chronic pain. -There was no physician's order to self-administer medications. Review of Resident #1's physician's orders dated 10/10/23 revealed there were no physician's orders for Sinex (used to treat nasal congestion), maximum strength sinus pressure and pain relief tablets (used to treat nasal congestion and sinus pain), and diclofenac topical gel (an anti-inflammatory used to treat pain).	D 375		

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D 375	Continued From page 34 Observation in Resident #1's room on 12/05/23 at 10:40am revealed: -There was a bottle of Sinex and a box of generic maximum strength sinus pressure and pain relief tablets setting on Resident #1's table. -There was a tube of diclofenac topical gel in an open drawer of Resident #1's nightstand. Interview with Resident #1 on 12/05/23 at 10:40am revealed: -She kept the Sinex, sinus pressure and pain relief tablets, and diclofenac topical gel in her room and used it when she needed them. -A family member bought the medications for her at a local pharmacy and brought them to her. -She did not know if her primary care provider (PCP) ordered the medications for her or if she had a self-administer order. Second interview with Resident #1 on 12/06/23 at 11:38am revealed: -She used the Sinex nasal spray usually twice daily in the morning and at night. -She had not taken any of the maximum strength sinus pressure and pain relief tablets in a long time. -She used the diclofenac topical gel three times per day if she could get the facility staff to assist her with applying the gel to her left shoulder because she was not able to reach the shoulder area by herself. Review of Resident #1's 11/09/23-11/30/23 electronic medication administration record (eMAR) revealed: -There was no entry for Sinex nasal spray. -There was no documentation Sinex nasal spray was administered. -There was no entry for maximum strength sinus pressure and pain relief tablets.	D 375		

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D 375	Continued From page 35 -There was no documentation the maximum strength sinus pressure and pain relief tablets were administered. -There was no entry for diclofenac topical gel. -There was no documentation diclofenac topical gel was applied to Resident #1. Review of Resident #1's 12/01/23-12/05/23 eMAR revealed: -There was no entry for Sinex nasal spray. -There was no documentation Sinex nasal spray was administered. -There was no entry for maximum strength sinus pressure and pain relief tablets. -There was no documentation the maximum strength sinus pressure and pain relief tablets were administered. -There was no entry for diclofenac topical gel. -There was no documentation diclofenac topical gel was applied to Resident #1. Interview with a medication aide (MA) on 12/05/23 at 11:18am revealed: -Resident #1 did not have a physician's order for Sinex, sinus pressure and pain relief tablets, or diclofenac topical gel. -Resident #1 did not have any orders to self-administer medications. -She knew Resident #1 had some over-the-counter medications in her room that Resident #1 did not have an order for but did not know what to do with the medications since there was no order. Interview with the Resident Care Coordinator (RCC) on 12/05/23 at 11:24am revealed: -She did not know Resident #1 was self-administering medications without a physician's order. -The facility's policy for a resident to keep	D 375		

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medications at the bedside to self-administer required a physician's order for each medication and an order to self-administer.
-The MAs should have called Resident #1's PCP to get orders for the medications and to self-administer.
-Resident #1 "kind of just does what she wants" and brought the medications in the facility to keep in her room.

Telephone interview with Resident #1's PCP medical assistant on 12/08/23 at 1:46pm revealed:
-The diclofenac topical cream should not be self-administered due to a risk of causing injury to some internal organs such as the liver or kidneys when taken with other medications Resident #1 was already being administered and there was no order for the medication.
-The Sinex nasal spray would not be necessary if the facility administered another medication for sinus congestion and allergies as it was ordered.
-The PCP did not want to order the sinus pressure and pain relief tablets for Resident #1 due to the medication could raise the blood pressure and Resident #1 already had high blood pressure that she was being medicated for.
-Resident #1 did not have any orders to self-administer medications.
-The PCP expected the facility to notify him of any medications Resident #1 self-administered that were not ordered including any over-the-counter medications.
-The facility did not request any orders for the Sinex, sinus pressure and pain relief tablets, or diclofenac topical gel.

Interview with the Administrator on 12/07/23 at 12:29pm revealed:
-She did not know Resident #1 was

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D 375	Continued From page 37 self-administering medications. -The MAs should have removed the medications from Resident #1's room, called and notified Resident #1's PCP to see if the PCP would order the medications and give an order to self-administer. -She expected the MAs to follow the facilities policies and procedures for self-administering medications and not allow residents to take medications without an order.	D 375		