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{C 000}	Initial Comments The Adult Care Licensure Section completed a Follow-Up survey on 01/25/24-01/26/24.	{C 000}		
C 059	10A NCAC 13G .0310 (b) Storage Areas 10A NCAC 13G .0310 Storage Areas (b) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be supervised while in use. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure cleaning products including bleach were stored in a locked area, resulting in hazardous chemicals being accessible to residents who were diagnosed with dementia. The findings are: Observation of the facility on 01/25/24 between 8:30am-10:05am and 4:30pm-6:30pm revealed: -Multiple cleaning products were sitting at eye level, on top of a bookcase in the hallway. -The bookcase was in the hallway between the resident rooms, bathroom, and dining room. -There was a 2.53-quart bottle of bleach, a 1.32-gallon of a multi-purpose cleaner, and two 1-quart spray bottles of an all-purpose cleaner with bleach. -The residents walked past the cleaning products multiple times throughout the day. Review of the labels of the chemicals revealed various warnings including avoiding contact with skin and eyes, could be a skin and eye irritant,	C 059		

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C 059	Continued From page 1	C 059		

keep out of reach of children and pets, and harmful if swallowed.

Review of two residents' current FL2s revealed a diagnosis of dementia.

Observation of the facility on 01/26/24 at 9:39am revealed:
-There was a door labeled as a laundry room, keep the door locked; the door was not locked.
-The laundry room was in the hallway between the resident rooms and the dining room.
-There were multiple cleaning products inside the unlocked room.
-There were residents in the hallway, their rooms, and the dining room.

Interview with the medication aide (MA) on 01/26/24 at 10:31am revealed:
-Chemicals were supposed to be kept in the laundry room and the door locked for safety.
-She had started a load of clothes today, 01/26/24, and forgot to lock the door. Yesterday, 01/25/24, she had taken the cleaning supplies out of the closet to clean and the morning got chaotic, and she never went back to cleaning.
-She had noticed the cleaning products in the hallway, but she just unconsciously forgot to put the cleaning products away.

Telephone interview with the Administrator on 01/26/24 at 11:28am revealed:
-The laundry room contained hazardous materials such as bleach and was to be locked when not in use.
-Cleaning supplies were not to be left in the hallway and should be "locked away" when not in use.
-Cleaning supplies should be locked because a

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C 059	Continued From page 2 resident could "get hold" of the chemicals and ingest them or get in their eyes.	C 059		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 3 sampled residents (#1) related to toenails that needed to be trimmed. The findings are: Review of Resident #1's current FL-2 revealed: -The FL-2 was not dated or signed. -The diagnoses included dementia, chronic obstructive pulmonary disease, and acute respiratory failure. -She was intermittently confused. -She was ambulatory and continent of bowel; there was no documentation for bladder. -She required assistance with bathing, feeding, and dressing. Review of Resident #1's Resident Register revealed an admission date of 09/22/22. Review of Resident #1's current plan of care dated 01/25/23 revealed: -Resident #3's skin was normal.	C 242		

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C 242	Continued From page 3 -Resident #3 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring. Observation of Resident #1's toenails on 01/25/24 at 9:01am revealed: -The toenails on both feet extended past the end of the toe one-fourth to one-half of an inch. -The toenails on both of her big toes on the left and right foot were broken and jagged. Interview with Resident #5 on 01/25/24 at 9:01am revealed: -She could not cut her toenails. -It had been a while since anyone had cut her toenails. -Her toenails hurt when she wore certain pairs of shoes. -She had not told anyone her toenails needed to be cut and no one had asked her. Interview with the medication aide on 01/25/24 at 4:54pm and 5:51pm revealed: -Resident #1 had a shower every morning; the resident did not need assistance. -She had noticed Resident #1's toenails needed to be cut but she was waiting for the resident to go to the foot doctor to have her toenails cut. -She did not know if Resident #1 had an appointment to cut her toenails. -She was allowed to cut resident's toenails, and she did not know why she had not cut Resident #1's toenails. -She had not told the Administrator Resident #1's toenails needed to be cut. Telephone interview with the Administrator on 01/26/24 at 11:28am revealed: -All of the residents were seen by a podiatrist. -Staff could cut Resident #1's toenails.	C 242		

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C 242	Continued From page 4 -He was not aware Resident #1's toenails needed to be cut.	C 242		
{C 246}	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute healthcare needs of 1 of 3 residents (#3) with a diagnosis of diabetes related to failing to contact the primary care provider (PCP) for finger stick blood sugar (FSBS) per parameters. The findings are: Review of Resident #3's current FL-2 dated 12/29/23 revealed diagnoses included diabetes, hypertension, and dementia. Review of Resident #3's signed physician's orders dated 12/29/23 revealed an order to check FSBS three times daily and contact the PCP for FSBS greater than 400 or less than 80. Review of Resident #3's January 2024 medication administration record (MAR) from 01/01/24-01/25/24 revealed: -There was an entry to check FSBS three times per day with a scheduled administration time of 8:00am, 12:00pm, and 4:00pm. -The entry included contacting the PCP for FSBS greater than 400 or less than 80. -There was documentation Resident #3's FSBS	{C 246}		

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{C 246}	Continued From page 5	{C 246}		

was checked three times per day from 01/01/24-01/24/24 and at 8:00am on 01/25/24.
-There was no documentation of the FSBS results on the MAR.

Review of Resident #3's FSBS log on 01/25/24 at 8:52am revealed:
-There was a column for date, time, note, if under 80, and was the PCP called.
-The first entry in the FSBS log was on 12/05/23.
-Resident #3's FSBS was documented as being less than 80, fifteen times between 12/05/23 and 01/12/24, and each time the PCP was documented as notified.
-Examples of Resident #3's FSBS included on 01/08/24, a FSBS reading of 55 was documented.
-On 01/12/24, at 8:00am, an FSBS reading of 63 was documented.
-There were 6 times Resident #3's FSBS was documented as greater than 80.
-The last entry in the FSBS log was on 01/12/24.
-There was not a second page to this log located in Resident #3's record or any other notebook provided by the MA.

Review of an insulin administration log for Resident #3 on 01/15/24 revealed:
-There was a column for the date, before breakfast, initials, before lunch, initials, and before dinner and initials.
-The log started on 01/15/24.
-There were 2 times Resident #3's FSBS was documented as less than 80.

Interview with Resident #3 on 01/25/24 at 8:33am revealed:
-Her FSBS was checked four times a day.
-She used to have "real high FSBS" but now she had "really low FSBS", in the 70's and 80's.

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{C 246}	Continued From page 6	{C 246}		

-When her FSBS was low she ate something sweet.
-She did not know if the staff notified her PCP of low FSBS.

Telephone interview with Resident #3's PCP's medical assistant on 01/25/24 at 1:43pm revealed:
-The last documentation they had for Resident #3's FSBS was on 12/26/23 when the resident's FSBS was 68.
-If someone called a low FSBS in for Resident #3, she or the receptionist would take the call and it would be documented in the resident's record.

Telephone interview with Resident #3's PCP on 01/25/24 at 4:23pm revealed:
-He had been notified of Resident #3 having low FSBS and last adjusted her insulin on 12/27/23 due to the low FSBS.
-He had not been notified of any low FSBS since 12/27/23.
-If he had known Resident #3 was continuing to have low FSBS he would have made additional adjustments to her insulin.
-Continuing to have low FSBS was dangerous as it could affect mental health status and "really" low FSBS could cause death.

Telephone interview with the Administrator on 01/25/24 at 6:13pm revealed:
-When Resident #3's FSBS was less than 80 the PCP was notified.
-They had an FSBS log the staff were supposed to be documenting when Resident #3's FSBS was less than 80 and the PCP was notified.
-If the MA did not reach the PCP the MA would leave a voicemail and the PCP was good about returning their calls.
-He sent an electronic message to Resident #3's

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{C 246}	Continued From page 7 PCP's assistant on 11/20/23 and they had received new orders. -The orders were to decrease the evening dose of insulin to 25 units and to keep the morning dose the same at 30 units. -He did not know why there was no documentation after 01/12/24, the MAs were supposed to be documenting the FSBS, and when the PCP was notified of FSBS less than 80. Interview with the MA on 01/25/24 at 6:38pm revealed: -Resident #3's PCP was always notified when the resident's FSBS was less than 80. -The MAs documented the FSBS results and called on the residents FSBS log. -The call log was in the notebook provided. -The second page of the FSBS log was clipped to the first page in Resident #3's record; the surveyor had missed seeing it. Review of a second page of Resident #3's FSBS log on 01/25/24 at 6:36pm revealed: -The log was paper clipped to the page that ended on 01/12/24. -The log started on 01/13/24 and ended on 01/21/24. -Resident #3's FSBS was documented as less than 80, four times and there was documentation the PCP was notified. -Examples of Resident #3's FSBS included on 01/17/24, at 8:00am a FSBS reading of 74 was documented and at 12:00pm the FSBS documented was 58. . -On 01/21/24, at 8:00am, an FSBS reading of 76 was documented. Second interview with the MA on 01/25/24 at 6:41pm revealed she recalled the second page was not in Resident #3's record, it had been in	{C 246}		

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{C 246}	Continued From page 8 the staff office.	{C 246}		
{C 249}	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 3 sampled residents (#1, #2) related to an order for dressing changes for a wound (#1),and an order for daily blood pressure checks for a resident who was experiencing elevated blood pressures (#2). The findings are: 1. Review of Resident #1's current FL-2 revealed: -The FL-2 was not dated or signed. -The diagnoses included dementia, chronic obstructive pulmonary disease, and acute respiratory failure. -She was intermittently confused. -She was ambulatory and continent of bowel; there was no documentation for bladder. -She required assistance with bathing, feeding, and dressing.	{C 249}		

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Review of Resident #1's Resident Register revealed an admission date of 09/22/22.

Review of Resident #1's current plan of care dated 01/25/23 revealed:
-Resident #3's skin was normal.
-Resident #3 required extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming/personal hygiene, and transferring.

Observation of the facility on 01/25/24 at various times between 8:30am-10:00am revealed:
-Resident #1 fed herself, cleaned the table area where she ate, and took her dishes to the sink.
-Resident #1 was able to independently move from bed to chair.
-Resident #1 walked without assistance or an assistive device.
-Resident #1 was able to put her shoes on and off independently.

Review of Resident #1's wound care clinic after-visit summary dated 10/25/23 revealed:
-New wound care orders this week; continue home health for wound care.
-The wound location was the sacrum.
-Home health was to change the dressing on Mondays and Wednesdays; Hydrofera blue (used for wounds that were undermining and tunneling, wicked bacteria-laden exudate (fluid), slough, & debris away from the wound into the dressing through capillary flow; facilitated healing and aided in comfort. Inhibited the growth of bacteria that could lead to infection with broad-spectrum antibacterial protection) was to be lightly packed into the wound bed.
-The secondary dressing was to apply a silicone border over the primary dressing as directed.

Review of Resident #1's wound care clinic

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after-visit summaries dated 11/01/23, 11/08/23, 11/15/23, 11/22/23, and 12/06/23 revealed:
-Diagnoses listed included pressure ulcer of the sacral region, stage 4, severe protein-calorie malnutrition, and generalized muscle weakness.
-Resident #1 may shower with protection but do not get wound dressings wet.
-There was a section titled, home health, no change in wound care order this week; continue home health for wound care, change on Mondays and Wednesdays.
-Wound treatment included cleaning the wound with wound cleanser before applying a clean dressing using gauze sponges, not tissue or cotton balls; home health was listed with this task.
-Primary dressing was Hydrofera blue classic foam rope dressing three times per week; moisten with saline before packing.
-May cut the rope in half if having a hard time packing into the wound.
-Secondary dressing was to apply Zetuvit plus silicone border dressing (used for the treatment of wounds with moderate to high levels of exudate, it had increased absorbency and antimicrobial protection) over the primary dressing as directed.
-Follow-up one one week.

Review of Resident #1's wound care clinic after visit summaries revealed there was no summary dated 11/29/23 or 12/13/23.

Review of Resident #1's wound care clinic after-visit summary dated 12/20/23 revealed:
-Follow-up appointment in two weeks.
-Facility was to change Monday, Wednesday, and Friday next week; there were three asterisks before and after this statement.
-Wound treatment included cleaning the wound with wound cleanser before applying a clean

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dressing using gauze sponges, not tissue or cotton balls.
-Primary dressing was Hydrofera blue classic foam rope dressing three times per week; moistened with saline before packing.
-May cut the rope in half if having a hard time packing into the wound.
-The secondary dressing was to apply Zetuvit plus silicone border dressing over the primary dressing as directed.
-There was a handwritten note on the top right-hand corner of 01/03/24 at 11:00am; a second note was written as rescheduled for 0/10/24 at 10:15am.

Review of Resident #1's wound care clinic after-visit summary dated 01/17/24 revealed:
-Diagnoses listed included pressure ulcer of the sacral region, stage 4, severe protein-calorie malnutrition, and generalized muscle weakness.
-Facility staff was to change the dressing on Monday, Wednesday, and Friday.
-If going to the wound care clinic weekly, it was okay to let the wound care clinic staff change the dressing on Wednesdays.
- Resident #1 was to turn and reposition every 2 hours.
-There was an order to admit to home health for skilled nursing wound care.
-Wound treatment included cleaning the wound with wound cleanser before applying a clean dressing using gauze sponges, not tissue or cotton balls.
-Primary dressing was Iodoform packing strips (medicated sterile gauze used to pack wounds), three times per week.
-Secondary dressing was to apply a silicone border over the primary dressing as directed.

Review of Resident #1's January 2024

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medication administration record (MAR) for 01/01/24-01/25/24 revealed:
-There was an as-needed (PRN) entry for saline wound wash with the directions to use as directed per wound care instruction three times weekly; done by home health.
-There was no documentation for this entry.
-There was no other entry related to wound care.
-There was no documentation wound care was completed.

Observation of Resident #1's medications on hand on 01/25/24 at 5:24pm revealed:
-Resident #1's medications were in an individual basket in the medication cabinet.
-Beside Resident #1's basket, were three brown bottles of Iodoform packing strips; each bottle was in a plastic bag.
-There were no other dressing/wound care supplies.

Interview with Resident #1 on 01/25/24 at 4:36pm revealed:
-She had a bedsore.
-She did not know how she got the sore, but she had it for 4-5 months.
-The facility used to put a dressing on top of the bedsore, but that had stopped a couple of months ago.
-The facility staff never packed the bedsore, they just "put something on top of it."
-The bedsore hurt, whether she was sitting or lying down, there was a throbbing pain.
-She told the provider at the wound care clinic the bedsore hurt.
-The wound care clinic sent the stuff to put on the bedsore but so far no one had put anything on it.

Interview with the medication aide on 01/25/24 at 4:54pm and 5:51pm revealed:

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{C 249}	Continued From page 13 -Resident #1 had a shower every morning; the resident did not need assistance. -Resident #1 was continent of bowel and bladder. -She administered pills to Resident #1, but the resident did not have any creams or dressings she applied. -She had not been told to do anything with Resident #1's wound. -Resident #1 came back from her wound care appointments with the bottles in the medication cabinet, but they did not do anything with the bottles because Resident #1 went to the wound clinic for her care. -Resident #1 was going to the wound care clinic once a week but it had been recently changed to three times per week. Telephone interview with a wound care clinic nurse on 01/25/24 at 2:00pm revealed: -She was concerned about Resident #1's wound because the facility was not doing what they were supposed to do. -They called the facility because Resident #1 had missed her last two appointments for her wound care. -Resident #1 was seen at the wound care clinic on 12/20/23. -On 12/20/23, they made the next appointment for two weeks out because they thought the nurse was coming in, so Resident #1's next appointment would have been on 01/03/24. -Resident #1 also missed her 01/03/24, and 01/10/24 appointments; it was documented as a no-call, no show. -In October 2023, they tried to find a home health agency to do Resident #1's dressing changes, but home health was not started because of insurance issues and staffing issues by the various home health agencies referrals were made to; she named six home health agencies.	{C 249}		

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{C 249}	Continued From page 14 -Because there had been an issue with home health agencies, the Administrator told them he would hire a nurse to do Resident #1's wound care. -On 11/08/24, the Administrator told them a Registered Nurse (RN) was dressing Resident #1's wound twice a week. -The wound clinic gave up on finding an actual home health agency when the Administrator told them a RN was going to the facility to do the dressing changes. -They did not find out until last week (week of 01/15/24), that the RN was not changing Resident #1's dressings. -When Resident #1 came in for her wound care appointments, her wound was not dressed, and it should have been. -Resident #1 started care at the wound care clinic on 10/25/23, and her wound was "better" then. -Resident #1's wound was documented as present since the beginning of August 2023 but there was no documentation as to how the wound started. -Resident #1 had a small opening on her sacrum with undermining that had gotten deeper every week. -Every week Resident #1 came to the wound care clinic without her wound being packed or covered. -On her appointment days, Resident #1's wound should have been packed and covered, but it was not. -Because Resident #3's wound had worsened, the resident was now being seen at the wound care clinic three times per week, it was the only way they could make sure the wound care was done. -Resident #1 was scheduled previously for three times per week before and it did not work out. -The facility would bring Resident #1 to all her	{C 249}		

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appointments for one week and then that would stop.
-The facility had a lot of excuses why Resident #1 did not attend her appointments including blaming it on the resident not wanting to go to the appointment, which they did not believe.
-Resident #1's wound needed to be covered and padded for comfort for the resident as the nerve endings on the surface tended to be more painful and to prevent infection.
-Resident #1 could get a shower, have her wound packed and dressed and the following day just "wash up" to ensure the wound care stayed intact.
-On 11/08/23, they did a scan to make sure there was no deep infection, and it was clear.
-They may have to do another scan at this point since Resident #1's wound had worsened.
-On 10/15/23, Resident #1's wound was 0.9cm in length, 0.5cm in width, and 0.7cm in depth with an undermining of 1.5cm.
-On 12/20/23, Resident #1's undermining was 2.5cm.
-On 01/24/24, Resident #1's wound was 0.3cm in length, 0.3cm in width, and 0.5cm in depth with an undermining of 4.0cm.
-It was a "big jump" to go from 2.5cm on 12/20/23 to 4.0cm on 01/14/24.
-The healing of the surface wound with an increase in the undermining was a classic sign the wound was not getting packed.
-Wound care for Resident #1 was "teachable" but she did not know what the facility could and could not do for wound care and the regulations for that wound care.
-Supplies were sent to the facility weekly with Resident #1 after her clinic visit for the facility to use until the next clinic visit.
-They had not trained staff on the dressing changes because the Administrator had assured

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them, he had an RN coming into the facility and the RN would know what to do.
-Resident #1 was ambulatory and was able to answer questions.
-Resident #1 told them no one was dressing her wound.
-They told the Administrator that Resident #1 could get sick/septic from her wound.
-If Resident #1's wound was not packed, the wound could heal on the surface but continue to tunnel and put the resident at risk of becoming septic.
-If Resident #1 became septic, she could die "pretty quickly."

Telephone interview with the Licensed Health Professional Services (LHPS) nurse on 01/25/24 at 3:15pm revealed:
-On 11/14/23, she was going through Resident #1's record and noted the resident had wound care.
-Resident #1 was not at the facility when she was there on 11/14/23.
-She had read Resident #1 was seen on 11/08/23 at the wound care clinic and home health was ordered for Monday and Wednesday and the resident would go to the clinic on Fridays.
-She called the Administrator who told her the wound care clinic staff had not been able to find a home health agency and the Administrator told her Resident #1's wound care providers were aware.
-She told the Administrator he needed to do something, and he told her he would take Resident #1 to the wound care clinic three times per week.
-She had not seen Resident #1.
-They had not trained staff on wound care for Resident #1.
-She thought Resident #1 had been discharged

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from the facility because of the wound as she had not seen the resident at the facility at other times when she was at the facility.
-If she had seen the resident, she would not have looked at the wound but would have looked at the documentation to ensure the wound care was being documented as done.
-Resident #1 had no LHPS tasks before she had developed the wound.

Telephone interview with the Administrator on 01/25/24 at 6:13pm revealed:
-When Resident #1 started going to the wound care clinic, she went once a week.
-The wound care clinic ordered home health, but they could not find an agency to provide the care, so they changed Resident #1's appointments to three times weekly.
-He did not know why Resident #1's appointments had been decreased to once a week, but just last week he told the staff at the wound care clinic they needed to increase the appointments back to three times a week.
-He told the staff at the wound care clinic in October 2023 that the facility staff could not do anything with Resident #1's wound.
-In the beginning, when the wound care clinic staff could not find an agency to go to the facility, he thought the facility staff tried to pack the wound; he did not think there was any documentation of this.
-He told the wound care clinic staff if they could not find a home health agency, they needed to get Resident #3 in the clinic three times a week.
-He did hire a nurse to go to the facility for Resident #1's wound, he thought twice, but he could not afford to pay the nurse.
-He did not want the facility to get involved from the beginning with Resident #1's wound care.
-He let the wound care clinic staff know he would

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{C 249}	Continued From page 18 not find anyone to do Resident #1's dressing changes. Telephone interview with the Administrator on 01/26/24 at 1:01pm and 2:08pm revealed: -Resident #1 did not want to go to her wound care clinic appointment on 01/03/24 and 01/10/24. -Resident #1 stated she did not feel good on 01/03/24 and on 01/10/24, and she did not want to go to her appointment. -He called the wound care clinic when Resident #3 did not want to go and rescheduled the appointments, but he did not recall the dates. -The facility staff documented information like this in a communication notebook kept at the facility. -He had to call Resident #1's family member before to have the family member to talk to the resident about going to her appointments. -He was not going to make Resident #1 do anything. -All the facility was responsible for arranging transportation for Resident #1 to go to the wound clinic. -He did not continue to pay for the nurse to continue to do dressing changes for Resident #1 because "it was not being done well." -He did not think it was being done well because, when Resident #1 would go in for her wound care clinic appointments, the staff at the wound care clinic were asking a lot of questions, as if it was not being done right, so he decided they were "just not going to be involved." Review of the communication notebook on 01/26/24 at 1:08pm revealed: -There was one page in the notebook with documentation. -It appeared multiple pages had been torn from the notebook. -There was documentation that on 01/03/24	{C 249}		

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{C 249}	Continued From page 19 Resident #1's transportation came to the facility to pick her up at 10:15am and the resident refused because she did not feel well. -Resident #1 also stated her appointment was not until next Wednesday. -They spoke with the Administrator and made notes; the page was torn off after this entry. Interview with the MA on 01/26/24 at 1:08pm revealed: -She did not recall anything about Resident #1's appointment on 01/03/24. -She did not know why the pages had been torn from the communication notebook or where the removed pages were located. Telephone interview with Resident #1's family member on 01/26/24 at 3:10pm revealed: -He had not received any calls about Resident #1 refusing to go to her appointments at the wound clinic. -Resident #1 had told him that the staff at the facility would not take her to her appointments. -Resident #1's wound care was important to the resident. 2. Review of Resident #2's current FL-2 dated 01/17/24 revealed diagnoses included hypertension and stage four chronic kidney disease. Review of Resident #2's Primary Care Provider's (PCP) after-visit summary signed, but not dated revealed: -Resident #2's blood pressure (BP) was 178/80. -There was documentation that Resident #2 was hypertensive, monitor BP daily. Review of Resident #2's medication administration records (MAR) for January 2024	{C 249}		

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from 01/17/24-01/26/24 revealed there was no entry for BP readings and no documentation that Resident #2's BP had been checked.

Interview with Resident #2 on 01/25/24 at 9:03am revealed:
-She had high BP secondary to kidney failure.
-When she saw her kidney doctor recently her BP had been elevated.
-No one had taken her BP since she had seen the facility doctor last week.

Interview with the medication aide (MA) on 01/25/24 at 6:00pm revealed:
-She did not know where a BP monitor was located.
-She did not recall the last time she used the BP monitor.
-There were no orders to check BP with the current residents.

Interview with the MA on 01/26/24 at 10:31am and 12:10pm revealed:
-She had not located a BP cuff.
-She called the Administrator to ask if he knew where the BP cuff was located.
-No one had an order to have BP checked.
-She thought the BP cuff had been taken to another facility.
-She had not seen the order to check Resident #2's BP.
-She did not know who was working on 01/17/24 when Resident #2 was seen by the PCP.

Telephone interview with Resident #2's PCP on 01/26/24 at 9:11am revealed:
-She saw Resident #2 for the first time on 01/17/24.
-Because Resident #2's BP was high on her examination and with her diagnoses of

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{C 249}	Continued From page 21 hypertension and stage four kidney failure, she thought it was important to monitor the resident's BP. -She expected Resident #2's order for daily BP to be implemented. -Resident #2 could have had a stroke if she had high BPs. Telephone interview with the Administrator on 01/26/24 at 11:28am revealed: -He did not recall if any residents had an order for BP checks or not. -When the facility's PCP left orders, whoever was working was supposed to call him to discuss the orders. -Whoever was working when Resident #2's PCP left the order for BP checks, should have contacted the pharmacy to get the order on the MAR, start checking the BP, and document the BP results. -He was not aware Resident #2 had an order to check her BP daily. -He did not know who was working on 01/17/24. -"It was a dropped ball." _____ The facility failed to implement orders for dressing changes for a resident twice weekly who had a stage four pressure ulcer that had improved on the surface, however, the wound had worsened underneath the skin which was concerning because if the wound healed on the surface without the wound underneath the skin being healed, the resident could become septic, which could result in death (#1); and a resident who had high blood pressure and stage four kidney disease, with an order for daily BP checks that had not been implemented (#2). This failure resulted in a substantial risk of harm and neglect to the residents, which constitutes a Type A2 Violation.	{C 249}		

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{C 249}	Continued From page 22 The facility provided a plan of protection in accordance with G.S. 131 D-34 on 01/26/24. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	{C 249}		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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: Based on observations and interviews, the facility failed to ensure residents' rights were maintained related to being treated with consideration and respect by requiring all the residents leave the facility and go with other residents to their appointments. The findings are: Interview with the medication aide on 01/25/24 at 10:08am revealed a resident had an appointment and the transportation had not arrived to take the resident so she was going to have to take all the residents with her to the resident's appointment. Observation of the facility on 01/25/24 between 10:08am-10:16am revealed all the residents were loaded into the facility's van and left the facility. Observation of the facility on 01/25/24 at 4:30pm revealed the staff member and residents returned to the facility.	C 311		

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C 311	Continued From page 23 Interview with a resident on 01/25/24 at 4:39pm revealed: -They had to go with other residents when they had appointments every time a resident had an appointment. -She understood residents had appointments, but there seemed to be a better way to handle it, so all the residents did not have to "load up and go." -She had arthritis and osteoporosis and it hurt to sit for an extended period. Interview with a second resident on 01/25/24 at 4:49pm revealed: -He wished he did not have to go with other residents to their appointments. -He would rather stay at the facility. -Today, 01/25/24, was a very long day. Interview with a third resident on 01/25/24 at 4:51pm revealed: -The residents were not able to stay at the facility when someone had an appointment unless there was a staff member at the facility, so the only time they did not have to go to an appointment was when a resident was transported by a local transportation company. -He preferred to stay at the facility. Interview with a fourth resident on 01/25/24 at 4:54pm revealed: -They usually went with other residents to an appointment or to run errands once or twice a week. -She usually did not mind going on these outings but today, 01/25/24, her foot was hurting from sitting in the van so long, and because she had to walk on the foot without an assistive device. -She was supposed to be non-weight bearing on her foot after a recent injury.	C 311		

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C 311	Continued From page 24 Interview with a fifth resident on 01/25/24 at 4:58pm revealed that sometimes she got cramped up from being in the facility's van for so long. Interview with the medication aide (MA) on 01/25/24 at 10:31am revealed: -She did not have to take all the residents with her to another resident's appointment, often, it just depended on transportation. -She usually asked the residents if they wanted to go or not. -There was only one resident who did not want to go, and after she talked to him, he agreed to go. -Residents had a choice if they wanted to go or not. -If a resident did not want to go to an appointment with another resident, she would take the resident to another facility. Telephone interview with the Administrator on 01/26/24 at 11:28am revealed: -He tried to prearrange transportation with a transportation company for residents with appointments. -If transportation could not be arranged or if the transport company did not show up, he would try to get a staff member who was off to take the resident to their appointment. -Taking all the residents with another resident was the last option rather than canceling the appointment. -All of the residents had to go because there was no other staff member to stay with the residents and the residents could not be left alone. -He had asked the residents and the residents told him they wanted to go out more. -None of the residents had complained to him about going with other residents to appointments.	C 311		

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C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .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:	C 335		

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C 335	Continued From page 26 Based on observations and interviews, the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration for three residents. The findings are: Observation of the facility on 01/25/24 at 8:30am revealed: -There were 2 small containers with lids, placed on the dining room tables. -Each container contained multiple medications. -The containers were not labeled with the resident's name or the medication in the container. -At 8:52am, a resident removed the top from the container at her place setting, took the medication, and left the room; the MA did not observe her take the medication. -The second container remained at a place setting; the resident was not present. Observation of the dining room on 01/25/24 at 8:58am revealed the MA removed an empty medication cup from the dining room table and returned it to the medication office. Interview with a resident on 01/25/24 at 9:03am revealed: -Her medication was always on the table, and she took the medication with her breakfast. -No one watched her take the medication, she just took it before she left the dining room. Observation of a resident's room on 01/25/24 at 9:07am revealed: -There was a small clear cup, with no lid, that contained 7 tablets and an individual foil packet	C 335		

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that contained a sublingual film.
-The container was not labeled with the resident's name or the medication in the container.

Interview with the resident on 01/25/24 at 9:05am revealed:
-Most of the medication aides (MA) administered medication in the front office.
-Today, 01/25/24, she went to the front office, the MA gave her the medication cup and she returned to her room.

Interview with the MA on 01/25/24 at 5:01pm revealed:
-She put each resident's medication in a medication cup, documented in the medication administration record (MAR), and took the cups to the table where the medication cup was placed where the resident sat.
-Residents came to breakfast at different times and would take their medications.
-If a resident did not come out to breakfast, she took the medication back to the office.
-She did not allow a resident to take their medication back to their rooms because the Administrator had told her she could not do that.
-She did not recall a resident taking medication back to their room today, 01/25/24; she must have missed it because she was running around.
-All the cups did have the residents' names written on the outside but some of the names had rubbed off.

Telephone interview with the Administrator on 01/26/24 at 11:28am revealed:
-He did not teach MAs to leave medications on the table or in resident rooms.
-The MAs knew they were not supposed to leave the residents' medication at the table.
-The MAs should observe each resident take

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C 335	Continued From page 28 their medication and then document the medication had been administered. -It was a "great concern" that the residents' medications were left out.	C 335		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were maintained locked and secured when not supervised by staff. The findings are: Observation of the facility on 01/25/24 between 8:30am-10:00am revealed: -There was a room to the left of the side entrance that had a bed, a computer desk, a tall black cabinet with the doors open, and a second smaller cabinet to the left of the door. -The door to the room was open. -Inside the tall black cabinet were multiple individual bins of medication labeled with the resident's names. -Residents were sitting in the living room and at the dining room table. -The medication aide (MA) was in and out of the room. -The MA went down the hall while residents were present in the vicinity of the medication room.	C 353		

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C 353	Continued From page 29 Observation of the medication cabinet on 01/25/24 between 8:30am-10:15am revealed the cabinet doors were either open or when the doors were pushed closed, the doors were not locked, and the medication was accessible. Observation of the medication room on 01/25/24 between 4:45pm-6:33pm revealed: -The door to the room was open. -The cabinet doors were either open or when the doors were pushed closed, the doors were not locked, and the medication was accessible. -The controlled medication had been placed in a lock box, the lid was open, and the box was on the floor, between the tall black cabinet of medication and the bed. Observation of the medication room on 01/26/24 between 9:00am-12:40pm revealed: -The door to the room was open. -The cabinet doors were either open or when the doors were pushed closed, the doors were not locked, and the medication was accessible. -The controlled medication had been placed in a lock box, the lid was open, and the box was on the floor, between the tall black cabinet of medication and the bed. Observation of the MA on 01/26/24 at 10:41am revealed: -She tried multiple keys on multiple key rings and could not lock the cabinet. -She looked in the drawer of the computer desk for keys. -She went back to the key rings and tried multiple keys in an attempt to lock the cabinet and control box. -She was able to locate the keys to lock both the medication cabinet and the lock box that contained the controlled medication.	C 353		

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C 353	Continued From page 30 Interview with the MA on 01/26/24 at 10:41am revealed: -She did not recall the last time she had locked the medication cabinet or the controlled medication lock box. -She had not locked them in the past two days; she could not answer why she had not locked the medication. Telephone interview with the Administrator on 01/26/24 at 11:28am revealed: -Medication should be locked in the medication closet located in the staff room. -The medication closet should always be locked. -Controlled medication should be in a locked container and then locked in the medication closet to make it double-locked. -He was concerned medication was not locked and the importance and danger of medications being out, opened, and accessible to the residents.	C 353		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the retrievable records of controlled substances were maintained and reconciled accurately with the documented	C 367		

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receipt and administration of the medication for 3 sampled residents (#1, #2, #5) related to a medication used to treat severe pain (#1), a medication used to treat narcotic dependence (#2) and a medication used to treat anxiety and agitation (#5).

The findings are:

1. Review of Resident #1's current FL-2 revealed:
-The FL-2 was not dated or signed.
-The diagnoses included dementia, chronic obstructive pulmonary disease, and acute respiratory failure.
-There was documentation to see attached, the attached medication list was not signed.
-There was documentation on the unsigned medication list for Tramadol (used to treat severe pain) 50mg four times daily.

Observation of the staff room on 01/25/24 at 8:8:41am revealed:
-The medication aide (MA) was sitting at the desk, with a controlled substance count sheet (CSCS) and a calculator.
-The CSCS did not appear to be completed for multiple dates.
-The CSCS was Resident #1's Tramadol CSCS.

Interview with the MA on 01/25/24 at 8:41am revealed she was documenting the controlled medication she administered today, 01/25/24.

Review of Resident #1's January 2024 medication administration record (MAR) from 01/01/24-01/25/24 revealed:
-There was an entry for Tramadol 50mg take 1.5 tablets to equal 75mg four times daily with a scheduled administration time of 8:00am, 12:00pm, 4:00pm and 8:00pm.

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-There was documentation Tramadol was administered four times daily from 01/01/24-01/24/24 at 8:00am, 12:00pm, 4:00pm and 8:00pm.

Review of Resident #1's Tramadol 50mg controlled substance count sheet (CSCS) revealed:
-The pharmacy dispensed 180 tablets of Tramadol 50mg with the directions to administer 1.5 tablets four times daily.
-There was documentation Tramadol was administered four times daily from 01/20/24-01/22/24 and twice on 01/23/24.
-The dates of 01/23/24 at 4:00pm and 8:00pm were written in with the amount given as 1.5 and the remaining amount of medication but the entry was not signed.
-The date of 01/24/24 at 8:00am was documented as the amount given and the remaining amount of medication but the entry was not signed.
-The next line was documented as the date of 01, but no further date information, at 4:00pm was documented, the amount given, and the remaining amount of medication were documented but the entry was not signed.
-The next line was documented as the time of 12:00pm but no other information was completed.
-There was no other documentation of Tramadol being administered.
-Incomplete entries included two entries on 01/23/24, three entries on 01/24/24, no documentation on 01/25/24.

Observation of Resident #1's medication on hand on 01/25/24 at 5:18pm revealed:
-Resident #1's Tramadol was dispensed with a start date of 01/20/24 in four punch cards with individually labeled blister packs for the date and

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time the medication was to be administered.
-Resident #1's Tramadol had been punched for the dates of 01/20/24-01/25/24 at 8:00am
-Resident #1's Tramadol had been punched for the dates of 01/20/24-01/25/24 at 12:00pm.
-Resident #1's Tramadol had been punched for the dates of 01/20/24-01/24/24 at 4:00pm and 8:00pm.

Refer to the interview with the MA on 01/26/24 at 10:31am.

Refer to the telephone interview with the Administrator on 01/26/24 at 11:28am.

2. Review of Resident #2's current FL-2 dated 01/17/24 revealed:
-The diagnoses included hypertension, chronic pain syndrome, and hypertension.
-There was an order for Buprenorphine-Nalox (used to treat severe pain) 8-2mg place one film under the tongue every 12 hours.

Review of Resident #2's January 2024 medication administration record (MAR) from 01/01/24-01/25/24 revealed:
-There was an entry for Buprenorphine-Nalox 8-2mg place one film under the tongue every 12 hours
with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Buprenorphine-Nalox was administered twice daily from 01/01/24-01/24/24 at 8:00am and 8:00pm.

Review of Resident #2's Buprenorphine-Nalox controlled substance count sheet (CSCS) revealed:
-The pharmacy dispensed 60 doses of Buprenorphine-Nalox with the directions to place

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one film under the tongue every 12 hours.
-There was documentation Buprenorphine-Nalox was administered twice daily from 001/20/24-01/23/24.
-The times of 8:00am and 8:00pm were written in with the amount given as 1 and the remaining amount of medication but the entry was not dated or signed.
-The CSCS was not completed for 01/24/24 at 8:00am or 8:00pm and 0/25/24 at 8:00am.
-If the CSCS was completed through 01/25/24 at 8:00am the remaining amount would have been 46.

Observation of Resident #2's medication on hand on 01/25/24 at 5:29pm revealed:
-Resident #2's Burprenorphine-Nalox was dispensed on 01/15/24, two separate boxes contained 30 pouches each.
-One box was opened and contained 16 of 30 pouches, the other box had not been opened.
-There was a total of 46 pouches available to be administered.

Refer to the interview with the MA on 01/26/24 at 10:31am.

Refer to the telephone interview with the Administrator on 01/26/24 at 11:28am.

3. Review of Resident #5's current FL-2 dated as 12/29/23 revealed:
-Diagnoses included dementia, physical debility, and anxiety.
-There was an order for Lorazepam (used to treat anxiety) 0.5mg once daily.

Review of Resident #5's January 2024 medication administration record (MAR) from 01/01/24-01/25/24 revealed:

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C 367	Continued From page 35 -There was an entry for Lorazepam 0.5mg with a scheduled administration time of 8:00am. -There was documentation Lorazepam was administered daily from 01/01/24-01/24/24 at 8:00am. Review of Resident #5's Lorazepam 0.5mg controlled substance count sheet (CSCS) revealed: -The pharmacy dispensed 30 tablets of Lorazepam 0.5mg on 01/04/24 with the directions to administer 1 tablet every morning. -There was documentation Lorazepam was administered at 8:00am daily from 01/20/24-01/23/24. -There was no documentation Lorazepam was administered at 8:00am on 01/24/24-01/25/24. Observation of Resident #5's medication on hand on 01/25/24 at 5:35pm revealed: -Resident #5's Lorazepam 0.5mg was dispensed with a start date of 01/20/24 in a punch card with individually labeled blister packs for the date and time the medication was to be administered. -Resident #5's Lorazepam had been punched for the dates of 01/20/24-01/25/24 at 8:00am. Refer to the interview with the MA on 01/26/24 at 10:31am. Refer to the telephone interview with the Administrator on 01/26/24 at 11:28am. _____ Interview with the MA on 01/26/24 at 10:41am revealed: -She usually documented on the CSCS when she documented on the MARs, but it had been chaotic. -She documented on the MARs when she put the residents' medications in their cups.	C 367		

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C 367	Continued From page 36 -She was filling in the CSCS on 01/25/24, but only for the dates she had worked. Telephone interview with the Administrator on 01/26/24 at 11:28am revealed: -He expected the administration of controlled medications to be documented when the controlled medication was administered. -The staff were supposed to count off between shifts to ensure the controlled medication was documented appropriately and if there were any discrepancies in the count documented versus the amount of medication on hand he was to be notified immediately.	C 367		