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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover Depatment of Social Services conducted a follow-up survey and complaint investigation on January 03, 2024, January 04, 2024 and January 05, 2024.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 6 medication aides sampled (D and F) who administered medications had the annual infection control training and met the 5 or 15- hour medication training. The findings are: 1. Review of Staff D's personnel record on 01/04/24 revealed: -Staff D was hired on 06/16/21. -Staff D was a medication aide (MA). -Staff D completed the state infection control training on 06/07/21. -There was no documentation Staff D had completed the annual infection control training	D 125		

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D 125	Continued From page 1 since 06/07/21. Review of a resident's December 2023 electronic Medication Administration Record (eMAR) revealed Staff D had administered medications. Interview with the Administrator on 01/05/24 at 7:56pm revealed: -Staff D has worked as a MA since being hired at the facility. -Staff D may not have her annual infection control training as Staff D worked weekends at the facility. -She was not aware Staff D had not had the required infection control training since 06/07/21. 2. Review of Staff F's personnel record on 01/04/24 revealed: -Staff F was hired on 01/06/23 as a MA. -Staff F had a clinical skills validation for medications dated 01/07/23. -Staff F passed the MA written exam on 10/10/22. -There was no documentation of a MA employment verification had been completed for Staff F. -There was no documentation Staff F had completed the 5 or 15-hour medication training. Review of a resident's December 2023 eMAR revealed Staff F had administered medications. Interview with the Administrator on 01/04/24 at 5:11pm revealed: -When Staff F was hired, she was grandfathered in and did not require the 5 and 15-hour medication aide training, as she had completed a medication aide assisted living class at a community college on 08/02/22. -She would have to see if a medication aide verification had been done for Staff F when hired,	D 125		

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D 125	Continued From page 2 as Staff F had previously worked at another community within the company. Interview with the Administrator on 01/05/24 at 7:56pm revealed: -Staff F had some paperwork at home related to medication training qualifications, which could include the medication verification form. -Staff F had not been asked to bring in paperwork she had at home related to medication training qualifications. -When Staff F was hired on 01/06/23, the Regional Nurse for the facility at that time would have been responsible for ensuring Staff F had all the clinical training and documentation to administer medications. -Staff F would have had to have a medication verification form or meet requirements for the 5 and 15-hour medication aide training prior to administering medications, as the documentation could have been missed filed in the Business Office Manager's (BOM) office. -The Resident Care Director (RCD) was responsible for ensuring medication aides met the clinical requirements and had paperwork in place to administer medications. -The RCD was to give paper work for required trainings to the BOM to file in personnel records. -The BOM was responsible for ensuring personnel files had all relevant information needed for state regulations. -She expected medication aides to have a medication clinical skills validation, medication aide verification form, and 5-hours of medication aide training prior to administering medications. -She would expect the medication aides to complete the 10-hour medication aide training within 60 days of completion of the 5-hour medication aide training. -She expected the medication aides to have the	D 125		

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D 125	Continued From page 3 infection control training at orientation and then annually . -She had used the perpetual staff log to conduct an audit of all personnel file about 6 months prior. -The personnel files were in compliance with the required information at the time of audit. The BOM was unavailable for interview on 01/04/24 and 01/05/24.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 3 of 5 sampled staff (A, B, and E) had a Health Care Personnel Registry check completed prior to hire to ensure no findings were listed. The findings are: 1. Review of Staff A's personnel record on 01/04/24 revealed: -Staff A was hired on 10/19/23. -Staff A was a medication aide (MA). -Staff A's Health Care Personnel Registry (HCPR) check was completed on 01/04/24 and there were no findings. 2. Review of Staff B's personnel record on	D 137		

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D 137	Continued From page 4 01/04/24 revealed: -Staff B was hired on 12/14/23. -Staff B was a MA. -Staff B's HCPR check was completed on 01/04/24 and there were no findings. 3. Review of Staff E's personnel record on 01/04/24 revealed: -Staff E was hired on 12/14/23. -Staff E was a MA. -Staff E's HCPR check was completed on 01/04/24 and there were no findings. Interview with the Administrator on 01/05/24 at 7:56pm revealed: -She was not aware the HCPR had not been checked for Staff A, B, D, E, and F prior to hire until 01/04/24 when personnel files were requested. -When she interviewed staff, she checked the Health Care Personnel Registry during the interview. -The Business Office Manager (BOM) was typically responsible for checking the HCPR. -She would expect the HCPR for staff to be checked prior to job offer or before the staff's first day of working in the facility. The BOM was unavailable for interview on 01/04/24 and 01/05/24.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 5 TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 3 sampled residents (#1) related to failing to ensure the resident was referred to a mental health provider. The findings are: Review of Resident #1's current FL-2 dated 03/31/23 revealed: -Diagnoses included depression, bipolar disorder, and anxiety disorder. -The resident's level of care was assisted living (AL). -The resident was ambulatory and did not have an orientation status assessment documented. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/08/21. Review of Resident #1's primary care provider (PCP) visit note dated 08/25/23 revealed: -The resident's diagnoses included anxiety disorder, bipolar disorder, major depressive disorder, and dementia. -The resident's family requested a referral for mental health services due to the resident struggling with a new diagnosis of dementia. -The resident was also struggling because her dog had to leave the facility and had to reside with her family member. -The resident was tearful during the PCP's visit. -The PCP wrote a referral for mental health services in the resident's progress note and provided facility staff with an order to refer her to mental health services.	D 273		

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D 273	Continued From page 6 Review of Resident #1's record on 01/04/24 revealed there were no notes from a mental health provider. Interview with Resident #1 on 01/03/24 at 9:38am revealed: -She was anxious at times and missed her dog which caused her to feel sad at times. -She missed her dog and cried sometimes because he kept her company. -She did not remember being seen by a mental health provider. Interview with Resident #1's family member on 01/03/24 at 9:25am revealed: -He was with Resident #1 when the family had to take the resident's dog to live with them because the resident's dog had nipped at someone at the facility. -The resident was "traumatized" after losing her dog and was having a difficult time with it. -The resident was more tearful during his visits, and she had a difficult time coping with her decline in health and the loss of her dog. -He met with the Administrator in late August 2023 and requested Resident #1 receive mental health services to help her cope with the loss of her dog, depression, and anxiety. -He met with the Administrator and the social worker in late August 2023 to sign forms so the resident could be referred for mental health services. -Several weeks later the Administrator or social worker contacted him to resign the documents so the resident's referral for mental services could be completed. -He signed the required documentation a second time in September 2023, however Resident #1 had still not received mental health services.	D 273		

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D 273	Continued From page 7 Interview with a medication aide (MA) on 01/04/24 at 4:43pm revealed she had observed Resident #1 tearful a few times because she missed her dog and complained of anxiety occasionally. Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:55pm revealed: -She and the medication aides (MAs) were responsible for reviewing PCP visit notes and orders. -Resident #1 should have been referred for mental health services after the PCP made the referral. -After the resident's family member signed the paperwork for the resident to be referred for mental health services, she or the MA should have contacted the mental health provider about the referral. -There had been some difficulties with scheduling the facility's contracted mental health provider to see Resident #1. -She was not sure why the resident had not received mental health services; however, the facility was attempting to contract with a new mental health provider. -The resident could have been referred to a mental health provider in the community to ensure she received mental services as ordered. Interview with the Administrator on 01/05/24 at 7:46pm revealed: -MAs and the DRC were responsible for ensuring referral orders by the PCP were completed. -Resident #1 had not received mental health services because the facility was in the process of changing mental health providers. -She and the RCC should have coordinated with the resident's PCP and family to find a mental	D 273		

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D 273	Continued From page 8 health provider to ensure the resident received mental health services as ordered by the PCP. Telephone interview with Resident #1's PCP on 01/05/24 at 9:48am revealed: -She visited Resident #1 with her family member on 08/25/23. -The resident was tearful and having a difficult time adjusting to her dog having to leave the facility and a new diagnosis of dementia. -She referred the resident to the facility's mental health provider at the request of the family member. -The facility had recently discussed changing mental health providers at the facility because the current provider they were contracted with was behind on resident assessments and visits. -She completed a mental health referral on 08/25/23 and the facility was responsible for faxing the referral to the mental health provider. -She was not aware that the facility had not coordinated mental health services for Resident #1 after her referral for services. -Resident #1 would benefit from mental health services with possible changes in her medications to help decrease her depression and anxiety. -Resident #1 needed talk therapy to provide her with support during a difficult time of adjusting to the loss of her dog and a new diagnosis of dementia. _____ The facility failed to meet the acute health care needs of a resident (#1) who had a diagnosis of depression, bipolar disorder, anxiety disorder, and newly diagnosed with dementia, who was traumatized when her dog had to be moved from the facility in August 2023 and difficulty coping with her decline in health. The resident's PCP	D 273		

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D 273	Continued From page 9 completed a mental health referral on 08/25/23 and the facility failed to provide the resident with mental health services. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2024.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime table service included a non-disposable beverage container. The findings are: Observation of the breakfast meal service in the	D 286		

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D 286	Continued From page 10 Special Care Unit (SCU) dining room on 01/04/24, from 7:40am to 8:05am, revealed: -There were place settings that consisted of a napkin, a non-disposable plate, a non-disposable fork, knife, and a non-disposable cup for juice. -There were 6 residents present for the meal at various times. -Water was served to the residents in plastic disposable cups. Interview with a dietary staff person on 01/04/24 at 12:39pm revealed: -There was a problem with the facility not having enough plates and glasses to serve all of the residents in the assisted living (AL) and SCU dining rooms. -Dietary staff took meals and drinks upstairs to the SCU. -Personal care aides (PCAs) from the SCU were expected to return the plates and glasses back to the kitchen once residents in the SCU finished their meal. -The PCAs on the SCU often forgot to return the plates and glasses to the kitchen once residents completed their meals. -The dietary staff had to use Styrofoam cups at times because there were not enough glasses to serve residents at the next dining service on the AL unit and SCU. -Dietary staff were not aware that there was a regulation about not using disposable plates or glasses until yesterday on 01/03/24. Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:51pm: -She was aware the residents were to have all non-disposable place settings at each meal. -She was not aware the residents in the SCU were served water in disposable plastic cups with their meal.	D 286		

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D 286	Continued From page 11 -She did not know why the residents were served water in disposable plastic cups with their meal. Interview with the Administrator on 01/05/24 at 8:28pm revealed: -Disposables were only to be used if there was an equipment issue with the dishwater. -She was surprised to hear that water was served to the SCU residents during the meal service in disposable plastic cups. -Staff were told not to use disposable serving items.	D 286		
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 interviews and record reviews, the facility failed to protect 2 of 2 residents (#10 and #11) from verbal and physical abuse by a staff member resulting in a resident (#10) reporting he was fearful of Staff G and did not feel safe and a resident (#11) who sustained new injuries to his right arm and reported staff abuse to his family and described the staff member that fit the same description for both instances. The findings are: Review of the facility's abuse, neglect, and exploitation prohibition and prevention program	D 338		

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D 338	Continued From page 12 policy dated 09/01/19 revealed: -The purpose of the policy was to provide a mechanism for the prompt identification, investigation, and reporting of any allegation or complaint of abuse, neglect or exploitation whether made by a resident, family or staff member, visitor, or another person. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish, this includes verbal abuse, physical abuse, and mental abuse. -Willful, as used in the facility's definition of abuse, means the individual must have acted deliberately-not that the individual must have intended to inflict injury or harm. -Physical abuse was defined as unconsented physical touching, including (but not limited to) hitting, slapping, pinching, kicking, physical restraint, or corporal punishment of any kind. -Injury of unknown source was an injury that was not observed by anyone, and the occurrence of which cannot be explained by the resident. -Every resident has the right to be free from verbal, sexual, physical, and mental abuse. -The facility was responsible for taking reasonable, appropriate steps to ensure that each resident is free from abuse, neglect, and exploitation by anyone, including but not limited to staff. -Prompt, thorough investigations are conducted in response to complaints or allegation of abuse, neglect, and/or exploitation, and all proper and required notifications are made to the proper individuals and authorities according to applicable state and federal regulations.	D 338		

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D 338	Continued From page 13 -Residents and staff are protected during incident investigations by ensuring reports are made without fear of retaliation and that anonymous reports are investigated. -The Administrator is responsible for the oversight and implementation of the Abuse, Neglect, and Exploitation Prohibition and Prevention Program. -The facility has a zero-tolerance policy with regard to abuse, neglect, and exploitation. -In responding to any allegation of abuse of a resident, the first priority is to protect the resident and to prevent further potential abuse the following steps may be taken: if the allegation involves an employee, the employee is immediately removed from contact with the resident and may be suspended, pending the outcome of the investigation, the Administrator or his/her designee personally meets with any involved resident and/or family member to reassure him/her and determine placement that is best for the resident's safety, in the event of physical abuse allegations, the Director of Nursing/Resident Services Director or designee immediately arranges for a physical examination of the resident. -The physical examination of the resident is conducted by an appropriately trained/licensed professional and the time, date, and person completing the examination are recorded in the medical record. -The resident is monitored for 72 hours post allegation. -All allegations of abuse are promptly investigated by the Administrator who is ultimately responsible for initiating and overseeing the investigation process. -Documentation of the investigation findings are maintained on applicable forms or reports. -The Administrator keeps the resident and his/her representative informed of the progress of the	D 338		

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D 338	Continued From page 14 investigation. -When the investigation is complete, the resident and his/her representative are informed of the results and correction action is taken. -If an allegation involves abuse, notification must occur immediately but no later than 24 hours. -The facility should maintain documentation in the resident's medical record of the identified signs/symptoms and allegation of abuse, assessment of the resident's condition, immediate interventions implemented, notification of the resident's physician, and notification of the family or responsible party for the resident. 1. Review of Resident #10's current FL-2 dated 11/10/23 revealed: -Diagnoses included cervical disc disease, diabetes, and hypertension. -Resident #10 was admitted to the assisted living unit of the facility on 12/06/23. Interview with Resident #10 on 01/03/24 at 1:05pm revealed: -He had been at the facility for about 1 month. -He would often wake up around 1:00am due to arthritis pain. -There was one female staff member that he felt "stalked" him. -He gave a physical description of the staff as a very heavy woman that only worked on the night shift. -The staff was a personal care aide (PCA). -She seemed dangerous to him. -She would sometimes be standing in his room when he woke up in the night. -She spoke very cruelly to him, she would tell him to pick up his leg and put his brief on and not take the brief off. -She would look at him with "hatred" if no one	D 338		

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was around.
-About two weeks ago, he woke up in pain and was going to the nurse's station to talk with the medication aide (MA),
-When he entered the hall, this PCA said "get back in that bed".
-He went to the MA and told her that he did not feel safe and did not want the PCA in his room.
-The MA said she would make a report, but he never heard anything back from her.
-The situation with this PCA had gotten better.

Confidential interview with a MA on 01/05/24 revealed:
-If a resident made a complaint, she would write a statement of the complaint and give it to the Wellness Coordinator (WC)
-She did not question Resident #10 about the incident with the PCA.
-She did not report it because she was not directly involved.
-She was not sure if this was reported by the MA on duty that night.

Telephone interview with a MA on 01/05/24 at 3:41PM revealed:
-If a resident made a complaint, there was a grievance form that she would complete, that included the residents name and description of the complaint.
-Resident #10 was usually oriented.
-She was working the night shift a couple weeks ago and Resident #10 came out of his room agitated and asked, "who is that lady that keeps coming into my room?".
-Resident #10 told her "I'm terrified, please don't let her come into my room and can we call 911".
-She accompanied Resident #10 back to his room and told him that she would not let anyone harm him.

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-While she was in Resident #10's room, Staff G, a PCA, came in and Resident #10 said "that is her, that is her".
-She described Staff G as a big woman with really short hair.
-The MA provided incontinence care for the resident and helped him to bed and told Resident #10 that Staff G would not come in his room again.
-She did not witness Staff G speaking harshly to Resident #10 but told her not to go into Resident #10's room.
-Staff G denied speaking harshly to Resident #10.
-She wrote a report of the incident on a sheet of notebook paper and made a copy and placed it in a crack on top of the door handle of the Administrator's door.
-She kept a copy of the report at her home but was not currently at her home.
-She had Staff G sign it as well.
-Other residents reported Staff G was mean but she had not witnessed anything.
-Other staff reported to her that Staff G may have pushed or popped a resident in the past, but she did not report this to the administrator because she had never witnessed anything.
-She did not hear back from the Administrator regarding the incident.
-She was off for a few days after the incident with Resident #10 and did not think to follow up with the Administrator regarding the incident.
-A few nights after the incident, Resident #10 thanked her for her help with Staff G..

Telephone interview with Staff G on 01/05/24 at 5:23pm revealed:
-She worked at the facility for seven years as a PCA.
-The battery was low on her cell phone and would probably lose the call.

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-The phone call was dropped, phoned her again and received recording that voice mail was full.

Interview with the Director of Resident Care (DRC) on 01/05/24 at 7:40pm revealed:
-Resident rights were discussed daily.
-PCAs were to report any complaints to the MA and the MAs were to report to her or to the Administrator.
-She was not aware of the complaints Resident #10 reported about Staff G.
-She provided frequent in-services regarding residents' rights.
-Staff were encouraged to always come and discuss issues and concerns.

Interview with the Administrator on 01/05/24 at 2:55pm revealed:
-If a resident had a concern they could discuss with the MA and the MA could handle it or come to management.
-If there was a concern about abuse, the MA wrote a report of the allegation and submitted this to the DRC or to the Administrator.
-An investigation would be launched, and 24 hour and 5-day reports were generated.
-She was not aware of abuse allegations for Resident #10.
-She never received any type of written or verbal notification of suspected verbal abuse for Resident #10.
-She expected all staff to always report any type of abuse of resident rights issues to management.
-She could not investigate if she was not made aware.
-The MA should have followed up with her about the complaint for Resident #10.

Second interview with the Administrator on

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01/05/23 at 8:42pm revealed:
-She had initiated an investigation 01/05/24 into the allegations of verbal abuse for Resident #10.
-She expected all staff to always report resident concerns to management.
-She expected all staff to treat the residents with dignity and respect.

2. Review of Resident #11's current FL-2 dated 03/23/23 revealed:
-Diagnoses included generalized weakness.
-The resident was intermittently disoriented.
-The resident had an indwelling catheter.
-The resident's level of care was assisted living.

Review of the Emergency Department (ED) Encounter for Resident #11 dated 10/13/23 revealed:
-Chief Complaint: Status Post fall from standing position, laceration to left temple, on blood thinners, skin tear to left arm.
-History of Present Illness: Patient with laceration to left parietal region as well as skin tears and abrasion to left elbow.
-Physical Exam, Skin: Warm and dry, multiple areas of bruising and skin tear to left elbow and forearm.

Telephone interview with Resident #11's family member on 01/02/24 at 11:52am revealed:
-Resident #11 had a fall on 10/13/23 that resulted in a visit to the local ED.
-As a result of the fall on 10/13/23, Resident #11 had a laceration to the left side of his head and skin tears to his left arm.
-Resident #11 contacted her by phone at 6:35am on 10/15/23 in a panic and said, "they beat me up" and that his catheter bag had been placed on his knee instead of his lower leg.
-The resident reported to her that a male

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medication aide (MA) that she named and a second employee that was a heavy-set female, whose name the resident did not know, roughed him up.
-She was unable to go the facility on 10/15/23 and contacted another family member and asked him to check on Resident #11.
-The other family member went to see Resident #11 on the morning of 10/15/23, he called and told her Resident #11 had a bandage on his right forearm.
-She went to the facility on 10/16/23 and demanded to speak to someone.
-She met with the Administrator and the Director of Resident Care (DRC) on 10/16/23 in Resident #11's room.
-She observed the Administrator interview Resident #11.
-The DRC never said a word and the Administrator thought Resident #11 somehow injured himself and that was why there were bruises and scratches on his right arm.
-The Administrator did not consider that a staff member had caused the injuries the resident's right arm despite her giving the administrator this information.
-She had Resident #11 moved to another facility later in the same week due to on-going concerns about his health care and she felt he was not safe.

Telephone interview with Resident #11's second family member on 01/02/24 at 11:58am revealed:
-He was contacted by another family member early in the morning on 10/15/23.
-His family member asked him to go check on Resident #11 after she had received a phone call from the resident that staff "roughed him up."
-He arrived at the facility on 10/15/23 between 9:30am and 10:00am.

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-He observed Resident #11 in his room with a gauze type wrap bandage over about three quarters of his right forearm.
-Resident #11 had a fall on 10/13/23 that resulted in a visit to the ED with skin tears to the left elbow but no injuries to the right arm.
-He was with Resident #11 at the local ED on 10/13/23 and observed bandages on the resident's left arm.
-He removed the gauze wrap from the resident's right forearm and saw bruising and small cuts that he described as fingernail marks.
-He reported that the resident's hospice nurse came later that day and re-dressed Resident #11's right forearm arm.
-He said no staff came in Resident #11's room while he was there, and he did not talk with any staff.

Review of staffing sheets provided by the facility on 01/03/24 for 10/14/23 and 10/15/23 revealed Staff G worked as a PCA on the Assisted Living (AL) unit 2:00pm to 10:00pm and 10:00pm to 6:00am on 10/14/23 and worked as a PCA on the AL unit 2:00pm to 10:00pm to 6:00am on 10/15/23.

Telephone Interview with Staff G on 01/05/24 at 5:23pm revealed:
-She worked at the facility for seven years as a PCA.
-The battery was low on her cell phone and would probably lose the call.
-The phone call was dropped, phoned her again and received recording that voice mail was full.

Interview with the Administrator on 01/05/24 at 8:43pm revealed:
-On 10/16/23, Resident #11's family member reported to her that Resident #11 told this family

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member that his catheter bag had been put on incorrectly and that staff was rough with him.
-On 10/16/23, Resident #11's family member voiced concern to her that the resident had been abused due to Resident #11's report of two staff members "roughing him up" and the resident had new bruises and cuts on his right arm 10/15/23.
-She interviewed Resident #11 with the resident's family member present on 10/16/23.
-She acknowledged that Resident #11 had cognitive impairment.
-She interviewed staff and was unable to substantiate the claim of abuse and completed the HCPR report as injury of unknown source.
-She elected to report the incident to the HCPR as injury of unknown source instead of resident abuse because the resident was a poor historian and could not tell her anything definitive.

The facility failed to ensure that Resident #10 was free of verbal abuse from staff resulting in the resident experiencing mental anguish reporting he felt unsafe and Resident #11 reporting physical abuse from a similarly described staff while Staff G was on duty at the facility was detrimental to the health, safety and welfare of Resident #10 and Resident #11 and constitutes a Type B Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/24 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2024.

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D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to contact the resident's endocrinologist to ensure clarification of medication orders for 1 of 5 sampled residents (#1) who was prescribed an insulin to treat high blood sugars and had a history of high blood sugars with four visits to a local emergency department in one month for high blood sugars. The findings are: Review of Resident #1's current FL-2 dated 03/31/23 revealed: -Diagnoses included diabetes. -The resident's level of care was assisted living (AL). -The resident was ambulatory and did not have an orientation status assessment documented. -There was an order for Humalog Solution 100	D 344		

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D 344	Continued From page 23 unit/ml sliding scale insulin (SSI) FSBS less than 130 do not administer insulin, FSBS 131-140 administer 1 unit of insulin, FSBS 141-150 administer 2 units of insulin, FSBS 151-160 administer 3 units of insulin, FSBS 161-170 administer 4 units of insulin, FSBS 171-180 administer 5 units of insulin, FSBS 181-190 administer 6 units of insulin, FSBS 191-200 administer 7 units of insulin, FSBS 201-210 administer 8 units of insulin, FSBS 211-220 administer 9 units of insulin, FSBS 221-230 administer 10 units of insulin, FSBS 231-240 administer 11 units of insulin, FSBS 241-250 administer 12 units of insulin, FSBS 251-260 administer 13 units of insulin, FSBS 261-270 administer 14 units of insulin, FSBS 271-280 administer 15 units of insulin, FSBS 281-290 administer 16 units of insulin, FSBS 291-300 administer 17 units of insulin, FSBS 301-310 administer 18 units of insulin, FSBS 311-320 administer 19 units of insulin, FSBS 321-330 administer 20 units of insulin, FSBS 331-340 administer 21 units of insulin, FSBS 341-350 administer 22 units of insulin, FSBS 351-360 administer 23 units of insulin, FSBS 361-370 administer 24 units of insulin, FSBS 371-380 administer 25 units of insulin, FSBS 381-390 administer 26 units of insulin, FSBS 391-400 administer 26 units of insulin, FSBS 401 or higher call provider (Humalog is fast-acting insulin used to control high blood sugar). Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/08/21. Review of Resident #1's care plan dated 10/31/23 revealed: -The resident had complex medication administration assistance.	D 344		

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-The resident required staff assistance for administration of her medications.
-Facility staff were responsible for monitoring the residents' medications for effectiveness, side effects and interactions.
-Facility staff were responsible for providing the resident with her medications safely and as prescribed.

Review of Resident #1's primary care provider's (PCP) visit note dated 08/27/21 revealed:
-Resident #1 was seen to complete paperwork needed for admission to the facility.
-There was an order to check FSBSs four times a day.
-The resident's Hemoglobin A1C (Hemoglobin A1C is a blood test that measures your average blood sugar levels over the past 3 months) was collected on 06/03/21 and there was a value of 11.7 (A normal A1C level is below 5.7%).

Review of Resident #1's PCP order dated 09/02/21 revealed there was an order to check the resident's FSBSs before meals and at bedtime.

Review of Resident #1's PCP order dated 09/08/23 revealed there was an order for Humalog Solution 100 unit/ml insulin to be administered three times a day, inject per sliding scale insulin (SSI) if FSBS less than 130 no SSI needed, FSBS 131-140 administer 1 unit of insulin, FSBS 141-150 administer 2 units of insulin, FSBS 151-160 administer 3 units of insulin, FSBS 161-170 administer 4 units of insulin, FSBS 171-180 administer 5 units of insulin, FSBS 181-190 administer 6 units of insulin, FSBS 191-200 administer 7 units of insulin, FSBS 201-210 administer 8 units of insulin, FSBS 211-220 administer 9 units of

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insulin, FSBS 221-230 administer 10 units of insulin, FSBS 231-240 administer 11 units of insulin, FSBS 241-250 administer 12 units of insulin, FSBS 251-260 administer 13 units of insulin, FSBS 261-270 administer 14 units of insulin, FSBS 271-280 administer 15 units of insulin, FSBS 281-290 administer 16 units of insulin, FSBS 291-300 administer 17 units of insulin, FSBS 301-310 administer 18 units of insulin, FSBS 311-320 administer 19 units of insulin, FSBS 321-330 administer 20 units of insulin, FSBS 331-340 administer 21 units of insulin, FSBS 341-350 administer 22 units of insulin, FSBS 351-360 administer 23 units of insulin, FSBS 361-370 administer 24 units of insulin, FSBS 371-380 administer 25 units of insulin, FSBS 381-390 administer 26 units of insulin, FSBS 391-400 administer 27 units of insulin, FSBS higher than 401 call provider for instructions.

Review of Resident #1's order from her endocrinologist dated 11/21/23 revealed there was an order to discontinue the resident's Humalog and SSI.

Review of Resident #1's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog Solution 100 unit/ml insulin to be administered three times subcutaneously a day at 6:30am, 10:30am, and 3:30pm SSI FSBS less than 130 do not administer insulin, FSBS 131-140 administer 1 unit of insulin, FSBS 141-150 administer 2 units of insulin, FSBS 151-160 administer 3 units of insulin, FSBS 161-170 administer 4 units of insulin, FSBS 171-180 administer 5 units of insulin, FSBS 181-190 administer 6 units of insulin, FSBS 191-200 administer 7 units of

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D 344	Continued From page 26 insulin, FSBS 201-210 administer 8 units of insulin, FSBS 211-220 administer 9 units of insulin, FSBS 221-230 administer 10 units of insulin, FSBS 231-240 administer 11 units of insulin, FSBS 241-250 administer 12 units of insulin, FSBS 251-260 administer 13 units of insulin, FSBS 261-270 administer 14 units of insulin, FSBS 271-280 administer 15 units of insulin, FSBS 281-290 administer 16 units of insulin, FSBS 291-300 administer 17 units of insulin, FSBS 301-310 administer 18 units of insulin, FSBS 311-320 administer 19 units of insulin, FSBS 321-330 administer 20 units of insulin, FSBS 331-340 administer 21 units of insulin, FSBS 341-350 administer 22 units of insulin, FSBS 351-360 administer 23 units of insulin, FSBS 361-370 administer 24 units of insulin, FSBS 371-380 administer 25 units of insulin, FSBS 381-390 administer 26 units of insulin, FSBS 391-400 administer 27 units of insulin, FSBS 401 or higher call provider for instructions. -There was documentation on the eMAR the SSI insulin order was discontinued on 11/21/23. -There was no documentation of a FSBS on 11/22/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/23/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/24/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/25/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/26/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/27/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/28/23 at 6:30am, 10:30am, and 3:30pm. -There was no documentation of a FSBS on 11/29/23 at 6:30am, 10:30am, and 3:30pm.	D 344		

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-There was no documentation of a FSBS on 11/30/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/25/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/26/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/27/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/28/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/29/23 at 6:30am, 10:30am, and 3:30pm.
-There was no documentation of a FSBS on 11/30/23 at 6:30am, 10:30am, and 3:30pm.

Review of Resident #1's record revealed there was no communication from the facility to clarify if FSBSs needed to be checked three times daily before meals or if there were parameters to follow if the resident's FSBS's were too high or too low or when to contact the endocrinologist.

Review of Resident #1's weight and vitals summary revealed there were no FSBS checks documented from 11/22/23 to 11/27/23.

Review of an after visit summary from a local emergency department (ED) for Resident #1 dated 12/01/23 revealed:
-Resident #1 was diagnosed with hyperglycemia (hyperglycemia means a high blood sugar level).
-Emergency Medical Services (EMS) obtained a FSBS for the resident of 560 prior to arrival at the ED (FSBS normal range is from 70 to 99).
-EMS administered 40 units of Humulin (Humulin is an insulin used to reduce high blood sugar) prior to arrival at the ED.
-The facility reported to EMS that when the resident's FSBS was checked on the morning of 12/01/23 the resident's FSBS was high, so they

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D 344	Continued From page 28 called EMS. -The resident's FSBS was 464 upon arrival at the ED at 9:08am. -The resident's FSBS was 470 at 9:11am, 423 at 10:14am, 261 at 12:05pm. -The resident received intravenous fluids (IV) and insulin at the ED and her FSBS came down to 261. Review of Resident #1's December 2023 electronic eMAR revealed: -There was an entry for Humalog Solution 100 unit/ml insulin to be administered three times a day at 8:30am, 1:00pm and 6:00pm sliding scale insulin (SSI) FSBS 396-500 call MD. -FSBS 121-131 administer 1 unit of insulin, FSBS 132-142 administer 2 units of insulin, FSBS 143-153 administer 3 units of insulin, FSBS 154-164 administer 4 units of insulin, FSBS 165-175 administer 5 units of insulin, FSBS 176-186 administer 6 units of insulin, FSBS 187-197 administer 7 units of insulin, FSBS 198-208 administer 8 units of insulin, FSBS 209-219 administer 9 units of insulin, FSBS 220-230 administer 10 units of insulin, FSBS 231-241 administer 11 units of insulin, FSBS 242-252 administer 12 units of insulin, FSBS 253-263 administer 13 units of insulin, FSBS 264-274 administer 14 units of insulin, FSBS 275-285 administer 15 units of insulin, FSBS 286-296 administer 16 units of insulin, FSBS 297-307 administer 17 units of insulin, FSBS 308-318 administer 18 units of insulin, FSBS 319-329 administer 19 units of insulin, FSBS 330-340 administer 20 units of insulin, FSBS 341-351 administer 21 units of insulin, FSBS 352-362 administer 22 units of insulin, FSBS 363-373 administer 23 units of insulin, FSBS 374-384 administer 24 units of insulin, FSBS 385-395 administer 25 units of insulin.	D 344		

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D 344	Continued From page 29 -There was no documentation of a FSBS at 8:30am, 1:00pm, and 6:00pm from 12/01/23 to 12/28/23. -A FSBS of 498 /STOP was documented on 12/29/23 at 8:30am with no units of Humalog administered. -There was no documentation that the PCP or resident's endocrinologist were notified of the resident's FSBS. -A FSBS of 390 was documented on 12/29/23 at 1:00pm with 25 units of Humalog documented as administered. -A FSBS of 325 was documented on 12/29/23 at 6:00pm with 19 units of Humalog documented as administered. -A FSBS of 356 was documented on 12/30/23 at 8:30am with 22 units of Humalog documented as administered. -A FSBS of 353 was documented on 12/30/23 at 1:00pm with 22 units of Humalog documented as administered. -A FSBS of 325 was documented on 12/30/23 at 6:00pm with 19 units of Humalog documented as administered. -A FSBS of 284 was documented on 12/31/23 at 8:30am with 15 units of Humalog documented as administered. -There was not a FSBS documented on 12/31/23 at 1:00pm, there was an entry of "5." -Review of the eMAR codes at the end of the eMAR revealed an entry of "5" which meant to hold and/or see progress note. -There was no documentation that the resident's endocrinologist or PCP was contacted. -There was not a FSBS documented on 12/31/23 at 6:00pm, there was an entry of HO, which meant hospitalized per the codes at the end of the eMAR. Review of a quarterly pharmacy review of	D 344		

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Resident #1's medications dated 12/20/23 revealed:
-The pharmacist recommended that the facility clarify with the provider when FSBSs should be checked because they were not being completed.
-The FSBSs were discontinued with the Humalog and SSI order on 11/21/23 by the resident's endocrinologist.

Review of a communication note from a medication aide (MA) to Resident #1's endocrinologist and PCP dated 12/20/23 revealed there was a request for a clarification order to clarify when FSBSs should completed.

Review of an order from Resident #1's PCP dated 12/20/23 revealed there was an order to check the resident's FSBSs three times daily before meals and to notify the provider if FSBSs were less than 60 or greater than 500.

Review of an after visit summary from a local ED for Resident #1 dated 12/22/23 revealed:
-Resident #1 was diagnosed with hyperglycemia.
-The resident's initial FSBS was greater than 600 upon arrival at the ED.
-The resident was treated aggressively with IV fluids and insulin.
-The resident's FSBS was greater than 600 at 7:50pm.
-The resident's FSBS was 439 at 1:35am and 279 at 3:44am.

Review of an order from Resident #1's endocrinologist dated 12/28/23 revealed there was an order to add Humalog U-100 three times a day as needed per SSI.

Review of Resident #1's record revealed there was no communication from the facility to clarify if

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FSBSs needed to be checked three times daily before meals or if there were parameters to follow if the resident's FSBSs were too high or too low on when to contact the Endocrinologist.

Review of an order from Resident #1's endocrinologist dated 12/28/23 revealed there was a clarification order to restart SSI coverage using Humalog U-100 insulin for meals using correctional factor of 10 with target of 120.

Review of Resident #1's record revealed there was no communication from the facility to clarify if FSBS's need to be checked three times daily before meals or if there were parameters to follow if the resident's FSBSs were too high or too low on when to contact the endocrinologist.

Review of an after visit summary from a local ED for Resident #1 dated 12/30/23 revealed:
-Resident #1 was diagnosed with hyperglycemia.
-The resident's FSBS was 528 when EMS checked at the facility.
-The resident's FSBS was 459 at 9:15pm, 428 at 10:28pm, and 430 at 11:31pm.

Review of an after visit summary from a local ED for Resident #1 dated 12/31/23 revealed:
-Resident #1 was diagnosed with hyperglycemia.
-The resident's FSBS was 525 at the facility and 57 units of Humalog was administered prior to leaving the facility (Humalog is a fast acting insulin used to reduce high blood sugar)
-There was documentation that the resident was supposed to get insulin in the morning, afternoon, and evening and facility staff had not administered the resident's afternoon dose of insulin when they called EMS.
-The resident's FSBS was 475 at 4:55pm, 347 at 7:03pm, 229 at 9:02pm, and 306 at 11:33pm.

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D 344	Continued From page 32 Review of Resident #1's weight and vitals summary revealed there were no FSBS checks documented from 12/01/23 to 12/20/23. Interview with Resident #1 on 01/03/24 at 9:38am revealed: -When she went to the local ED for high blood sugar she did not feel differently and did not have any symptoms. -She thought her FSBS's were doing well, she did not have symptoms when her FSBS was high. Interview with Resident #1's family member on 01/03/24 at 9:25am revealed: -Resident #1 lived at the facility for a few years and she had a history of high blood sugar. -The resident was sent to the local ED four times due to high blood sugars in December 2023. -The family member and another family member had spoken with several MAs and the Administrator about their concern of the resident's high blood sugars. -The Administrator told him recently that the facility was doing the best they could to help manage the residents' high blood sugars. Interview with the MA on 01/04/24 at 4:43pm revealed: -Resident #1 had her FSBSs checked three times a day. -The resident's FSBSs had been better recently. -She always checked the resident's FSBS prior to meals because that was the only way she knew how much Humalog to administer based on the SSI. -When the FSBS order was removed from the eMAR she still checked the resident's FSBS before meals to ensure she administered the correct amount of Humalog per the SSI.	D 344		

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D 344	Continued From page 33 Observation of a MA check Resident #1's FSBS on 01/04/24 at 4:45pm revealed the resident's FSBS was 299. Interview with the Wellness Coordinator (WC) on 01/05/24 at 11:59am revealed: -She supervised the MAs on the first floor of the AL unit where Resident #1 resided. -There was an order from the resident's endocrinologist to discontinue the Humalog with SSI on 11/21/23. -She or the MAs should have contacted the endocrinologist for a clarification order to determine if FSBSs should be continued three times a day for Resident #1. -She completed her last audit of resident medications on the first floor of the AL on 12/20/23. -When she completed an audit of resident medications she compared physician orders, the eMAR and medications on hand. -The facility's pharmacy consultant notified her on 12/20/23 during a quarterly medication review that a clarification order was needed to determine if FSBS checks needed to be continued three times a day. -The pharmacy consultant informed her on 12/20/23 that on 11/21/23 the endocrinologist discontinued the Humalog with SSI and the resident's FSBSs had not been checked since 11/22/23. -She thought she communicated to a MA and the Director of Resident Care (DRC) that the resident needed a clarification order. -A MA sent a clarification order for FSBSs three times a day was sent to the resident's PCP and endocrinologist on 12/20/23. -MAs could make changes to orders on the eMAR in November 2023, however since	D 344		

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December 2023 only clinical managers or the Administrator could make changes on the eMAR.
-When a resident returned from the hospital the MAs were responsible for reviewing the discharge paperwork and notify the resident's PCP of any medication changes or new referrals.
-She knew that the resident had been to the local ED a few times in December 2023 for high blood sugar.
-It was important to check the resident's FSBSs three times a day to ensure her FSBSs were not too high or too low.
-The resident was at risk of her blood sugar dropping too low or being too high if her FSBSs were not checked three times a day prior to the administration of Humalog based on her SSI.
-The resident was at risk of becoming unresponsive or going into a coma if her blood sugar was too high or too low.

Interview with the DRC on 01/05/24 at 3:56pm revealed:
-A MA or the WC should have sent a clarification order to the resident's endocrinologist to see if the provider wanted the resident's FSBSs checked three times a day.
-The FSBS order was connected to the Humalog SSI order and when the Humalog SSI was removed from the eMAR it also removed the FSBS order for the resident.
-The residents FSBSs needed to be checked to monitor her blood sugar levels.
-The resident had a history of high blood sugar and was at risk of returning to the hospital if her blood sugars were not controlled properly.

Interview with the Administrator on 01/05/24 at 7:46pm revealed:
-The order for FSBS checks for Resident #1 was connected to her order for Humalog in the eMAR

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system.
-When the Humalog was discontinued, it also removed the FSBS order for the resident.
-The MA, WC, or DRC should have notified the resident's PCP and endocrinologist to obtain a clarification order so staff would know whether or not to check the resident's FSBSs.
-The facility had a system in place to complete medication audits to ensure residents were administered the correct medication.
-The facility should have realized that the resident needed a clarification order for her FSBS checks prior to the pharmacy review on 12/20/23.
-Staff should have entered the order for Humalog and FSBS checks as two separate orders on the eMAR to enable staff to continue checking FSBSs three times a day after the SSI order was discontinued.
-The facility staff placed the resident at risk of death due to high blood sugars.

Telephone interview with a nurse at Resident #1's endocrinologist office on 01/05/24 at 1:30pm revealed:
-The facility should have contacted the endocrinologist for a clarification order when the endocrinologist ordered the resident's Humalog with SSI to be discontinued on 11/21/23 to clarify if FSBSs needed to be checked three times a day.
-The resident's FSBSs needed to be checked three times a day even with the Humalog with SSI discontinued so the endocrinologist could monitor the resident's blood sugars.
-The resident was at risk of diabetic ketoacidosis (DKA) a serious complication that could be life threatening due to extremely high blood sugar levels when the facility did not check the resident's FSBS three times a day.
-The resident was also at risk of cardiovascular

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problems related to DKA due to electrolyte imbalances which could cause arrhythmia (arrhythmia is an abnormal heart rhythm) or cardiac arrest.

Telephone interview with Resident #1's PCP on 01/05/24 at 9:48am revealed:
-Resident #1's blood sugar had been up and down since she had been admitted to the facility.
-The resident's family requested that the endocrinologist have the sole responsibility for managing the resident's insulin and FSBS checks.
-She reviewed notes from the resident's endocrinologist when she visited the resident.
-The facility staff had called her several times to inform her that the resident's FSBS was high.
-She received a call from a MA on 12/20/23 to ask if the resident needed to still have her FSBSs checked and she ordered the Resident had FSBSs checked three times a day and to notify her or the endocrinologist if the resident's FSBS was less than 60 or greater than 500.
-Resident #1's blood sugar needed to be controlled to ensure her blood sugars did not go too high.
-The resident was at risk of complications if her blood sugar remained too high, such as problems with her heart and kidneys.
-The resident was at risk of DKA which was caused by high blood sugar levels and could be life threatening.

Attempted telephone interview with Resident #1's endocrinologist on 01/05/24 at 11:03am was unsuccessful.

_____

The facility failed to obtain a clarification of an order for a resident with a history of high blood sugars (Resident #1) issued by an

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D 344	Continued From page 37 endocrinologist to discontinue the sliding scale insulin which resulted in the facility discontinuing all blood sugar monitoring from 11/21/23 through 12/21/23 and Resident #1 was sent to the local ED with a FSBS of 560. The facility failed to seek any clarification of the FSBS order which resulted in subsequent visits to the ED on 12/22/23, 12/30/23, and 12/31/23 with a FSBS above 600, 528, and 525 respectively. This failure resulted in substantial risk for serious physical harm to Resident #1 and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2024.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications	D 358		

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were administered as ordered for 4 of 5 residents (#5, #6, #7, #8) observed during the medication pass including errors with a medication used to treat nerve pain, a medication used to treat hypertension and congestive heart failure, a medication used to treat constipation (#5), a medication used to treat moderate to severe pain, two types of eye drops to treat dry eyes (#6), 2 supplements, a topical medication to treat arthritis pain, and a medication to treat high blood pressure (#7) and three medications administered late to treat high blood pressure, constipation and depression (#8); and for 2 of 5 residents (#1, #2) sampled for record review for a medication used to treat depression, a supplement used to treat low magnesium levels in the body, a medication used to treat restless leg syndrome, a medication used to treat major depressive disorder (#1), and for a medication used to treat elevated cholesterol and triglyceride levels (#2).

The findings are:

1. The medication error rate was 50% as evidenced by the observation of 13 errors out of 26 opportunities during the morning medication pass on 01/03/24 and 01/04/24.

a. Review of Resident #5's current FI-2 dated 09/18/23 revealed diagnoses included congestive heart failure, hypomagnesemia, type 2 diabetes, muscle weakness, hypertension, restless leg, and anemia.

i. Review of Resident #5's current order sheet dated 11/28/23 revealed an order for Gabapentin 600mg, three times daily. (Gabapentin is used to treat nerve pain.)

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D 358	Continued From page 39 Observation of the morning medication pass on 01/03/24 revealed Gabapentin 600mg was not administered to Resident #5 at 9:12am when he received his other medications. Review of Resident #5's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Gabapentin 600mg, one tablet by mouth three times daily, scheduled at 9:00am, 1:00pm, and 5:00pm. -Gabapentin was documented as administered 01/01/24 through 01/02/24 at 9:00am, 1:00pm, and 5:00pm. -On 01/03/24, there was a number 5 above the medication aides (MA) initials, at 9:00am, 1:00pm, and 5:00pm. -Gabapentin was documented as administered 01/04/24 at 9:00am and 1:00pm. -On 01/04/24, there was a number 5 above the medication aides (MA) initials, at 5:00pm -Per the chart codes on the eMAR, 5=Hold/See Progress Notes. Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Gabapentin 600mg available on the medication cart for Resident #5. Interview with Resident #5 on 01/04/24 at 1:08pm revealed: -Resident #5's pain level was a 4 out of 10 which was unusual because his nerve pain was usually controlled. -He did not know if he had ever run out of his Gabapentin. Interview with the MA on 01/03/24 at 4:00pm revealed: -Resident #5 was out of his Gabapentin, and she	D 358		

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was waiting on pharmacy to send.
-She had written the medication down on the medication order sheet.
-She had not called the pharmacy to check on the status of the medication.

Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed Resident #5's Gabapentin was not listed on the drugs returned to pharmacy sheet.

Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-Resident #5's Gabapentin 600mg was dispensed on 11/28/23 for a 30-day supply (90 tablets).
-A 30-day supply (90 tablets) of Gabapentin 600mg was dispensed for Resident #5 on 12/23/23.
-A 30-day supply (90 tablets) of Gabapentin 600mg was dispensed for Resident #5 on 01/04/24.
-Resident #5's pain could increase if he was not taking the Gabapentin as scheduled.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She did not know Resident #5 was out of his Gabapentin.
-She would expect that Resident #5's pain would increase if he missed doses of Gabapentin.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on 01/05/24 at 7:48pm.

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D 358	Continued From page 41 ii. Review of Resident #5's physician order sheet dated 11/28/23 revealed an order for Isosorbide Dinitrate 10mg twice daily, hold if systolic blood pressure (SBP) is less than 120 or diastolic blood pressure (DBP) is less than 60. (Isosorbide Dinitrate is used to treat hypertension and congestive heart failure.) Observation of the morning medication pass on 01/03/24 revealed Isosorbide Dinitrate 10mg was not administered to Resident #5 at 9:12am when he received his other medications. Review of Resident #5's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Isosorbide Dinitrate 10mg twice daily, scheduled at 9:00am and 9:00pm. -Isosorbide Dinitrate was documented as administered 01/01/24 through 01/02/24 at 9:00am and 9:00pm. -On 01/03/24, there was an "O" above the medication aides (MA) initials, at 9:00am and 9:00pm. -Isosorbide Dinitrate was documented as administered 01/04/24 at 9:00am and 9:00pm. -Per the chart codes on the eMAR, O=Other/See Progress Notes. -Resident #5's blood pressure was documented on 01/03/24 at 9:00am (167/73), 9:00pm (not documented), and on 01/04/24 at 9:00am (158/88) and 9:00pm (146/62). Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Isosorbide Dinitrate 10mg available on the medication cart for Resident #5. Interview with Resident #5 on 01/04/24 at 1:08pm	D 358		

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revealed he was having a slight headache.

Interview with the first shift MA on 01/03/24 at 4:00pm revealed:
-Resident #5 was out of the Isosorbide Dinitrate, and she was waiting on pharmacy to send it.
-She wrote the medication down on the medication order sheet.
-She had not called the pharmacy to check on the status of the medication.

Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed Resident #5's Isosorbide Dinitrate was not listed on the drugs returned to pharmacy sheet.

Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-The last time a 30-day supply (60 tablets) of Isosorbide Dinitrate 10mg was dispensed for Resident #5 on 12/19/23.
-Resident #5's Isosorbide Dinitrate 10mg had not been requested or dispensed since 12/19/23.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She did not know Resident #5 was out of his Isosorbide Dinitrate.
-Resident #5's blood pressure could increase, and he could develop chest pain if he did not receive Isosorbide Dinitrate as ordered.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on

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D 358	Continued From page 43 01/05/24 at 7:48pm. iii. Review of Resident #5's physician order sheet dated 11/28/23 revealed an order for Polyethylene Glycol Powder give 17 grams by mouth two times daily mix with 4-8 ounces fluid of choice. (Polyethylene Glycol Powder is used to treat constipation.) Observation of the morning medication pass on 01/03/24 at 9:12am revealed Polyethylene Glycol Powder was not administered to Resident #5 at 9:12am when he received his other medications. (Polyethylene Glycol Powder is used to treat constipation.) Review of Resident #5's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Polyethylene Glycol Powder twice daily, scheduled at 9:00am and 9:00pm. -Polyethylene Glycol Powder was documented as administered 01/01/24 through 01/02/24 at 9:00am and 9:00pm. -On 01/03/24, there was a RF above the medication aides (MA) initials at 9:00am and 9:00pm. -Polyethylene Glycol Powder was documented as administered 01/04/24 at 9:00am and 9:00pm. -Per the chart codes on the eMAR, RF=Declined/Refused. Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not Polyethylene Glycol Powder available on the medication cart for Resident #5. Interview with Resident #5 on 01/04/24 at 1:08pm revealed:	D 358		

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D 358	Continued From page 44 -He was not having any problems with constipation. -His last bowel movement was this morning (01/04/24). -He had never refused any medications. Interview with the MA on 01/03/24 at 4:00pm revealed: -Resident #5 was out of his Polyethylene Glycol Powder, and she was waiting for the pharmacy to send. -She wrote the medication down on the medication order sheet. -She had not called the pharmacy to check on the status of the medication. Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed Resident #5's Polyethylene Glycol Powder was not listed on the drugs returned to pharmacy sheet. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed: -The only order in their system for Polyethylene Glycol Powder was from a hospital discharge summary dated 10/11/23 which was to be used twice daily for 3 days. -They did not have the current order dated 11/28/23 for twice daily. -Resident #5's Polyethylene Glycol Powder had not been requested by the facility or dispensed since 10/11/23. Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed: -She had never written an order or prescription for Polyethylene Glycol Powder. -She was not sure why it was listed on the orders she signed on 11/28/23.	D 358		

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D 358	Continued From page 45 Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm. Refer to interview with the Administrator on 01/05/24 at 7:48pm. b. Review of Resident #6's current FI-2 dated 05/08/23 revealed diagnoses included displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, and back pain. i. Review of Resident #6's physician order sheet dated 12/19/23 revealed an order for Oxycontin ER 15mg two times daily.(Oxycontin ER was used to treat moderate to severe pain.) Observation of the morning medication pass on 01/03/24 revealed Oxycontin ER 15mg was not administered to Resident #6 at 8:57am when she received her other medications scheduled at 9:00am. (Oxycontin ER was used to treat moderate to severe pain.) Review of Resident #6's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Oxycontin ER 15mg twice daily, scheduled at 9:00am and 9:00pm. -Oxycontin ER 15mg was not documented as administered on 01/01/24 through 01/04/24 at 9:00am and 9:00pm. -On 01/02/24 at 9:00pm it was documented as administered. -On 01/01/24 and 01/03/24, there was a "O" above the medication aides (MA) initials, at	D 358		

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9:00am and 9:00pm.
-On 01/04/24, there was a "O" above the MA initials, at 9:00pm.
-On 01/02/24 and 01/02/24, there was a 5 above the MA initials at 9:00am.
-Per the chart codes on the eMAR, O=Other/See progress notes, 5=Hold/See progress notes.

Observation of Resident #6's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Oxycontin ER available on the medication cart for Resident #5.

Interview with Resident #6 on 01/04/24 at 8:00am revealed her pain was not controlled and was a 7 out of 10 on a pain scale with 10 being the worst pain and she was experiencing diarrhea.

Second interview with Resident #6 on 01/04/24 at 1:10pm revealed her pain was not controlled and a was 6 out of 10 on a pain scale with 10 being the worst pain.

Third interview with Resident #6 on 01/04/24 at 5:00pm revealed her pain was not controlled and was a 5 out of 10 on a pain scale with 10 being the worst pain and she stated she had just received some medication for pain but did not know the name of the medication.

Interview with the MA on 01/03/24 at 4:00pm revealed:
-Resident #6 was out of her Oxycontin ER, and she was waiting for the pharmacy to send.
-She wrote the medication down on the medication order sheet.
-She had not called the pharmacy to check on the status of the medication.

Telephone interview with the facility's contracted

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pharmacist on 01/05/24 at 8:20am revealed:
-The last time Oxycontin ER 15mg was dispensed for Resident #6 was on 11/10/23 for 60 tablets which was a 30-day supply.
-Resident #6's Oxycontin ER 15mg had not been dispensed since 11/10/23, a new refill request was sent to Resident #6's PCP on 12/14/23 with no response.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She had sent a prescription refill request to the facility's contracted pharmacy on 12/15/23 but it was not filled.
-Resident #6 could experience withdrawal symptoms like nausea, vomiting, diarrhea, sweating, and increased pain if she did not receive her Oxycontin as ordered.
-She examined the resident on 01/02/24 and she was complaining of diarrhea and pain, but she did not know she was out of her Oxycontin ER.

Review of staff progress notes dated 01/01/24 through 01/03/24 revealed that the Oxycontin ER 15mg was on order and awaiting pharmacy delivery.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

ii. Review of Resident #6's physician order sheet dated 12/19/23 revealed an order for Refresh eye drops one drop in each eye two times daily.

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D 358	Continued From page 48 (Refresh eye drops are used to treat eye dryness.) Observation of the morning medication pass on 01/03/24 revealed Refresh eye drops were not administered to Resident #6 at 8:57am when she received her other medications. (Refresh eye drops are used to treat eye dryness.) Review of Resident #6's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Refresh eye drops twice daily, scheduled at 9:00am and 9:00pm. -Refresh eye drops was documented as administered on 01/01/24 and 01/04/24 at 9:00am and 9:00pm. -Refresh eye drops was documented as administered on 01/02/24 at 9:00am and 01/03/24 at 9:00pm. -On 01/02/24 at 9:00pm and 01/03/24 at 9:00am, there was a "O" above the medication aides (MA) initials. -Per the chart codes on the eMAR, O=Other/See progress notes. Observation of Resident #6's medications on hand on 01/03/24 at 4:00pm revealed there was not any Refresh eye drops available on the medication cart for Resident #6. Interview with Resident #6 on 01/04/24 at 1:04pm revealed she was not experiencing any eye dryness. Interview with the MA on 01/03/24 at 4:00pm revealed Resident #6 was out of her Refresh eye drops and she was waiting for the pharmacy to send.	D 358		

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Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-The last time Refresh eye drops was dispensed for Resident #6 was on 12/08/23 for 50 doses.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-Resident #6 could have symptoms of dry eye which would be pain and blurred vision if she did not receive Refresh eye drops as ordered.

Review of staff progress notes dated 01/02/24 through 01/03/24 revealed that Refresh eye drops was on order.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

iii. Review of Resident #6's physician order dated 12/19/23 revealed an order for Systane eye drops one drop in each eye four times daily as needed. (Systane eye drops is used to treat eye burning and irritation due to dryness.)

Observation of the morning medication pass on 01/03/24 revealed Systane eye drops, one drop in each eye was administered to Resident #6 at 8:57am when she received her other medications scheduled at 9:00am. (Systane eye drops is used to treat eye burning and irritation due to dryness.)

Interview with Resident #6 on 01/04/24 at 1:04pm revealed she was not experiencing eye dryness

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and did not remember requesting her Systane eye drops.

Interview with the medication aide (MA) on 01/03/24 at 4:00pm revealed:
-Resident #6 was out of her Refresh eye drops and she administered Systane eye drops instead.
-Resident #6 did not request her Systane eye drops.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed she expected the medication to be administered as ordered.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

c. Review of Resident #7's current FI-2 dated 04/13/23 revealed diagnoses included dementia.

i. Review of Resident #7's current physician order sheet dated 11/28/23 revealed an order for Cholecalciferol 1000 units two tabs daily. (Cholecalciferol is a vitamin D3 supplement).

Observation of the morning medication pass on 01/04/24 revealed Cholecalciferol 1000 units two tabs daily was not administered to Resident #7 at 8:08am when she received her other medications scheduled at 8:00am. (Cholecalciferol is a vitamin D3 supplement).

Review of Resident #7's January 2024 electronic

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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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medication administration records (eMARs) revealed:
-There was an entry for Cholecalciferol 1000 units 2 tablets daily, scheduled at 8:00am.
-Cholecalciferol 2000 units was documented as administered on 01/01/24, 01/02/24, and 01/05/24 at 8:00am.
-On 01/03/24 at 8:00am was left blank.
-On 01/04/24 there was a "O" above the medication aides (MA) initials, at 8:00am.
-Per the chart codes on the eMAR, O=Other/See progress notes and there was not a code for blank spaces.

Observation of Resident #7's medications on hand on 01/04/24 at 11:57am revealed there was no Cholecalciferol 2000 units available on the medication cart for Resident #7.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable on 01/04/24 at 11:57am.

Interview with the MA on 01/04/24 at 11:57am revealed:
-When medications were not on the medication cart, we write it on the medication order sheet and then call the pharmacy.
-Medications were requested from the pharmacy when there were 4 doses left.

Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed:
-Resident #7's Cholecalciferol was listed on the drugs returned to pharmacy sheet.
-Resident #7 had 29 Cholecalciferol 2000 units returned on 01/03/24.

Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:

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D 358	Continued From page 52 -The last time Cholecalciferol 2000 units (dispensed so resident would only have to take one tablet instead of 2) was dispensed for Resident #7 was on 12/27/23 for 28 tablets for 28-day supply. -Cholecalciferol 2000 units was dispensed on 01/04/24 for 28 tablets for 28-day supply. Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed: -She did not know Resident #7 was out of her Cholecalciferol 2000 units. -She had no concerns about Resident #7 missing a few days of Cholecalciferol. Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm. Refer to interview with the Administer on 01/05/24 at 7:48pm. ii. Review of Resident #7's current physician order dated 11/28/23 revealed an order for B Complex Vitamins daily. (B Complex Vitamins was given as a supplement.) Observation of the morning medication pass on 01/04/24 revealed B Complex Vitamins daily was not administered to Resident #7 at 8:08am when she received her other medications scheduled at 8:00am. (B Complex Vitamins was given as a supplement.) Review of Resident #7's January 2024 electronic medication administration records (eMARs) revealed:	D 358		

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-There was an entry for B Complex Vitamins daily, scheduled at 8:00am.
-B Complex Vitamins daily was documented as administered on 01/01/24 through 01/05/24 at 8:00am.

Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable on 01/04/24 at 11:57am.

Interview with the medication aide (MA) on 01/04/24 at 11:57am revealed she did not realize that she had not administered the B Complex Vitamins to Resident #7 as ordered.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She expected the medication to be administered as ordered.
-She was not concerned that Resident #7 missed a dose of B Complex Vitamins.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

iii. Review of Resident #7's current physician order dated 11/28/23 revealed an order for Diclofenac Gel 1% 4 grams topically to left knee 3 times daily. (Diclofenac Gel is used for arthritis pain.)

Observation of the morning medication pass on 01/04/24 revealed Diclofenac Gel 1% was

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administered to both of Resident #7's knees at 8:08am when she received her other medications scheduled at 8:00am. (Diclofenac Gel is used for arthritis pain.)

Review of Resident #7's January 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Diclofenac Gel 1% 3 times daily to left knee, scheduled at 8:00am, 2:00pm, and 8:00pm.
-Diclofenac Gel 1% was documented as administered on 01/01/24 through 01/05/24 at 8:00am, 2:00pm, and 8:00pm.
Based on observations, interviews, and record reviews it was determined Resident #7 was not interviewable on 01/04/24 at 11:57am.

Interview with the medication aide (MA) on 01/04/24 at 11:57am revealed:
-She had been applying Diclofenac Gel 1% to both of Resident #7's knees.
-She did not realize Diclofenac Gel 1% was ordered for her left knee only because Resident #7 complained of pain in both knees.
-She did not refer to the eMAR or directions on the medication before applying the Diclofenac Gel !% to Resident #7's knees.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She expected Resident #7's medication to be administered as ordered.
-She did not know Resident #7 was having pain in her right knee.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

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D 358	Continued From page 55 Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm. Refer to interview with the Administer on 01/05/24 at 7:48pm. d. Review of Resident #8's current FI-2 dated 04/27/23 revealed diagnoses included hypertension, hypothyroidism, anxiety disorder, and major depressive disorder. i. Review of Resident #8's current physician order dated 12/22/23 revealed an order for Losartan 100mg daily. (Losartan is used to treat hypertension.) Observation of the morning medication pass on 01/03/24 revealed Losartan 100mg was not administered to Resident #8 at 9:25am when she received her other medications scheduled at 8:00am. (Losartan is used to treat hypertension.) Review of Resident #8's January 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Losartan 100mg, scheduled at 8:00am. -Losartan 100mg was documented as administered on 01/01/24 through 01/04/24 at 8:00am. -Resident #8's blood pressure was documented on 01/03/24 at 9:00am (158/75), 9:00pm (166/80), and on 01/04/24 at 9:00am (168/72) and 9:00pm (160/64). Interview with Resident #8 on 01/04/24 at 1:15pm revealed: -She had a headache this morning when she woke up and felt weak, no dizziness, or nausea.	D 358		

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Interview with the medication aide (MA) on 01/03/24 at 11:57am revealed:
-She was not aware that she had not administered Losartan 100mg to Resident #8.
-She documented administering the medication by mistake.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 9:48am revealed:
-She expected Resident #8's medication to be administered as ordered.
-Resident #8's blood pressure would increase, cause dizziness, increase fall risk, stroke, and kidney failure.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on 01/05/24 at 7:48pm.

ii. Review of Resident #8's current physician order dated 12/22/23 revealed an order for Labetalol 200mg twice daily. (Labetalol is used to treat hypertension.)

Observation of the medication pass on 01/03/24 revealed Labetalol 200mg was administered to Resident #8 at 9:25am

Review of Resident #8's January 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Labetalol 200mg, scheduled at 8:00am and 8:00pm.
-Labetalol 200mg was documented as

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administered on 01/01/24 through 01/04/24 at 8:00am and 8:00pm.
-Resident #8's blood pressure was documented on 01/03/24 at 9:00am (158/75), 9:00pm (166/80), and on 01/04/24 at 9:00am (168/72) and 9:00pm (160/64).

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 10:10am revealed:
-She was not notified that Resident #8's medications were administered late.
-She was concerned that Resident #8's Labetalol was administered late because Resident #8 was having problems with elevated blood pressure (BP).
-Elevated blood pressure could lead to a stroke, kidney failure, and increased fall risk.
-She was not notified of elevated BP's this week.

iii. Review of Resident #8's current physician order dated 12/22/23 revealed an order for Bupropion 100mg twice daily. (Bupropion is used to treat depression.)

Observation of the medication pass on 01/03/24 revealed Bupropion 100mg was administered to Resident #8 at 9:25am

Review of Resident #8's January 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Bupropion 100mg, scheduled at 8:00am and 8:00pm.
-Bupropion 100mg was documented as administered on 01/01/24 through 01/04/24 at 8:00am and 8:00pm.

Interview with Resident #8 on 01/03/24 at 3:00pm revealed she had a headache this morning when

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she woke up and felt weak, no dizziness, or nausea.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/05/24 at 10:10am revealed:
-Bupropion can cause dizziness and nausea this could increase with inconsistent times that are not 12 hours apart.
-Could decrease efficacy of the drug if not taken at consistent times.
-She was not notified that Resident #8's medications were administered late.

iv. Review of Resident #8's current physician order dated 12/22/23 revealed an order for Metamucil 0.52 grams twice daily. (Metamucil is used to treat constipation.)

Observation of the medication pass on 01/03/24 revealed Metamucil 0.52 grams was administered to Resident #8 at 9:25am

Review of Resident #8's January 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Metamucil 0.52 grams, scheduled at 8:00am and 8:00pm.
-Metamucil 0.52 grams was documented as administered on 01/01/24 through 01/04/24 at 8:00am and 8:00pm.

Interview with Resident #8 on 01/03/24 at 3:00pm revealed:
-She was late getting her medications.
-She had not had any issues with constipation.
-She stated her last bowel movement was on 01/03/24 at 7:30am.

Telephone interview with the facility's contracted

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primary care provider (PCP) on 01/05/24 at 10:10am revealed:
-She was not notified that Resident #8's medications were administered late.
-She expected the medication to be administered as ordered.
-She did not have any concerns with Metamucil 0.52 grams administered closer that 12 hours but should not be routinely.

Interview with the medication aide MA on 01/03/24 at 1:00pm revealed:
-She was slow passing medications because she was new.
-She passed medications to both halls on the first floor.
-There were 30 residents on both halls.
-She had not been trained on what to do if she was running late on passing medications.

Interview with the Wellness Coordinator on 01/05/24 at 12:00pm revealed:
-She did not know that Resident #8 medications were administered late.
-MAs should tell her that they were behind on passing medications.
-She did not know of a process at the facility when medications were administered late.

Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm revealed:
-Medications should be passed on time.
-She did not know that Resident #8 medications were administered late.
-MAs should tell their supervisor or her if they were late administering medication.
-MAs were trained to ask for help when they needed it.
-One MA was assigned to pass medications on the first floor.

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D 358	Continued From page 60 Interview with the Administrator on 01/05/24 at 7:48pm revealed: -MAs have been trained to let their supervisor or the DRC know when medications were late. -She did not know that Resident #8's medications were administrated late. -There was one MA assigned to pass medications on the first floor. Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm. Refer to interview with the Administrator on 01/05/24 at 7:48pm. _____ Interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm revealed: -Medications should be on the medication cart and available to be administered. -MAs documented on a medication order sheet when a resident was out of medication, and then called the pharmacy or give the sheet to the WC, and she would follow up on the medication status. Interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm revealed: -Medications should be available and on the medication cart. -MAs should call the pharmacy when a resident was out of medication. -All medications was pulled off the medication carts on 01/03/24 at 4:00am and the new batch of medications was placed on the medication carts. -Medications were not verified that there was a replacement batch medication before removal.	D 358		

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D 358	Continued From page 61 -Batch medications arrived on 12/29/23 but could not be used until 01/03/24 per pharmacy. Interview with the Administrator on 01/05/24 at 7:48pm revealed: -Resident medications should be available and on medication carts. -Medications should be ordered at least one week before they ran out. _____ 5. Review of Resident #1's current FL-2 dated 03/31/23 revealed diagnoses of depression, bipolar disorder, and anxiety disorder. a. Review of Resident #1's current FL-2 dated 03/31/23 revealed there was an order for Fluoxetine HCl 20mg take three tablets (60mg) every morning (Fluoxetine HCl is used to treat major depressive disorder and bipolar disorder). Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Fluoxetine HCL Capsule 20mg, administer 3 capsules one time a day for depression at 7:00am. -Fluoxetine HCL was documented as administered at 9:00am on 01/01/24, 01/02/24, and 01/04/24. -Fluoxetine HCL was not documented as administered at 9:00am on 01/03/24. -There was an entry on 01/03/24 with the letter "O" above the medication aides (MAs) initials on the eMAR. -Per the chart codes on the eMAR, "O" meant other and see progress notes. Review of Resident #1's electronic progress notes revealed there was no documentation for why the letter "O" was entered on the resident's	D 358		

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D 358	Continued From page 62 eMAR on 01/03/24. Observations of medications on hand for Resident #1 on 01//05/24 at 5:15pm revealed there were 66 Fluoxetine HCL capsules available for administration. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed Fluoxetine HCL Capsule 20mg was last dispensed for Resident #1 on 12/28/23, with a quantity of 84 capsules for a 28 day supply. Interview with Resident #1 on 01/03/24 at 9:38am revealed: -She thought she received all her medications from staff in the morning and before bedtime. -Sometimes she felt anxious. -She cried at times because she missed her dog that had to go live with her family member when he nipped someone at the facility. Interview with MA on 01/04/24 at 4:43pm revealed: -She was not sure why staff did not administer Resident #1 her Fluoxetine HCL on at 9:00am on 01/03/24. -The letter "O" on the eMAR meant other or to see progress notes. -She was unable to locate a progress note about why Resident #1 was not administered her Fluoxetine HCL on 01/03/24. Interview with Administrator on 01/05/24 at 7:46pm revealed: -She was not aware that Fluoxetine HCL was not administered to Resident #1 on 01/03/24. -She was not sure why there was not a progress note about why Resident #1 was not administered Fluoxetine HCL on 01/03/24.	D 358		

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D 358	Continued From page 63 Telephone interview with Resident #1's PCP on 01/05/24 at 9:48am revealed: Resident #1 could have adverse side effects from missing a dose of Fluoxetine HCL such as nausea, vomiting, and diarrhea. -Resident #1 could experience increased anxiety due to a missed dose of Fluoxetine HCL. Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm. Refer to interview with the Administer on 01/05/24 at 7:48pm. b. Review of Resident #1's current FL-2 dated 03/31/23 revealed there was an order for Magnesium Oxide 400mg take one tablet every morning at 7:00am (Magnesium Oxide is used to treat low amounts of magnesium in the blood). Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Magnesium Oxide 400mg, administer one tablet every morning at 7:00am. -Magnesium Oxide was documented as administered at 9:00am on 01/01/24, 01/02/24, and 01/04/24. -Magnesium Oxide was not documented as administered at 9:00am on 01/03/24. -There was an entry on 01/03/24 with the letter "O" above the MAs initials on the eMAR. -Per the chart codes on the eMAR, "O" meant other and see progress notes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

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D 358	Continued From page 64 Review of Resident #1's electronic progress notes revealed there was no documentation for why the letter "O" was entered on the resident's eMAR on 01/03/24. Observations of medications on hand for Resident #1 on 01/05/24 at 5:15pm revealed there were 20 Magnesium Oxide tablets available for administration. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed Magnesium Oxide 400mg was last dispensed for Resident #1 on 12/27/23, with a quantity of 28 pills for a 28 day supply. Interview with Resident #1 on 01/03/24 at 9:38am revealed she thought she received all her medications from staff in the morning and before bedtime. Interview with MA on 01/04/24 at 4:43pm revealed: -She was not sure why staff did not administer Resident #1's Magnesium Oxide at 9:00am on 01/03/24. -The letter "O" on the eMAR meant other or to see progress notes. -She was unable to locate a progress note about why Resident #1 was not administered her Fluoxetine HCL on 01/03/24. Interview with Administrator on 01/05/24 at 7:46pm revealed: -She was not aware of Magnesium Oxide was not administered to Resident #1 on 01/03/24. -She was not sure why there was not a progress note about why Resident #1 was not administered Magnesium Oxide on 01/03/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 65 Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm. Refer to interview with the Administer on 01/05/24 at 7:48pm. c. Review of Resident #1's current FL-2 dated 03/31/23 revealed there was an order for Pramipexole 0.125mg, take one tablet a day at 8:00pm (Pramipexole is used to treat restless leg syndrome). Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Pramipexole 0.125mg, administer one tablet once a day at 8:00pm. -Pramipexole 0.125mg was documented as administered at 8:00pm on 01/01/24, 01/02/24, and 01/04/24. -Pramipexole 0.125mg was not documented as administered at 8:00pm on 01/03/24, there was an entry on 01/03/24 on the eMAR with the letter "O" above the MAs initials on the eMAR. -Per the chart codes on the eMAR, "O" meant other and see progress notes. Review of Resident #1's electronic progress notes revealed there was no documentation for why the letter O was entered on the resident's eMAR on 01/03/24. Observations of medications on hand for Resident #1 on 01//05/24 at 5:15pm revealed there were 23 Pramipexole 0.125mg tablets available for administration.	D 358		

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D 358	Continued From page 66	D 358		

Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed Pramipexole 0.125mg was last dispensed for Resident #1 on 12/27/23, with a quantity of 30 tablets for a 30 day supply.

Interview with Resident #1 on 01/03/24 at 9:38am revealed:
-She usually slept well.
-She thought she received all her medications from staff in the morning and before bedtime.

Interview with MA on 01/04/24 at 4:43pm revealed:
-She was not sure why staff did not administer Resident #1 her Pramipexole 0.125mg at 9:00pm on 01/03/24.
-The letter "O" on the eMAR meant other or to see progress notes.
-She was unable to locate a progress note about why Resident #1 was not administered her Fluoxetine HCL on 01/03/24.
-She usually worked first shift and was not aware that Resident #1 had any problems with sleeping.

Interview with Administrator on 01/05/24 at 7:46pm revealed:
-She was not aware that Pramipexole 0.125mg was not administered to Resident #1 on 01/03/24.
-She was not sure why there was not a progress note about why Resident #1 was not administered Pramipexole 0.125mg on 01/03/24.

Telephone interview with Resident #1's PCP on 01/05/24 at 9:48am revealed Resident #1 could have difficulty sleeping when she missed a dose of Pramipexole because it helped with her restless legs.

Refer to interview with the Wellness Coordinator

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D 358	Continued From page 67 (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm. Refer to interview with the Administer on 01/05/24 at 7:48pm. d. Review of Resident #1's current FL-2 dated 03/31/23 revealed there was an order for Quetiapine 100mg, take one tablet at bedtime (Quetiapine is used to treat bipolar disorder). Review of Resident #1's January 2024 eMAR revealed: -There was an entry for Quetiapine 100mg, take one tablet at bedtime. -Quetiapine 100mg was documented as administered at 9:00pm on 01/01/24, 01/02/24, and 01/04/24. -Quetiapine 100mg was not documented as administered at 9:00pm on 01/03/24. -There was an entry on 01/03/24 with the letter "O" above the MAs initials on the eMAR. -Per the chart codes on the eMAR, "O" meant other and see progress notes. Review of Resident #1's electronic progress notes revealed there was no documentation for why the letter O was entered on the resident's eMAR on 01/03/24. Observations of medications on hand for Resident #1 on 01//05/24 at 5:15pm revealed there were 21 tablets available for administration. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed Quetiapine 100mg was last dispensed for Resident #1 on 12/27/23 with a quantity of 28	D 358		

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D 358	Continued From page 68 tablets for a 28 day supply. Interview with Resident #1 on 01/03/24 at 9:38am revealed: -She thought she received all her medications from staff in the morning and before bedtime. -Sometimes she felt sad and cried because she missed her dog. Interview with MA on 01/04/24 at 4:43pm revealed: -She was not sure why staff did not administer Resident #1 her Quetiapine 100mg at 9:00pm on 01/03/24. -The letter "O" on the eMAR meant other or to see progress notes. -She was unable to locate a progress note about why Resident #1 was not administered her Fluoxetine HCL on 01/03/24. -She usually worked first shift and was not aware that Resident #1 had any problems with sleeping. Interview with Administrator on 01/05/24 at 7:46pm revealed: -She was not aware that Quetiapine 100mg was not administered to Resident #1 on 01/03/24. -She was not sure why there was not a progress note about why Resident #1 was not administered Quetiapine 100mg on 01/03/24. Telephone interview with Resident #1's PCP on 01/05/24 at 9:48am revealed Resident #1 could have difficulty sleeping when she missed a dose of Quetiapine. Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm.	D 358		

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D 358	Continued From page 69 Refer to interview with the Administer on 01/05/24 at 7:48pm. 6. Review of Resident #2's current FL-2 dated 04/04/23 revealed: -Diagnoses included hyperlipidemia. -There was an order for atorvastatin 20mg one tablet by mouth every evening (atorvastatin is used to treat high cholesterol and triglyceride levels). Review of a physician's order sheet for Resident #2 dated 11/28/23 revealed a physician's order for atorvastatin 20mg, take one tablet by mouth in the evening. Interview with Resident #2 on 01/03/24 at 9:14am revealed: -He was not sure exactly what medications he took. -The facility was often out of his medications. Review of Resident #2's December 2023 electronic medication administration records (eMARs) revealed: -There was an entry for atorvastatin 20mg, one tablet by mouth in the evening, scheduled at 7:00pm. -Atorvastatin 20mg was documented as administered 12/01/23 through 12/29/23 at 7:00pm. -On 12/30/23 and 12/31/23, there was a letter "O" above the medication aides (MA) initials. -Per the chart codes on the eMAR, O=Other/See Progress Notes. Review of Resident #2's January 2024 eMAR revealed:	D 358		

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D 358	Continued From page 70 -There was an entry for atorvastatin 20mg, one tablet in the evening, scheduled at 7:00pm. -Atorvastatin 20mg was documented as administered on 01/03/24 at 7:00pm. -On 01/01/24 and 01/02/24, there was a letter "O" above the MA's initials. -Per the chart codes on the eMAR, O=Other/See Progress Note. Review of Resident #2's electronic progress notes revealed: -There was an entry for 12/30/23 for atorvastatin 20mg tablet was pending pharmacy. -There was an entry for 12/31/23 for atorvastatin 20mg tablet but there was no other notation. -There was an entry for 01/01/24 for atorvastatin 20mg tablet, pending pharmacy, MA had sent request for refill. -There was an entry for 01/02/24 for atorvastatin 20mg tablet, needs to be ordered. Observations of Resident #2's medications on hand on 01/04/24 at 3:19pm revealed there was a bubble card of atorvastatin 20mg dispensed 01/03/24 for a quantity of 28 tablets with 27 tablets remaining. Telephone interview with a pharmacist with the facility's contracted pharmacy on 01/04/24 at 8:41am revealed: -On 11/28/23, 30 tablets of atorvastatin 20mg were dispensed for Resident #2. -Atorvastatin 20mg 28 tablets for a 28-day supply was delivered to the facility on 12/29/23 for Resident #2.. -Atorvastatin 20mg 1 tablet was dispensed to the facility on 01/03/24 for Resident #2 and she was not sure why. Interview with a MA on 01/04/24 at 3:19pm	D 358		

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D 358	Continued From page 71 revealed: -Medications were received in 30 or 28-day bubble packs. -The MAs could request medication refills. -She usually requested medication refills when there were 7-8 days remaining on the bubble card to avoid running out of medications. -When medications needed to be re-ordered, she placed a label from the current medication bubble pack on a medication re-order form and faxed it to the facility's contracted pharmacy and followed up with a phone call. -Medications usually arrived the same day or the following day, if they did not arrive the following day, she placed a call to the pharmacy. -If she requested a medication refill for a resident, she would communicate this to the oncoming MA at shift change. -She did not know why Resident #2 had been without atorvastatin for 4 days. -She knew it was important for medications to be re-ordered for the residents so they would not be without their medications. Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:51 revealed she was not aware that Resident #2 did not receive atorvastatin for 4 days and the MA should have notified her. Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/05/24 at 9:53am was unsuccessful. Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm. Refer to interview with the DRC on 01/05/24 at 6:50pm.	D 358		

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D 358	Continued From page 72 Refer to interview with the Administrator on 01/05/24 at 8:05pm. _____ Interview with the WC on 01/04/24 at 5:20pm revealed: -Medications should be on the medication cart and available to be administered. -MAs documented on a medication order sheet when a resident was out of medication, and then called the pharmacy or give the sheet to the WC, and she would follow up on the medication status. Interview with the DRC on 01/05/24 at 6:50pm revealed: -Medications were to be re-ordered when the medications were at the last line of the bubble card, with 7 days remaining. -The MAs or the managers could request medication refills from the pharmacy. -If a medication was ordered and did not come in by the next day, the MAs should contact the pharmacy by phone or notify a supervisor and the supervisor would contact the pharmacy. -The MAs completed the medication re-order form with the resident's name and medication and faxed it to the facility's contracted pharmacy. -The contracted pharmacy delivered medications the same day in the evening or the next day if the re-order form was faxed late in the day. -The facility had just implemented batch cycling this month to try to eliminate residents being without their medications. -The facility had received the most recent batch of medications on 12/29/23 but said the medications could not be administered until 01/03/24. -A resident may have to miss a day of medication when it was re-ordered but should not miss consecutive days of medication.	D 358		

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D 358	Continued From page 73 -She expected medications to be re-ordered before they ran out and to be available for the residents. -She expected medications to be administered as ordered. Interview with the Administrator on 01/05/24 at 8:05pm revealed: -The MAs or managers could request medication refills from the contracted pharmacy. -Medication refills should be requested from the pharmacy when there was a one week supply remaining. -If a requested medication did not come from the contracted pharmacy provider, there was a backup pharmacy available. -The MAs should notify the supervisor if a medication was not received. -She expected the residents to get their medications as ordered and to not miss doses. _____ The facility failed to administer medications as ordered during the medication pass with 13 errors out of 26 opportunities, which resulted in an error rate of 50%. Resident #5, whose pain is normally well controlled, did not have Gabapentin available for administration and was not administered Gabapentin which resulted in Resident #5 experiencing a 4 out of 10 on the pain scale. Resident #5, whose diagnoses included hypertension and heart failure, also did not have Isosorbide or labetalol available for administration and was not administered Isosorbide or Labetalol which increased his risk of stroke, kidney failure, falls and chest pain, and had a documented systolic blood pressure of 167 and a diastolic blood pressure of 88 in January 2024. Resident #6 did not have Oxycontin ER 15mg available for administration and was not administered as ordered for at least four days and was	D 358		

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D 358	Continued From page 74 experiencing a withdrawal symptom of diarrhea and a 7 out of 10 on the pain scale. Resident #8 received 3 medications late that included Labetalol used to treat high blood pressure, who had a documented systolic blood pressure of 168 and a diastolic blood pressure of 80 in January 2024. Upon record review 2 of 5 residents also did not receive medications as ordered, Resident #1 missed doses of a prescribed antidepressant, fluoxetine 60mg daily, and a medication used to treat bipolar disorder, quetiapine 100mg daily, and was struggling with a newly diagnosed progressive disease and being separated from her dog due to her facility placement and dog's behavior, and verbalized being sad and crying at times. The failure of the facility to administer medications as ordered resulted in substantial risk for serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2024.	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	D 367		

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#5, #7, and #8) to include medications for pain, hypertension, heart failure, and constipation (Resident #5), a vitamin supplement (Resident #7), and hypertension (Resident #8).

The findings are:

1. Review of Resident #5's current FL-2 dated 09/18/23 revealed diagnoses included congestive heart failure, atrial fibrillation, hypomagnesium, type 2 diabetes, muscle weakness, hypertension, restless leg, and anemia.

a. Review of a physician's order sheet for Resident #5 dated 11/28/23 revealed an order for Isosorbide Dinitrate 10mg, two times per day (a medication used for hypertension and heart failure.)

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Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Isosorbide Dinitrate 10mg available on the medication cart for Resident #5.

Second observation of Resident #5's medications on hand on 01/05/24 at 5:52pm revealed that there was no Isosorbide Dinitrate 10mg available on the medication cart for Resident #5.

Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Isosorbide Dinitrate 10mg, 1 twice a day scheduled at 9:00am and 9:00pm.
- Isosorbide Dinitrate 10mg was documented as administered on 01/01/24 through 01/02/24 at 9:00am and 9:00pm.
-On 01/03/24 eMAR was documented as not given with an "O" (other/see progress note) for 9:00am and 9:00pm.
-On 01/03/24 at 10:16am it was documented in the progress notes that the Isosorbide Dinitrate 10mg was on order.
-Isosorbide Dinitrate 10mg was documented as administered on 01/04/24 at 9:00am and 9:00pm.

Interview with the first medication aide (MA) on 01/03/24 at 4:00pm revealed:
-Resident #5 was out of his Isosorbide Dinitrate, and she was waiting on pharmacy to send.
-She wrote the medication down on the medication order sheet to send to pharmacy.
-She had not called the pharmacy to check on the status of the medication.

Interview with the second MA on 01/05/24 at 5:52pm revealed:
-Resident #5's Isosorbide Dinitrate was still not

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MORNINGSIDE OF WILMINGTON	2744 S 17TH STREET WILMINGTON, NC 28412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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available on the medication cart.
-She had called the pharmacy today (01/05/24) requesting the Isosorbide Dinitrate.
-She documented by mistake on administering Isosorbide Dinitrate on 01/04/24 at 9:00am.

Review of the medication disposition sheet dated 01/03/24 revealed Resident #5's Isosorbide Dinitrate was not listed on the drugs returned to pharmacy sheet.

Interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-The last time Isosorbide Dinitrate 10mg was dispensed was on 12/19/23 for 60 tablets which was a 30-day supply.
-The medication had not been requested or dispensed since the last time it was dispensed on 12/19/23.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

b. Review of a physician's order sheet for Resident #5 dated 11/28/23 revealed an order for Gabapentin 600mg, three times per day (a medication used for nerve pain.)

Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Gabapentin 600mg available on the medication cart for Resident #5.

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D 367	Continued From page 78 Observation of Resident #5's medications on hand on 01/05/24 at 5:52pm revealed that there was Gabapentin 600mg 90 tablets for a 30-day supply dispensed on 01/04/24. Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin 600mg, three times a day scheduled for 9:00am, 1:00pm, and 5:00pm. -Gabapentin 600mg was documented as administered as ordered on 01/01/24 through 01/02/24. -On 01/03/24, it was documented as not given with a "5" (hold/see progress notes) for 9:00am, 1:00pm, and 5:00pm. -On 01/03/24 at 9:17am it was documented in the progress notes that the Gabapentin 600mg was on order. -Gabapentin 600mg was documented as administered on 01/04/24 at 9:00am and 1:00pm. -On 01/04/24 it was documented as not given with a "5" (hold/see progress notes for 5:00pm). Interview with the first medication aide (MA) on 01/03/24 at 4:00pm revealed: -Resident #5 was out of his Gabapentin 600mg, and she was waiting on pharmacy to send. -She wrote the medication down on the medication order sheet. -She had not called the pharmacy to check on the status of the medication. Interview with the second MA on 01/05/24 at 5:52pm revealed: -Resident #5's Gabapentin 600mg was not available on the medication cart on 01/04/24. -She documented by mistake administering Gabapentin 600mg on 01/04/24 at 9:00am and	D 367		

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1:00pm.
-Medications sent from pharmacy usually arrive between 11:00pm and 1:00am, sometimes later in the morning.

Attempted interview with third MA on 01/05/24 at 6:00pm was unsuccessful.

Review of the medication disposition sheet dated 01/03/24 revealed Resident #5's Gabapentin was not listed.

Interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-Gabapentin 600mg to be administered three times daily was dispensed on 11/28/23 for 90 tablets which was a 30-day supply.
-Gabapentin 600mg to be administered three times daily was dispensed on 12/23/23 for 90 tablets which was a 30-day supply.
-Gabapentin 600mg to be administered three times daily was dispensed on 01/04/24 for 90 tablets which was a 30-day supply.
-Pain would increase without taking the medication as scheduled.

Refer to interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administer on 01/05/24 at 7:48pm.

c. Review of a physician's order sheet for Resident #5 dated 11/28/23 revealed an order for Polyethylene Glycol Powder, take two times per day, 17 grams mix in 4-8 ounces in fluid of choice (a medication used for constipation.)

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D 367	Continued From page 80 Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Polyethylene Glycol Powder available on the medication cart for Resident #5. Review of Resident #5's December 2023 eMAR revealed: -There was an entry for Polyethylene Glycol Powder two times a day scheduled for 9:00am and 9:00pm. -Polyethylene Glycol Powder was documented as administered at 9:00am on 12/01/23 through 12/04/23, 12/07/23 and 12/08/23, 12/11/23 through 12/16/23, 12/18/23, 12/20/23 through 12/31/23. -Polyethylene Glycol Powder was documented as refused at 9:00am on 12/05/23, 12/06/23, 12/09/23, 12/10/23, 12/17/23, 12/19/23. -Polyethylene Glycol Powder was documented as administered at 9:00pm on 12/03/23,12/07/23 through 12/12/23, 12/14/23, 12/15/23, 12/19/23, 12/21/23,12/23/23, 12/27/23 through 12/31/23. -Polyethylene Glycol Powder was documented as refused at 9:00pm on 12/02/23, 12/20/23. -Polyethylene Glycol Powder was documented as "O" at 9:00pm on 12/01/23, 12/04/23 through 12/06/23, 12/13/23, 12/16/23 through 12/18/23, 12/22/23, 12/24/23 through 12/26/23, the "O" on the eMAR stands for Other/See progress note. -On 12/01/23 at 8:11pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available. -On 12/04/23 at 9:44pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available. -On 12/05/23 at 8:23pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available. -On 12/06/23 at 8:08pm it was documented in the	D 367		

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progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/13/23 at 9:08pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/16/23 at 9:28pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/17/23 at 8:30pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/18/23 at 8:39pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/22/23 at 8:08pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/24/23 at 8:10pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/24/23 at 8:10pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/25/23 at 8:48pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.
-On 12/26/23 at 8:37pm it was documented in the progress notes that Resident #5 Polyethylene Glycol Powder was not available.

Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Polyethylene Glycol Powder two times a day,17 grams mix in 4-8 ounces of fluid of choice, scheduled for 9:00am and 9:00pm.
-Polyethylene Glycol Powder was documented as administered on 01/01/24 through 01/02/24.
-On 01/03/24, it was documented as not given

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with a "RF" (declined/refused progress notes for 9:00am and 9:00pm.
-On 01/03/24 at 9:17am, it was not documented in the progress notes that Resident #5 declined or refused the medication.
-Polyethylene Glycol Powder was documented as administered on 01/04/24 at 9:00am and 9:00pm.

Review of the medication disposition sheet dated 01/03/24 revealed Resident #5's Polyethylene Glycol Powder was not listed.

Interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed:
-Polyethylene Glycol Powder administer two times a day was last dispensed on 10/11/23, 6 packets for a 3-day supply.
-They did not have the current order dated 11/28/23.
-The pharmacy did not compete the eMARS for the facility.

Interview with the first medication aide (MA) on 01/03/24 at 4:00pm revealed:
-Resident #5 was out of his Polyethylene Glycol Powder, and she was waiting for the pharmacy to send.
-She was not sure why she documented refused and did not write a note in the progress notes.

Interview with the second MA on 01/05/24 at 5:52pm revealed:
-She documented by mistake on administering Polyethylene Glycol Powder on 01/04/24 at 9:00am
Review of the medication disposition sheet dated 01/03/24 revealed Resident #5's Polyethylene Glycol Powder was not listed.

Attempted interview with third MA on 01/05/24 at

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6:00pm was unsuccessful.

Interview with a second facility contracted pharmacist on 01/05/24 at 9:40am revealed:
-Polyethylene Glycol Powder administered two times a day was last dispensed on 10/11/23, 6 packets for a 3-day supply from a hospital discharge summary.
-They did not have any other orders for Polyethylene Glycol Powder.

Refer to interview with the Wellness Coordinator (WC) on 01/05/24 at 5:30pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on 01/05/24 at 7:48pm.

2. Review of Resident #7's current FL-2 dated 04/13/23 revealed diagnoses included dementia.

Review of a physician's order sheet for Resident #7 dated 11/28/23 revealed an order for B Complex Vitamins one time per day (a medication used for supplement).

Observation of Resident #7's medications on hand on 01/04/24 at 11:57am revealed that there was a full medication card of B Complex Vitamins available on the medication cart for Resident #7.

Review of Resident #7's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for B Complex Vitamins, one time a day scheduled at 8:00am.
-B Complex Vitamins was documented as

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administered on 01/04/24 at 8:00am.

Interview with the medication aide (MA) on 01/04/24 at 11:57am revealed:
-She did not realize that she had not given the B Complex Vitamin.
-It was a mistake that she documented she had administered the B Complex Vitamin.

Refer to interview with the Wellness Coordinator (WC) on 01/05/24 at 5:30pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on 01/05/24 at 7:48pm.

3. Review of Resident #8's current FL-2 dated 04/27/23 revealed diagnoses included hypertension, hypothyroidism, anxiety disorder, and major depressive disorder.

Review of a physician's order sheet for Resident #8 dated 12/22/23 revealed an order for Losartan 100mg one time per day (a medication used for high blood pressure.)

Observation of the morning medication pass on 01/03/24 revealed Losartan 100mg was not administered to Resident #8 at 9:25am when she received her other medications scheduled at 8:00am. (Losartan is used to treat hypertension.)

Observation of Resident #8's medications on hand on 01/03/24 at 4:00pm revealed that there was a full medication card of Losartan 100mg available on the medication cart for Resident #8.

Review of Resident #8's January 2024 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Losartan 100mg, one time a day scheduled at 8:00am.
- Losartan 100 mg was documented as administered on 01/03/24 at 8:00am.

Interview with the medication aide (MA) on 01/03/24 at 4:00pm revealed:
-She did not realize that she had not given the Losartan 100mg.
-It was a mistake that she documented she had given the Losartan 100mg.

Refer to interview with the Wellness Coordinator (WC) on 01/05/24 at 5:30pm.

Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm.

Refer to interview with the Administrator on 01/05/24 at 7:48pm.

_____

Interview with the Wellness Coordinator (WC) on 01/04/24 at 5:20pm revealed:
-MA's are trained how to correctly document on the eMAR.
-Medications are documented after they are administered.
-When the medication is not administered they document the reason why.

Interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm revealed:
-MA's were trained on how to correctly complete the eMARs.
-They should document once the medication is administered.
-If a medication is not administered they

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D 367	Continued From page 86 document the reason. -She is not sure why a medication is documented as administered if it was not. Interview with the Administrator on 01/05/24 at 7:48pm revealed: -MA's have been trained on how to administer medications and complete the eMAR. -MA's should not document a medication as administered if it was not.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by a medication aide (MA) observed during the morning medication pass on 01/03/24, who did not sanitize her hands between obtaining a blood pressure, preparation, and administration of medications, and did not wear gloves administering eye drops to each resident to prevent the transmission of disease and infection, to prevent cross-contamination, and provide a safe and sanitary environment for residents. The findings are:	D 371		

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D 371	Continued From page 87 Observation of the medication aide (MA) on 01/03/2024 between 8:57am and 9:12am revealed: -The MA was ungloved and at the medication cart in the facility hallway. -There was a bottle of alcohol-based hand sanitizer on the medication cart. -She prepared the first resident's medication by punching the medication from the bubble cards into a medication cup and obtained an eye drop bottle from the medication cart. -She used her key to lock the medication cart. -She administered the prepared medications to the first resident, and she administered eye drops to both eyes without gloves and returned to the medication cart. -She used her key to unlock the medication cart and then documented medications administered in the electronic medication administration record (eMAR). -She did not wash her hands with soap and water or use hand sanitizer. -She prepared the second resident's medication by punching the medication from the bubble cards into a medication cup. -She used her key to lock the medication cart. -She administered the prepared medications to the second resident and then obtained his blood pressure (BP). -She used her key to unlock the medication cart and then documented medications administered in the electronic medication administration record (eMAR). -She did not wash her hands with soap and water or use hand sanitizer. -She prepared the third resident's medication by punching the medication from the bubble cards into a medication cup. -She used her key to lock the medication cart. -She administered the prepared medications to	D 371		

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D 371	Continued From page 88 the third resident. -She used her key to unlock the medication cart and then documented medications administered in the electronic medication administration record (eMAR). -She did not wash her hands with soap and water or use hand sanitizer. Interview with the MA on 01/03/24 at 4:00pm revealed: -She did not know that she should wash or sanitize her hands during medication administration. -She was not taught to use gloves when administrating eye drops. -She did not know that she should sanitize her hands after obtaining a BP. Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm revealed all MAs had been trained on infection control when passing medications. Interview with the Administrator on 01/05/24 at 7:48pm revealed all of the MAs had been educated on infection control in medication administration.	D 371		
D 390	10A NCAC 13F .1007 (e) Medication Disposition 10A NCAC 13F .1007 Medication Disposition e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the	D 390		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 390	Continued From page 89	D 390		

licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. These records shall be maintained by the facility for a minimum of one year.

This Rule is not met as evidenced by:
The facility failed to provide documentation of returned medications to the contracted pharmacy for 3 of 5 sampled residents. (#2, #3, #5).

The findings are:

1.Review of Resident #3's current FL-2 dated 10/03/23 revealed diagnoses included dementia without behaviors, insomnia, hypertension, muscle weakness, hypothyroidism, protein calorie malnutrition, constipation, and fracture of left pubis.

Review of Resident #3's physician order sheet dated 11/28/23 revealed a medication order for levoxyl 50 mcg (used to treat hypothyroidism) daily.

Review of the "Drugs Returned to Pharmacy or Released to the Patient" form revealed:
-A column for date returned.
-A column for nurse's initial.
-A column for the patient's name.
-A section labeled facility use, which included the name, strength, and form of drug; prescription number, date of issue, and quantity returned.
-A section labeled disposition, which included discontinued, patient discharged, patient expired, and released to patient.
-The form had a space for a signature and witness under the medications released at the

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D 390	Continued From page 90 bottom of the form. Review of Resident #3's "Drugs Returned to Pharmacy or Released to the Patient" form dated 01/03/24 revealed: -There was no documentation that levoxyl was sent back to the pharmacy. -Batch switch was hand written in the section for disposition. -The Director of Resident Care (DRC) completed and signed the form. -There were no other signatures/witnesses on the form. Interview with a medication aide (MA) on 01/04/24 at 12:15pm revealed: -Resident #3 was sent out to a local hospital on 01/01/24 due to a fall. -Resident #3 was admitted to the hospital. -Resident #3's medication had been sent back to the pharmacy except Miralax. Observation of Resident #3's medications on hand on 01/04/24 at 12:20pm revealed: -There was a bottle of Miralax on medication cart with instructions to take 17 grams in 8 ounces of water daily. -There was no levoxyl. Interview with the Special Care Coordinator (SCC) on 01/04/24 at 12:55pm revealed: -Resident #3 was admitted to the hospital on 01/01/24 due to a fall. -Resident #3's medications had been sent back to the pharmacy. -The medication aide or nurse completed a return to pharmacy form that listed the medications being sent back to the facility. -She had not seen a return to pharmacy form for Resident #3.	D 390		

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D 390	Continued From page 91 -She would ask the Director of Resident Care about Resident #3's return to pharmacy form, as the facility should have a copy of the form listing the medications sent back to the pharmacy. Interview with the DRC on 01/04/24 at 3:30pm revealed: -The facility did not have a copy of Resident #3's Return to Pharmacy Form that listed the resident's medications that were sent back to the pharmacy. -When the pharmacy picked up Resident #3's medications they took all three copies of the Return to Pharmacy Form without leaving the facility a copy. -She would have to call the facility pharmacy to get a copy of the Return to Pharmacy Form for Resident #3 that listed the resident's medications sent back to the pharmacy. A second interview with the DRC on 01/05/24 at 6:50pm revealed: -She completed Resident #3's "Drugs Returned to Pharmacy or Released to the Patient" form on 01/03/24 for medications being sent back to the pharmacy. -She did not complete Resident #3's form correctly with the required information. -The facility staff were to sign the form as well as the courier when the medications were being picked up. Refer to the interview with the Wellness Coordinator (WC) on 01/05/24 at 12:26pm. Refer to the interview with the DRC on 01/05/24 at 6:50pm. Refer to the interview with the Administrator on 01/05/24 at 7:56pm.	D 390		

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D 390	Continued From page 92 2. Review of Resident #2's current FL-2 dated 04/04/23 revealed: -Diagnoses included hyperlipidemia, history of transient ischemic attacks with cerebral infarctions, cerebral infarctions due to occlusions or stenosis of small arteries. -There was an order for atorvastatin 20mg one tablet by mouth every evening (atorvastatin is used to treat high cholesterol and triglyceride levels). Review of a physician's order sheet for Resident #2 dated 11/28/23 revealed a physician's order for atorvastatin 20mg, take one tablet by mouth in the evening. Review of Resident #2's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg, one tablet by mouth in the evening, scheduled at 7:00pm. -Atorvastatin 20mg was documented as administered 12/01/23 through 12/29/23 at 7:00pm. -On 12/30/23 and 12/31/23, there was a letter O above the medication aides (MA) initials. -Per the chart codes on the eMAR, O=Other/See Progress Notes. Review of Resident #2's January 2024 eMAR revealed: -There was an entry for atorvastatin 20mg, one tablet in the evening, scheduled at 7:00pm. -Atorvastatin 20mg was documented as administered on 01/03/24 at 7:00pm. -On 01/01/24 and 01/02/24, there was a letter O above the MA's initials. -Per the chart codes on the eMAR, O=Other/See	D 390		

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D 390	Continued From page 93 Progress Note. Review of Resident #2's electronic progress notes revealed: -There was an entry for 12/30/23 for atorvastatin 20mg tablet was pending pharmacy. -There was an entry for 12/31/23 for atorvastatin 20mg tablet but there was no other notation. -There was an entry for 01/01/24 for atorvastatin 20mg tablet, pending pharmacy, MA had sent request for refill. -There was an entry for 01/02/24 for atorvastatin 20mg tablet, needs to be ordered. Observations of Resident #2's medications on hand on 01/04/24 at 3:19pm revealed there was a bubble card of atorvastatin 20mg dispensed 01/03/24 for a quantity of 28 tablets with 27 tablets remaining. Review of the Drugs Returned to Pharmacy sheet dated 01/04/24 revealed Resident's #2's atorvastatin was not listed on the drugs returned to pharmacy sheet. Telephone interview with a pharmacist with the facility's contracted pharmacy on 01/04/24 at 8:41am revealed: -On 11/28/23, atorvastatin 20mg #30 was dispensed for a 30-day supply. -On 12/27/23, a claim was submitted for atorvastatin 20mg refill. -Atorvastatin 20mg #28 tablets for a 28-day supply was delivered to the facility on 12/29/23. -Atorvastatin 20mg #1 tablet was dispensed to the facility on 01/03/24, she was not sure why. Telephone interview with a second pharmacist from the facility's contracted pharmacy provider on 01/04/24 at 9:44am revealed:	D 390		

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D 390	Continued From page 94 -All medications on hand for the residents were sent back to the pharmacy for destruction when a new drug cycle started. -There was no pharmacy return sheet for atorvastatin that was delivered to the facility on 12/29/23. Refer to the interview with the Wellness Coordinator (WC) on 01/05/24 at 12:26pm. Refer to the interview with the Director of Resident Care on 01/05/24 at 6:51pm. Refer to the interview with the Administrator on 01/05/24 at 7:56pm. _____ Interview with the WC on 01/05/24 at 12:26pm revealed: -The "Drug Returned to Pharmacy or Released to Patient" form was to be used to document medications being sent back to the pharmacy. -Staff were to document the prescription number and the reason the medication was being sent back to the pharmacy. -Staff were expected to complete the form with the required information as indicated on the form. -The "Drug Returned to Pharmacy or Release to Patient" form was a 3-page carbon form. -The courier signed the form when picking up the box of medications. -She did not know if it was the facility's policy to keep a copy of the form for medications being sent back to the pharmacy. Interview with the DRC on 01/05/24 at 6:50pm revealed: -The facility used the "Drugs Returned to Pharmacy or Released to the Patient" form to document medications being sent back to the	D 390		

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pharmacy.
-The form was a 3-page carbon form.
-The form should include the name of the resident, name of the medication, date returned, the dosage, and the quantity being sent back to the pharmacy.
-When the courier picked up medications on 01/03/24 they did not leave any copies of the form with facility staff.
-She called the pharmacy on 01/04/24 to request a copy of the forms regarding the medications picked up on 01/03/24.
-She would expect the facility staff to get a copy of the form when medications are picked up for their records.

Interview with the Administrator on 01/05/24 at 7:56pm revealed:
-The facility used the "Drugs Returned to Pharmacy or Released to the Patient" form to document medication sent back to the pharmacy.
-The staff were to document the resident's name, the name of the medication, and how many of the medications were being sent back to the pharmacy.
-The staff should keep 1 of the 3 carbon pages of the form when medications were picked up by the pharmacy courier.
-The pharmacy courier did not leave any copies of the forms for the medications picked up on 01/03/24.
-She would expect the facility staff to complete the form with all the required information and to keep a copy of the form for their records.
3. Review of Resident #5's current FL-2 dated 09/18/23 revealed diagnoses included congestive heart failure, atrial fibrillation, hypomagnesium, type 2 diabetes, muscle weakness, hypertension, restless leg, and anemia.

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a. Review of Resident #5's physician order sheet dated 11/28/23 revealed an order for Isosorbide Dinitrate 10mg twice daily, hold if systolic blood pressure (SBP) is less than 120 or diastolic blood pressure (DBP) is less than 60. (Isosorbide Dinitrate is used to treat hypertension and congestive heart failure).

Observation of the morning medication pass on 01/03/24 revealed Isosorbide Dinitrate 10mg was not administered to Resident #5 at 9:12am when he received his other medications.

Review of Resident #5's January 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Isosorbide Dinitrate 10mg twice daily, scheduled at 9:00am and 9:00pm.
-Isosorbide Dinitrate was documented as administered 01/01/24 through 01/02/24 at 9:00am and 9:00pm.
-On 01/03/24, there was a "O" above the medication aides (MA) initials, at 9:00am and 9:00pm.
-Isosorbide Dinitrate was documented as administered 01/04/24 at 9:00am and 9:00pm.
-Per the chart codes on the eMAR, O=Other/See Progress Notes.

Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Isosorbide Dinitrate 10mg available on the medication cart for Resident #5.

Interview with the first MA on 01/03/24 at 4:00pm revealed:
-Resident #5 was out of the Isosorbide Dinitrate, and she was waiting on pharmacy to send.
-She wrote the medication down on the medication order sheet.

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D 390	Continued From page 97 -She had not called the pharmacy to check on the status of the medication. Interview with the second MA on 01/05/24 at 5:52pm revealed: -Resident #5's Isosorbide Dinitrate was still not available on the medication cart. -She had called the pharmacy today (01/05/24) requesting the Isosorbide Dinitrate. -She documented by mistake on administering Isosorbide Dinitrate on 01/04/24 at 9:00am. Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed Resident #5's Isosorbide Dinitrate was not listed on the drugs returned to pharmacy sheet. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed: -The last time a 30-day supply (60 tablets) of Isosorbide Dinitrate 10mg was dispensed for Resident #5 on 12/19/23. -Resident #5's Isosorbide Dinitrate 10mg had not been requested or dispensed since 12/19/23. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm. b. Review of Resident #5's current physician order sheet dated 11/28/23 revealed an order for Gabapentin 600mg three times daily. (Gabapentin is used to treat nerve pain). Observation of the morning medication pass on 01/03/24 revealed Gabapentin 600mg was not administered to Resident #5 at 9:12am when he received his other medications. Review of Resident #5's January 2024 electronic medication administration records (eMARs)	D 390		

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D 390	Continued From page 98 revealed: -There was an entry for Gabapentin 600mg, one tablet by mouth three times daily, scheduled at 9:00am, 1:00pm, and 5:00pm. -Gabapentin was documented as administered 01/01/24 through 01/02/24 at 9:00am, 1:00pm, and 5:00pm. -On 01/03/24, there was a number 5 above the medication aides (MA) initials, at 9:00am, 1:00pm, and 5:00pm. -Gabapentin was documented as administered 01/04/24 at 9:00am and 1:00pm. -On 01/04/24, there was a number 5 above the medication aides (MA) initials, at 5:00pm -Per the chart codes on the eMAR, 5=Hold/See Progress Notes. Observation of Resident #5's medications on hand on 01/03/24 at 4:00pm revealed that there was not any Gabapentin 600mg available on the medication cart for Resident #5. Interview with the MA on 01/03/24 at 4:00pm revealed: -Resident #5 was out of his Gabapentin, and she was waiting on the pharmacy to send. -She had written the medication down on the medication order sheet. -She had not called the pharmacy to check on the status of the medication. Review of the drugs returned to pharmacy sheet dated 01/03/24 revealed Resident #5's Gabapentin was not listed on the drugs returned to pharmacy sheet. Telephone interview with the facility's contracted pharmacist on 01/05/24 at 8:20am revealed: -Resident #5's Gabapentin 600mg was dispensed on 11/28/23 for a 30-day supply (90 tablets).	D 390		

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D 390	Continued From page 99 -A 30-day supply (90 tablets) of Gabapentin 600mg was dispensed for Resident #5 on 12/23/23. -A 30-day supply (90 tablets) of Gabapentin 600mg was dispensed for Resident #5 on 01/04/24. -Resident #5's pain could increase if he was not taking the Gabapentin as scheduled. Refer to interview with the Wellness Coordinator (WC) on 01/05/24 at 12:26pm. Refer to interview with the Director of Resident Care (DRC) on 01/05/24 6:50pm. Refer to interview with the Administrator on 01/05/24 at 7:56pm. _____ Interview with the Wellness Coordinator (WC) on 01/05/24 at 12:26pm revealed: -The "Drug Returned to Pharmacy or Released to Patient" form was to be used to document medications being sent back to the pharmacy. -Staff were to document the prescription number and the reason the medication was being sent back to the pharmacy. -Staff were expected to complete the form with the required information as indicated on the form. -The "Drug Returned to Pharmacy or Release to Patient" form was a 3-page carbon form. -The courier signed the form when picking up the box of medications. -She did not know if it was the facility's policy to keep a copy of the form for medications being sent back to the pharmacy. Interview with the Director of Resident Care (DRC) on 01/05/24 at 6:50pm revealed: -The facility used the "Drugs Returned to	D 390		

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D 390	Continued From page 100 Pharmacy or Released to the Patient" form to document medications being sent back to the pharmacy. -The form was a 3-page carbon form. -The form should include the name of the resident, name of the medication, date returned, the dosage, and the quantity being sent back to the pharmacy. -When the courier picked up medications on 01/03/24 they did not leave any copies of the form with facility staff. -She called the pharmacy on 01/04/24 to request a copy of the forms regarding the medications picked up on 01/03/24. -She would expect the facility staff to get a copy of the form when medications are picked up for their records. Interview with the Administrator on 01/05/24 at 7:56pm revealed: -The facility used the "Drugs Returned to Pharmacy or Released to the Patient" form to document medication sent back to the pharmacy. -The staff were to document the resident's name, the name of the medication, and how many of the medications were being sent back to the pharmacy.	D 390		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by:	D 438		

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D 438	Continued From page 101 TYPE B VIOLATION Based on interviews and record reviews, the facility failed to accurately complete the Health Care Personnel Registry (HCPR) 24 Hour Initial and 5 Working Day Investigative Report after a resident's (#11) family member reported concern of physical abuse to the Administrator. The findings are: Review of the facility's abuse, neglect, and exploitation prohibition and prevention program policy dated 09/01/19 revealed: -The purpose of the policy was to provide a mechanism for the prompt identification, investigation, and reporting of any allegation or complaint of abuse, neglect or exploitation whether made by a resident, family or staff member, visitor, or another person. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish, this includes verbal abuse, physical abuse, and mental abuse. -Willful, as used in the facility's definition of abuse, means the individual must have acted deliberately-not that the individual must have intended to inflict injury or harm. -Physical abuse was defined as unconsented physical touching, including (but not limited to) hitting, slapping, pinching, kicking, physical restraint, or corporal punishment of any kind. -Injury of unknown source was an injury that was not observed by anyone, and the occurrence of which cannot be explained by the resident.	D 438		

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D 438	Continued From page 102 -Every resident has the right to be free from verbal, sexual, physical, and mental abuse. -The facility was responsible for taking reasonable, appropriate steps to ensure that each resident is free from abuse, neglect, and exploitation by anyone, including but not limited to staff. -Prompt, thorough investigations are conducted in response to complaints or allegation of abuse, neglect, and/or exploitation, and all proper and required notifications are made to the proper individuals and authorities according to applicable state and federal regulations. -Residents and staff are protected during incident investigations by ensuring reports are made without fear of retaliation and that anonymous reports are investigated. -The Administrator is responsible for the oversight and implementation of the Abuse, Neglect, and Exploitation Prohibition and Prevention Program. -The facility has a zero-tolerance policy with regard to abuse, neglect, and exploitation. -In responding to any allegation of abuse of a resident, the first priority is to protect the resident and to prevent further potential abuse the following steps may be taken: if the allegation involves an employee, the employee is immediately removed from contact with the resident and may be suspended, pending the outcome of the investigation, the Administrator or his/her designee personally meets with any involved resident and/or family member to reassure him/her and determine placement that is best for the resident's safety, in the event of physical abuse allegations, the Director of Nursing/Resident Services Director or designee immediately arranges for a physical examination of the resident. -The physical examination of the resident is conducted by an appropriately trained/licensed	D 438		

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professional and the time, date, and person completing the examination are recorded in the medical record.
-The resident is monitored for 72 hours post allegation.
-All allegations of abuse are promptly investigated by the Administrator who is ultimately responsible for initiating and overseeing the investigation process.
-Documentation of the investigation findings are maintained on applicable forms or reports.
-The Administrator keeps the resident and his/her representative informed of the progress of the investigation.
-When the investigation is complete, the resident and his/her representative are informed of the results and correction action is taken.
-If an allegation involves abuse, notification must occur immediately but no later than 24 hours.
-The facility should maintain documentation in the resident's medical record of the identified signs/symptoms and allegation of abuse, assessment of the resident's condition, immediate interventions implemented, notification of the resident's physician, and notification of the family or responsible party for the resident.

Review of Resident #11's current FL-2 dated 03/23/23 revealed:
-Diagnoses included generalized weakness.
-The resident was intermittently disoriented.
-The resident had an indwelling catheter.
-The resident's level of care was assisted living.

Review of the Emergency Department (ED) Encounter for Resident #11 dated 10/13/23 revealed:
-Chief Complaint: Status Post fall from standing position, laceration to left temple, on blood thinners, skin tear to left arm.

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D 438	Continued From page 104 -History of Present Illness: Patient with laceration to left parietal region as well as skin tears and abrasion to left elbow. -Physical Exam, Skin: Warm and dry, multiple areas of bruising and skin tear to left elbow and forearm. Interview with Resident #11's family member on 01/02/24 at 11:52am revealed: -Resident #11 had a fall on 10/13/23 that resulted in a visit to the local ED. -As a result of the fall on 10/13/23, Resident #11 had a laceration to the left side of his head and skin tears to his left arm. -Resident #11 contacted her by phone at 6:35am on 10/15/23 in a panic and said, "they beat me up" and that his catheter bag had been placed incorrectly. -The resident reported to her that a male medication aide (MA) that she named and a second employee that was a heavy-set female, whose name the resident did not know, roughed him up. -The resident reported to her that staff beat him up, threw the resident back in the back and told the family member "you gotta get me out of here." -She was unable to go the facility on 10/15/23 and contacted another family member and asked him to check on Resident #11. -The other family member went to see Resident #11 on the morning of 10/15/23, he called and told her Resident #11 had a bandage on his right forearm. -She went to the facility on 10/16/23 and demanded to speak to someone. -She met with the Administrator and the Director of Resident Care (DRC) on 10/16/23 in Resident #11's room. -She reported to the Administrator and the DRC that the resident called her at 6:35am on 10/15/23	D 438		

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and reported that staff beat him up, the resident was afraid to stay at the facility, and staff had injured the resident's right forearm.
-She explained to the Administrator on 10/16/23 that she was concerned that Resident #11 was physically abused by staff the morning of 10/15/23 with injuries to his right forearm.
-The DRC never said a word and the Administrator told her Resident #11 somehow injured himself and that was why there were bruises and scratches on his right arm.
-She also called the local Ombudsman and reported her concern that Resident #11 reported to her that he had been "roughed up," the resident had new injuries to his right forearm, the resident was afraid to stay at the facility and she was concerned the resident had been abused by staff on 10/15/23.
-The Administrator did not consider that a staff member had caused the injuries to the resident's right arm, despite her giving the Administrator this information.

Interview with Resident #11's second family member on 01/02/24 at 11:58am revealed:
-He was contacted by another family member early in the morning on 10/15/23.
-His family member asked him to go check on Resident #11 after she received a phone call from the resident that staff "roughed him up."
-He arrived at the facility on 10/15/23 between 9:30am and 10:00am.
-He observed Resident #11 in his room with a gauze type wrap bandage over about three quarters of his right forearm.
-Resident #11 had a fall on 10/13/23 that resulted in a visit to the ED with skin tears to the left elbow but no injuries to the right arm.
-He was with Resident #11 at the local ED on 10/13/23 and observed bandages on the

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resident's left arm.
-He removed the gauze wrap from the resident's right forearm and saw bruising and small cuts that he described as fingernail marks.
-The resident's hospice nurse came later that day and re-dressed Resident #11's right forearm arm.
-He said no staff came in Resident #11's room while he was there, and he did not talk with any staff.

Review of Resident #11's Health Care Personnel Registry (HCPR) 24-Hour Initial Report dated 10/16/23 revealed:
-In the Allegation/Incident Type section, No was selected for the question, Is reasonable suspicion of a crime related to any allegation checked below?
-In the Allegation/Incident Type section, Injury of Unknown Source was selected.
-In the Allegation Description section, the Incident date was 10/15/23 at approximately 10:00am.
-In the Allegation Description section, there was an entry the resident had open areas on his right forearm.
-In the Law Enforcement section, No was selected for the question, Is there a Reasonable Suspicion of a Crime?
-In the Law Enforcement section, No was checked for the question, Incident reported to law enforcement.
-The 24-Hour Initial Report was signed by the Administrator on 10/16/23.
-There was a fax confirmation sheet that the HCPR 24-Hour Initial Report was transmitted by fax on 10/16/23 at 4:42pm.
-There was no information related to the resident's family member's specific allegations of abuse.

Review of Resident #11's HCPR 5-Working Day

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D 438	Continued From page 107 Report dated 10/23/23 revealed: -In the Allegation/Incident Type section, No was selected for the question, Is reasonable suspicion of a crime related to any allegation checked below? -In the Allegation/Incident Type section, Injury of Unknown Source was selected. -In the Allegation/Incident Details section, the incident date was 10/15/23 at approximately 10:00am. -In the Allegation/Incident Details section there was an entry for Description of Incident: -Family called for assistance to room. The Executive Director (ED)/(Administrator) and DRC went to the resident's room. -Family stated the resident told her that the resident stated that a big woman was in the room with the resident. -The Administrator documented that she interviewed the resident and the resident reported that he was trying to go outside, and a man and a woman told him he could not go outside. -The Administrator documented that she asked the resident if anyone hurt or harmed him, and the resident stated that he could not remember. -The Administrator documented that the resident had open areas on his right arm. -In the Allegation/Incident section, Yes was selected for the question Incident result in physical/harm? With injury described as two open areas on right forearm. -In the Allegation/Incident section, No was selected for the question Mental Anguish lasting 5 days or more. -In the Resident Information section, Yes was selected for the question, is Resident interviewable and Cognitive Impairment was listed for Memory & Orientation of Resident. -In the Actions section, No was selected for the question Allegations Substantiated and the	D 438		

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D 438	Continued From page 108 investigation end date was 10/20/23 and investigated by the Administrator. -In the Social Services Section, the County Department of Social Services was notified on 10/17/23 and there was an on-site visit on 10/18/23. -In the Law Enforcement section, No was selected for the question, Is there a Reasonable Suspicion of a Crime. -In the Law Enforcement section, No was selected for the question, Is there Serious Bodily Injury? -In the Law Enforcement section, No was selected for the question, Incident reported to Law Enforcement. -In the Witness(es) section, No was selected for the question, Witnesses to Incident. -The HCPR 5-Working Day Report was signed by the Administrator on 10/23/23. -There was documentation that the HCPR 5-Working Day report was faxed on 10/23/23 but fax did not transmit due to continuous busy signal and a phone call was placed. -There was a fax confirmation sheet that the HCPR 5-Working Day Report was transmitted on 10/24/23 at 10:29am. Interview with the Administrator on 01/05/24 at 8:43pm revealed: -On 10/16/23, Resident #11's family member reported to her that Resident #11 told this family member that his catheter bag had been put on incorrectly and that staff was rough with him. -On 10/16/23, Resident #11's family member voiced concern to her that the resident had been abused due to his report of two staff members "roughing him up" and the resident had new bruises and cuts on his right arm 10/15/23. -She interviewed Resident #11 with the resident's family member present on 10/16/23.	D 438		

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D 438	Continued From page 109 -She elected to report the incident to the HCPR as injury of unknown source instead of resident abuse because the resident was not able to remember what happened and he was not a good historian and could not tell her anything definitive. -She acknowledged that Resident #11 had cognitive impairment. -She interviewed staff and was unable to substantiate the claim of abuse and completed the HCPR report as injury of unknown source. _____ The Administrator failed to report allegations of physical abuse to the health care personnel registry (HCPR) despite receiving a direct report from a family member and the resident having injuries on his right arm consistent with the allegation. This failure to report allegations of physical abuse to the HCPR was detrimental to the safety 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 01/24/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 19, 2024.	D 438		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.	D980		

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D980	Continued From page 110 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to ensure the Administrator was responsible for the total operation of the facility, to meet and maintain the rules in rules areas of Qualifications of Medication Staff, Other Staff Qualifications, Health Care, Nutrition and Food Service, Declaration of Resident Rights, Medication Administration, Medication Disposition, and Health Care Personal Registry. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 101 residents with a Special Care Unit (SCU) capacity of 28 residents, and a current census of 79 residents, 18 residing in the SCU. Interview with Resident #1's family member on 01/03/24 at 9:25am revealed: -Resident #1 had lived at the facility for a few years and she had a history of high blood sugar. -He and another family member had shared their concerns about the resident's frequent high blood sugars with the Administrator. -The Administrator told the family members that the facility was doing the best they could to manage the resident's high blood sugars and that she would follow up with staff about the resident's blood sugars. -The family members had not received any communication back from the Administrator about her communication with staff to help manage the resident's high blood sugars. -The family members were frustrated because they felt that the resident continued to have high	D980		

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blood sugars and was sent to a local emergency department (ED) four times in December 2023.
-The resident had a diagnoses of bipolar and depression.
-The resident had a difficult time in August 2023 when she was no longer able to keep her dog at the facility and was diagnosed with dementia.
-The resident had a difficult time adjusting to the loss of her dog, it was traumatic for her, and she had a difficult time with the diagnosis of dementia.
-The resident was tearful about the loss of her dog and the new diagnosis of dementia.
-The family members spoke to the Administrator in August 2023 and September 2023 about Resident #1 being referred for mental health services.
-One family member came to the facility to sign the required documents needed for the resident to be referred to mental health services.
-The family member met with the Administrator and a social worker at the facility to complete the paperwork for the resident to be referred for mental health services.
-He was later told by either the Administrator or the social worker that he would need to sign the paperwork again for the resident to be referred for mental health services because staff were unable to locate the first forms he signed.
-The resident had not received mental health services as of 01/03/24.

Interview with a resident on the assisted living (AL) unit on 01/03/24 at 9:25am revealed:
-The facility had recently increased his monthly bill.
-He had attempted to speak with the Administrator to obtain clarification on why his monthly bill was increased.
-A person with the business office informed him that his level of care (LOC) was changed which

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caused his monthly bill to be increased.
-The resident reported that he dressed, bathed, and emptied his urinal independently.
-He had not had any falls and he had been told by someone in management that his care plan had been changed to show that he was at a high risk of falls.
-He tried to speak with the Administrator several times, asked for meetings with the Administrator but had not been able to meet with the Administrator to obtain clarification on why his monthly bill had been increased.
-He was frustrated, felt his concerns were ignored and felt that he should not have to "force the issue" to meet and speak with the Administrator about his monthly bill.

Interview with a resident on 01/03/24 at 10:03am revealed:
-Call bells had been inoperable this past weekend (12/29/23, 12/30/23, and 12/31/23).
-Residents had no way to call for help except to yell.
-Staff did not have corresponding pagers for the residents call bells.
-Staff forgot to pass the pagers on to the next shift and took the pager home.
-The call bells had not worked on three different occasions since the resident was admitted in September 2023.
-She notified the Assistant Director Resident Care (ADRC), the Director Resident Care (DRC), and the Administrator three times each time the call bells were not working.
-It has done no good to notify them as nothing had been done to correct the call bells not working.

Interview with a resident on 01/03/24 at 10:20am revealed:

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D980	Continued From page 113 -He fell mid-morning last Friday (12/29/23) pushed his call bell and no one came. -He had to yell until someone came, not sure how long it took. -He was told that he had to lay on the floor until Emergency Medical Services (EMS) arrived because staff were not allowed to get up unwitnessed resident falls. -He got himself up into his recliner by himself and scrapped both elbows and knees. -He had a diagnosis of Multiple Sclerosis (MS) and could not lie on the floor. -He did not go to the local hospital for treatment. -He had not reported the incident to anyone. Interview with the family of a resident on 01/03/24 at 10:47am revealed: -Staff did not answer the call bells when activated. -If the resident needed something,she would have had to go find staff. -That morning medications could be given as late as 11:00am and evening medications could be given early. -On 11/14/23, the day shift medication aide (MA) medicated the resident with her night medications at 5:50pm and the night shift MA brought the same medications in again at 6:30pm and stated they were not documented as given. -On 12/13/23, the day shift MA medicated resident with her night medications at 5:45pm and the night shift MA brought the same medications in at 6:40pm,and stated they were not documented as given. -The family member spoke with the Administrator both times the medications were brought in to be given again and nothing had changed. -The Administrator told her "They were short staffed."	D980		

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D980	Continued From page 114 Interview with first MA on 01/03/24 at 11:25am revealed: -Sometimes staff could not find the pagers for the call bells. -She notified the Wellness Coordinator (WC). Interview with a second MA on 1/3/24 at 4:00pm revealed: -We had not had the pagers for the call bells several times recently. -She notified her supervisor (WC). Interview with the WC on 01/05/24 at 12:00pm revealed that she did not remember being told that staff could not find the call bell pagers. Interview with the DRC on 01/05/24 at 6:50pm revealed that she did not remember being told that the call bells were not working. Interview with the Administrator on 01/05/24 at 7:45pm revealed she was not notified that the call bells had not been working or that the pagers were missing. Interview with a dietary staff person on 01/04/24 at 12:39pm revealed: -There was a problem of not enough plates and glasses to serve all of the residents on the assisted living (AL) and special care unit (SCU) dining rooms. -Dietary staff took meals and drinks upstairs to the SCU. -Personal care aides (PCAs) from the SCU were expected to return the plates and glasses back to the kitchen once residents in the SCU finished their meal. -The PCAs on the SCU often forgot to return the plates and glasses to the kitchen once residents completed their meals.	D980		

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D980	Continued From page 115 -The dietary staff had to use Styrofoam cups at times because there were not enough glasses to serve residents at the next dining service on the AL unit and SCU. -Dietary staff needed more support from the Administrator to help ensure that PCAs were held accountable and returned plates and glasses back to the kitchen after the SCU residents completed their meals. -Dietary staff were not aware that there was a regulation about not using disposable plates or glasses until yesterday on 01/03/24. -This state requirement was not communicated to the dietary staff about the use of disposable beverage containers. Non-compliance was identified in the following areas: 1. Based on observations, interviews and record reviews, the facility failed to contact the resident's endocrinologist to ensure clarification of medication orders for 1 of 5 sampled residents (#1) who was prescribed an insulin to treat high blood sugars for a resident who had a history of high blood sugars and had four visits to a local emergency department in one month for high blood sugars. [Refer to Tag 344, 10A NCAC 13F .1002(a) Medication Orders (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 5 residents (#5, #6, #7, #8) observed during the medication pass including errors with a medication used to treat nerve pain, a medication used to treat hypertension and congestive heart failure, a medication used to treat constipation (#5), a medication used to treat moderate to severe pain, two types of eye drops to treat dry eyes (#6), 2	D980		

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	HAL065045	A. BUILDING: _____ B. WING _____	R 01/05/2024

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D980	Continued From page 116	D980		

supplements, a topical medication to treat arthritis pain, and a medication to treat high blood pressure (#7) and three medications administered late to treat high blood pressure, constipation and depression (#8); and for 2 of 5 residents (#1, #2) sampled for record review for a medication used to treat depression, a supplement used to treat low magnesium levels in the body, a medication used to treat restless leg syndrome, a medication used to treat major depressive disorder (#1), and for a medication used to treat elevated cholesterol and triglyceride levels (#2). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].

3. Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 3 sampled residents (#1) related to failing to ensure the resident was referred to a mental health provider. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].

4. Based on interviews and record reviews, the facility failed to protect 2 of 2 residents (#10 and #11) from verbal and physical abuse by a staff member resulting in a resident (#10) reporting he was fearful of Staff G and did not feel safe and a resident (#11) who sustained new injuries to his right arm and reported staff abuse to his family and described the staff member that fit the same description for both instances.. [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

5. Based on interviews and record reviews, the facility failed to accurately complete the Health Care Personnel Registry (HCPR) 24 Hour Initial and 5 Working Day Investigative Report after a

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D980	Continued From page 117	D980		

resident's (#11) family member reported concern of physical abuse to the Administrator.. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel and Registry (Type B Violation)].

6. Based on interviews and record reviews, the facility failed to ensure 2 of 6 medication aides sampled (D and F) who administered medications had the annual infection control training and met the 5 or 15- hour medication training. [Refer to Tag 125, 10A NCAC 13F .0403(a) Qualifications of Medication Staff].

7. Based on interviews and record reviews the facility failed to ensure 3 of 5 sampled staff (A, B, and E) had a Health Care Personnel Registry check completed prior to hire to ensure no findings were listed.[Refer to Tag 137, 10A NCAC 13F .0407(a)(5) Other Staff Qualifications].

8. Based on observations and interviews, the facility failed to ensure mealtime table service included a non-disposable beverage container. [Refer to Tag 286, 10A NCAC 13F .0904(b)(1)Nutrition and Food Service].

9. Based on observations, interviews, and record reviews the facility failed to ensure the medication administration records were accurate for 3 of 5 sampled residents (#5, #7, and #8) to include medications for pain, hypertension, heart failure, and constipation (Resident #5), a vitamin supplement (Resident #7), and hypertension (Resident #8).. [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration].

10. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by a medication

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D980	Continued From page 118 aide (MA) observed during the morning medication pass on 01/03/24, who did not sanitize her hands between obtaining a blood pressure, preparation, and administration of medications, and did not wear gloves administering eye drops to each resident to prevent the transmission of disease and infection, to prevent cross-contamination, and provide a safe and sanitary environment for residents. [Refer to Tag 371, 10A NCAC 13F .1004(n) Medication Administration]. 11. The facility failed to provide documentation of returned medications to the contracted pharmacy for 3 of 5 sampled residents. (#2, #3 and #5). [Refer to Tag 390, 10A NCAC 13F .1007(e) Medication Disposition]. _____ The Administrator failed to ensure the management, operations, and policies of the facility, as evidenced by the failure to implement, and maintain substantial compliance with the rules and statues governing adult care homes as related to qualifications of medication staff, other staff qualifications, medication administration, medication disposition, health care referral, and nutrition and food services. The Administrators failure resulted in medications not being administered as ordered for 4 of 5 residents risking resident safety and clarification of medication orders for 1 of 5 residents who was prescribed insulin and had four visits to a local emergency department in one month due to high blood sugars. The Administrators failed to ensure residents were treated with dignity and respect and to be free from physical abuse, intimidation, and fear of retaliation, and ensure that a report of physical abuse was properly investigated with the Health Care Personnel Registry to protect the	D980		

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D980	Continued From page 119 resident from physical abuse. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 01/5/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 4, 2023.	D980		