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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up survey on February 14, 2024 and February 15, 2024 with an exit conference via telephone on February 16, 2024.	D 000		
D 238	10A NCAC 13F .0703 (c-4) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the facility shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify the FL2s for 2 of 3 sampled residents (#2, #3) for medications used to treat anxiety (#2) and depression, anxiety, allergies, constipation and nausea and vomiting (#3). The findings are: 1. Review of Resident #2's current FL2 dated 01/24/24 revealed: -Diagnoses included altered mental status and schizophrenia.	D 238		

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D 238	Continued From page 1 -There was an order for Buspirone HCL 5mg, 1 tablet twice a day. (Buspirone is used to treat generalized anxiety disorder.) -There was an order for Lorazepam 0.5mg 2 tablets daily. (Lorazepam is used to treat anxiety and sleeping problems that are related to anxiety.) Review of Resident #2's January 2024 electronic medication administration record (eMAR) revealed: -There was no entry for Buspirone. -There was an entry for Lorazepam 1mg take one tablet by mouth every six hours as needed for anxiety/restlessness. -There was no entry for Lorazepam 0.5mg. Review of Resident #2's February 2024 eMAR revealed: -There was no entry for Buspirone. -There was an entry for Lorazepam 1mg take one tablet by mouth every six hours as needed for anxiety/restlessness. -There was no entry for Lorazepam 0.5mg. Observation of Resident #2's medications on hand on 02/15/24 revealed: -There was no Buspirone on hand. -There were 3 packs of Lorazepam 1mg tablets, 1 pack with 30 tablets dispensed on 01/02/24 with 8 tablets left and 2 packs of 30 tablets dispensed on 01/31/24 with 60 tablets left with instructions to take 1 tablet by mouth every six hours as needed. Telephone interview with the pharmacist at the facility's contracted pharmacy on 02/15/24 at 4:32pm revealed: -The pharmacy updated the resident's eMARs when an electronic order (escript) was sent in by the primary care provider (PCP).	D 238		

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-Handwritten orders from the PCP were updated on the eMAR once the facility sent the order in via fax.
-Resident #2's order for Buspirone HCL 5mg was discontinued on 11/11/22.
-The only order for Lorazepam on file for Resident #2 was for 1mg as needed.
-There was no order for Lorazepam 0.5mg for Resident #2.
-Resident #2's order for Lorazepam 0.5mg was discontinued on 11/11/22.

Telephone interview with the PCP on 02/16/24 at 8:21am revealed:
-Resident #2's Buspirone was not to be restarted.
-The Lorazepam order for Resident #2 was Lorazepam 0.5mg take two tablets every day which was the same as Lorazepam 1mg tablet every day.

Refer to interview with a medication aide (MA) on 02/15/24 at 5:00pm.

Refer to interview with a second MA on 02/15/24 at 5:50pm.

Refer to interview with the Administrator on 02/15/24 at 6:00pm.

Refer to interview with the PCP on 02/16/24 at 8:21am.

2. Review of Resident #3's current FL2 dated 01/21/24 revealed:
-Diagnoses included chronic pain, depression, anxiety and fibromyalgia.
-There was an order for Trazodone HCL 100mg daily at bedtime. (Trazodone is used to treat depression.)
-There was an order for Loratadine 10mg 1 tab by

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mouth daily. (Loratadine is used to treat allergy symptoms.)

Review of Resident #3's January 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for Trazodone HCL 100mg.
-There was no entry for Loratadine 10mg.
-There was an entry for Trazodone 300mg take 1 tablet by mouth as needed at bedtime.
-There was an entry for Cetirizine HCL 10mg take 1 tablet by mouth every day. (Cetirizine is used to treat allergies.)
-There was an entry for Duloxetine HCL DR 30mg take 1 capsule by mouth every day. (Duloxetine is used to treat anxiety and depression.)
-There was an entry for Ondansetron HCL 4mg take 1 tablet by mouth every day. (Ondansetron is used to treat nausea and vomiting.)
-There was an entry for Ondansetron HCL 8mg take 1 tablet by mouth every 8 hours as needed.
-There was an entry for Relistor 150mg take 3 tablets-450mg, by mouth once daily before first meal. (Relistor is used to treat constipation.)
-There was an entry for Triamcinolone 55mcg nasal spray, 2 sprays in each nostril once daily. (Triamcinolone is used to treat allergies.)

Review of Resident #3's February 2024 eMAR revealed:
-There was no entry for Trazodone HCL 100mg.
-There was no entry for Loratadine 10mg.
-There was an entry for Trazodone 300mg take 1 tablet by mouth as needed at bedtime.
-There was an entry for Cetirizine HCL 10mg take 1 tablet by mouth every day.
-There was an entry for Duloxetine HCL DR 30mg take 1 capsule by mouth every day.
-There was an entry for Ondansetron HCL 4mg

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take 1 tablet by mouth every day.
-There was an entry for Ondansetron HCL 8mg take 1 tablet by mouth every 8 hours as needed.
-There was an entry for Relistor 150mg take 3 tablets-450mg, by mouth once daily before first meal.
-There was an entry for Triamcinolone 55mcg nasal spray, 2 sprays in each nostril once daily.

Observations of Resident #3's medication on hand on 02/15/24 revealed:
-There was a pack of Trazodone 300mg tablets with 30 dispensed on 02/08/24 and 25 tablets left.
-There was a pack Cetirizine HCL 10mg in a multidose pack.
-There was a pack of Duloxetine HCL DR in a multidose pack.
-There was one pack of Ondansetron 4mg tablets dispensed on 11/28/23 with 8 left and 2 packs of Ondensetron 4mg dispensed on 01/25/24 with 29 tablets left.
-There was a pack of Ondansetron 8mg tablets dispensed on 12/28/23 with 14 tablets left.
-There was a pack of Relistor 150mg tablets dispensed on 12/26/23.
-There was a bottle of Triamcinolone 55mcg nasal spray.

Telephone interview with the pharmacist at the facility's contracted pharmacy 02/15/24 at 4:32pm revealed:
-The most recent FL2 she had for Resident #3 was dated 08/28/23.
-The pharmacy updated resident's eMARs when an electronic order (escript) was sent in by the primary care provider (PCP).
-Handwritten orders from the PCP were updated on the eMAR once the facility sent the order in via fax.
-Resident #3's order for Trazodone 300mg was

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the most current order from a physician's order dated 08/26/23.
-Resident #3's order for Trazodone 100mg was discontinued on 05/03/23.
-Resident #3's order for Loratadine 10mg was discontinued on 07/01/22.
-Resident #3's order for Cetirizine HCL 10mg 1 tablet by mouth daily was an electronic prescription (escript) from the PCP on 01/08/24.
-Resident #3's order for Duloxetine 30mg 1 capsule by mouth daily was an escript from the PCP on 10/31/23.
-Resident #3's order for Ondansetron 4mg daily was an escript from the PCP on 11/29/23.
-Resident #3's order for Ondansetron 8mg as needed was on file from 2019.
-Resident #3's order for Relistor 150mg 3 tablets =450mg by mouth once daily before the first meal was an escript from the PCP on 01/25/24.
-Resident #3's order for Triamcinolone 55mcg Nasal Spray 2 sprays in each nostril once daily was an escript from the PCP on 01/09/24.

Refer to interview with a medication aide (MA) on 02/15/24 at 5:00pm.

Refer to interview with a second MA on 02/15/24 at 5:50pm.

Refer to interview with the Administrator on 02/15/24 at 6:00pm.

Refer to interview with the PCP on 02/16/24 at 8:21am.

_____

Interview with a medication aide (MA) on 02/15/24 at 5:00pm revealed:
-The Administrator completed the FL2 on all residents.
-The primary care provider (PCP) then signed the

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D 238	Continued From page 6 FL2s. -The pharmacy added the medications to the electronic medication administration record (eMAR). -When a medication was prescribed, the PCP sent the order directly to the pharmacy and the pharmacy added the medication to the eMAR. -If the facility received a handwritten order for medication from the PCP, the MA faxed the order to the pharmacy. Interview with a second MA on 02/15/24 at 5:50pm revealed: -The Administrator completed the FL2 on all residents. -The PCP electronically prescribed (escribed) any new orders directly to the pharmacy. -The facility did not send a copy of the updated FL2 to the pharmacy. -The facility considered the FL2 as an order. Interview with the Administrator on 02/15/24 at 6:00pm revealed: -He completed the FL2 on all residents using PCP orders and the resident's previous FL2. -He used the PCP orders to determine what medications went on the FL2. -He attempted to verify the previous FL2 using the physician orders and then gave the FL2 to the PCP to sign. -The pharmacy completed the eMAR from the physician orders and any orders they received from the PCP. -The facility was supposed to send an updated FL2 to the pharmacy for Resident #2 and Resident #3 but had not sent their most recent FL2s. -Once the PCP signed the FL2, the Administrator or the MA was responsible for sending the FL2 to the pharmacy.	D 238		

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D 238	Continued From page 7 -The current FL2s for Resident #2 and Resident #3 were not sent to the pharmacy because there were no checks in place to ensure the FL2s were sent. -The PCP sent all medication orders to the pharmacy and provided the facility with a copy of the orders. Telephone interview with the PCP on 02/16/24 at 8:21am revealed: -The physician orders for Resident #2 and Resident #3 were not accurately reconciled. -The errors on the FL2 should have been caught prior to him signing the FL2's.	D 238		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to meet the acute health care needs for 2 of 3 sampled residents (#1 and #2) related to not notifying the primary care provider (PCP) of refusals of medications used to treat disorders of the thyroid, immune system, digestive system, depression, and a dietary supplement (#1), a recent increase in falls (#1), and 1 of 1 elevated fingerstick blood sugar (FSBS) reading above the physician prescribed reportable parameter (#2). The findings are:	D 273		

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Review of the facility medication policies and procedures dated 10/29/2004 revealed:
-In the event of medication errors and adverse reactions to medications, facility staff would notify a physician or appropriate professional and their immediate supervisor.
-The staff would document any orders received by the physician or health professional and action taken by the facility to comply with the order.
-Charting would identify if documentation error, unavailability of medications or resident refusals of medications may have led to the error.

1. Review of Resident #1's current FL-2 dated 03/14/23 revealed diagnoses included major neurocognitive disorder (decreased mental functioning due to a medical disease), progressive multifocal leukoencephalopathy (infection that damages the cover of the brain), cachexia (weight and muscle loss), immunodeficiency infection, cognitive impairment, and severe malnutrition.

Review of a hospital discharge summary dated 02/24/23 for Resident #1's revealed:
-The resident had a past medical history of an immune deficiency disorder, a major neurocognitive disorder, and behavioral disturbance.
-The resident "intermittently refuses to eat or take his medications".
-The resident was discharged from the hospital to the facility on 02/24/23.

A. Review of a prescription from Resident #1's Internal Medicine physician dated 12/28/23 revealed orders forTrintellix, Tivicay, Descovy, Protonix, Synthroid, and Multivitamin.

Review of the Internal Medicine Physician's

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progress note for Resident #1 dated 01/29/24 revealed:
-The resident was seen for a follow-up.
-The resident had multiple wounds on his back.
-The resident's family member reported the resident fell at the facility.
-The resident stated he was feeling well.
-The resident stated the facility gave him his medications "sometimes".

Review of Resident #1's medication administration records (MARs) for December 2023, January 2024, and February 2024 revealed documentation for multiple medication refusals.

Interview with a medication aide (MA) on 02/15/24 at 9:32am revealed
-After a resident refused medication administration three times the PCP was to be notified.
-The PCP was notified of medication refusals when the PCP visited the facility monthly.

a. Review of physician's orders dated 08/26/23 and 12/28/23 for Resident #1 revealed Tivicay (used to treat an immune system disorder) 50mg tablet every day.

Review of Resident #1's December 2023, January 2024, and February 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Tivicay 50mg tablet daily scheduled at "hour of sleep".
-In December 2023, there was a symbol documented in the section for documentation of administration for 18 of 31 days (12/04, 12/05, 12/07-12/09, 12/11, 12/13, 12/14, 12/17-12/25, and 12/27/23) when the resident refused the medication.

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D 273	Continued From page 10 -In January 2024, there was a symbol documented in the section for documentation of administration for 20 of 31 days (01/01-01/03, 01/05, 01/08-01/11, 01/13-01/15, 01/17-01/19, 01/21, 01/23, 01/25-01/28, and 01/31/24) when the resident refused the medication. -In February 2024, there was a symbol documented in the section for documentation of administration for 4 of 13 days (02/02, 02/06, 02/09, and 02/12/24) when the resident refused the medication. Review of the symbol key printed on the eMARs revealed the corresponding meaning for the symbol was "Not Administered See Notes." Review of Resident #1's Medication Notes on the December 2023, January 2024, and February 2024 revealed there was documentation "Patient refused medication". Observation of Resident #1's medications on hand on 02/15/24 at 11:06am revealed trintellix 10mg tablets, trivicay 50mg tablets, protonix 40mg tablets, descovy 200/25mg tablets, levothyroxine 0.025mg tablets, and sentry senior multivatamin tablets were available for administration. Telephone interview with the contracted pharmacy provider Pharmacist on 02/15/24 at 9:54am revealed: -Trivicay 50mg tablets were filled on 11/20/23, 12/28/23, and 01/23/24, a quantity of 30 tablets dispensed each time. -The Trivicay had to be ordered by the pharmacy and the delivery date to the facility might be within a day or two of the fill dates. -Resident #1 had a history of an immune disorder and would be at risk for a "flare up" of the	D 273		

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immune disorder if the Trivicay was not taken.
-There would be symptoms of lethargy, diarrhea, headache, flu-like symptoms, and lab work results for monitoring the immune disorder could "flare up".

Interview with a medication aide (MA) on 02/15/24 at 4:12pm revealed:
-Resident #1 refused the Trivicay at night because the medication made him drowsy the next day.
-She did not call the PCP after the refusals.

Refer to interview with Resident #1 on 02/15/24 at 8:51am.

Refer to interview with the MA on 02/15/24 at 9:19am.

Refer to interview with the Administrator on 02/15/24 at 12:21pm.

Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm.

Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm.

Refer to interview with the PCP on 02/16/24 at 7:25am.

Refer to interview with the Internal Medicine Physician on 02/16/24 at 10:45am.

b. Review of physician's orders dated 08/26/23 and 12/28/23 for Resident #1 revealed Descovy (used to treat an immune system disorder) 200-25mg tablet every day.

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Review of Resident #1's December 2023, January 2024, and February 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Descovy 200-25mg tablet daily scheduled at bedtime.
-In December 2023, there was a symbol documented in the section for documentation of administration for 9 of 31 days (12/03, 12/11, 12/14, 12/17-12/20, 12/23, and 12/25/23) when the resident refused the medication.
-In January 2024, there was a symbol documented in the section for documentation of administration for 10 of 31 days (01/02, 01/06, 01/13-01/15, 01/17, 01/18, 01/22, 01/24, and 01/28/24) when the resident refused the medication.
-In February 2024, there was a symbol documented in the section for documentation of administration for 2 of 13 days (02/04 and 02/12/24) when the resident refused the medication.

Review of the symbol key printed on the eMARs revealed the corresponding meaning for the symbol was "Not Administered See Notes."

Review of Resident #1's Medication Notes for December 2023, January 2024, and February 2024 revealed there was documentation for "Patient refused medication", except on 01/12/24 and 02/13/24 the MA documented "LOA [leave of absence]", and on 02/07/24 the MA documented "medication on hold".

Telephone interview with the contracted pharmacy provider Pharmacist on 02/15/24 at 9:54am revealed:
-Descovy 200-25mg tablets were filled on 11/20/23, 12/28/23, and 01/23/24 for Resident #1,

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a quantity of 30 tablets.
-The Descovy had to be ordered by the pharmacy and the delivery date to the facility might be within a day or two of the fill dates.
-Resident #1 had a history of an immune disorder and would be at risk for a "flare up" of the immune disorder if not taking the Descovy.
-There would be symptoms of lethargy, diarrhea, headache, flu-like symptoms, and lab work for monitoring the immune disorder could flare up.

Telephone interview with the contracted facility primary care provider (PCP) on 02/16/24 at 7:25am revealed:
-Resident #1 was prescribed Descovy 200-25mg tablet at bedtime.
-The Descovy was used to keep the resident's immune system working, to keep the viral load down, and to fight fungal and parasitic infections.

Refer to interview with Resident #1 on 02/15/24 at 8:51am.

Refer to interview with the MA on 02/15/24 at 9:19am.

Refer to interview with the Administrator on 02/15/24 at 12:21pm.

Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm.

Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm.

Refer to interview with the PCP on 02/16/24 at 7:25am.

Refer to interview with the Internal Medicine

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D 273	Continued From page 14 Physician on 02/16/24 at 10:45am. c. Review of physician's orders dated 11/06/23 and 12/28/23 for Resident #1 revealed levothyroxine (used to treat an underactive thyroid gland) 25mcg tablet every day. Review of Resident #1's December 2023, January 2024, and February 2024 electronic medication administration records (eMARs) revealed: -There was an entry for levothyroxine 25mcg tablet daily scheduled at 7:15pm. -In December 2023, there was a symbol documented in the section for documentation of administration for 19 of 31 days (12/03, 12/04, 12/09, 12/14, 12/16-12/23, and 12/25-31/23) when the resident refused the medication. -In January 2024, there was a symbol documented in the section for documentation of administration for 21 of 31 days (01/01, 01/02, 01/04-01/08, 01/10, 01/11, 01/13-01/15, 01/17, 01/18, 01/19, 01/21, 01/23, 01/24, 01/26, 01/27, and 01/29/24) when the resident refused the medication. -In February 2024, there was a symbol documented in the section for documentation of administration for 2 of 13 days (02/03/24, and 02/08/24) when the resident refused the medication. Review of the symbol key printed on the eMARs revealed the corresponding meaning for the symbol was "Not Administered See Notes." Review of Resident #1's medication notes for December 2023, January 2024, and February 2024 revealed there was documentation "Patient refused medication".	D 273		

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D 273	Continued From page 15 Telephone interview with the facility's contracted pharmacy provider on 02/15/24 at 9:54am revealed: -The levothyroxine 25mcg tablets were delivered to the facility on 11/02/23, 11/16/23, 11/30/23, 12/14/23, 12/28/23, 01/11/24, 01/25/24, and 02/08/24, in 14 day supply multi-dose packaging. -Resident #1's levothyroxine was used to treat a low thyroid level. -Continued missed dosages of the levothyroxine could result in lethargy, diarrhea, weight gain, mood disturbances, and increased depression. Telephone interview with the contracted facility primary care provider (PCP) on 02/16/24 at 7:25am revealed: -Resident #1 was prescribed levothyroxine. -Symptoms such as slow heart rate, constipation, or sluggishness which would be exhibited related to missed levothyroxine dosages. Refer to interview with Resident #1 on 02/15/24 at 8:51am. Refer to interview with the MA on 02/15/24 at 9:19am. Refer to interview with the Administrator on 02/15/24 at 12:21pm. Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm. Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm. Refer to interview with the PCP on 02/16/24 at 7:25am.	D 273		

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D 273	Continued From page 16 Refer to interview with the Internal Medicine Physician on 02/16/24 at 10:45am. d. Review of a physician's orders dated 08/26/23 and 12/28/23 for Resident #1 revealed Trintellix (used to treat depression) 10mg tablet every day. Review of Resident #1's December 2023, January 2024, and February 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Trintellix 10mg tablet daily scheduled at 8:00am. -In December 2023, there was a symbol documented in the section for documentation of administration for 4 of 31 days (12/12, 12/13, 12/18, and 12/20/23) when the resident refused the medication. -In January 2024, there was a symbol documented in the section for documentation of administration for 7 of 31 days (01/03, 01/09, 01/13-01/15, 01/21, and 01/25/24) when the resident refused the medication. -In February 2024, there was a symbol documented in the section for documentation of administration for 2 of 13 days (02/02/24, and 02/08/24) when the resident refused the medication. Review of the symbol key printed on the eMARs revealed the corresponding meaning for the symbol was "Not Administered See Notes." Review of Resident #1's medication notes for December 2023, January 2024, and February 2024 revealed there was documentation "Patient refused medication". Telephone interview with the Pharmacist at the contracted pharmacy provider on 02/15/24 at	D 273		

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D 273	Continued From page 17 9:54am revealed: -Resident #1's Trintellix 10mg tablets were delivered to the facility on 11/02/23, 11/16/23, 11/30/23, 12/14/23, 12/28/23, 01/11/24, 01/25/24, and 02/08/24, in 14 day supply multi-dose packaging. -Trintellix was used to treat major depression disorders. -Continued missed dosages of Trintellix could result in increased depression, irritability, agitation, and thoughts of suicide. Interview with a MA on 02/14/24 at 3:37pm revealed: -Resident #1 was "difficult". -Resident #1 would not comply and would refuse his medications. Interview with another MA on 02/15/24 at 8:04am revealed: -Resident #1 threw a pencil at another resident on one occasion. -Resident #1 would slam the door if he did not want someone in his room. Telephone interview with the facility visiting physician on 02/16/24 at 7:25am revealed: -Resident #1 was prescribed Trintellix used as an anti-depressant. -Resident #1's judgement was impaired. Refer to interview with Resident #1 on 02/15/24 at 8:51am. Refer to interview with the MA on 02/15/24 at 9:19am. Refer to interview with the Administrator on 02/15/24 at 12:21pm.	D 273		

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D 273	Continued From page 18 Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm. Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm. Refer to interview with the PCP on 02/16/24 at 7:25am. Refer to interview with the Internal Medicine Physician on 02/16/24 at 10:45am. e. Review of physician's orders dated 08/26/23 and 12/28/23 for Resident #1 revealed pantoprazole (used to treat gastroesophageal reflux disease) 40mg tablet every day. Review of Resident #1's December 2023, January 2024, and February 2024 eMARs revealed: -There was an entry for pantoprazole 40mg tablet daily scheduled at 8:00am. -In December 2023, there was a symbol documented in the section for documentation of administration for 5 of 31 days (12/12, 12/13, 12/18, 12/20, and 12/24/23) when the resident refused the medication. -In January 2024, there was a symbol documented in the section for documentation of administration for 7 of 31 days (01/03, 01/09, 01/13-01/15, 01/21, and 01/25/24) when the resident refused the medication. -In February 2024, there was a symbol documented in the section for documentation of administration for 2 of 13 days (02/02/24 and 02/08/24) when the resident refused the medication. Review of the symbol key printed on the eMARs	D 273		

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revealed the corresponding meaning for the symbol was "Not Administered See Notes."

Review of Resident #1's medication notes for December 2023, January 2024, and February 2024 revealed there was documentation "Patient refused medication".

Telephone interview with the Pharmacist at the contracted pharmacy provider on 02/15/24 at 9:54am revealed:
-The pantoprazole 40mg tablets were delivered to the facility on 11/02/23, 11/16/23, 11/30/23, 12/14/23, 12/28/23, 01/11/24, 01/25/24, and 02/08/24, in 14 day supply multi-dose packaging.
-The pantoprazole was used to treat acid reflux.
-Continued missed dosages of pantoprazole could result in heartburn, regurgitation, and scratchy throat.
-Long term missed dosages could result in ulcers in the stomach and could affect the lining of the throat.

Refer to interview with Resident #1 on 02/15/24 at 8:51am.

Refer to interview with the MA on 02/15/24 at 9:19am.

Refer to interview with the Administrator on 02/15/24 at 12:21pm.

Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm.

Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm.

Refer to interview with the PCP on 02/16/24 at

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D 273	Continued From page 20 7:25am. Refer to interview with the Internal Medicine Physician on 02/16/24 at 10:45am. f. Review of physician's orders dated 08/26/23 and 12/28/23 for Resident #1 revealed Sentry Senior tablet (dietary supplement) every day. Review of Resident #1's December 2023, January 2024, and February 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Sentry Senior tablet daily scheduled at 8:00am. -In December 2023, there was a symbol documented in the section for documentation of administration for 5 of 31 days (12/12, 12/13, 12/18, 12/20, and 12/24/23) when the resident refused the medication. -In January 2024, there was a symbol documented in the section for documentation of administration for 7 of 31 days (01/03, 01/09, 01/13-01/15, 01/21, and 01/25/24) when the resident refused the medication. -In February 2024, there was a symbol documented in the section for documentation of administration for 2 of 13 days (02/02/24 and 02/08/24) when the resident refused the medication. Review of the symbol key printed on the eMARs revealed the corresponding meaning for the symbol was "Not Administered See Notes." Review of Resident #1's medication notes for December 2023, January 2024, and February 2024 revealed the medication aide (MA) documented "Patient refused medication".	D 273		

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D 273	Continued From page 21 Telephone interview with the Pharmacist at the contracted pharmacy provider on 02/15/24 at 9:54am revealed: -Resident #1's sentry senior tablets were delivered to the facility on 11/02/23, 11/16/23, 11/30/23, 12/14/23, 12/28/23, 01/11/24, 01/25/24, and 02/08/24, in 14 day supply multi-dose packaging. -The Sentry Senior tablet was used a multivitamin used to promote increased energy. Interview with a MA on 02/14/24 at 3:37pm revealed: -Resident #1 fell "a lot". -Resident #1 would slide on the floor. -Resident #1 liked to rest during the day and "move around" at night. Refer to interview with Resident #1 on 02/15/24 at 8:51am. Refer to interview with the MA on 02/15/24 at 9:19am. Refer to interview with the Administrator on 02/15/24 at 12:21pm. Refer to interview with a second MA on 02/15/24 between 3:52pm - 4:12pm. Refer to telephone interview with the contracted Primary Care Provider (PCP) representative on 02/15/24 at 3:07pm. Refer to interview with the PCP on 02/16/24 at 7:25am. Refer to interview with the Internal Medicine Physician on 02/16/24 at 10:45am.	D 273		

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D 273	Continued From page 22 Interview with Resident #1 on 02/15/24 at 8:51am revealed: -He took the same medicine every day. -He "refuse the pill and looked for the formula". Interview with the MA on 02/15/24 at 9:19am revealed: -Resident #1 wanted to take his medication when he wanted the medication. -Staff administered him medication. -She tried to make sure Resident #1 got his medication. -Resident #1 was non-compliant with medications. -The MAs let the physician know when the physician made his monthly visit at the facility that Resident #1 refused medications. -She last told the physician in December 2023 when he visited the facility that Resident #1 refused medication. -The physician visited the facility monthly. -She did not think she documented when she verbally informed the physician about Resident #1 refusing medications. -She (MA) had not notified the internal medicine physician of Resident #1's medication refusals. but she informed Resident #1's family member about the resident's medication refusals every time the family member picked the resident up to transport the resident to the internal medicine physician who prescribed medications. -The medication refusal process was to notify the physician after the resident refused medication three times. Interview with the Administrator on 02/15/24 at 12:21pm revealed: -Resident #1 refused medications sometimes. -The facility would "leave word" with the facility contracted provider (PCP).	D 273		

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-The PCP would say try to get Resident #1 to take the medication.
-He last notified the PCP in January 2024 but did not know a specific date of the physician notification of medication refusals for Resident #1.
-He did not document when the PCP was notified about Resident #1 medication refusals.
-He notified the internal medicine provider "verbally" and talked with that physician's office staff (no specific date provided).

Telephone interview with a PCP representative on 02/15/24 at 3:07pm revealed:
-There was a voicemail message from the facility on 02/15/24 at 9:55am about Resident #1 refusing medication.
-There was a second message at 3:56pm on 02/15/24 from a male voice.
-There were no other documented phone messages from the facility.

Interview with a second MA on 02/15/24 between 3:52pm - 4:12pm revealed:
-Resident #1 sometimes told her he was not administered his medications.
-She did not know if Resident #1 was refusing those medications or if the resident was not administered the medications at those specific times.
-The medication was considered refused after she asked the resident once and a second time in about 30 minutes after the first time.
-She would report to the oncoming MA the refusal and that MA could attempt to get the resident to take the medication.
-If a resident refused medication, she reported it to the oncoming MA and the Administrator.
-If the Administrator was not in the facility, she would let the Administrator know about the refusal

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when the Administrator returned.
-She had not documented any notes when a doctor was notified about medication refusals.

Telephone interview with the contracted facility primary care provider (PCP) on 02/16/24 at 7:25am revealed:
-Resident #1 was difficult to manage.
-Resident #1 would say to him that he was not going to take some prescribed medications.
-Resident #1 probably needed a psychiatric evaluation.
-It was important for Resident #1 to take prescribed medications.
-Resident #1 was not able to make sound decisions and lacked insight in terms of taking his medications.
-He last visited the facility in January 2024.
-The Administrator or MA sat with him during his monthly facility visits and would tell him Resident #1 was not taking his medications.
-He was not aware of the exact number of times Resident #1 had refused prescribed medication but was informed by the Administrator or MA during facility visits that Resident #1 would refuse medications.
-He was not notified via telephone prior to his visits of any medication refusals.

Telephone interview with the Internal Medicine Physician on 02/16/24 at 10:45am revealed:
-He had seen Resident #1 for the last ten (10) years.
-He saw Resident #1 every month.
-He was the primary care physician for Resident #1.
-Resident #1's family member bought the resident to an appointment on 01/29/24 (no additional physician visit dates provided).
-When he last saw Resident #1 on 01/29/24, the

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resident was "in horrible condition, soiled undergarments, clothes were not clean, looked like he had lost weight".
-He had never seen Resident #1 in the condition as Resident #1 was on 01/29/24.
-The resident reported the facility was not giving him medications.
-Resident #1 was on "critical [immune disorder] medicines - Descovy and Tivicay."
-It was critical for the resident to take his medications because the immune disorder might re-activate.
-The resident's brain dysfunction from PML would re-activate and the resident "would die."

B. Review of the facility Slip, Trip, and Falls policy provided by the Administrator on 02/15/24 revealed:
-The employer would be responsible to thoroughly investigate all slips, trips, and falls with or without injury, and the slip, trip, and falls would be recorded. Corrective action to prevent repeat occurrences would be taken immediately.
-The employee was responsible to report immediately all slips, trips, and falls, with or without injury.

Review of a physician progress note for Resident #1 dated 01/29/24 revealed:
-The resident was seen for a follow-up.
-The resident had multiple wounds on his back.
-The resident's family member reported the resident fell at the facility.

Review of an after visit summary report for Resident #1 revealed the resident was seen at a local hospital emergency room for a fall on 01/12/24.

Interview with the supervisor/medication aide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL078082	A. BUILDING: _____ B. WING _____	R 02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROMARTIE SPRING VILLAGE REST HOME	508 WORTH STREET SAINT PAULS, NC 28384

(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 273	Continued From page 26 (S/MA) on 02/14/24 at 8:56am revealed: -Resident #1 went to the hospital on 02/13/24 after a fall. -The resident used a walker for assistance with ambulation and liked to walk without the walker. -The resident had a history of falling and fell about one week ago. -When Resident #1 had a fall, the resident was assessed and asked by staff if he got hurt. Second interview with the S/MA on 02/14/24 at 10:24am revealed: -Sometimes Resident #1 fell, would get himself up, and let staff know he had fallen. -Staff would ask the resident if he was hurt and if he needed help. -Resident #1 did not want staff to assist him and would decline. -Resident #1 wobbled when he walked and did not have good balance. -Instructions to staff from the Administrator was to try and get Resident #1 to let staff help him. Third interview with the S/MA on 02/14/24 at 3:37pm revealed: -Resident #1 fell on 02/02/24 while walking around his bed. -She asked the resident to allow staff to walk with him. -Instructions from the Administrator included assessing the resident for injury and calling emergency medical services if the resident was injured. -When Resident #1 fell on 02/02/24 she did not notify the Primary Care Provider (PCP) because "he did not get hurt". -Resident #1 fell on 02/05/24 when he slid from his walker. -She found the resident beside the walker on the floor when she went in the resident's room.	D 273		

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D 273	Continued From page 27	D 273		

-She did not notify PCP because the resident "had no injury".
-Instructions from the Administrator was "same thing as before, to tell him to let us help him to walk".
-Physical therapy was discussed with the PCP but Resident #1 would not agree to the physical therapy.

Review of an incident report dated 02/13/24 for Resident #1 revealed:
-The resident was heard to scream.
-The resident was found in bathroom and reported he hit the right side of his face on the bathroom sink.
-Emergency medical service was contacted, and the resident was transported to the local hospital for evaluation.
-The staff documented a time next to the section for family notified.
-The section next to doctor notified was blank.

Review of an incident report dated 02/02/24 for Resident #1 revealed:
-The resident was heard to scream.
-Staff went in the resident's room and the resident had fallen.
-The resident was in his room walking around his bed when he fell.
-There was no injury when the staff examined the resident.
-The staff documented "no" next to family notified and doctor notified.

There was no incident/accident report for the 02/05/24 reported occurrence for Resident #1 when the resident was reported to have slid from his chair.

Interview with the Administrator on 02/15/24 at

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D 273	Continued From page 28 11:49am revealed: -If a resident had a fall, the resident was evaluated by the MA on duty. -A "general evaluation" was completed to determine what caused the fall. -The resident's family and PCP were supposed to be notified of the fall. -Resident #1 had a history of being in a position that staff did not know what had happened to him as far as whether it was a fall, or the resident put himself on the floor. -If a resident was found on the floor, it "did not necessarily constitute a fall". -Resident #1 got agitated and aggressive for no given reason. -A fall meant a person was seen to have fallen, was on the floor, and acknowledged falling. -He would have thought the MAs talked to the PCP about the falls Resident #1 had in February 2024. -He would expect the MAs to notify the PCP of falls. Telephone interview with the PCP receptionist on 02/15/24 at 3:07pm revealed: -There was a message from the facility on 02/15/24, but the message was not concerning a fall. -There were no additional messages from the facility to the PCP concerning falls for Resident #1. Telephone interview the contracted facility primary care provider (PCP) on 02/16/24 at 7:25am revealed: -He wanted to know when the resident had a fall. -He did not think the facility acknowledged how important it was to notify the PCP. -The facility had not informed him about Resident #1 falling and no conversation had taken place.	D 273		

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D 273	Continued From page 29 -He needed to be notified as soon as possible when the resident had a fall. 2. Review of Resident #2's current FL2 dated 01/21/24 revealed diagnoses included diabetes mellitus 2. Review of Resident #2's January 2024 eMAR revealed: -There was an entry dated 05/31/23 for Novolog FlePen SSI as follows: Novolog 100 unit (U)/mL 200-250=5U, 251-300=10U, 301-350=15U, 351-400=20U, >400 Call primary care provider (PCP). -Resident #2's fingerstick blood sugar (FSBS) was documented as 468 at 7pm on 01/05/24. -There was an entry dated 05/31/23 for FSBS twice daily scheduled at 8:00am and 8:00pm. -There was documentation Novolog 20U was administered on 01/05/24 at 8pm. -There was no documentation on the eMAR that the PCP was notified. Review of Resident #2's progress notes revealed there was no documentation of the PCP being notified of the FSBS of 468 on 01/05/24. Telephone interview with Resident #2's PCP on 02/16/24 revealed he was not notified by the facility that Resident #2's FSBS was 468 on 01/05/24. _____ The facility failed to notify the primary care provider of a resident (#1) who refused medications on multiple occasions that were used to treat an immune system disorder, thyroid disease, and behaviors of agitation and aggression until the primary care provider made monthly visits to the facility on an ongoig basis. The internal medicine physician noted a noticable	D 273		

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D 273	Continued From page 30 decline in the Resident #1's presentation which included weight loss and after a fall which resulted in a visit to the emergency department. The facility failed to notify the PCP when a resident' FSBS was above 400 (#2) as per the physician ordered parameters. The facility's failure placed residents at 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 02/15/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 17, 2024.	D 273		