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BROOKDALE LEXINGTON	161 YOUNG DRIVE LEXINGTON, NC 27292

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 02/21/24 to 02/22/24.	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 record reviews and interviews, the facility failed to ensure 1 of 6 sampled medication aide (MA) staff (Staff C) had completed a 5, 10, or 15-hour MA training course. The findings are: Review of Staff C's, MA personnel record revealed: -Staff C was hired on 07/07/23. -She had taken and passed the written MA examination on 06/02/21. -She completed the Medication Aide Clinical Skills Competency Validation checklist on 03/31/21. -There was no MA employment verification form available for review. -There was no documentation Staff C had	D 125		

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D 125	Continued From page 1 completed a 5, 10, or 15-hour MA training course. Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed: -There was documentation Staff C administered medications on 7 days from 12/01/23 through 12/31/23. -There was documentation Staff C administered medications on 9 days from 01/01/24 through 01/31/24. -There was documentation Staff C administered medications on 14 days from 02/01/24 through 02/21/24. Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed: -Staff C did not have any documentation of completing the 5, 10 or 15-hour MA training course in her personnel record. -She was not aware Staff C was missing MA training in her personnel record. -She was not responsible for verifying MA training at the time Staff C was initially hired in 2021 or when she came back to work for the facility in 2023. -She was responsible for ensuring all personnel records were complete with the required training including the 5, 10 or 15-hour MA training course. -She was in the process of auditing personnel records but had not seen the 5, 10, or 15-hour MA training certificate listed on her checklist for what needed to be included in all the MA personnel records. Interview with Staff C on 02/22/24 at 4:20pm revealed: -She worked for the facility for 18 months starting in July of 2020, and returned to work for the facility again in July 2023.	D 125		

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D 125	Continued From page 2 -She completed the 15-hour MA training course at the facility at the end of 2020 or in early 2021. -She had not been given a copy of her 15-hour training certificate. -She had not been asked by the BOM or anyone else at the facility about having completed the 15-hour MA training course. Interview with the Administrator on 02/22/24 at 6:32pm revealed: -The BOM was responsible for the personnel records. -He had given the BOM a training tracker to help the BOM know what was required for each MA record. -The 5, 10, or 15-hour MA training course was listed on the training tracker. -He was not aware that Staff C was missing documentation of completing the 15-hour MA training course. -He was aware that each MA was required to have completed either a 5-hour and 10-hour MA training course or the 15-hour MA training course if they did not have an employment verification form completed.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following:	D 164		

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D 164	Continued From page 3 (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 of 6 sampled medication aide (MA) staff (Staff A, C, D, E, and F) had completed training on the care of the diabetic resident prior to administering insulin. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -She was hired on 09/22/08. -She passed the written MA examination on 08/27/14. -There was no certification of completion for training on the care of the diabetic resident. Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed: -There was documentation Staff A administered	D 164		

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insulin 32 times from 12/01/23 through 12/31/23.
-There was documentation Staff A administered insulin 39 times from 01/01/24 through 01/31/24.
-There was documentation Staff A administered insulin 28 times from 02/01/24 through 02/21/24.

Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed she was not aware Staff A was missing training on the care of the diabetic resident.

Interview with the Administrator on 02/22/24 at 6:32pm revealed he was not aware Staff A was missing training on the care of the diabetic resident.

Attempted telephone interview with Staff A on 02/22/24 at 4:30pm was unsuccessful.

Refer to the interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm.

Refer to the interview with the Administrator on 02/22/24 at 6:32pm.

2. Review of Staff C's medication aide (MA) personnel record revealed:
-She was hired on 07/07/23.
-She passed the written MA examination on 06/02/21.
-There was no certification of completion on training on the care of the diabetic resident.

Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed:
-There was documentation Staff C administered insulin 7 times from 12/01/23 through 12/31/23.
-There was documentation Staff C administered insulin 9 times from 01/01/24 through 01/31/24.

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-There was documentation Staff C administered insulin 14 times from 02/01/24 through 02/21/24.

Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed she was not aware Staff C was missing training on the care of the diabetic resident.

Interview with Staff C on 02/22/24 at 4:20pm revealed:
-The only training she had completed on care of diabetic residents was during her 15-hour MA training class.
-She had not completed a separate training on diabetic care with a nurse.
-Nobody at the facility had told her she needed additional training on care of the diabetic resident.

Interview with the Administrator on 02/22/24 at 6:32pm revealed he was not aware Staff C was missing training on the care of the diabetic resident.

Refer to the interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm.

Refer to the interview with the Administrator on 02/22/24 at 6:32pm.

3. Review of Staff D's medication aide (MA) personnel record revealed:
-She was hired on 09/04/23.
-She passed the written MA examination on 12/26/23.
-There was no certification of completion on training on the care of the diabetic resident.

Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed:

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-There was documentation Staff D administered insulin 2 times from 12/01/23 through 12/31/23.
-There was documentation Staff D administered insulin 12 times from 01/01/24 through 01/31/24.
-There was documentation Staff D administered insulin 6 times from 02/01/24 through 02/21/24.

Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed she was not aware Staff D was missing training on the care of the diabetic resident.

Interview with the Administrator on 02/22/24 at 6:32pm revealed he was not aware Staff D was missing training on the care of the diabetic resident.

Attempted telephone interview with Staff D on 02/22/24 at 4:40pm was unsuccessful.

Refer to the interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm.

Refer to the interview with the Administrator on 02/22/24 at 6:32pm.

4. Review of Staff E's medication aide (MA) personnel record revealed:
-She was hired on 07/22/21.
-She passed the written MA examination on 03/04/04.
-There was no certification of completion on training on the care of the diabetic resident.

Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed:
-There was documentation Staff E administered insulin 1 time from 12/01/23 through 12/31/23.
-There was documentation Staff E administered

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insulin 4 times from 01/01/24 through 01/31/24.
-There was documentation Staff E administered insulin 2 times from 02/01/24 through 02/21/24.

Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed she was not aware Staff E was missing training on the care of the diabetic resident.

Interview with the Administrator on 02/22/24 at 6:32pm revealed he was not aware Staff E was missing training on the care of the diabetic resident.

Telephone interview with Staff E on 02/22/24 at 4:32pm revealed:
-She had not completed training on the care of diabetic residents while employed at the facility.
-She was not aware she was missing training on the care of the diabetic resident.

Refer to the interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm.

Refer to the interview with the Administrator on 02/22/24 at 6:32pm.

5. Review of Staff F's medication aide (MA) personnel record revealed:
-She was hired on 05/11/16.
-She passed the written MA examination on 10/15/18.
-There was no certification of completion of training on the care of the diabetic resident.

Review of a resident's December 2023, January and February 2024 electronic medication administration records (eMARs) revealed:
-There was documentation Staff F administered insulin 22 times from 12/01/23 through 12/31/23.

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D 164	Continued From page 8 -There was documentation Staff F administered insulin 18 times from 01/01/24 through 01/31/24. -There was documentation Staff F administered insulin 17 times from 02/01/24 through 02/21/24. Interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm revealed she was not aware Staff F was missing training on the care of the diabetic resident. Interview with the Administrator on 02/22/24 at 6:32pm revealed he was not aware Staff F was missing training on the care of the diabetic resident. Attempted telephone interview with Staff F on 02/22/24 at 4:35pm was unsuccessful. Refer to the interview with the Business Office Manager (BOM) on 02/22/24 at 3:25pm. Refer to the interview with the Administrator on 02/22/24 at 6:32pm. _____ Interview with the BOM on 02/22/24 at 3:25pm revealed: -She was responsible for ensuring all of the required MA trainings including training on the care of the diabetic resident were in each MA personnel record. -She was not aware that training on the care of the diabetic resident was required for the MAs. -A nurse used to do diabetic training with the MAs at the facility but she could not remember when the training had last been completed. -The Administrator had given her a training tracker with everything that was required for the MAs but she did not think that diabetic training was listed on the tracker.	D 164		

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D 164	Continued From page 9 Interview with the Administrator on 02/22/24 6:32pm revealed: -The BOM was responsible for maintaining personnel records. -He gave the BOM a training tracker listing all the required training for the MAs but he did not think that diabetic training was listed on the tracker. -He was not aware that the MAs were supposed to receive training on care of the diabetic residents beyond what they receive in their MA training course.	D 164		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure supervision for 3 of 5 sampled residents (#3, #4, and #5) related to a resident who had 9 falls in 3 months resulting in head injuries and skin tears to the right elbow and right thigh (#4), a resident who had 6 falls in 3 months resulting in a skin tear to the left shoulder and a skin abrasion to the right knee (#5), and a resident who had 4 falls in 3 months resulting in a head injuries, pain, and bruising (#3).	D 270		

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D 270	Continued From page 10 The findings are: Review of the facility's Falls Management Policy dated 10/2023 revealed: -A resident who sustained a fall should have had a post fall evaluation completed to consider possible interventions to reduce the potential for future falls and injury. -Individualized interventions were considered as a part of the post fall evaluation and the evaluation was a part of the resident record. -When a fall occurred, staff were to document the resident's fall/injuries, resident response, and interventions taken in the resident's progress notes. -The resident's service plan was reviewed for potential fall interventions and updated as necessary. -The fall was reviewed at the next stand-up meeting and discussed at the next collaborative care review meeting. Interview with Area Nurse Manager (ANM) on 02/22/24 at 11:30am revealed: -The Management policy post-fall evaluation should be completed by the medication aide (MA) assigned to the resident who sustained a fall. -The Health and Wellness Coordinator (HWC) or the Health and Wellness Director (HWD) were expected to complete a post fall analysis where the HWC or HWD evaluated and assessed residents' condition and determined interventions after a resident sustained a fall. -The HWC, HWD, and the Administrator were expected to update care plans with interventions which reflected increased care tasks for the personal care aide (PCA) assigned to a resident. -Interventions were not referenced on the PCA's daily assignment plans and MAs/PCAs were expected to discuss fall interventions in a post	D 270		

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huddle meeting after a resident sustained a fall where details of interventions, increased rounding, and primary care provider (PCP) notification were discussed by MAs/PCAs of the shift when the incident occurred.
-The post-fall evaluations and post-fall analysis for the falls dated between 12/01/23 through 02/20/24 for Resident #3, Resident #4, and Resident #5 had not been completed and she was unable to provide a justifiable reason.

1. Review of Resident #4's current FL2 dated 07/11/23 revealed:
-Diagnoses included dementia, postprocedural states, cervical disc disorder, and essential hypertension.
-Resident #4 was total care, semi-ambulatory, and intermittently disoriented for a special care unit (SCU).

Review of Resident #4's care plan dated 02/05/24 revealed:
-Resident #4 required total staff assistance with transfers and dressing.
-Staff were to provide attention for mobility assistance for Resident #4 to attend meals in the dining room and for participation in community activities as needed.
-There was documentation of universal fall precautions for all residents, but there were no fall precautions documented for Resident #4.
-Resident #4's interventions included considering a request for further evaluation by the PCP regarding changes and observations and which may include laboratory work and medication review.
-Resident #4's interventions also included considering involvement of physical and/or occupational therapy to consult strength, gait training, cognition, and adaptive equipment.

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-Resident #4's interventions further included encouraging program participation to increase observation.

Observation of Resident #4 on 02/21/24 between 12:00pm and 12:50pm revealed:
-Resident #4 was seated in her wheelchair at a table in the dining room.
-She was scooted down toward the edge of the seat of the wheelchair.
-A PCA attempted to lift her up in her wheelchair and called for assistance.
-A MA came and lifted Resident #4 up and pulled her to the back of the wheelchair while the PCA held the wheelchair.
-Resident #4 did not have any visible signs of bruises or injuries.

a. Review of Resident #4's progress note dated 12/02/23 revealed:
-Resident #4 had an unwitnessed fall in her room beside her bed.
-She was kneeling on the floor beside her bed when staff entered the room.
-She was wearing sneakers, but she was not clothed from the waist down.
-Resident #4 stated she had bad dreams, got spooked, and fell when she tried to get up out of bed.
-Her vital signs were taken and there were no physical signs of a head injury.
-Resident #4 denied having pain, but she had an abrasion to her upper right thigh that was bleeding; a band aid was applied.

The Health and Wellness Coordinator (HWC) who documented Resident #4's progress note dated 12/02/23 was unavailable for an interview.

Review of Resident #4's Incident/Accident report

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dated 12/02/23 revealed:
-Resident #4 had an unwitnessed fall in her bathroom.
-Resident #4's vital signs were checked, and she was assessed for injuries.
-Resident #4 had a scrape/abrasion on her right thigh.
-There was no follow up information documented.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/02/23.

b. Review of Resident #4's progress note dated 12/03/23 revealed:
-Resident #4 had an unwitnessed fall in her room near her dresser.
-She was searching in her dresser for night clothes when she lost her balance and fell.
-Resident #4 stated that she did not hit her head, but she was a little sore from the fall.
-Her vital signs were taken and there were no physical signs of skin injury or a head injury.

Interview with the MA on 02/22/24 at 5:45pm revealed:
-She documented the progress note on 12/03/23.
-Resident #4 was found on the floor when the MA had administered medications near Resident #4's room at 6:30pm.
-Resident #4 was not injured and was not sent to the local hospital.
-The MA contacted Resident #4's guardian and left a message with the resident's PCP about the fall on 12/03/23.
-Resident #4's PCP recommended increased rounding until she provided a follow-up visit for Resident #4.
-The MA did not know of any interventions put in

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place for Resident #4 after her fall on 12/03/23.

Review of Resident #4's Incident/Accident report dated 12/03/23 revealed:
-Resident #4 had an unwitnessed fall in her room.
-Resident #4's vital signs were checked, and she was assessed for injuries.
-There were no apparent injuries.
-There was no follow up information documented.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/03/23.

c. Review of Resident #4's progress note dated 12/06/23 revealed:
-Resident #4 had an unwitnessed fall in the hallway of the SCU.
-She was observed on the floor without her walker.
-Resident #4 stated she hit her head.
-Her vital signs were taken and there were no physical signs of skin injury or a head injury.

Attempted telephone interview with the MA on 2/22/24 at 4:35pm who documented the 12/06/23 progress note was unsuccessful.

Review of Resident #4's Incident/Accident report dated 12/06/23 revealed:
-Resident #4 had an unwitnessed fall in the SCU hallway.
-Her vital signs were checked, and she was assessed for injuries.
-Resident #4 had a head injury and was sent to the emergency room (ER).
-There was no follow up information documented.

Resident #4's hospital discharge summary dated

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D 270	Continued From page 15 12/06/23 was requested on 02/22/24 at 11:30am but was not provided prior to the exit on 02/22/24. Interview with the PCA on 02/22/24 at 5:30pm revealed: -She was assigned to care for Resident #4 on 12/06/23. -The PCA located Resident #4 on the hallway floor outside of her room. -Resident #4 told the PCA she fell and had hit her head. -Resident #4 did not have her rollator walker. -She was not aware of any other interventions put in place for Resident #4 after her fall on 12/06/23. Review of Resident #4's record revealed there was no post-fall evaluation documented, or post-fall analysis completed, or interventions implemented after her fall on 12/06/23. d. Review of Resident #4's progress note dated 12/30/23 revealed: -Resident #4 had an unwitnessed fall on 12/30/23 in her room coming out of her bathroom. -She was assessed for injuries and there were no visible signs of injuries. Review of Resident #4's Incident/Accident reports revealed there was no Incident/Accident report dated 12/30/23 available for review. Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/30/23. Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 5:22pm revealed: -She documented the progress note dated 12/30/23.	D 270		

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-The RCC had not witnessed Resident #4 fall on 12/30/23.
-Resident #4 told the RCC she fell when she exited the bathroom into her room.
-The RCC evaluated Resident #4 and she was uninjured.
-She notified Resident #4's guardian and her PCP about the fall on 12/30/23.
-She was not aware of specific interventions implemented after each of Resident #4's falls other than the wheelchair recommended by the Resident #4's PCP after the resident's sustained fall on 01/05/24 to assist the resident's mobility to prevent falls.
-There was no documentation of a post-fall evaluation or a post-fall analysis for Resident #4 for her fall on 12/30/23.
-The RCC did not know who was responsible for determining which residents were placed on 1-hour safety checks for increased falls.
-If 1-hour safety checks for increased falls had been implemented for Resident #4, there would have been documentation of the 1-hour safety checks with dates, and times.
-PCAs, MAs, and the management present were expected to discuss interventions at every shift stand-up meeting, but the interventions were not documented.

e. Review of Resident #4's progress note dated 01/04/24 revealed:
-Resident #4 had an unwitnessed fall in her room near her bed.
-When Resident #4 was found, she was bracing herself against her bed trying to get up off the floor.
-Resident #4 stated she hit her head when she fell, but she could not articulate what happened.
-Her vital signs were taken and there were no physical signs of a head injury.

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D 270	Continued From page 17 -She had a skin tear on her right elbow. Review of Resident #4's Incident/Accident report dated 01/04/24 revealed: -Resident #4 had an unwitnessed fall on 01/04/24 in her room. -Her vital signs were checked, and she was assessed for injuries. -Resident #4 had a skin tear on her right elbow. -She was sent to the emergency room. -There was no follow up information documented. Resident #4's hospital discharge summary dated 01/04/24 was requested on 02/22/24 at 11:30am but was not provided prior to the exit on 02/22/24. Interview with the PCA on 02/22/24 at 5:30pm revealed: -She was assigned to care for Resident #4 on 01/04/24. -The PCA heard Resident #4 fall in her room while walking down the hall to complete his rounds. -Resident #4 obtained a scrape on her right elbow when she fell on 01/04/24. -He did not know of interventions put in place for Resident #4 after her fall on 01/04/24. Review of Resident #4's record revealed there was no documentation of a post-fall evaluation, post-fall analysis completed, or interventions implemented after her fall on 01/04/24. f. Review of Resident #4's progress note dated 01/05/24 revealed: -Resident #4 was pushing another resident when the other resident started pushing back and they both fell. -Resident #4 hit her head and it started bleeding. -Resident #4 was sent to the emergency room.	D 270		

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D 270	Continued From page 18 Interview with the MA on 02/22/24 at 5:05pm revealed: -She documented the progress note dated 01/05/24. -The MA had not witnessed Resident #4's fall on 01/05/24, but the MA heard the resident arguing with another resident and heard her fall while she passed medications in the hallway to the SCU residents. -Resident #4 received a cut to the back of the head from the fall on 01/05/24 which resulted in the resident's head bleeding. -The MA contacted Emergency Medical Services (EMS) and sent Resident #4 to the local hospital for evaluation and treatment of the resident's head injury. -She contacted Resident #4's guardian and the residents PCP about the fall on 01/05/24. -She was not aware MAs and PCAs were to monitor Resident #4 in the common areas more as recommended by the resident's PCP. Review of Resident #4's Incident/Accident report dated 01/05/24 revealed: -Resident #4 had an unwitnessed fall in the hallway. -Her vital signs were checked, and she was assessed for injuries. -She had a laceration on the back of her head and was sent to the emergency room. Resident #4's hospital discharge summary dated 01/05/24 was requested on 02/22/24 at 11:30am but was not provided prior to the exit on 02/22/24. Review of Resident #4's PCP visit notes dated 01/09/24 revealed: -A follow-up visit was provided due to the concern from Resident #4's guardian of so many falls.	D 270		

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-Intervention for physical therapy (PT)/ occupational therapy (OT) evaluation was recommended due to 2 recent falls for Resident #4 as expressed by Resident #4's guardian.
-Staff were expected to provide fall interventions as discussed by the PCP and were expected to monitor Resident #4 with 1-hour increased monitoring and bring her out to the common areas to be in the staff's view.

Review of Resident #4's PCP visit notes dated 01/23/24 revealed:
-The PCP recommended a wheelchair as an intervention due to Resident #4's mobility limitations.
-The PCP referenced the PT/OT home health agency's recommended fall precautions for Resident #4.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 01/04/24.

g. Review of Resident #4's progress note dated 02/02/24 revealed:
-Resident #4 had an unwitnessed fall in the SCU library.
-She was found crawling to the hallway from the library and stated she was trying to get to her family member.
-Her vital signs were taken and there were no physical signs of skin injury or a head injury.

Attempted telephone interview with the MA on 02/22/24 at 4:42pm who documented the 02/02/24 progress note was unsuccessful.

Review of Resident #4's Incident/Accident report dated 02/02/24 revealed:

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-Resident #4 had an unwitnessed fall in SCU library.
-Her vital signs were checked, and she was assessed for injuries.
-There were no injuries identified.
-There was no follow up information, post-fall evaluation, or post-fall analysis documented for Resident #4.

Interview with the PCA on 02/22/24 at 5:30pm revealed:
-She was assigned to care for Resident #4 on 02/02/24.
-The PCA had not witnessed Resident #4's fall on 02/02/24 but found her at 4:15pm on the hallway floor located outside of the SCU library while the PCA walked down the hall.
-The PCA was not aware Resident #4's PCP had recommended PCAs and MAs to bring Resident #4 out to the common areas for 1-hour increased monitoring for the resident.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 02/02/24.

h. Review of Resident #4's progress note dated 02/04/24 revealed Resident #4 had an unwitnessed fall in her room and stated she hit her head.

Interview with the MA on 02/22/24 at 5:05pm revealed:
-She documented the progress note on 02/04/24.
-The MA had not witnessed Resident #4's fall on 02/04/24, but Resident #4 told her and the PCA she fell in her room and hit her head.
-She had contacted Resident #4's guardian, and she left a message with the resident's PCP about

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the fall on 02/04/24.
-Resident #4's guardian declined medical attention at the local hospital, and she did not send out the resident.
-She was not aware of any other interventions put in place for Resident #4 after her fall on 02/04/24 and was not aware Resident #4 should be brought to common areas to be monitored by PCAs and MAs as ordered by the resident's PCP.

Review of Resident #4's Incident/Accident reports revealed there was not an Incident/Accident report dated 02/04/24 available for review.

Review of Resident #4's PCP visit notes dated 02/13/24 revealed:
-The PCP provided a follow-up visit related to Resident #4's general decline and impaired mobility.
-The PCP referenced the PT/OT home health agency's recommended fall precautions and recommended the PCAs, and MAs continue to monitor Resident #4 with 1-hour rounding along with the resident brought out to the common areas.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 02/04/24.

i. Review of Resident #4's progress note dated 02/19/24 revealed:
-Resident #4 had a fall by the table in the common area.
-She denied being in any pain and did not have any injuries.

Interview with the MA on 02/22/24 at 5:45pm revealed:

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-She documented the progress note on 02/19/24.
-The MA had not witnessed Resident #4 fall in the living room when the MA administered medications to the SCU residents on 02/19/24.
-The MA had not witnessed Resident #4's fall on 02/19/24 but witnessed her holding onto a table while seated in her wheelchair in the living room before she fell.
-Resident #4 was uninjured and was not sent to the local hospital.
-The MA contacted Resident #4's guardian and left a message for the residents PCP about the fall on 02/19/24.
-Resident #4's guardian declined medical attention at the local hospital, and she did not send out the resident.
-She was not aware of PT/OT home health therapy in place for Resident #4 after her fall on 02/19/24.

Review of Resident #4's Incident/Accident report dated 02/19/24 revealed:
-Resident #4 had an unwitnessed fall in the common area.
-Her vital signs were checked, and she was assessed for injuries.
-There were no injuries identified.
-There was no follow up information documented.

Interview with the PCA on 02/22/24 at 5:30pm revealed:
-She was assigned to care for Resident #4 on 02/19/24.
-She had not witnessed Resident #4's fall on 02/19/24 but witnessed her holding onto a table while seated in her wheelchair in the living room before she fell.
-She was not aware if the MA contacted Resident #4's guardian or PCP.
-She was not aware of other interventions put in

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place for Resident #4 after her fall on 02/19/24.
-She was not aware Resident #4's PCP had ordered for the resident be brought into the common areas as an intervention for staff to monitor Resident #4.

Review of Resident #4's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 02/19/24.

Interview with Resident #4's PCP on 02/22/24 at 3:30pm revealed:
-She was aware of Resident #4's falls in December 2023, January 2024, and February 2024.
-Resident #4 had a history of back pain related to spinal surgery, suffered from a degenerative disk disorder located in her back, and she was at high risk for falls.
-She ordered PT/ OT home therapy for Resident #4 at the beginning of January 2024 to improve upper and lower extremity strength.
-She ordered a wheelchair for Resident #4 and had hoped the residents' falls would decrease with wheelchair and with the PT/OT home health therapy intervention which should have started at the middle of January 2024.
-She also ordered increased 1-hour rounding for PCAs and MAs to complete and instructed Resident #4 be brought out into the common areas by staff as an intervention; but she was not aware if this intervention was being followed by staff.
-She expected the facility to report falls for Resident #4 to her and for her orders to be followed for fall interventions.
-She could not think of anything the facility could have done differently for Resident #4 if staff provided the safety checks every 1-2 hours and

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continued to monitor her and the resident be brought out into the common areas for staff to monitor.
-She expected possible injuries and a decline for Resident #4 if the facility staff failed to follow her recommended fall interventions.

Refer to interview with the Administrator on 02/22/24 at 6:30pm.

2. Review of Resident #5's current FL2 dated 11/27/23 revealed:
-Diagnoses included repeated falls, urinary tract infection, and pain in right knee.
-Resident #5 was recommended for assisted living level-of-care with being non-ambulatory and was intermittently disoriented.

Review of Resident #5's care plan dated 03/16/23 revealed:
-Resident #5 required extensive assistance in toileting, ambulation, bathing, dressing, grooming, and transferring.
-Staff were to provide attention for her mobility to and from the dining room and/or community activities as needed.
-There was documentation of universal fall precautions for all residents, but there were no fall precautions documented for Resident #5.
-Resident #5's interventions included considering a request for further evaluation by the primary care provider (PCP) regarding changes and observations and may include laboratory work and medication review.
-Resident #5's interventions also included considering involvement of physical and/or occupational therapy to consult strength, gait training, cognition, and adaptive equipment.

Observation of Resident #5's room on 02/22/24 at

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12:25pm revealed:
-Resident #5 had a regular bed with a mobility rail on the right side of the bed.
-She did not have any visible rollator walker or cane in the room.

Interview with Resident #5 on 02/22/24 at 12:25pm revealed:
-She fell multiple times over the last several months.
-She was not aware of how often staff checked on her after she experienced a fall.
-She used her mobility rail on the right side of her bed to move around and used her wheelchair to get around the facility.
-She was not aware of interventions her PCP may have discussed with the staff to prevent her from falling.

a. Review of Resident #5's progress note dated 12/08/23 revealed:
-Resident #5 had an unwitnessed fall, but the location was not documented.
-Resident #5 was found on the floor in front of her wheelchair.
-She was trying to push herself back into the wheelchair and slid out onto the floor.
-Resident #5's vital signs were taken and there were no physical signs of skin injury or of a head injury.

Attempted telephone interview on 02/22/24 at 4:42pm with the medication aide (MA) who documented the 12/08/23 progress note was unsuccessful.

Review of Resident #5's Incident/Accident report dated 12/08/23 revealed:
-Resident #5 had an unwitnessed fall in her room.
-Resident #5's vital signs were checked, and she

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was assessed for injuries.
-Resident #5 had no apparent injuries.
-There was no follow up information documented.

Review of Resident #5's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/08/23.

b. Review of Resident #5's Incident/Accident report dated 12/10/23 revealed:
-Resident #5 had an unwitnessed fall in her room.
-Resident #5's vital signs were checked, and she was assessed for injuries.
-Resident #5 had a scrape to her right knee.
-There was no follow up information documented.

Attempted telephone interview with the MA on 02/22/24 at 4:45pm who documented the 12/10/23 Incident/Accident report was unsuccessful.

Review of Resident #5's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/10/23.

c. Review of Resident #5's progress note dated 12/13/23 revealed:
-Resident #5 had an unwitnessed fall in her room near her bed.
-Resident #5's vital signs were taken and there were no physical signs of skin injury or of a head injury.

Review of Resident #5's Incident/Accident report dated 12/13/23 revealed:
-Resident #5 had an unwitnessed fall in her room.
-Resident #5's vital signs were checked, and she was assessed for injuries.

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-Resident #5 had no apparent injuries.
-There was no follow up information documented.

Interview with the personal care aide (PCA) on 02/22/24 at 3:00pm revealed:
-She was assigned to care for Resident #5 on 02/22/24.
-The PCA had not witnessed Resident #5's fall on 12/13/23 but heard the fall from the hallway while completing resident safety checks every 2 hours.
-She located Resident #5 on the floor in her room next to the bed.
-Resident #5 would not tell the PCA how she fell to the floor and said she was fine.
-She was not aware of interventions put in place for Resident #5 after her fall on 12/13/23.

Review of Resident #5's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/13/23.

d. Review of Resident #5's progress note dated 12/18/23 revealed:
-Resident #5 had an unwitnessed fall in her bathroom near the toilet.
-Resident #5 was taking herself to the bathroom when she fell; she did not pull the call light for help.
-Resident #5's vital signs were taken and there were no physical signs of skin injury or of a head injury.
-Resident #5 had some redness on her back.

Review of Resident #5's Incident/Accident report dated 12/18/23 revealed:
-Resident #5 had an unwitnessed fall in her bathroom.
-Resident #5's vital signs were checked, and she was assessed for injuries.

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-Resident #5 had redness to her lower back.
-There was no follow up information documented.

Review of Resident #5's PCP visit note dated 12/19/23 revealed:
-Resident #5 had several falls recently and was high risk for falls.
-She had no skin breakdown and could not ambulate.
-There were not any fall interventions documented for Resident #5.

Review of Resident #5's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/19/23.

e. Review of Resident #5's progress note dated 01/01/24 revealed:
-Resident #5 had an unwitnessed fall near the door inside her room.
-Resident #5 was observed on the floor and when asked what happened, she stated that she was going to another resident's room to ask for help.
-Resident #5 did not pull her call light to ask for help.
-Resident #5's vital signs were taken and there were no physical signs of a head injury.
-She had a scrape to a mole on her left shoulder.

Interview with the MA on 02/22/24 at 4:15pm revealed:
-She documented the progress note on 01/01/24.
-The MA had not witnessed Resident #5 fall on 01/01/24.
-Resident #5 was found by the PCA on the floor inside of her room.
-She told the MA and the PCA she tried to get to another resident's room for help.
-Resident #5 sustained a scrape on her left

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shoulder from the fall on 01/01/24 and refused to be sent out to the local hospital.
-She contacted Resident #5's PCP about the fall on 01/01/24.
-She did not know of interventions put in place for Resident #5 after her fall on 01/01/24 other than 1-hour checks.

Review of Resident #5's Incident/Accident reports revealed there was no Incident/Accident report dated 01/01/24 available for review.

Review of Resident #5's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 01/01/24.

f. Review of Resident #5's progress note dated 02/20/24 revealed:
-Resident #5 had a fall in her bedroom.
-Resident #5 was observed on the floor next to her closet.
-Emergency medical services (EMS) were called to evaluate Resident #5, but she refused to be transported to the emergency room (ER).

Interview with the MA on 02/22/24 at 4:15pm revealed:
-She documented the progress note on 02/20/24.
-The MA had not witnessed Resident #5's fall on 02/20/24.
-Resident #5 was uninjured and was not sent to the local hospital due to the resident refused to be treated.
-She contacted Resident #5's guardian and left a message with the resident's PCP about the fall on 02/20/24.
-She did not know of interventions put in place for Resident #5 after her fall on 02/20/24.

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Review of Resident #5's Incident/Accident report dated 02/20/24 revealed:
-Resident #5 had an unwitnessed fall in her room.
-Resident #5's vital signs were checked, and she was assessed for injuries.
-Resident #5 had no apparent injuries.
-There was no follow up information documented.

Review of Resident #5's record revealed there was no documentation of a post-fall after her fall on 02/20/24.

Interview with Resident #5's PCP on 02/22/24 at 3:30pm revealed:
-She was aware of Resident #5's falls in December 2023, January 2024, and February 2024.
-Resident #5 had a history of repeated falls, pain in the right knee and she was high risk for falls.
-She had not ordered physical therapy and occupational therapy for Resident #5, but she had ordered regular safety checks on Resident #5.
-She expected the facility to report falls for Resident #5 to her and for her orders to be followed for interventions to recommend increased 1-hour safety checks.
-She could not think of anything the facility could have done differently for Resident #5 if they provided the regular safety checks every 1-2 hours.
-She expected possible injuries to Resident #5 if her recommended 1-2 hours safety checks were not followed by the facility staff for fall prevention.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 5:22pm revealed:
-She knew about Resident #5's falls.
-Resident #5 refused to use her call light for staff assistance.
-She did not know of specific interventions

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implemented after each of Resident #5's falls related to the PCP's recommendations for safety checks.
-She was not aware if post-fall huddle meetings, post-fall evaluations, or post-fall analysis had been completed for Resident #5.
-Resident #5 had not been on documented increased safety checks.
-She did not know who was responsible for determining who was placed on increased 1-hour safety checks.
-She was aware MAs were responsible for post-fall evaluations and the HWC/HWD was responsible for post-fall analysis, but she did not know if Resident #5's post-fall evaluations or post-fall analysis were completed.
-If increased 1-hour safety checks had been implemented for Resident #5, there would have been documentation of the increased checks, with dates, times, documentation, and staff would be required to check on Resident #5 every hour instead of every 2 hours.

Refer to interview with the Administrator on 02/22/24 at 6:30pm.

3. Review of Resident #3's current FL2 dated 12/27/23 revealed:
-Diagnoses included dementia without behavioral disturbance, essential hypertension, lower extremity edema, and age-related physical debility.
-Resident #3 was ambulatory and constantly disoriented.
-Resident #3's recommended level of care was domiciliary and Special Care Unit (SCU)

Review of Resident #3's personal care plan dated 03/22/23 revealed:
-Resident #3 had frequent falls, mostly sliding out

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of bed or her chair while asleep.
-She required staff supervision with ambulation and was independent with transfers.
-Resident #3 was independent with going to and from the dining room or community activities and staff were to be alert of heightened risk for falling.
-Resident #3 had falls with injuries and was treated in the emergency room (ER) in the last twelve months.
-There was documentation of universal fall precautions for all residents, but there were no fall precautions documented for Resident #3.
-Resident #3's interventions included considering a request for further evaluation by the PCP regarding changes and observations and may include laboratory work and medication review.
-Resident #3's interventions also included considering involvement of physical and/or occupational therapy to consult strength, gait training, cognition, and adaptive equipment.

Observation of Resident #3 on 02/21/24 at various times between 9:15am and 1:00pm revealed:
-Resident #3 was standing at a dining room table after breakfast.
-She had yellowish and greenish bruising from the right side of her forehead along her right eye and stopped at the bottom of her right eye.
-Resident #3 was standing at a chair in the hallway, leaning towards the chair, playing with baby dolls.
-The Special Care Unit Coordinator (SCUC) walked Resident #3 to the dining hall.
-Resident #3 was standing at a dining room table, while eating, during the lunch meal.
-She had on non-slip socks and the non-slip part of her left sock was on the top of her foot.
-Resident #3 did not have her rollator walker during any observations on 02/21/24.

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D 270	Continued From page 33 Observation of Resident #3's room on 02/22/24 at 12:14pm revealed: -Resident #3 had a regular bed and there was a rollator walker beside her bed. -There was a regular wheeled walker folded up and placed against the wall near the door. -There was an armed, high back chair in the room. -Resident #3 was not in the room. a. Review of Resident #3's progress note dated 12/09/23 revealed: -Resident #3 had an unwitnessed fall in the common area. -She was asleep in a chair and slid out of the chair onto the floor. -Resident #3's vital signs were taken and there were no physical signs of skin or head injury. Review of Resident #3's Incident/Accident report dated 12/09/23 revealed: -Resident #3 had an unwitnessed fall in the common area. -Resident #3's vital signs were taken and there was no apparent injury. -There was no follow up information documented. Telephone interview with the personal care aide (PCA) on 02/22/24 at 4:21pm who was assigned on 12/09/23 to care for Resident #3 revealed: -Resident #3 had dozed off in a chair in the common area and tumbled out of the chair. -She was not aware of any interventions put in place for Resident #3 after her fall on 12/09/23. -She tried to scan the area for Resident #3 and talk to her, but she was not told to do anything specifically for her. -She was not told to increase safety checks for Resident #3 after her fall on 12/09/23.	D 270		

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D 270	Continued From page 34 -Resident #3 would not sleep in her bed; she usually slept in a chair in the common area. Review of Resident #3's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/09/23. b. Review of Resident #3's progress note dated 12/13/23 revealed: -Resident #3 was asleep in a chair and fell out of the chair. -The location of the fall was not documented. -Resident #3 was bleeding from a lump on her forehead and sent to the emergency room (ER) for evaluation. Attempted telephone interview on 02/22/24 at 4:35pm with the medication aide (MA) who documented Resident #3's 12/13/23 progress note was unsuccessful. Review of Resident #3's Incident/Accident reports revealed there was no Incident/Accident report dated 12/13/23 available for review. Review of Resident #3's hospital discharge summary dated 12/13/23 revealed: -Resident #3 visited the ER due to a fall. -Resident #3 had a diagnosis of a closed head injury. Review of Resident #3's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/13/23. c. Review of Resident #3's progress notes dated 12/18/23 revealed: -Resident #3 had an unwitnessed fall in the	D 270		

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hallway.
-She had fallen asleep in the chair and fell out of the chair onto her knees.
-The MA and the PCA were in the common area when they heard a yell from the hallway.
-The MA and the PCA rushed to the hallway and observed Resident #3 on the floor in front of the arm chair with her baby doll beside her on the floor.
-Resident #3's vital signs were taken, and she was assessed for injury.
-She had a red bump forming on her right temple and held her forehead claiming to be in pain.
-Resident #3 was sent to the ER for evaluation.

Interview with the MA on 02/22/24 at 12:14pm who documented Resident #3's 12/18/23 progress note revealed:
-After Resident #3 fell on 12/18/23, staff were not told to do any specific interventions.
-Staff tried to monitor her more closely, encouraged her to use her walker, sleep in her bed, and prop her feet up.
-She could not remember if Resident #3 was on increased safety checks after her fall on 12/18/23.

Review of Resident #3's Incident/Accident report dated 12/18/23 revealed:
-Resident #3 had an unwitnessed fall in the hallway.
-Resident #3's vital signs were taken and there was no apparent injury.
-There was no follow up information documented.

Review of Resident #3's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 12/18/23.

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D 270	Continued From page 36 d. Review of Resident #3's progress note dated 02/16/24 revealed: -Resident #3 fell out of a chair and hit her head. -She was sent to the ER for evaluation. Review of Resident #3's Incident/Accident report dated 02/16/24 revealed: -Resident #3 had a witnessed fall in the dining room. -Resident #3's vital signs were taken, and she had a head injury. -There was no follow up information documented. Interview with the MA on 02/22/24 at 12:14pm who documented Resident #3's 02/16/24 progress note revealed: -Resident #3 fell on 02/16/24 and hit the right side of her forehead. -Resident #3 currently had bruising on the right side of her face from her fall on 02/16/24. -She had a "goose egg" on the right side of her head, but there was no bleeding. -After Resident #3 fell on 02/16/24, staff were not told to do any specific interventions. -Staff tried to monitor her more closely, encouraged her to use her walker, sleep in her bed, and prop her feet up. -She could not remember if Resident #3 was on increased safety checks after her fall on 02/16/24. Interview with the PCA on 02/22/24 at 4:46pm who was assigned on 02/16/24 to care for Resident #3 revealed: -On 02/16/24, most residents had finished breakfast, but Resident #3 had not finished yet. -One staff was cleaning the dining room and taking dirty dishes back to the kitchen and she was pushing residents out of the dining room. -Before the staff working in the dining hall could	D 270		

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get to her, Resident #3 fell to the floor and hit her head.
-She stayed with Resident #3 and the other staff called emergency medical services (EMS).
-She was not sure of Resident #3's injuries.
-There were no interventions put in place for Resident #3 that she knew of.
-She usually tried to check on all residents every 5 to 10 minutes.

Interview with a MA on 02/22/24 at 12:15pm revealed:
-Resident #3 had a wheelchair and a rollator walker, but she would not use them.
-Resident #3's wheelchair was probably in storage because her family did not want her to use it.
-Staff took Resident #3's rollator walker to her when they saw her without it, but she walked off and left the rollator walker or would take it back to her room and would leave it there.
-Resident #3 refused to sleep in her bed and slept in a chair in the common area.
-If she was asleep in the chair in the hallway, staff tried to monitor her and tried to get her to lay down.
-Staff checked on all residents every 30 minutes or so, but there was no documentation.

Interview with the Special Care Unit Coordinator (SCUC) on 02/22/24 at 5:08pm revealed:
-She was aware of all Resident #3's falls.
-Resident #3 had a head injury with bruising on her head from a fall on 02/16/24.
-Resident #3 sat in a chair in the common area and leaned forward causing her to fall.
-She had a wheelchair when she came back from a hospital visit and had difficultly walking, but she started walking again and no longer used it.
-Resident #3 had a rollator walker, but she

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refused to use it.
-She discussed falls in the Special Care Unit (SCU) with the Health and Wellness Coordinator (HWC) once weekly, but she was not currently available in the facility.
-There was a notebook of suggested interventions, but she could not say that the interventions had been implemented for Resident #3.
-If interventions were implemented, they would have been placed on assignment sheets for staff and would have been discussed in staff stand up meetings.
-Resident #3 would not sleep in her bed and used to sleep in a chair in the hallway of the SCU; staff moved her to a chair in the common area to sleep.
-Staff also escorted her to the dining room and assisted her if they saw her leaning in a chair to prevent her from falling.
-She was not aware of any specific interventions implemented for Resident #3.
-Staff checked on all residents every 2 hours.
-She did not think staff checked on Resident #3 more frequently than every 2 hours after her falls; if so, the increased checks would have been on Resident #3's daily assignment sheets.
-The HWC was responsible for implementing interventions, increased checks, updating the assignment sheets, and for updating the resident's care plan.

Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 5:39pm revealed:
-She knew about Resident #3's falls.
-She first thought Resident #3's falls were related to her carrying baby dolls, dropping them, then reaching over to pick them up and falling, but most of her falls had been from falling out of a chair.

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-Resident #3 slept in a chair because she would not get in her bed in her room.
-She used to sleep in chair in her room, so staff took the chair out of her room thinking she would sleep in her bed.
-Once the chair was out of Resident #3's room, she started sleeping in a chair in the common area.
-Resident #3 was falling out of the chair in the common area.
-There were usually two staff in the SCU and there were many residents who were at risk for falls and required two person assists.
-It was hard to keep an eye on everybody.
-She was not aware of any specific interventions implemented after each of Resident #3's falls other than staff made sure she sat in a lower chair in the common area.
-Resident #3 had not been on documented increased safety checks.
-She did not know who was responsible for determining who was placed on increased safety checks.

Interview with the Administrator on 02/22/24 at 6:46pm revealed he was not aware of any interventions implemented after each of Resident #3's falls.

Review of Resident #3's record revealed there was no documentation of a post-fall evaluation or post-fall analysis completed after her fall on 02/22/24.

Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's responsible party on 02/22/24 at 4:19pm was

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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 270	Continued From page 40 unsuccessful. Attempted telephone interview with Resident #3's PCP on 02/22/24 at 2:37pm was unsuccessful. Refer to interview with the Administrator on 02/22/24 at 6:30pm. _____ Interview with the Administrator on 02/22/24 at 6:30pm revealed: -The MAs and PCAs were responsible for having a post-fall meeting following a resident fall incident and discussed interventions related to specific residents. -MAs and PCAs should have discussed possible interventions for resident falls, filled out 24-hour shift reports, documented post-fall evaluations, with completing an accident/incident form, and submitted the accident/incident form to the HWD (There was not currently a HWD employed at the facility.) -He expected interventions to be implemented and for staff to increase supervision to 1-hour rounding instead of normal 2-hour rounding for residents after falls. -The increased time for PCAs rounding depended on the severity of the resident's fall. -If there was increased 1-hour rounding for a resident, it should have been documented in the resident's progress note. -He was not aware the post-falls evaluations and post-fall analyses were not being completed and this must have been an oversight. _____ The facility failed to ensure supervision according to their assessed needs and failed to follow their fall policy including a post-fall analysis after each fall for 3 of 5 residents (#3, #4, and #5) related to a resident who had 9 unwitnessed falls in 3 months with 1 fall occurring on 12/2/23 and	D 270		

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D 270	Continued From page 41 another fall occurring on 12/3/23, resulting in 2 ER visits, a head injury, a laceration to the back of her head, a skin tear to her right upper thigh, and a skin tear on her right elbow (#4), a resident who had 6 unwitnessed falls in 3 months resulting in a scrape on her right knee, a scrape on her left shoulder, and redness to her lower back (#5) and a resident who had 4 falls in 3 months resulting in 2 ER visits, a closed head injury, an injury to her head, a bump on her right temple, pain, and bruising to the right side of her face (#3). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/22/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2024.	D 270		
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: Based on observations, record reviews, and interviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled resident (#3) related to a hearing aid and an order for weekly weights. The findings are:	D 273		

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D 273	Continued From page 42 Review of Resident #3's current FL2 dated 12/27/23 revealed diagnoses included dementia without behavioral disturbance, essential hypertension, lower extremity edema, and age-related physical debility. a. Review of Resident #3's physician's orders dated 08/17/23 revealed there was an order for hearing aid put in left ear in the morning and remove at bedtime. Review of Resident #3's physician's orders dated 02/07/24 revealed there was an order for hearing aid put in left ear in the morning and remove at bedtime. Review of Resident #3's electronic medication administration record (eMAR) for December 2023 revealed: -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be applied at 8:00am. -There was documentation Resident #3's hearing aid was applied 5 of 31 opportunities. -There was documentation Resident #3's hearing aid was not applied on 12/04/23 due to Resident #3 was asleep; there was no documentation for the reason why Resident #3's hearing aid was not applied on other days. -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be removed at 8:00pm. -There was documentation Resident #3's hearing aid was removed 5 of 31 opportunities. Review of Resident #3's MAR for January 2024 revealed: -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be applied at 8:00am.	D 273		

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D 273	Continued From page 43 -There was documentation Resident #3's hearing aid was applied 5 of 31 opportunities. -There was documentation Resident #3's hearing aid was not applied on 01/09/24, 01/17/24, 01/18/24, 01/20/24, 01/23/24, and 01/24/24 due to Resident #3 was asleep; there was no documentation for the reason why Resident #3's hearing aid was not applied on other days. -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be removed at 8:00pm. -There was documentation Resident #3's hearing aid was removed 1 of 31 opportunities. -There was documentation Resident #3's hearing aid was not removed on 01/25/24 due to Resident #3 was asleep. Review of Resident #3's eMAR for February 2024 from 02/01/24 through 02/20/24 revealed: -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be applied at 8:00am. -There was documentation Resident #3's hearing aid was applied 6 of 20 opportunities. -There was no documentation for the reason why Resident #3's hearing aid was not applied. -There was an entry for hearing aid put in left ear in the morning and remove at bedtime schedule to be removed at 8:00pm. -There was documentation Resident #3's hearing aid was removed 5 of 20 opportunities. -There was no documentation for the reason why Resident #3's hearing aid was not removed. Review of Resident #3's progress notes revealed there was no documentation regarding Resident #3's hearing aid. Observation of the medication cart on 02/22/24 at 11:23am revealed:	D 273		

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D 273	Continued From page 44 -There was a pair of hearing aids and a single hearing aid on the medication cart. -There was a hearing aid charger that had the silver piece of a universal serial bus (USB) cord inserted into the side of it. -There was a USB cord on the medication cart, but it did not have a USB plug in adapter to plug into the wall to charge. Interview with a medication aide (MA) on 02/22/24 at 10:09am revealed: -Resident #3's hearing aid had been missing, but her responsible party brought in a new pair for her. -She placed Resident #3's hearing aid when she could get it to charge. -The USB cord that attached to the hearing aid charger did not have the adapter that was to be inserted into an electrical outlet. -There was a USB piece connected to the hearing aid charger that she hooked into the USB port of the laptop on the medication cart. -She could not get the hearing aid charger to work this week. -She talked to Resident #3's responsible party about the hearing aide charger and her responsible party stated that she would get another charger when she could. -She also told the Resident Care Coordinator (RCC) and the Administrator that Resident 3's hearing aid charger was not working properly. -She thought she told the Special Care Unit Coordinator (SCUC) about Resident #3's hearing aid charger, but she was not sure. -She had not notified Resident #3's primary care provider (PCP), but Resident #3's PCP visited her at the facility about a week ago. Interview with a second MA on 02/22/24 at 6:16pm revealed:	D 273		

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-She saw hearing aids on the medication cart, but she did not know they belonged to Resident #3.
-She did not know of any other resident in the SCU who wore hearing aids and she did not ask anyone about the hearing aids on the medication cart.
-She thought Resident #3's hearing aids were lost, and the family got tired of replacing them.
-She had not followed up with the RCC, the Health and Wellness Coordinator (HWC) (The HWC was not available in the facility to interview), or Resident #3's PCP regarding the hearing aid or the hearing aid charger.

Interview with the SCUC on 02/22/24 at 12:24pm revealed:
-MAs were responsible for putting Resident #3's hearing aid in her ear daily.
-There were issues with Resident #3's hearing aids being lost, but she did not know Resident #3 had hearing aids were available on the medication cart and there was an issue with the hearing aid charger.
-She was not responsible for following up regarding Resident #3's hearing aid and would have notified the facility's HWC or Health and Wellness Director (HWD) (There was not currently a HWD employed at the facility.) regarding the hearing aid.

Telephone interview with a personal care aide (PCA) on 02/22/24 at 4:21pm revealed:
-She knew Resident #3 had hearing aids, but she had not seen any in Resident #3's left ear.
-She did not know who was responsible to put Resident #3's hearing aid placed in her left ear.

Interview with a second PCA on 02/22/24 at 4:46pm revealed:
-She did not know Resident #3 had hearing aids

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because she had never seen any in her left ear.
-Resident #3 did not hear well and staff had to speak loudly for her to hear.
-MAs were responsible for placing the hearing aid in Resident #3's left ear and following up with Resident #3's PCP if there were any issues with the hearing aid.

Interview with the RCC on 02/22/24 at 5:39pm revealed:
-The last she heard about Resident #3's hearing aid was that they were lost.
-Nobody made her aware that Resident #3 currently had a hearing aid available and that there was an issue with the hearing aid charger.
-MAs should have let her know about issues with Resident #3's hearing aid, and they should have followed up with Resident #3's responsible party and her PCP regarding issues with the hearing aid.

Interview with the Administrator on 02/22/24 at 6:46pm revealed:
-He did not know about Resident #3's hearing aid was not being placed daily or that there was an issue with the hearing aid charger.
-The MAs were responsible for reaching out to Resident #3's family and PCP regarding the hearing aid and charger and to let the RCC, HWC, and the know that there was an issue.

Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's responsible party on 02/22/24 at 4:19pm was unsuccessful.

Attempted telephone interview with Resident #3's

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D 273	Continued From page 47 PCP on 02/22/24 at 2:37pm was unsuccessful. b. Review of Resident #3's physician's order dated 01/02/24 revealed: -There was an order to manually check Resident #4's blood pressure and weight once weekly for 3 weeks and fax results to Resident #3's PCP. -The order was associated with the diagnoses of lower extremity edema, essential hypertension. Review of Resident #3's physician's order dated 01/09/24 revealed: -There were medication orders for Lasix (used to treat fluid retention). -There was a medication order for potassium chloride (used to treat low blood levels of potassium). -There was an order to manually check Resident #3's blood pressure and weight once weekly for 3 weeks and fax the results to Resident #3's PCP as previously requested. Review of Resident #3's physician's orders dated 02/07/24 revealed: -There were signed medication and treatment orders. -There was handwritten documentation: "I had asked for weights and blood pressures to be faxed to me and I have not received any." -There was a handwritten order to send Resident #3's weights and blood pressures as soon as possible and the PCP's fax number was provided. Review of Resident #3's electronic medication administration record (eMAR) for January 2024 revealed: -There was an entry for check blood pressure and weight once weekly for 3 weeks and then fax the results to Resident #3's PCP on the morning of every Tuesday for edema for 3 weeks with	D 273		

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blood pressures and weights to be checked on Tuesdays at 9:00am.
-There was documentation Resident #3's blood pressure and weight were check on 01/09/24, 01/16/24, and 01/23/24.
-Her blood pressure was 174/88 and her weight was 128 pounds on 01/09/24; her blood pressure was 168/80 and her weight was 128 pounds on 01/16/24; and her blood pressure was 170/84 and her weight was 128 pounds on 01/23/24.

Interview with the RCC on 02/22/24 at 4:02pm revealed:
-The MAs were responsible for sending Resident #3's weights and blood pressures to her PCP weekly as ordered.
-If the Resident #3's weights and blood pressures had been faxed to her PCP as ordered, there should have been a fax confirmation in Resident #3's record.

Interview with a MA on 02/22/24 at 4:35pm revealed:
-She documented Resident #3's weights and blood pressures on 01/09/24, 01/16/24, and 01/23/24, but she did not send Resident #3's weights and blood pressure results weekly to her PCP.
-"It just slipped her mind" to fax Resident #3's weights and blood pressure results to her PCP because there was not a fax machine in the Special Care Unit (SCU).
-In order to fax documents, she had to go the Assisted Living side of the facility and someone had to take her place in the SCU.
-She gave a copy of Resident #'3's weights and blood pressures to her PCP, when the PCP visited Resident #3 about a week ago.

Interview with the RCC on 02/22/24 at 5:39pm

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D 273	Continued From page 49 revealed: -She did not know about Resident #3's order for to check her blood pressure and weight weekly and fax the results to her PCP weekly on Tuesdays. -She expected the MA who checked Resident #3's blood pressure and weight to fax the results to her PCP. -She did not know the PCP had requested Resident #3's blood pressure and weights on 01/02/24, 01/09/24, and on 02/07/24. -She did not know if Resident #3's blood pressures and weights results had been faxed to Resident #3's PCP weekly for 3 weeks. Interview with the Administrator on 02/22/24 at 6:46pm revealed: -He did not know about Resident #3's order to have her blood pressure and weight checked once a week for 3 weeks and results were to be faxed to her PCP. -He expected the MA who obtained Resident #3's blood pressure and weight to fax the results to Resident #3's PCP every Tuesday for 3 weeks as ordered. Based on observations, record reviews, and interviews, it was determined Resident #3 was not interviewable. Attempted telephone interview with Resident #3's responsible party on 02/22/24 at 4:19pm was unsuccessful. Attempted telephone interview with Resident #3's PCP on 02/22/24 at 2:37pm was unsuccessful.	D 273		
D 344	10A NCAC 13F .1002(a) Medication Orders	D 344		

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D 344	Continued From page 50 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: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#3) for medications on the medication cart for Resident #3 including vitamin supplements, a homeopathic cream, and a homeopathic ointment. The findings are: Review of Resident #3's current FL2 dated 12/27/23 revealed: -Diagnoses included dementia without behavioral disturbance, essential hypertension, lower extremity edema, and age-related physical debility. -There was no order for Cannabidiol (CBD) gummies with melatonin (used for sleep). -There was no order for Ceriva vitamin supplement (used to support cognition and memory). -There was no order for SeroSyn vitamin supplement (used to support metabolism and neurological function with vitamin B).	D 344		

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-There was no order for SPM Active vitamin supplement (used to support tissue health and help with physical discomfort).
-There was no order for Mag L-Threonate 98mg vitamin supplement (used to treat and prevent low levels of magnesium in the blood, support brain health, and treat post-traumatic stress disorder and anxiety).
-There was no order for Arnicare homeopathic cream (used to soothe muscle aches, reduce inflammation, and heal wounds).
-There was no order for Lion's Mane vitamin supplement (used to reduce mild symptoms of anxiety and depression, and for dementia).
-There was no order for Calendula ointment (used for healing wounds, soothing eczema, and relieving diaper rash).

Observation of medications available for Resident #3 on 02/22/24 at 10:29am revealed Cannabidiol (CBD) gummies with melatonin, Ceriva vitamin supplement, SeroSyn vitamin supplement, SPM Active vitamin supplement, Mag L-Threonate 98mg vitamin supplement, Arnicare homeopathic cream, Lion's Mane vitamin supplement, and Calendula homeopathic ointment were available for Resident #3 on the medication cart for administration.

Review of Resident #3's physician's orders dated 08/17/23 revealed there were no orders for Cannabidiol (CBD) gummies with melatonin, Ceriva vitamin supplement, SeroSyn vitamin supplement, SPM Active vitamin supplement, Mag L-Threonate 98mg vitamin supplement, Arnicare homeopathic cream, Lion's Mane vitamin supplement, and Calendula homeopathic ointment.

Review of Resident #3's physician's orders dated

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D 344	Continued From page 52 02/07/24 revealed there were no orders for Cannabidiol (CBD) gummies with melatonin, Ceriva vitamin supplement, SeroSyn vitamin supplement, SPM Active vitamin supplement, Mag L-Threonate 98mg vitamin supplement, Arnicare homeopathic cream, Lion's Mane vitamin supplement, and Calendula homeopathic ointment. Review of Resident #3's electronic medication administration record (eMAR) for December 2023, January 2024, and 02/01/24 through 02/20/24 revealed there were no entries for Cannabidiol (CBD) gummies with melatonin, Ceriva vitamin supplement, SeroSyn vitamin supplement, SPM Active vitamin supplement, Mag L-Threonate 98mg vitamin supplement, Arnicare homeopathic cream, Lion's Mane vitamin supplement, and Calendula homeopathic ointment. Interview with a pharmacist at Resident #3's pharmacy on 02/22/24 at 2:35pm revealed: -Cannabidiol (CBD) gummies with melatonin, Ceriva vitamin supplement, SeroSyn vitamin supplement, SPM Active vitamin supplement, Mag L-Threonate 98mg vitamin supplement, Arnicare homeopathic cream, Lion's Mane vitamin supplement, and Calendula homeopathic ointment were all over the counter vitamin supplements, and a homeopathic cream and ointment. -The supplements would not have been dispensed by the pharmacy and there was no documentation of physician's orders for the vitamin supplements and homeopathic cream and ointment. Interview with a medication aide (MA) on 02/22/24 at 10:09am revealed:	D 344		

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-Resident #3's responsible party brought in vitamin supplements to the facility that did not have a physician's order.
-If she had been working when the vitamin supplements were brought in, she would have asked Resident #3's responsible party to take the vitamin supplements back home until there was a physician's order in place.
-Other MAs probably placed the vitamin supplements on the medication cart brought in by Resident #3's responsible party because they did not know what to do with them.
-There was no place to store the extra vitamin supplements.
-She did not notice until 02/21/24 that Resident #3 had vitamin supplements in the medication that were not listed on her eMAR.
-She called Resident #3's responsible party to have her pick up the vitamin supplements.
-She did not tell the RCC about the vitamin supplements, but she told the Special Care Unit Coordinator (SCUC) that there was "stuff" on the medication cart for Resident #3 that she did not need.
-She administered the CBD gummies with melatonin to Resident #3 and documented it under the entry Melatonin-Gaba-Valerian on the eMAR.
-She noticed the CBD gummies did not match the entry on the eMAR, but that was what Resident #3's responsible party brought to the facility for Resident #3.
-She administered Arnicare Cream instead of Diclofenac cream (used to treat aches and pain) and documented on the eMAR Diclofenac cream was administered.
-She used calendula ointment on Resident #3's bottom when there was redness.
-Any vitamin supplements administered to Resident #3 should have been documented on

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Resident #3's eMAR.
-She did not administer any other vitamin supplements to Resident #3 that did not have a physician's order and were not on Resident 3's eMAR.
-She had not clarified the use of Arnicare cream, calendula ointment, CBD gummies, or any other vitamin supplements that were on the medication cart without physician's orders for Resident #3.
-She thought the RCC was responsible for cart audits, but she did not know how often.

Interview with a second MA on 02/22/24 at 6:16pm revealed:
-She did not know there were vitamin supplements on the medication cart that were not on the eMAR.
-She did notice CBD gummies on the medication cart, but she did not administer them to Resident #3 because they were not on the eMAR to administer to her.
-She had not talked to anyone about the CBD gummies because they were not on the eMAR to be administered during her shift, but they could have been scheduled to be administered during a different shift.
-She only administered medications and vitamin supplements that were on Resident #3's eMAR.
-She would not know what to do if she found multiple vitamin supplements on the medication cart that were not on the eMAR.
-MAs were responsible for clarifying medications including vitamin supplements.
-She did not know who was responsible for conducting a medication cart audit.

Interview with the SCUC on 02/22/24 at 5:08pm revealed:
-She knew Resident #3 had vitamin supplements on the medication cart, but she assumed all the

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vitamin supplements available for Resident #3 were on her eMAR.
-She did not work with the residents' medications and staff usually went directly to the Health and Wellness Coordinator (HWC) for medication issues.
-MAs had not talked to her about any of Resident #3's vitamin supplements.
-The HWC was not currently available in the facility.

Interview with the RCC on 02/22/24 at 5:39pm revealed:
-She did not know there were medications available for Resident #3 on the medication cart that were not on Resident #3's eMAR.
-MAs had not talked to her about any vitamin supplements.
-The Health and Wellness Director (HWD) was conducting medication cart audits, but there was not currently anyone employed in the HWD position.
-She or the MAs were responsible for clarifying medications/vitamin supplements with Resident #3's primary care provider (PCP).

Interview with the Administrator on 02/22/24 at 6:46pm revealed:
-He did not know there were supplements on the medication cart that were not on Resident #3's eMAR.
-MAs should have contacted Resident #3's PCP to clarify whether Resident #3 should have been administered the vitamin supplements and to obtain orders for the supplements.
-MAs should have let the HWC know about the vitamin supplements.
-When Resident #3's family brought in the vitamin supplements for Resident #3, the MA should not have accepted the vitamin supplements and

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D 344	Continued From page 56 should not have put the supplements on the medication cart before clarifying them with Resident #3's PCP. -The RCC, HWC, or HWD was responsible for conducting medication cart audits monthly. Attempted telephone interview with Resident #3's responsible party on 02/22/24 at 4:19pm was unsuccessful. Attempted telephone interview with Resident #3's PCP on 02/22/24 at 2:37pm was unsuccessful.	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: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #2) who had an order for sliding scale insulin (#2) and an order for a long-acting insulin (#1). The findings are: 1. Review of Resident #2's current FL2 dated 09/26/23 revealed diagnoses included hyperlipidemia, cerebral infarction, anemia, and	D 358		

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thrombocytosis.

Review of Resident #2's physician's order dated 10/10/23 revealed an order for Novolog (a rapid-acting insulin to lower blood sugar spikes at meal time) sliding scale insulin (SSI): if fingerstick blood sugar (FSBS) above 150 give 1 unit, if FSBS above 200 give 2 units, if FSBS above 250 give 3 units, if FSBS above 300 give 4 units, if FSBS above 350 give 5 units, and if FSBS above 400 give 6 units and call the doctor.

Review of Resident #2's physician's order dated 12/10/23 revealed an order to adjust Novolog SSI as follows: if FSBS greater than 200 give 1 unit, if FSBS above 250 give 2 units, if FSBS above 300 give 3 units, if FSBS above 350 give 4 units, if FSBS above 400 give 5 units.

Review of Resident #2's December 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog SSI: for FSBS 150 to 200 give 1 unit, for FSBS 201 to 250 give 2 units, for FSBS 251 to 300 give 3 units, for FSBS 301 to 350 give 4 units, for FSBS 351 to 400 give 5 units, and for FSBS 400 to 450 give 6 units and call the doctor scheduled at 8:00am, 12:00pm and 5:00pm.
-There was documentation Novolog SSI was administered per the sliding scale insulin order dated 10/10/23 from 12/01/23 through 12/31/23 with examples as follows:
-On 12/07/23 at 8:00am, Resident #2's FSBS was 190 and should have received 0 units of SSI but received 1 unit of SSI.
-On 12/12/23 at 12:00pm, Resident #2's FSBS was 206 and should have received 1 unit of SSI but received 2 units of SSI.
-On 12/27/23 at 5:00pm, Resident #2's FSBS

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was 305 and should have received 3 units of SSI but received 4 units of SSI.
-Resident #2's FSBS values for December 2023 ranged from 75 to 351.
-There was no entry on the eMAR for Novolog SSI current order dated 12/10/23 for, if FSBS greater than 200 give 1 unit, if FSBS above 250 give 2 units, if FSBS above 300 give 3 units, if FSBS above 350 give 4 units, if FSBS above 400 give 5 units.

Review of Resident #2's January 2024 eMAR revealed:
-There was an entry for Novolog SSI: for FSBS 150 to 200 give 1 unit, for FSBS 201 to 250 give 2 units, for FSBS 251 to 300 give 3 units, for FSBS 301 to 350 give 4 units, for FSBS 351 to 400 give 5 units, and for FSBS 400 to 450 give 6 units and call the doctor scheduled at 8:00am, 12:00pm and 5:00pm.
-There was documentation Novolog SSI was administered per the for sliding scale insulin order dated 10/10/23 from 01/01/24 through 01/31/24 with examples as follows:
-On 01/01/24 at 8:00am, Resident #2's FSBS was 203 and should have received 1 unit of SSI but received 2 units of SSI.
-On 01/13/24 at 12:00pm, Resident #2's FSBS was 276 and should have received 2 units of SSI but received 3 units of SSI.
-On 01/23/24 at 5:00pm, Resident #2's FSBS was 162 and should have received 0 units of SSI but received 1 unit of SSI.
-Resident #2's FSBS values for January 2024 ranged from 86 to 354.
-There was no entry on the eMAR for Novolog SSI current order dated 12/10/23 for, if FSBS greater than 200 give 1 unit, if FSBS above 250 give 2 units, if FSBS above 300 give 3 units, if FSBS above 350 give 4 units, if FSBS above 400

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give 5 units.

Review of Resident #2's February 2024 eMAR from 02/01/24 through 02/21/24 revealed:
-There was an entry for Novolog SSI: for FSBS 150 to 200 give 1 unit, for FSBS 201 to 250 give 2 units, for FSBS 251 to 300 give 3 units, for FSBS 301 to 350 give 4 units, for FSBS 351 to 400 give 5 units, and for FSBS 400 to 450 give 6 units and call the doctor scheduled at 8:00am, 12:00pm and 5:00pm.
-There was documentation Novolog SSI was administered per the sliding scale order dated 10/10/23 from 02/01/24 through 02/21/24 with examples as follows:
-On 02/01/24 at 8:00am, Resident #2's FSBS was 195 and should have received 0 units of SSI but received 1 unit of SSI.
-On 02/10/24 at 12:00pm, Resident #2's FSBS was 222 and should have received 1 unit of SSI but received 2 units of SSI.
-On 02/19/24 at 5:00pm, Resident #2's FSBS was 249 and should have received 1 unit of SSI but received 2 units of SSI.
-Resident #2's FSBS values for 01/02/24 through 02/21/24 ranged from 144 to 311.
-There was no entry on the eMAR for Novolog SSI current order dated 12/10/23 for, if FSBS greater than 200 give 1 unit, if FSBS above 250 give 2 units, if FSBS above 300 give 3 units, if FSBS above 350 give 4 units, if FSBS above 400 give 5 units.

Observation of medications on hand for Resident #2 on 02/22/24 at 9:42am revealed:
-There was one Novolog insulin pen with a dispensed date of 02/02/24 and an opened-on date of 02/10/24.
-There were 100 units out of 250 total units remaining in the insulin pen.

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D 358	Continued From page 60 Telephone interview with a representative from the facility's contracted pharmacy on 02/22/24 at 11:15am revealed: -Resident #2's current order for Novolog SSI was to give 1 unit for FSBS 200 to 250, for FSBS 251 to 300 give 2 units, for FSBS 301 to 350 give 3 units, for FSBS 351 to 400 give 4 units, and for FSBS greater than 400 give 5 units. -Resident #2 had been on that same SSI order since her sliding scale changed by 1 unit on 12/10/23. -The most recent Novolog SSI order the pharmacy had received for Resident #2 was on 01/26/24 and was electronically sent to the pharmacy from the endocrinologist's office. -The pharmacy entered medication orders into their own computer system and dispensed medication to the facility; the pharmacy did not enter medication orders into the facility's medication administration documentation system. -The facility staff were responsible for entering medication orders on their eMAR. Interview with a medication aide (MA) on 02/22/24 at 4:20pm revealed: -The only SSI order she was familiar with was the order that was on the eMAR. -She administered however many units of Novolog SSI were due to be administered per the order on the eMAR. -When a doctor's office faxed new medication orders to the facility, either a MA or the Resident Care Coordinator (RCC) were responsible to take the order and fax it to the pharmacy and ensure it was entered correctly into the eMAR system. -She did not remember seeing an order to change Resident #2's Novolog SSI order in December 2023.	D 358		

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D 358	Continued From page 61 Interview with the RCC on 02/22/24 at 5:15pm revealed: -New physician orders came to the facility on their fax machine. -During office hours she was responsible for checking the fax machine for new orders, faxing them to the pharmacy and updating the eMAR accordingly. -The MAs were responsible for checking the fax machine for orders and processing the orders if she was not at the facility at the time the order arrived. -If a medication order reflected e-scribe on it, the order had already been sent directly to the pharmacy from the doctor and all she or the MAs had to do was update the eMAR. -She had not noticed Resident #2's Novolog SSI order had been adjusted in December 2023. -She had not audited Resident #2's record for accuracy of medication orders compared to the orders on the eMAR. -She was not aware Resident #2 had been receiving the incorrect SSI dose since December 2023. Interview with a second MA on 02/22/24 at 5:45pm revealed: -She had not processed any new medication orders for Resident #2 from the fax machine in the previous three months. -She was not aware Resident #2's Novolog SSI order had changed in December 2023. -She administered however many units of Novolog SSI the eMAR order showed as being due based on Resident #2's FSBS value. Interview with the Administrator on 02/22/24 at 6:32pm revealed: -When Resident #2's endocrinology office faxed her Novolog SSI order to the facility, either a MA	D 358		

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or the RCC was responsible for faxing the order to the pharmacy.
-The MA or RCC was responsible for entering the new order into the eMAR system.
-He was not aware Resident #2 had been receiving the incorrect Novolog SSI doses since December 2023.
-He expected all new medication orders to be read thoroughly and to be correctly entered onto the eMAR so the MAs knew the correct dose to administer.
-Resident #2 had not had any really high or low FSBS values outside of her normal range and had not had symptoms of high or low blood sugar in the previous three months.

Attempted telephone interview with Resident #2's endocrinologist on 02/22/24 at 10:40am was unsuccessful.

2. Review of Resident #1's current FL2 dated 01/03/24 revealed diagnoses included atrial fibrillation, muscle weakness, cirrhosis of the liver, and osteoporosis.

Review of Resident #1's physician's order dated 01/16/24 revealed an order for Lantus (a long-acting insulin) 5 units every night at bedtime.

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for Lantus insulin inject 5 units at bedtime and scheduled at 8:00pm.
-There was documentation Lantus 5 units was not administered from 02/16/24 through 02/20/24.
-There was no documented reason why Lantus was not administered on 02/16/24.
-The documented reason Lantus was not administered from 02/17/24 through 02/20/24 was "pharmacy action required."

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-Resident #1's fingerstick blood sugar (FSBS) values from 02/02/24 through 02/21/24 ranged from 79 to 282.
-Resident #1's fasting FSBS values the mornings after not receiving Lantus 5 units the evening prior ranged from 116 to 260.

Observation of medications on hand for Resident #1 on 02/22/24 at 9:50am revealed there was one full Lantus insulin pen with a dispensed date of 02/20/24 and an opened-on date of 02/21/24.

Interview with a medication aide (MA) on 02/22/24 at 9:55am revealed:
-When a MA documented that pharmacy action was required it usually meant they were waiting on the pharmacy to send a refill of the medication.
-She worked day shift so she did not know Resident #1 had ran out of Lantus insulin, but Resident #1 had not had any increased FSBS values the morning after not receiving the Lantus at night.

Telephone interview with a representative from the facility's contracted pharmacy on 02/02/24 at 11:15am revealed:
-The pharmacy dispensed one Lantus insulin pen to the facility for Resident #1 on 01/16/24 and each Lantus insulin pen expired 28-days after opening.
-The pharmacy dispensed one Lantus insulin pen to the facility for Resident #1 on 02/19/24 but the facility said they had not received it, so they sent another one on 02/20/24.
-At a dose of 5 units nightly, the Lantus insulin pen would expire before it would run out of insulin.
-Resident #1's Lantus insulin was not on cycle-full because it was a refrigerated medication so the

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facility would have to contact the pharmacy to request each refill.
-The pharmacy had received a refill request for Resident #1's Lantus on 02/19/24 at 11:00am.

Interview with Resident #1 on 02/22/24 at 3:45pm revealed:
-She had missed a couple doses of Lantus insulin that week but she had not realized she missed 5 nights in a row.
-The MAs had told her that her insulin ran out and it needed to be reordered from the pharmacy.
-She did not need to take the Lantus at night as ordered because her FSBS values had been on the low-end of normal for her lately.

Telephone interview with a representative from Resident #1's primary care provider's (PCP) office on 02/02/24 at 3:55pm revealed:
-Resident #1 had an order for Lantus insulin 5 units nightly.
-She was not aware that Resident #5 had missed 5 consecutive nights of taking Lantus.
-Possible adverse effects from not receiving Lantus as ordered included an increase in her FSBS values.
-She thought Resident #5's fasting FSBS values would have been lower if she had received Lantus as ordered.
-She expected the facility's staff to administer Lantus to Resident #1 as ordered or to contact their office if they were not able to administer Lantus to Resident #1.

Interview with a second MA on 02/22/24 at 4:20pm revealed:
-She had documented Resident #1's Lantus as not administered on 02/17/24, 02/18/24, 02/19/24 and 02/20/24, and she had worked the evenings prior to Resident #1's Lantus running out.

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	HAL029006	A. BUILDING: _____ B. WING _____	R 02/22/2024

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D 358	Continued From page 65 -She did not work the night Resident #1's Lantus ran out and she thought it had already been reordered when she came back to work the following evening. -Medications were supposed to be reordered 5 to 7 days before they ran out. -She had not requested a refill of Resident #1's Lantus prior to it running out but she could not remember why. Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 5:15pm revealed: -On Monday, 02/19/24 she became aware that Resident #1 had been out of her Lantus because the night shift MA left her a note saying the Lantus had not arrived from the pharmacy yet. -She called the pharmacy that day on 02/19/24 to request another refill of Lantus for Resident #1 and she was advised by pharmacy staff that they would send one in that night's delivery. -The MAs were expected to request medication refills when the medication was running low, not after it had ran out. -She was not aware of any increased FSBS values for Resident #1 as a result of her missing 5 days of Lantus insulin. Interview with a third MA on 02/22/24 at 5:45pm revealed: -She worked an evening when Resident #1 did not have Lantus insulin available for administration on the medication cart. -She had called the RCC that evening to let her know Resident #1 did not have Lantus and the RCC advised her to check the medication cart again and if it was not there, she would have to document the Lantus as not administered. -The RCC did not ask her to request a refill from the pharmacy but she thought she had clicked on the "reorder" button in the eMAR system.	D 358		

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D 358	Continued From page 66 -Resident #1's Lantus had been on the medication cart and was administered to her yesterday evening, 02/21/24. -The MAs were supposed to request a medication refill from the pharmacy prior to it running out. Interview with the Administrator on 02/22/24 at 6:32pm revealed: -He was not aware Resident #1 had missed 5 consecutive days of Lantus insulin. -The MAs were expected to request medication refills from the pharmacy at least 5 days prior to the medication running out. -If a medication was due on the eMAR but not available on the medication cart, the were responsible for either letting him or the RCC know so they could contact the doctor or pharmacy and ensure the medication was delivered to the facility that same day.	D 358		
D 388	10A NCAC 13F .1007 (c) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (c) Medications, excluding controlled medications, shall be destroyed at the facility or returned to a pharmacy within 90 days of the expiration or discontinuation of medication or following the death of the resident. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure an expired medication was destroyed at the facility or returned to the pharmacy within 90 days of the expiration date for 1 of 5 sampled residents (#4).	D 388		

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D 388	Continued From page 67 The findings are: Review of Resident #4's current FL2 dated 07/11/23 revealed: -Diagnoses included dementia and essential hypertension. -There was an order for Lisinopril 10mg (used to treat hypertension) daily. Review of Resident #4's physician's orders dated 02/13/24 revealed: -There was an order for Lisinopril 10mg daily. -There was an order to fill non-controlled prescriptions within thirty days supply and with twelve refills. Review of Resident #4's December 2023, January 2024, and February from 02/01/24 to 02/22/24 electronic medication administration record (eMAR) revealed there was documentation Lisinopril 10mg was administered daily in December 2023, January 2024 and from 02/01/24 to 02/2/22/24. Observation of Resident #4's medications available for administration on 02/22/24 at 11:50am revealed: -There was a bubble pack of lisinopril 10mg 1 tablet daily dispensed on 01/27/24 with a quantity of 30 tablets and 30 tablets were remaining. -There was a bottle of lisinopril 10mg 1 tablet daily dispensed on 10/06/22 with a quantity of 90 tablets and it could not be determined how many tablets were remaining. -The bottle of lisinopril was to be discarded by 10/06/23. Observation of Resident #4 on 02/21/24 at 12:50pm revealed Resident #4 was seated in her	D 388		

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wheelchair at a table in the dining room in the Special Care Unit (SCU).

Interview with a medication aide (MA) on 02/22/24 at 11:51am revealed:
-Resident #4 had an unused bubble card of lisinopril dispensed to the facility on 01/27/24.
-Resident #4 also had a bottle of lisinopril brought with him to the facility when she was admitted to the facility.
-There was a label on the unused bubble card of lisinopril which instructed staff to use the bottle of lisinopril first.
-She did not realize the bottle of lisinopril was dispensed on 10/06/22 and had an expiration date of 10/06/23.
-She had been administering lisinopril from the medication bottle and she did not know the lisinopril had expired.
-She asked the Resident Care Coordinator (RCC) if she could toss the bottle of lisinopril when the bubble card of lisinopril was dispensed to the facility, but she asked the RCC "in passing" and did not know if the RCC heard her.
-She had not talked to anyone else about using the bubble pack of lisinopril.
-She thought the RCC was responsible for conducting medication cart audits, but she did not know how often.

Interview with another MA on 02/22/24 at 5:30pm revealed:
-She had been aware of the 10/06/23 expiration date on medication bottle for Resident #4's Lisinopril 10mg.
-She told the previous Health and Wellness Director (HWD) about the expired medication, but the previous HWD told her to administer Resident #4's Lisinopril from the expired medication bottle.
(There was not currently a HWD employed at the

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D 388	Continued From page 69 facility.) Interview with the RCC on 02/22/24 at 5:22pm revealed: -The RCC was not aware the MA had administered expired Lisinopril 10mg to Resident #4. -The RCC was not aware the previous HWD had told the MA to use an expired medication bottle of Lisinopril 10mg for Resident #4. -The RCC expected the MAs to follow the facility's medication disposition policies and to either send expired medications back to the dispensing pharmacy or to followed the procedure to destroy expired medications. -The MAs, the RCC, and the HWC were expected to complete medication cart audits weekly and should have noticed the expired Lisinopril for Resident #4. Interview with a representative from facility's contracted pharmacy on 02/22/24 at 2:30pm revealed: -The pharmacy dispensed 30 tablets of Lisinopril 10mg for Resident #4 on 01/27/24 and recently dispensed 30 tablets of Lisinopril 10mg on 02/22/24. -The pharmacy had not dispensed any tablets of Lisinopril 10mg for Resident #4 prior to 01/27/24. Interview with a representative from Resident #4's previous pharmacy on 02/22/24 at 2:45pm revealed: -The pharmacy dispensed 30 tablets of Lisinopril 10mg for Resident #4 on 01/27/24 and recently dispensed 30 tablets of Lisinopril 10mg on 02/22/24. -The pharmacy had previously dispensed 30 tablets of Lisinopril 10mg on 03/03/23 and dispensed 90 tablets of Lisinopril 10mg on	D 388		

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D 388	Continued From page 70 06/30/23. Interview with Resident #4's primary care provider (PCP) on 02/22/24 at 3:30pm revealed: -She was not aware the facility had administered expired Lisinopril 10mg to Resident #4 December 2023, January 2024, and from 02/01/24 to 02/22/24. -Resident #4 had a history of dementia and hypertension. -She had not received a request from the facility staff for assistance with Lisinopril 10mg for Resident #4. -She expected staff to follow up with her for any issues with medications related to Resident #4 including expired medications. -She expected low effective treatment results of hypertension and possible side effects for Resident #4 if the facility failed to stop administering expired Lisinopril 10mg. Interview with the Administrator on 02/22/24 at 6:30pm revealed: -He was not aware the MAs had administered expired Lisinopril 10mg to Resident #4. -He was not aware the previous HWD had told a MA to use an expired medication bottle of Lisinopril 10mg for Resident #4. -He expected the MAs to follow the facility's medication disposition policies and send expired medications back to the pharmacy or to dispose of medications within 90 days of the expiration date. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident #4's guardian on 2/22/24 at 3:20pm was unsuccessful.	D 388		

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D 388	Continued From page 71 The HWC was not available for interview on 02/22/24.	D 388		