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THE ADDISON OF FUQUAY VARINA	6516 JOHNSON POND ROAD FUQUAY VARINA, NC 27526

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, and follow-up survey, and complaint investigation on 03/12/24 - 03/14/24.	D 000		
D 242	10A NCAC 13F .0703 (e) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (e) The facility shall make arrangements for any resident, who has been an inpatient of a psychiatric facility within 12 months before entering the home and who does not have a current plan for psychiatric care, to be examined by a local physician or a physician in a mental health center within 30 days after admission and to have a plan for psychiatric follow-up care when indicated This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there was a plan for psychiatric care within 30 days after admission for 1 of 1 sampled resident (#5) who received more than 30 days inpatient evaluation and treatment for mental health diagnoses immediately prior to admission and was prescribed psychiatric medications after admission to the facility. The findings are: Review of Resident #5's admitting FL-2 dated 02/17/23 revealed diagnoses included major neurocognitive disorder, paranoid psychosis, hypertension, hypothyroidism, cardiomyopathy, obsessive compulsive disorder, myocardial infarction, hypokalemia, hypotension, and chest	D 242		

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pain.

Review of Resident #5's Resident Register dated 02/22/23 revealed the resident was admitted to the facility on 02/28/23 from her home.

Review of Resident #5's hospital discharge summary dated 02/28/23 revealed:
-Resident #5 presented to the hospital on 01/19/23 with paranoid psychosis and underlying obsessive compulsive disorder.
-Resident #5 was involuntarily committed (IVC) which expired on 01/25/23.
-Resident #5 was seen by psychiatrist who recommended a psychiatric hospitalization which was challenging for placement due to the resident's medical conditions.
-There were instructions to follow up with outpatient geriatric psychiatry within 2 weeks.
-Resident #5 was discharged on 02/28/23 to home.

Review of Resident #5's physician's order dated 03/16/23 revealed there was an order to administer olanzapine crushed and dissolved in 20ml of hot water, placed in Resident #5's supper drink and served with her supper meal. (Olanzapine is used to treat psychosis.)

Telephone interview with Resident #5 on 03/14/23 at 11:35am revealed:
-She was not referred to a psychiatrist while she was at the facility (02/28/23 - 05/13/23).
-The primary care provider (PCP) was prescribing olanzapine for her which she did not take except for the three times it was slipped to her without her knowledge.

Telephone interview with Resident #5's PCP on 03/13/24 at 12:07pm revealed:

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-The contracted physician's group did not have a mental health provider (MHP) when Resident #5 was at the facility (02/28/23 - 05/13/23).
-She was not seen by a secondary physician's group with a MHP during that time.
-She set up a psychiatric referral for Resident #5 on 04/11/23.
-Resident #5 canceled the appointment herself and said she was going to see someone else.
-Resident #5 was hospitalized prior to admission at the facility (02/28/23) primarily for cardiac issues, but she did not have good judgement and was not making good medical decisions.
-Resident #5's family member took the resident to the hospital initially for psychiatric reasons.
-The required medical work up found medical issues Resident #5 denied having.
-Resident #5 was not able to be admitted to a psychiatric facility because of her medical issues.
-Resident #5 was admitted to the PCP's service on 03/02/23.
-Resident #5 had issues with judgement, bipolar disorder, and paranoid psychosis.

Second telephone interview with Resident #5 on 03/14/23 at 11:35am revealed:
-Resident #5's mental health showed no improvement while she was at the facility.
-Resident #5 was as paranoid when she was discharged as she was when she was admitted.
-After 03/30/23, several psychiatric appointments were made for Resident #5 which she canceled.
-Resident #5's family member/health care power of attorney (HCPOA) said that he would follow up with rescheduling and getting Resident #5 to a psychiatrist.

Telephone interview with the Memory Care Director (MCD) on 03/14/24 at 5:11pm revealed:
-Resident #5's family member/HCPOA made an

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D 242	Continued From page 3 appointment with a psychiatrist during one of their conversations. -Resident #5 refused everything related to mental health including referrals to psychiatrists and medications. -When Resident #5 did take her antipsychotic medications, she was better. -She did not know which medications Resident #5 took that helped her. Interview with the Administrator on 03/14/24 at 4:00pm revealed she did not know if there were referrals and/or consultations for evaluation by psychiatry and neurology for Resident #5.	D 242		
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 interviews and record reviews, the facility failed to ensure follow up with the primary care provider (PCP) for 1 of 5 sampled residents (#5) who had complaints of gastrointestinal illness, was admitted to the hospital, and diagnosed with norovirus (a highly contagious gastrointestinal virus). The findings are: Review of Resident #5's current FL-2 dated 04/20/23 revealed diagnoses included major neurocognitive disorder with predominantly poor executive function, norovirus, and hypertension. Review of Resident #5's electronic progress	D 273		

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notes dated 04/16/23 revealed:
-At 2:47pm Resident #5 called emergency medical services (EMS) for complaints of diarrhea.
-There was no documentation Resident #5's vital signs were checked or that her primary care provider (PCP) was notified.

Review of Resident #5's hospital discharge summary dated 04/20/23 revealed:
-Resident #5 was admitted to the hospital on 04/16/23 and diagnosed with gastroenteritis (intestinal infection) due to norovirus.
-Resident #5 developed nausea, vomiting, diarrhea, and dizziness after dinner on 04/15/23.
-She was treated with intravenous fluids and antinausea medications and was discharged on 04/20/23.

Telephone interview with Resident #5 on 03/12/24 at 3:42pm revealed:
-She did not consume all meats, only chicken, fish, and eggs.
-One day she had an egg salad sandwich as an alternative to the meal provided and got sick with vomiting and diarrhea.
-She asked the staff to call EMS; staff would not call so she called EMS herself.
-Her blood pressure was low when EMS checked it.

Interviews with a medication aide (MA) on 03/13/23 at 2:11pm and 3:00pm revealed:
-Certain foods would trigger Resident #5 to have diarrhea; she could not remember if the resident had diarrhea or COVID on 04/16/23.
-Resident #5 called EMS herself because she had her own cellular phone.
-She did not remember if Resident #5 told her she was sick and needed to go to the hospital on

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04/16/23.
-She did not remember if she checked Resident #5's vital signs before the resident went to the hospital.
-Resident #5 did not ask staff for anything; she kept up with everything she needed herself.

Interview with Resident #5's primary care provider (PCP) on 03/14/23 at 12:15pm revealed:
-She was not notified Resident #5 was sent to the hospital on 04/16/23 for vomiting, diarrhea, and weakness.
-She was not notified Resident #5 was diagnosed with norovirus until she saw the resident on 04/24/23.
-Staff should have notified her on 04/16/23.
-Norovirus was serious; it was highly contagious and spread rapidly.
-She should have been notified so she could have instructed staff to implement hand washing for everyone and standing orders for a clear liquid diet for any symptomatic resident.

Telephone interview with the Memory Care Director (MCD) on 03/14/24 at 5:11pm revealed:
-Resident #5 had a history of repetitive calls to EMS and law enforcement which was why the family member took her to the hospital in January 2023.
-She did not know if Resident #5 was "for real" related to the resident's complaints about norovirus on 04/16/23.
-If Resident #5 called EMS, the MA on duty should have checked the resident's vital signs, notified the resident's PCP, and documented in the resident's electronic progress notes.
-She thought the MA might not have known that Resident #5 called EMS until they arrived at the facility.

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D 273	Continued From page 6 Interview with the Administrator on 03/14/24 at 4:00pm revealed: -Staff should have talked with Resident #5 when they became aware of the need for a hospital evaluation, checked her vital signs, notified her family member and PCP, and documented everything in the resident's electronic progress notes. -If Resident #5 called EMS, the MA was still responsible to check the resident when EMS arrived and notify the resident's PCP. Attempted telephone interview on 03/13/24 at 10:37am with the former Memory Care Coordinator (MCC) was unsuccessful. Attempted telephone interview on 03/13/24 at 8:36am with the local EMS was unsuccessful.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the rights of a resident related to being free from the abuse of unreasonable confinement on the memory care unit (MCU) after identifying the resident had mild cognitive impairment and recommended placement for the assisted living (Resident #5). The facility failed to permit the resident to receive	D 338		

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mail promptly and unopened and to respond to a reasonable request for the resident's medical records (Resident #5). The facility also failed to respond in a timely manner to call pendants for residents who were observed waiting more than 15 minutes for a response to their call pendants and required assistance with activities of daily living and had a history of falls.

The findings are:

1. Review of the facility's Memory Care Move In/Move Out Policy and Procedure dated 05/01/16 and last revised 01/26/24 revealed:
-The community provided services to individuals with a diagnosis of dementia and may benefit from the specialized services provided in the memory care environment.
-Admitting diagnoses may include (but not limited to): Alzheimer's disease, vascular dementia, Parkinson's dementia, mixed dementia, mild cognitive impairment, or dementia.
-Residents may be discharged from Memory Care and assisted with admission into a suitable environment under the following circumstances: the resident requests assistance with transfer to another living environment.

a. Review of Resident #5's admitting FL-2 dated 02/17/23 revealed:
-Diagnoses included major neurocognitive disorder, paranoid psychosis, hypertension, hypothyroidism, cardiomyopathy, obsessive compulsive disorder, myocardial infarction, hypokalemia, hypotension, and chest pain.
-The recommended level of care was memory care.

Review of Resident #5's Resident Register dated 02/22/23 revealed Resident #5 was admitted to

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the facility on 02/28/23 from "her home."

Review of Resident #5's Health Care Power of Attorney dated 10/08/17 revealed:
-Resident #5 named her family member her health care agent.
-The document was signed by Resident #5, two witnesses and signed and stamped by the notary public.

Review of the "About the Health Care Proxy" form revealed:
-The form explained the extent and limitations of the health care agent.
-The health care agent would start making decisions for Resident #5 when her doctor determined she was not able to make health care decisions for herself.
-Even though Resident #5 signed the form, she had the right to make health care decisions for herself as long as she was able to do so, and treatment could not be given to her or stopped if she objected, nor would her agent have any power to object.
-Resident #5 may cancel the authority given to her agent by telling them or her health care provider orally or in writing.

Telephone interview with Resident #5 on 03/12/24 at 3:42pm revealed:
-Prior to admission to the facility she was hospitalized for 37 days (01/19/23 - 02/28/23) following increased stresses at home that led to illnesses.
-During the hospitalization, her family member obtained involuntary commitment (IVC) orders which also expired during the hospitalization.
-In that time, her family member began acting as her HCPOA to have control over her.
-The hospital stay was extended because her

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family member wanted placement in a facility.
-She experienced physical deconditioning during the hospitalization and required the assistance of a walker for ambulation when she was admitted to the facility.
-She was brought to the facility from the hospital and told she had to stay at the facility.
-She was always lucid, and staff would tell her she was the only coherent resident in the Memory Care Unit (MCU).
-Most of the time staff were kind to her.
-The current Memory Care Director (MCD) refused to accept the signed revocation of HCPOA that she completed with her attorney.

Review of Resident #5's electronic progress notes dated 03/01/23 through 03/06/23 revealed:
-The first note was dated 03/01/23, Resident #5 was still at the hospital awaiting transport.
-On 03/02/23, resident had no incidents or complaints of discomfort.
-On 03/06/23, there was a late entry for 02/28/23, documenting Resident #5 was admitted to the facility, oriented to person, time and place, and able to make her needs known.

Review of Resident #5's FL-2 dated 03/09/23 revealed:
-Diagnoses included obsessive compulsive disorder, major neurocognitive disorder, paranoid delusions, hypertension, cardiomyopathy, myocardial infarction, hypokalemia, and hypotension.
-The recommended level of care was memory care.

Review of Resident #5's Service Plan dated 03/16/23 revealed:
-Resident #5 was oriented to person, time, place and situation.

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D 338	Continued From page 10 -The resident did not have long term memory deficit and is able to make needs known. -She was independent with grooming/hygiene, toileting, eating, dressing, transfers, was not a fall risk and ambulatory with a walker. -Resident #5 had a current or history of occasional difficulty remembering and using information. -Resident #5 had a current or history of occasional disruptive, aggressive, or socially inappropriate behavior. -Resident #5 resisted care at times. -Resident #5 had a current or history of wandering that did not jeopardize safety. -Resident #5 was ambulatory and had a regular diet. -Resident #5 was not able to take medications without assistance and unable to handle financial matters. -The service plan was not signed. Review of Resident #5 primary care provider (PCP) visit note dated 03/23/23 revealed: -Resident #5's diabetes was improved with good environmental controls and the resident taking her medications. -Resident #5 lost 8 more pounds in the last week with improvement in her edema (swelling due to water retention). -Resident #5's psychosis and bipolar disorder was controlled now that she was taking her antipsychotic medications. -Resident #5's "train of thought and actions were much more aligned with an educated person." -Resident #5 was making more educated decisions. -She and Resident #5 discussed that the resident could move out of the MCU and be discharged from the facility in 1-2 weeks if the resident desired.	D 338		

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D 338	Continued From page 11 Further review of Resident #5's electronic progress notes dated 03/24/23 through 03/29/23 revealed: -On 03/24/23, the MCD was advised to complete a screening tool for cognitive impairment and contact the corporate legal representative. -On 03/28/23, the Area Nurse and corporate legal representative advised the facility to complete a cognitive impairment screening tool. -Resident #5 was going to meet with an attorney on 03/29/23 to revoke the HCPOA. -Resident #5 sent the necessary paperwork to the attorney last week (03/21/23). -Resident #5 told the MCD she was signing herself out of the facility after Wednesday (03/29/23). Telephone interview with the Area Nurse on 03/14/24 at 2:49pm revealed: -She was named in the electronic progress note dated 03/28/23 along with a member of the corporate legal team. -She recommended completing the screening tool to evaluate whether Resident #5 was still appropriate for the MCU. -She believed Resident #5 might have been better served on assisted living. -She thought Resident #5's PCP completed the screening tool evaluation for Resident #5. -If the PCP felt Resident #5 needed to stay on the MCU she followed the PCP's orders. -Resident #5 was discharged from the facility by the time she returned to the facility to follow up. Review of Resident #5's Cognitive Impairment Screening Tool dated 03/30/23 revealed: -Resident #5's total score was 23 out of 30. -The scoring key indicated 25-30 was normal, 20-24 was mild cognitive impairment, and 1-19	D 338		

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D 338	Continued From page 12 was dementia. Review of the Alzheimer's Association's website revealed: -The definition of mild cognitive impairment is an early stage of memory loss or other cognitive ability loss in individuals who maintain the ability to independently perform most activities of daily living. With mild cognitive impairment, some individuals revert to normal cognition or remain stable. (https://www.alz.org/alzheimers-dementia/what-is-dementia/related_conditions/mild-cognitive-impairment) -Dementia was defined as symptoms which trigger a decline in thinking severe enough to impair daily life and independent function. (https://www.alz.org/alzheimers-dementia/what-is-dementia) Review of Resident #5's care plan dated 04/13/23 revealed: -Resident #5 was admitted to the facility "from home" and had wandering behaviors. -Resident #5 had major memory loss at times. -Resident #5's family member was her "power of attorney" (POA) and was to be informed of all medical issues and visitors. -Resident #5 was ambulatory and continent. -Resident #5 required assistance with bathing. Review of an email dated 04/06/23 revealed: -Resident #5's family member/HCPOA emailed the resident's PCP reporting Resident #5 told him the PCP would authorize the resident's discharge from the facility. -The PCP emailed the family member/HCPOA that Resident #5 seemed competent with services in place to be independent. -The PCP saw residents living in independent	D 338		

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condos who were more ill in mind and body, than Resident #5 was.

Further review of Resident #5's electronic progress notes dated 04/16/23 through 04/20/23 revealed:
-On 04/16/23, Resident #5 called 911 complaining of diarrhea at 2:47pm.
-On 04/18/23, Resident #5 called the MCD from the hospital and told her a realtor would be picking up her belongings from the facility on 04/19/23.
-The MCD immediately notified the family member/HCPOA.
-On 04/20/23, Resident #5 returned from the hospital and was "set in her room with all her belongings".

Review of Resident #5's re-admission FL-2 dated 04/20/23 revealed:
-Diagnoses included new onset of Norovirus, major neurocognitive disorder with predominantly poor executive function, date of onset was documented as "chronic", and a history of hypertension.
-The recommended level of care was Adult Care Home/Assisted Living.

Review of a letter from Resident #5's attorney dated 04/27/23 revealed there were two copies of the revocation of Resident #5's HCPOA/Health Care Proxy included with the letter.

Review of a handwritten letter from Resident #5 to the Administrator dated 05/02/23 revealed:
-Resident #5 attached a copy of the family member's HCPOA revocation.
-Resident #5 attached an explanatory sheet for a HCPOA provided by her attorney.
-The HCPOA was a limited authority valid only in

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the case of being declared mentally incompetent or having a medical condition such as a coma and unable to render medical decisions.

Review of a handwritten letter from Resident #5 to the Administrator dated 05/03/23 revealed:
-Resident #5 planned to leave the facility on 05/11/23.
-The letter constituted her 14 day notice.

Review of an email dated 05/04/23 revealed:
-The Vice President of Compliance emailed the Administrator, the MCD, and the family member/HCPOA.
-As long as Resident #5 had the ability to make her own decisions, "this" document revoked the POA in place.
-Resident #5 was to make her own decisions.
-The family member had no authority to make decisions or access any information.
-Based on the "letter" the POA referenced was only effective if the resident was declared by a physician to be mentally incompetent or in a situation where she was unable to make decisions.
-If neither occurred, then the POA was never active, and the family member never had any authority.

Interview with a personal care aide (PCA) on 03/14/24 at 2:05pm revealed:
-Resident #5 was ambulatory and toileted herself; she required staff assistance with showers.
-She did not think Resident #5 had dementia and did not need to be on the MCU.
-Resident #5 contacted an attorney and worked hard to get out of the MCU.
-Resident #5 worked every day to find and furnish an apartment before she left.
-Resident #5 did not have wandering or exit

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D 338	Continued From page 15 seeking behaviors. Interviews with a medication aide (MA) on 03/13/24 at 2:11pm and 3:00pm revealed: -Resident #5 was smart; she thought the resident did not need to be on the MCU. -If Resident #5 had dementia, she did not show it. -Resident #5 knew all her medications, she was intelligent, kept staff "on their Ps and Qs." -Resident #5 called EMS herself because she had her own cellular phone that she kept on her person 24/7. -She did not remember if Resident #5 told her she was sick and needed to go to the hospital on 04/16/23. -She did not remember if she checked Resident #5's vital signs before the resident went to the hospital. -Resident #5 did not ask staff for anything; she kept up with everything she needed herself. -Resident #5 told the staff when she came through the doors of the MCU that she would not be there long. -Resident #5 went through her medications one by one and took out any pill she did not want to take. -Resident #5 was nice about not taking medications. -Resident #5 wanted to be treated in a certain way and addressed by her title (doctor). Second telephone interview with Resident #5 on 03/14/23 at 11:35am revealed: -She was immediately vocal to all staff about leaving the MCU. -She told staff that she did not want her family member/HCPOA to make decisions for her. -She contacted an attorney as soon as possible to revoke the HCPOA; she could not remember the exact date.	D 338		

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-She obtained the services of a realtor to find and rent an apartment which she did on or about 04/14/23.
-She was in the process of furnishing the apartment when she was hospitalized (04/16/23 - 04/20/23).
-She wanted to get discharged to a hotel form the hospital on 04/20/23, and then go to her apartment when it was furnished.
-The hospital refused and discharged her back to the facility on 04/20/23, and she was admitted back into the MCU.
-Transfer to the assisted living at the facility was never offered to her.
-Her family member/HCPOA wanted her on the MCU because he was afraid she would elope from the facility.
-She chose 05/11/23 to leave because that was the first date her family member gave that he would take her out of the facility.
-The Administrator had called her family member about her (Resident #5's) lawyer threatening a lawsuit and the Administrator wanted her (Resident #5) out of the facility.
-She gave a copy of the signed revocation of her HCPOA to the MCD.
-The MCD refused to acknowledge the HCPOA revocation.

Telephone interview with Resident #5's family member on 03/13/24 at 11:15am revealed:
-He was Resident #5's HCPOA which was effective only if she was unable to make medical decisions.
-He was not aware of any court or medical authority deciding that Resident #5 was unable to make her own medical decisions.
-Resident #5 was admitted to the MCU at the facility on the advice of psychiatrists at the hospital which he thought was the proper thing to

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do.
-He was not able to make the determination that Resident #5 was unable to make her own decisions.
-Resident #5's behavior was psychotic and paranoid.
-Resident #5 did not have memory loss; the resident was psychotic and angry, not demented.
-Resident #5 was angry with him and angry about being locked up on the MCU.
-Resident #5's PCP said the resident was able to leave the facility.
-He picked her up from the facility and took her to her own apartment (05/13/23).

Telephone interview with Resident #5's PCP on 03/13/24 at 12:07pm revealed:
-Resident #5 did not have dementia.
-Resident #5 was hospitalized prior to admission at the facility (02/28/23) primarily for cardiac issues, but she did not have good judgement and was not making good medical decisions.
-She was refusing medications and medical procedures while at the hospital.
-Residents had the right to refuse medications.
-There was documentation in Resident #5's hospital record that she was not competent.
-The hospital ordered MCU level of care, the facility accepted, and she (PCP) was bound by the orders from the hospital and Resident #5's HCPOA.
-Resident #5's family member took the resident to the hospital initially for psychiatric reasons.
-The required medical work up found medical issues Resident #5 denied having.
-Resident #5 had an enlarged heart and grossly swollen lower extremities.
-Resident #5 was not able to be admitted to a psychiatric ward because of her medical issues.
-Resident #5 was admitted to the PCP's service

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on 03/02/23.
-Resident #5 had issues with judgement, bipolar disorder, and paranoid psychosis.
-She completed a screening tool that was used to identify cognitive impairment.
-Resident #5 scored 23/30 which showed mild cognitive impairment.
-Any question about Resident #5 being admitted to the MCU should be directed to the hospital because they wrote the order for the resident to be on a locked MCU.
-The facility's protocol determined whether a resident should stay on the MCU once it was identified the resident was not severely cognitively impaired.
-Resident #5 stayed on the MCU rather than transfer to assisted living because she needed assistance not provided on assisted living including assistance with ambulation, bathing, proper diet, and food choices.

Second interview with Resident #5's PCP on 03/14/24 at 12:15pm revealed:
-She never saw a copy of Resident #5's HCPOA revocation.
-There was a different administrative team in the facility then (April/May 2023).
-Resident #5 lost weight from fluid overload because she encouraged a low salt diet.
-Resident #5's blood work showed improved blood sugar control because snacks she bought, and snacks brought to her by her family member were discouraged.
-She did not order the psychiatric medications for Resident #5.
-A mental health provider (MHP) must have seen Resident #5 and wrote orders for olanzapine (an antipsychotic) and valproic acid (a medication used to treat mood disorders and/or seizures) if those medications were not on the resident's

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admitting FL-2.
-The MCD, Resident Care Coordinator (RCC) and Administrator had a discussion with Resident #5 around the middle of March 2023.
-Resident #5's mental health showed no improvement while she was at the facility.
-Resident #5 was as paranoid when she was discharged as she was when she was admitted.
-She documented Resident #5 ready for discharge in her 03/23/23 visit note because the resident was appropriate at that time.
-Resident #5 was appropriate at that time because she was taking her medications without knowing it.
-She would have discharged Resident #5 on 03/23/23 but the resident did not ask to leave on that day, the resident only talked about her "luxury" apartment.
-Resident #5 was focused on making decisions to leave the facility in 1-2 weeks (from 03/23/23).
-Resident #5 wanted to leave the facility from the day she was admitted; most residents admitted to a MCU want to leave.
-Resident #5 was not discharged because she got worse with psychosis and paranoia which happened frequently when antipsychotic medications were not taken as prescribed.
-She thought that Resident #5 might not have taken the prescribed antipsychotic medications due to illness between 03/23/23 and 05/13/23.
-She did not remember if she discussed Resident #5 being discharged with the MCD, Memory Care Coordinator (MCC) and Administrator between 03/23/23 and 05/13/23.
-She did not know the facility's move out process.
-The MCD, Memory Care Coordinator (MCC), or Administrator did not come to her to discuss discharging Resident #5 from the facility between 03/23/23 and 05/13/23.
-She discussed the possibility of discharging

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Resident #5 with the resident's family member/HCPOA.
-She did not discuss the possibility of moving to assisted living with the MCC, MCD, Administrator or family member.

Telephone interview with the Memory Care Director (MCD) on 03/14/24 at 5:11pm revealed:
-Resident #5 was admitted to the MCU because the resident was out of compliance with "a lot".
-The hospital would not release Resident #5 to the public until the resident got her healthcare in order.
-Resident #5 was appropriate for the MCU "because she had more bad days than good days".
-Good days meant ordering from online marketplaces.
-One minute Resident #5 was talking about being the psychiatrist for the MCU and the next minute the resident refused to take a shower and refused to take medications.
-On the surface it did not look like Resident #5 belonged on the MCU, but when she talked the need for the MCU was heard.
-Resident #5 refused everything related to mental health including referrals to psychiatrists and medications.
-When Resident #5 did take her antipsychotic medications, she was better.
-She did not know which medications Resident #5 took that helped her.
-The revocation of Resident #5's HCPOA did not happen.
-She never saw a copy of Resident #5's HCPOA revocation.
-She was discharged from the facility because her family member/HCPOA came to the facility and got her.
-The PCP's visit note dated 03/23/23 was

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between Resident #5 and her PCP and not discussed with her (MCD).

Telephone interview with Resident #5's attorney on 03/14/24 at 9:15am revealed:
-As soon as Resident #5 was able to say, "I don't want him as my HCPOA," the family member should no longer have been acting as Resident #5's HCPOA.
-In order for Resident #5's HCPOA to have assumed decision making, Resident #5 would have to have been declared incompetent.
-Incompetency required going before a judge, having a guardian assigned and local law enforcement to serve the paperwork which was not done for Resident #5.
-Resident #5 spoke in the same manner currently as she did in March through May 2023.
-Resident #5 was in her right mind the whole time and was incredibly well spoken.
-He had never seen someone treated so poorly.
-Staff took personal items out of Resident #5's room, a male MA told the resident he would not administer her regular medications unless she took the antipsychotic medications, staff ignored Resident #5 and listened to her family member/HCPOA.
-The facility basically held Resident #5 hostage.
-Staff at the facility initially told him not to call back and to leave that situation alone.
-Resident #5 signed the HCPOA revocation on 05/01/23 while at the facility.

Interview with the Administrator on 03/14/24 at 4:00pm revealed:
-It was the hospital physician that wrote the order for Resident #5 to be placed on a MCU.
-She talked with Resident #5 several times on the MCU.
-Resident #5 did not call her by name and might

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not have remembered that they had spoken.
-Resident #5 said she wanted to get out of the MCU.
-Resident #5 was not the same person when she was admitted to the facility as the person who wrote all the emails to her (Administrator).
-She believed Resident #5 needed to be on the MCU because on one day she could be present and the next day she was mentally "way over there".
-Resident #5's family member brought a copy of the HCPOA to the facility which was honored.
-Facility staff helped Resident #5 get better and then the resident was able to leave the facility.
-If Resident #5 had the sense to get the HCPOA revoked, that attorney should have ensured Resident #5 was not at the facility for 2 more months.
-If Resident #5 improved by 03/23/23 when the PCP wrote the visit note that was a "kudos" to a good community that helped her improve.
-She did not know about the PCP's visit note dated 03/23/23.
-The PCP should have come to her and discussed Resident #5 being ready for discharge within 1-2 weeks of 03/23/23.
-She and the MCD discussed moving Resident #5 to assisted living, but it was Resident #5's PCP who was responsible for making that decision.
-Resident #5's PCP would have had to sign an order to change the resident's level of care.
-She also did not want to go against the directives of Resident #5's HCPOA.
-Resident #5 was not discharged from the facility between 03/30/23 and 05/13/23 because the corporate legal team stopped the discharge.
-Resident #5 needed to be on a MCU because she was having bad days (behaviors and paranoia) and not following dietary orders.

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-She did not know where the behaviors were documented.
-She provided all the documentation on Resident #5 that was in the facility.
-The record had been copied many times and perhaps some documentation was lost or misplaced.

Review of Resident #5's Resident Register dated 02/22/23 revealed:
-Resident #5 was discharged from the facility to her own residence on 05/13/23.
-The discharge notice was signed by Resident #5's family member as her health care power of attorney (HCPOA).

Attempted telephone interview on 03/13/24 at 10:37am with the former Memory Care Coordinator (MCC) was unsuccessful.

b. Review of Resident #5's admitting FL-2 dated 02/17/23 revealed there were no special nutritional needs ordered.

Review of Resident #5's Physician Plan of Care dated 02/27/23 revealed an order for a regular diet.

Review of Resident #5's FL-2 dated 03/09/23 revealed there was an order for a regular diet.

Review of Resident #5's diet communication dated 04/03/23 revealed an order for a regular diet.

Review of Resident #5's re-admission FL-2 dated 04/20/23 revealed there were no special nutritional needs ordered.

Review of Resident #5's electronic progress

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D 338	Continued From page 24 notes dated 03/23/23 through 03/24/23 revealed: -On 03/23/23, there was a late entry for 03/21/23 documenting two packages were given to Resident #5 with the permission of her family member/health care power of attorney (HCPOA). -There were 3 bags of sea salted chips, wipes, hand soap, vitamins, and tic-tac candy in the package. -The Memory Care Director (MCD) explained to Resident #5 the vitamins and salted chips were not permitted and the toiletries needed to be locked up. -Resident #5 received a large package that contained chips, medications, disinfectant spray, soap, and lotion. Resident #5 said she would donate the chips and candy, but the MCD required permission from the resident's family member/HCPOA. -Another package arrived on 03/24/23. -The family member/HCPOA instructed the MCD to open the package, removed any prohibited items, and donate those items to the community. -The MCD locked up the items for the family member/HCPOA to pick up. Further review of Resident #5's electronic progress notes dated 03/23/23 revealed: -On 03/23/23, Resident #5 hired a private caregiver to run errands and assist with activities of daily living (ADLs) daily. -The caregiver came to the Memory Care Unit (MCU) with several grocery bags that contained "major items against her medical guidelines" including chips, creams, medications, high sodium packaged meats, cheeses, and wipes. -All items were removed from Resident #5's room. -The MCD contacted the home health agency and told them to reconsider errands and transportation services for Resident #5.	D 338		

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-Resident #5 told the MCD that she did not want to see her family member/HCPOA or have him visit without a third-party present.

Telephone interview with Resident #5 on 03/12/24 at 3:42pm revealed:
-Most of the time staff were kind to her.
-There were a few staff she worked hard to win over.
-There was a first shift medication aide (MA) that walked with a limp and a male MA (named) that worked in the evening who were especially hurtful.
-There were a few staff who were verbally abusive when she did not comply with taking medications or restrictions on food and other items she ordered.
-She used her electronic device to order food, toiletries, towels, and wash clothes which were otherwise rationed out to her by staff.
-Staff confiscated what she ordered and said she could not have food and toiletries in her room.

Interviews with a MA on 03/13/23 at 2:11pm and 3:00pm revealed:
-Resident #5 would order anything she wanted from online markets.
-The MCD told Resident #5 she could not have the items she ordered from online markets in her room on the MCU.
-Resident #5 had swelling in her lower extremities so the MCD did not want the resident to have foods with a lot of salt.
-Certain foods would trigger Resident #5 to have diarrhea; she could not remember if the resident had diarrhea or COVID on 04/16/23.

Telephone interview with Resident #5's PCP on 03/13/24 at 12:07pm revealed:
-Resident #5 had her own cellular phone and was

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ordering "stuff" online which she thought was inappropriate.
-Resident #5 had congestive heart failure and diabetes mellitus and it was inappropriate for the resident to order potato chips.
-Resident #5 ordered food, cleaning supplies and over the counter medications electronically that were delivered to her at the facility.
-The items Resident #5 were not allowed on a MCU and not in line with Resident #5's health.

Second interview with Resident #5's PCP on 03/14/24 at 12:15pm revealed:
-Resident #5 lost weight from fluid overload because she encouraged a low salt diet.
-Resident #5's blood work showed improved blood sugar control because snacks she bought, and snacks brought to her by her family member were discouraged.
-Staff did not restrict her diet.
-She was not able to keep certain things in her room because she was on the MCU.
-She thought they found over the counter medications among other items in Resident #5's room on the MCU.
-Resident #5 had also hired a personal attendant through an agency to shop for and deliver to her.
-Having someone shop for and deliver items to her on the MCU was not permissible because it put other residents at risk on the MCU.
-The staff had to search her room frequently.

Telephone interview with Resident #5's family member on 03/13/24 at 11:15am revealed:
-He did not know why staff at the facility took packages that Resident #5 had ordered and delivered to the facility.
-He did not know of any dietary restrictions.

Interview with a personal care aide (PCA) on

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D 338	Continued From page 27 03/14/24 at 2:05pm revealed: -All Resident #5's packages went to the MCD. -The MCD said there were certain foods Resident #5 could not have. -Resident #5 knew she was not supposed to have things with a lot of salt like potato chips. -Resident #5 ordered shoes, lotion, soaps, and things like that. -Resident #5's packages went to the MCD because she was checking for things Resident #5 could not have. Interview with a medication aide (MA) on 03/13/23 at 3:00pm revealed: -Resident #5 was given all her mail and packages. -Resident #5 opened her own packages and mail in front of staff. -It was a violation of her rights for staff to open her mail and packages. Second telephone interview with Resident #5 on 03/14/23 at 11:35am revealed: -Some of the packages she ordered from online marketplaces disappeared at the front the facility. -Some of the things she had in her room disappeared. -She found things she had ordered like disinfectant cleaning wipes at the front desk for "institutional" use. -The packages she did get were already opened by staff. -The staff removed food, soap, body wash, and lotion; she did not have access to items removed by staff. -She had to go and ask staff for everything and was not always allowed to have what she was asking for such as food she bought. Telephone interview with Resident #5's attorney	D 338		

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on 03/14/24 at 9:15am revealed:
-Staff at the facility took Resident #5's mail and did not give it to her.
-He tried 3-4 times to get mail to Resident #5 at the facility that never reached her.

Interview with the Administrator on 03/14/24 at 4:00pm revealed:
-Resident #5 made a dangerous situation on the MCU with all the online ordering she was doing.
-Resident #5 was given all packages and mail that came to the facility for her.
-Staff had to go in and check her room frequently.
-Staff found over-the-counter medications amongst other things in her room.
-Other residents could have wandered into her room and had access to those things which was dangerous on a MCU.

c. Review of letter dated 10/04/23 revealed Resident #5 requested copies of her medical record from the facility.

Review of a Request to Access Health Records form dated 10/08/23 revealed Resident #5 completed the form requesting an electronic copy of all records related to her care including care notes, primary care provider (PCP) visit notes, pharmacy records, medication orders and administration records, and the Administrator's emails.

Review of an email from Resident #5 to the Administrator dated 11/22/23 revealed the resident had not received the requested records related to medicationorders and administration.

Review of an email from Resident #5 to the Administrator dated 12/03/23 revealed:
-Resident #5 requested all medical records

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related to her care at the facility be sent to her.
-Records including documentation by the Memory Care Director (MCD) and Administrator and an accounting of all medications prescribed and administered.

Telephone interview with Resident #5 on 03/14/23 at 11:35am revealed:
-She did not remember the date she first requested all records related to stay at the facility.
-Initially the facility refused her request because her family member was the health care power of attorney (HCPOA).
-She had to get the family member/HCPOA to send a written directive to release her records from the facility to her.
-She never received all her records.
-The records she finally received sometime during the fall 2023, did not include her medication administration records, care notes or physician's orders.

Interview with the Administrator on 03/14/24 at 4:00pm revealed:
-She sent Resident #5 her records from the facility.
-She would have to find the email, but there was an email documenting the records were sent.
-She was not sure when the records were sent to Resident #5.
-She sent what the corporate attorneys gave permission to send.
-There were documents that were considered internal that were not sent.

2. Interview with a resident on 03/12/24 at 9:15am revealed:
-The facility staff did not answer call pendants consistently.
-She had waited up to an hour for assistance

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after pressing her call pendant.
-Some staff members did a good job of answering the call pendant in a timely manner.

Interview with a second resident on 03/12/24 at 9:35am revealed:
-She pressed her call pendant for assistance and nobody came.
-She had waited over an hour for assistance after pressing her call pendant.
-She was scared that if she had an emergency and needed help, staff would not come in time to assist her.

Interview with a third resident on 03/12/24 at 10:00am revealed:
-She had to wait for a long time when she pressed her pendant button for assistance.
-She had to wait longer on the weekends for assistance when pressing her call pendant.

Observations on the B hall on 03/12/24 from 3:26pm to 3:41pm revealed:
-At 3:36pm, the surveyor asked a resident to push her call pendant.
-The call pendant began to blink red when the resident pressed it.
-At 3:41pm, no staff came to assist the resident.
-The Resident reported that a staff came at 4:07pm to assist her.

Observations on the D hall on 03/12/24 from 3:44pm to 3:59pm revealed:
-At 3:44pm, the surveyor asked a resident to push her call pendant.
-The call pendant began to blink red when the resident pressed it.
-At 3:59pm, no staff came to assist the resident.
-Staff were observed at the front desk at 4:00pm.

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D 338	Continued From page 31 Interview with the personal care aide (PCA) on 03/12/24 at 4:05pm revealed: -When a resident pressed the call pendant, a notification was received at the front desk monitor. -All of the PCAs were responsible to check the monitor to see if any residents needed assistance. -When the PCAs went on break they let the supervisor know so they could watch the monitor for resident call pendant. Interview with the Resident Care Coordinator (RCC) on 03/12/24 at 4:15am revealed: -When a resident pressed the call pendant, a notification was received at the front desk monitor. -It was the responsibility of all care staff to check the monitor for notifications of call pendants. -She expected staff to respond to a call pendant within five minutes. -A resident waiting over 15 minutes was unacceptable. -She did not know why the staff did not assist the residents sooner. Interview with the Administrator on 03/12/24 at 4:22pm revealed: -When a resident pressed the call pendant, a notification was received at the front desk monitor. -It was the responsibility of all care staff to check the monitor for notifications of call pendants. -She expected staff to respond to a call pendant within three to five minutes. -A resident waiting over 15 minutes. was unacceptable. -She did not know why the staff members did not assist the residents within five minutes.	D 338		

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D 338	Continued From page 32 The facility failed to ensure Resident #5 was free from unreasonable confinement after identifying through standard cognitive screening tools the resident had mild cognitive impairment, was assessed at the hospital as needing assisted living placement and observed the resident take action to meet her own legal, financial and housing needs by obtaining an attorney and realtor. The facility's failure resulted in violations to Resident #5's rights to leave the Memory Care Unit (MCU), maintain individual dietary preferences, have personal belongings and experience mental and emotional anguish related to being cognitively aware of confinement in the MCU, which resulted in serious , mental and emotional abuse and neglect constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/14/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 13, 2024.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure that medications were administered as ordered for 2 of 5 sampled residents (#4, #5) related to medications used to treat psychiatric disorders (#4, #5) , a medication used to treat osteoporosis (#5) , a medication used to treat hypothyroidism (#5) , a medication used to treat mood disorders (#5) , and a medication used to treat fluid retention (#5).

The findings are:

1. Review of Resident #4's current FL2 dated 12/07/23 revealed:
-Diagnoses included dementia with behaviors, major depressive disorder, hyperlipidemia, and obstructive sleep apnea.
-There was an order for Seroquel 25mg, three tablets (75mg) by mouth every evening (Seroquel is a medication used to treat psychiatric disorders).

Review of Resident #4's physician order form dated 01/30/24 revealed:
-There was an order to discontinue Seroquel 75mg by mouth every evening.
-There was an order to begin Risperdal 0.5mg 1 tablet by mouth twice daily (Risperdal is a medication used to treat psychiatric disorders.

Review of Resident #4's January 2024 electronic medication record (eMAR) revealed:
-Seroquel 75mg was documented as "-" on 01/30/24 at 8:00pm.
-Seroquel 75mg was documented as administered on 01/31/24 at 8:00pm.
-There was no entry for Risperdal 0.5mg..

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D 358	Continued From page 34 Review of Resident #4's February 2024 eMAR revealed: -Seroquel 75mg was documented as administered at 8:00pm from 02/01/24 to 02/29/24 except for 02/22/24. -Risperdal 0.5mg was documented as administered at 8:00am and 8:00pm from 02/01/24 to 02/29/24 except for the 8:00pm dose on 02/22/24 and the 8:00am dose on 02/25/24. Review of Resident #4's March 2024 eMAR revealed: -Seroquel 75mg was documented as administered at 8:00pm from 03/01/24 to 03/11/24 except for 03/09/24 and 03/11/24. -Risperdal 0.5mg was documented as administered at 8:00am and 8:00pm from 03/01/24 to 03/12/24 except for the 8:00am and 8:00pm doses on 03/09/24 and the 8:00pm dose on 03/11/24. Observation of Resident #4 on 03/12/24 at 2:49am revealed that Resident #4 was awake and sitting in a common area with other residents. Observation of Resident #4's medications on hand on 03/12/24 at 2:51pm revealed: -There was a unit dose card of Seroquel 25mg dated 12/24/23 with three tablets (75mg) in each bubble with 20 doses remaining and 90 tablets were dispensed on 12/24/23. -There was a unit dose card of Risperdal 0.5mg dated 02/22/24 with 19 doses remaining and 60 tablets were dispensed on 02/22/24. Interview with a medication aide (MA) on 03/12/24 at 2:40pm revealed: -The residents' primary care provider (PCP) or mental health provider (MHP) sent all new medication orders to the pharmacy.	D 358		

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D 358	Continued From page 35 -The pharmacy entered new medication orders on the eMARs. -She administered medications according to the medication orders listed on the residents' eMARs. Interview with the Memory Care Coordinator (MCC) on 03/12/24 at 2:55pm revealed: -When a residents' PCP or MHP wrote a new medication order, the providers communicated those medication orders to the facility staff and electronically mailed (e-mailed) them to the Memory Care Director (MCD), Resident Care Coordinator (RCC) and pharmacy. -The pharmacy entered new orders and the orders would then be visible on the eMAR system. -She was unsure why Resident #4 was taking both Risperdal and Seroquel if Seroquel had been discontinued. Interview with the RCC on 03/12/24 at 3:05pm revealed: -The residents' PCP and MHP e-mailed the RCC, MCD, and the pharmacy all new medication orders after each visit to the facility. -The facility's contracted pharmacy entered all new orders into the eMAR system. -A nurse from the facility's contracted pharmacy visited the facility quarterly to audit the eMARS and medication carts for accuracy. -She was unsure why the order for Seroquel for Resident #4 was not discontinued. -Resident #4 should not be receiving both Seroquel and Risperdal if Seroquel had been discontinued. Interview with the Administrator on 03/12/24 at 3:18pm revealed: -The MHP emailed new orders to the RCC, MCD, and to the facility's contracted pharmacy.	D 358		

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D 358	Continued From page 36 -The contracted pharmacy entered all the medication orders into the residents' eMARs. -The area registered nurse (RN) usually performed audits on eMARs and charts once a week. -If Resident #4's Seroquel was discontinued, the medication should have been stopped. Interview with the area RN on 03/12/24 at 3:54pm revealed: -The facility's contracted pharmacy received the order to discontinue Resident #4's Seroquel on 01/30/24. -It appeared that Resident #4 had been receiving Risperdal 0.5mg twice daily and Seroquel 75mg every evening. -Resident #4 should not have received Seroquel after it was discontinued by the MHP on 01/30/24. -There was a technical issue that caused the Seroquel to not be discontinued on the eMAR. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/12/24 at 3:34pm revealed: -The pharmacy received the order to discontinue Resident #4's Seroquel and begin Risperdal on 01/30/24 at 8:48pm from Resident #4's mental health provider. -The pharmacy processed the order to discontinue Seroquel and begin Risperdal on 01/31/24. -The pharmacy filled the new order for Risperdal 0.5mg and sent the medication to the facility on 01/31/24. -The pharmacy entered new orders into their system, which should carry over the facility's eMAR system. -Resident #4 could have side effects such as sedation or increased confusion from receiving Risperdal and Seroquel at the same time.	D 358		

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D 358	Continued From page 37 Telephone interview with Resident #4's MHP on 03/12/24 at 4:45pm revealed: -She discontinued Resident #4's Seroquel and wrote a new order for Risperdal 0.5mg twice daily on 01/30/24. -She was not aware that both Seroquel and Risperdal were still on Resident #4's eMAR. -Resident #4 should not be taking Seroquel and Risperdal both, only Risperdal 0.5mg. -She last saw Resident #4 on 02/27/24 at the facility and observed her sitting in a common area with other residents. -Resident #4 was awake and did not appear sedated on 02/27/24 but seemed to have a "flat affect" and complained of feeling tired. -Resident #4 was at risk for potential side effects that included increased drowsiness and sedation and increased risk of stroke or other cardiovascular conditions by taking both medications. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. 2. Review of Resident #5's current FL-2 dated 04/20/23 revealed diagnoses included major neurocognitive disorder with predominantly poor executive function, norovirus, and hypertension. a. Review of Resident #5's primary care provider (PCP) orders dated 03/02/23 revealed there was an order for olanzapine 5mg daily bedtime. (Olanzapine is used to treat psychosis.) Review of Resident #5's PCP orders dated 03/09/23 revealed there was an order to change the administration time of olanzapine 5mg from 8:00pm to supper time and to put the olanzapine	D 358		

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D 358	Continued From page 38 in a liquid served with dinner. Review of Resident #5's FL-2 dated 04/20/23 revealed olanzapine 5mg daily bedtime was not listed on the medication list. Review of Resident #5's pharmacy dispensing records dated 10/16/23 revealed the pharmacy dispensed 27 olanzapine 5mg tablets on 03/03/23, and 30 olanzapine 5mg tablets on 03/27/23 and 04/26/23. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for olanzapine 5mg daily at bedtime scheduled for 8:00pm with a start date of 03/04/23. -There was documentation olanzapine 5mg was administered on 03/04/23, 03/05/23, refused 03/06/23 through 03/12/23, and administered on 03/13/23. -There was a second entry for olanzapine 5mg daily at bedtime, crush and dissolve in 20ml hot water and put in tea/supper drink scheduled at 5:00pm. -There was documentation olanzapine 5mg crushed was refused on 03/14/23 through 03/18/23, administered at 5:00pm on 03/19/23, refused 03/20/23 through 03/22/23, administered at 5:00pm on 03/23/23, refused 03/24/23 through 03/26/23, administered at 5:00pm on 03/27/23, and refused 0328/23 through 03/31/23. -There was a third entry for olanzapine 5mg daily at bedtime scheduled at 8:00pm. -There was administration documentation 03/17/23 through 03/31/23 including documentation olanzapine 5mg was administered at 8:00pm on 03/19/23, 03/23/23 and 03/27/23.	D 358		

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Review of Resident #5's April 2023 eMAR revealed:
-There was an entry for olanzapine 5mg daily at bedtime scheduled for 5:00pm.
-There was documentation olanzapine was refused 04/01/23 through 04/04/23.
-There were no entries for olanzapine 5mg at 5:00pm from 04/05/23 through 04/30/23.
-There was a second entry for olanzapine 5mg daily at bedtime scheduled for 8:00pm.
-There was documentation olanzapine was refused 04/01/23 through 04/04/23.
-There were no entries for olanzapine 5mg at 5:00pm from 04/05/23 through 04/30/23.
-There was a third entry for olanzapine 5mg daily at bedtime scheduled for 8:00pm with a start date of 04/21/23.
-There was documentation olanzapine was administered at 8:00pm on 04/21/23 through 04/23/23, refused on 04/24/23, and administered at 8:00pm on 04/25/23 through 04/30/23.

Review of Resident #5's May 2023 eMAR revealed:
-There was an entry for olanzapine 5mg at bedtime scheduled for 8:00pm.
-There was administration documentation for 05/01/23 through 05/12/23.
-There was documentation 6 of 12 doses of olanzapine were administered at 8:00pm.
-There was documentation 6 of 12 doses of olanzapine were refused.

Interview with a medication aide (MA) on 03/14/24 at 3:27pm revealed:
-His initials were documented on Resident #5's 03/23/23 eMAR at 5:00pm.
-He remembered that the administration time for olanzapine changed from 8:00pm to 5:00pm.
-He did not think Resident #5 received 2 doses of

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olanzapine because the MA would have seen that it was already administered on the eMAR.
-He was not sure if it was documentation error because that was hard to know, and it happened a long time ago.
-If he documented olanzapine was administered it must have been crushed and mixed in Resident #5's food or beverage because she would not have taken it.
-He did not know why there was no documentation for olanzapine administration from 04/05/23 through 04/15/23.

Interview with Resident #5's PCP on 03/14/24 at 12:15pm revealed:
-She did not know of an order to hold, change, or discontinue olanzapine 04/05/23 through 04/15/23.
-Olanzapine was used to treat paranoia and psychosis and if it was not given that could cause increased symptoms.
-Resident #5 was always paranoid so it was difficult to determine if there was an increase in symptoms.

Telephone interview with the Memory Care Director (MCD) on 03/14/23 at 5:11pm revealed:
-When nothing was documented on the eMAR it meant there was a new order entry that was not started yet.
-She would have to look at the entries for olanzapine in April 2023 for Resident #5 to identify what happened.
-She could not tell exactly what was going on with Resident #5's March 2023 eMAR entries for olanzapine.
-It looked like Resident #5 refused just about all doses of olanzapine in March 2023.
-She did not know why it was documented as administered on 03/19/23, 03/25/23 and

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D 358	Continued From page 41 03/27/23. Upon request on 03/12/24, 03/13/24, and 03/14/24, Resident #5's physician's order to continue olanzapine 5mg daily at bedtime after 04/20/23 was not provided for review. b. Review of Resident #5's admitting FL-2 dated 02/17/23 revealed there was an order for risedronate 150mg every 30 days. (Risedronate is used to treat osteoporosis.) Review of Resident #5's FL-2 dated 03/09/23 revealed there was an order for risedronate 150mg every month. Review of Resident #5's pharmacy dispensing record dated 10/16/23 revealed the pharmacy dispensed 1 risedronate 150mg tablet on 03/02/23, 03/24/23, and 04/28/23. Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for risedronate 150mg every month at 6:30am with a start date of 03/15/23. -There was documentation risedronate was administered on 03/15/23 at 6:30am. -There was a second entry for risedronate 150mg every month at 8:00am with a start date of 03/21/23. -There were no doses of risedronate documented as administered at 8:00am (unspecified start date). -There was a third entry for risedronate 150mg every month at 6:30am. -There was documentation risedronate was administered on 03/25/23 and 03/27/23. Review of Resident #5's FL-2 dated 04/20/23	D 358		

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revealed:
-The was a note to refer to the hospital discharge for medication orders.
-The list of medications to continue, stop and start taking was not included for review.
-There was a list of medications with start and end dates (not all listed had a start date).
-Risedronate was not listed on the medication list.

Review of Resident #5's April 2023 eMAR revealed:
-There was an entry for risedronate 150mg every month scheduled at 6:30am.
-There was documentation risedronate was administered on 04/04/23, 04/07/23, and 04/09/23.

Interview with a medication aide (MA) on 03/14/24 at 3:27pm revealed the pharmacy did not put which day of the month to administer risedronate; the staff approving the order usually picked the day.

Interview with Resident #5's primary care provider (PCP) on 03/14/24 at 12:15pm revealed:
-Risedronate was used to treat osteoporosis and should have been administered once a month.
-There were possible adverse effects with any medication; she did not have additional concern if risedronate was administered to Resident #5 twice in March 2023.

Telephone interview with the Memory Care Director (MCD) on 03/14/23 at 5:11pm revealed:
-Risedronate was entered wrong on the electronic medication system.
-The MA should have documented "DNG" for do not give.
-The risedronate could not have been administered 3 times in March 2023 to Resident

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#5 because the pharmacy would not have sent the medication 3 times that month.
-Even if the risedronate was dispensed twice in March 2023 for Resident #5, she knew it was not given.
-The risedronate was scheduled for 6:30am and Resident #5 would not let anyone in her room at 6:30am.

c. Review of Resident #5's primary care provider (PCP) orders dated 03/02/23 revealed there was an order for valproic acid 250mg/5ml give 5ml twice daily. (Valproic acid is used to stabilize moods and behaviors.)

Review of Resident #5's PCP orders dated 03/09/23 revealed there was an order to change the administration time of valproic acid pm dose from 8:00pm to supper time and to put the valproic acid in a liquid served with dinner.

Review of Resident #5's pharmacy dispensing record dated 10/16/23 revealed the pharmacy dispensed 300ml of valproic acid 250mg/5ml on 03/03/23.

Review of Resident #5's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for valproic acid 250mg/5ml give 5ml twice daily at 8:00am and 8:00pm with a start date of 03/04/23.
-There was documentation valproic acid was administered daily at 8:00am from 03/04/23 through 03/31/23.
-There was documentation valproic acid was administered at 8:00pm on 03/04/23 and 03/05/23, refused at 8:00pm on 03/06/23 through 03/16/23, administered at 8:00pm on 03/17/23, refused at 8:00pm on 03/18/23 - 03/20/23,

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administered at 8:00pm on 03/21/23 through 03/24/23, refused at 8:00pm on 03/25/23, no entry at 8:00pm on 03/26/23, administered at 8:00pm on 03/27/23, not given at 8:00pm 03/28/23, and administered at 8:00pm on 03/29/23 through 03/31/23.

Review of Resident #5's FL-2 dated 04/20/23 revealed valproic acid 250mg/5ml give 5ml twice daily was not listed on the medication list.

Review of Resident #5's April 2023 eMAR revealed:
-There was an entry for valproic acid 250mg/5ml give 5ml twice daily scheduled at 8:00am and 8:00pm.
-There was administration documentation for 04/01/23 through 04/15/23 and documentation valproic acid was discontinued on 04/15/23.
-There was documentation 6 of 15 valproic acid 8:00am doses were administered and 9 refused.
-There was documentation 4 of 14 valproic acid 8:00am doses were administered and 10 refused.

Review of Resident #5's May 2023 eMAR revealed there was no entry for valproic acid.

Interview with Resident #5's primary care provider (PCP) on 03/14/24 at 12:15pm revealed:
-Valproic acid was prescribed for Resident #5 to treat behaviors.
-She thought staff documented administering valproic acid at 5:00pm and 8:00pm in error.
-She did not think Resident #5 received two doses of valproic acid on those dates.

Upon request on 03/12/24, 03/13/24, and 03/14/24, Resident #5's a physician's order to discontinue valproic acid on 04/15/23 was not provided for review.

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D 358	Continued From page 45 Interview with a medication aide (MA) on 03/14/24 at 3:27pm revealed: -Resident #5 knew her medications well and did not want to take medications that would alter her. -Resident #5 routinely went through each medication and told him which medication she was not going to take. -MAs did not enter or change orders on the eMAR; the PCP and Memory care Coordinator (MCC) managed medication orders. -The pharmacy entered orders onto the eMAR and the MCC approved the orders entered by the pharmacy. Interview with Resident #5's primary care provider (PCP) on 03/14/24 at 12:15pm revealed: -She did not have electronic copies of Resident #5's original orders because her office switched to a new electronic charting system and those orders were lost. -The facility did not have a fax machine at the time Resident #5 was there, so all orders were emailed to the Memory Care Coordinator (MCC). -Refill, new order and changed order requests all had to go through the MCC. -She did not know what happened to the order if the order was not printed from the email. -She did not know why there was no medication administration record (MAR) documentation for medications administered from 02/28/23 through 03/02/23. Telephone interview with the Memory Care Director (MCD) on 03/14/23 at 5:11pm revealed: -She was new to the MCD role when Resident #5 was at the facility. -All Resident #5's orders should have been in her record. -She contacted the pharmacy during the current	D 358		

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interview.
-The pharmacy representative said that all of Resident #5's original orders from admission and March 2023 were lost in the system and she was unable to access those orders.
-The pharmacy representative said a request had been made in the past for those orders and that was why the pharmacy sent Resident #5's dispense record.
-The pharmacy representative said the pharmacy only dispensed according to the orders they had for Resident #5.
-March 2023 was around the time Resident #5 argued about her medications.
-Medication orders were entered and restarted each time Resident #5 went out to the hospital and came back which created multiple entries for same medication on one month's eMAR.
-Resident #5 went out to the hospital frequently; she was admitted to the hospital the same day she came to the facility.
-She could not remember exactly and it might have been another resident.
-She did not know why Resident #5's hospital admissions were not documented in her record.
-She knew Resident #5 was back and forth between the hospital and the facility a lot.
-The pharmacy entered orders on the eMAR but did not have the ability in the electronic medication system to enter stop dates or designate a day of the week or the date in a month to administer medications.
-The Regional Nurse, herself, the Memory Care Coordinator (MCC) and MAs were responsible for medication orders.
-The MAs scanned orders to the pharmacy, Regional Nurse, herself and the MCC.
-She, the Regional Nurse or the MCC reviewed and approved orders entered by the pharmacy and did any follow up with the pharmacy as

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needed.
-The next shift MA was responsible for checking the medication on arrival to the facility and the written order.
-She completed an audit daily of the previous 24 hours for any order entry errors.
-Every MA was trained to document medication administration accurately on the eMAR.

Interview with the Administrator on 03/14/24 at 4:00pm revealed:
-Orders were sent electronically to the pharmacy and a paper copy was sent to the facility.
-She handled the order process in the absence of the MCD; the MCD was responsible for the order process when she was working.
-At the time Resident #5 was in the facility, the MCD and MCC processed all medication orders.
-MAs were responsible for administering medications as ordered and documented on the eMAR.
-MAs were responsible for documenting medications administered or not administered accurately on the eMAR.
-She would have to look at the documentation on Resident #5's eMARs.
-She did not know of any discrepancies in the documentation on Resident #5's eMARs for March and April 2023.

Upon request, Resident #5's February 2023 electronic medication administration record (eMAR) was not provided for review.

Attempted telephone interview on 03/14/24 at 3:15pm with the facility's contracted pharmacy was unsuccessful.

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that monthly medication administration records were accurate for 2 of 6 sampled residents related to a medication used to treat depression, a medication used to treat osteoporosis, and a medication used to treat psychiatric disorders and to help stabilize mood. The findings are: 1.Review of Resident #6's current FL2 dated 10/17/23 revealed:	D 367		

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D 367	Continued From page 49 -Diagnoses included dementia with hallucinations, depression, anxiety, and diabetes mellitus. -There was an order for Paxil 40mg, one tablet by mouth daily (Paxil is a medication used to treat depression). Review of Resident #6's physician order form dated 01/01/24 revealed there was an order to discontinue Paxil and begin Lexapro 10mg by mouth daily (Lexapro is a medication used to treat depression). Observation of the 8:00am medication pass on 03/13/24 from 8:04am to 8:15am revealed there was no Paxil 40mg available on the medication cart when the medication aide (MA) prepared Resident #6's 8:00am medications. Review of Resident #6's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Paxil 40mg, take one tablet once daily. -Paxil 40mg was documented as administered from 01/01/24 to 01/31/24 at 8:00am except for 01/22/24 and 01/29/24. Review of Resident #6's February 2024 eMAR revealed: -There was an entry for Paxil 40mg, take one tablet once daily. -Paxil 40mg was documented as administered on 18 of 29 days in February 2024. Review of Resident #6 March 2024 eMAR revealed: -There was an entry for Paxil 40mg, take one tablet once daily. -Paxil 40mg was documented as administered on	D 367		

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D 367	Continued From page 50 9 of 13 days in March 2024. Interview with Resident #6 on 03/13/24 at 11:15am revealed: -She moved to the facility in October 2023. -She had seen the mental health provider (MHP) but was unsure of the date. -The MHP made some changes to her medications, and the new medication seemed to help her feel less depressed. -She was unsure of the names of all her medications. Interview with a pharmacist from the facility's contracted pharmacy on 03/13/24 at 10:58am revealed: -Resident #6's order for Paxil 40mg was discontinued on 01/01/24. -The last time the pharmacy filled Paxil 40mg for Resident #6 was on 12/21/23 and 30 tablets were sent to the facility. -The facility returned the unit dose card of Paxil 40mg dispensed on 12/21/23 with all 30 tablets remaining in January 2024. Interview with the medication aide (MA) on 03/13/24 at 10:10am revealed: -She did not give Paxil 40mg this morning because she could not find it on the medication cart. -The facility's medications were on cycle fill, so most of the residents' medications arrived every month without needing to be reordered. -If a medication was on the eMAR, she was supposed to administer that medication. -If a residents' medication was not available on the medication cart, she notified the Resident Care Coordinator (RCC). -She notified the RCC today, 03/13/24, when she could not locate Resident #6's Paxil 40mg on the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092219	A. BUILDING: _____ B. WING _____	R 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 51 medication cart. Interview with the RCC on 03/13/24 at 2:45pm revealed: -The facility had some recent issues with medication orders on the eMAR. -She was unsure if the issues were with the facility's contracted pharmacy or the company that serviced the facility's eMAR system. -The facility's contracted pharmacy entered medication orders and the medication orders should show up on the eMAR, but sometimes the facility had to call the company who serviced their eMAR when there were problems. -The RCC, Memory Care Coordinator (MCC), and Memory Care Director (MCD) approved all new orders on the eMAR system after the pharmacy entered the new orders. -A nurse from the facility's contracted pharmacy was responsible for auditing the medications and eMARs quarterly. -Medication orders that were discontinued should automatically be removed from a residents' eMAR once the pharmacy entered the discontinue order. -She was not aware that Resident #6's Paxil 40mg was discontinued on 01/01/24. -She was unsure why Paxil 40mg continued to be on Resident #6's eMAR even though it was discontinued. -She was unsure why the MAs documented Paxil 40mg as administered if the medication was not available. Interview with the Administrator on 03/13/24 at 3:15pm revealed: -The facility's contracted pharmacy did not service the facility's current eMAR system. -Medications that were discontinued should not show up on the residents' eMAR when the order	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 52 was discontinued at the pharmacy. -There should not be a delay in discontinued medications being removed from the eMAR, the discontinued medication should be removed when the pharmacy discontinued the medication order. -The facility had to contact the company that serviced the eMARs to fix any issues. -She was unsure why Resident #6's Paxil 40mg was on the eMAR if the medication was discontinued.	D 367		