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D 000	Initial Comments The Adult Care Licensure Section and the New Hanover County Department of Social Services conducted a follow-up survey, a state involved complaint investigation and a county complaint investigation from March 12, 2024, to March 15, 2024. The state involved complaint investigation was initiated by the New Hanover County Department of Social Services on February 7, 2024, and the county complaint investigation was initiated by the New Hanover County Department of Social Services on February 21, 2024.	D 000		
D 235	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 sampled residents (#2) had a current FL-2 completed annually. The findings are: Review of Resident #2's FL-2 dated on 02/22/22	D 235		

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revealed:
-Diagnoses included primary lung cancer, coronary artery disease, polyneuropathy, Ogilvie's syndrome, chronic obstructive pulmonary disease, type 2 diabetes mellitus with microalbuminuria, hypertension, and polycythemia.
-The resident was ambulatory.
-The resident was continent of bowel and bladder.
-There was no information regarding Resident #2's disorientation.
-The resident's level of care was assisted living.

Review of Resident #2's record on 02/21/24 revealed Resident #2's FL-2 had not been updated since 02/22/22.

Review of Resident #2's move in record form revealed an admission date of 02/28/22.

On 02/23/24, the Director of Resident Care (DRC) provided a current FL-2 for Resident #2 that was completed and signed by Resident #2's Primary Care Provider (PCP) on 02/23/24.

Review of Resident #2's current FL-2 dated 02/23/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, atherosclerosis and coronary artery disease, Ogilvie syndrome, type 2 diabetes mellitus with other diabetic kidney complication, hypertension, secondary polycythemia, malignant neoplasm of bronchus and lung, polyneuropathy, and rash.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident was continent of bowel and bladder.
-The resident's level of care was assisted living.

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Interview with the DRC on 02/23/24 at 10:32am revealed she was not aware Resident #2's FL-2 had not been updated annually.

Interview with Resident #2 on 03/13/24 at 10:38am revealed he had seen his PCP multiple times since admission to the facility, but he did not know anything about an FL-2 being completed.

Telephone interview with clinic coordinator for Resident #2's PCP on 03/15/23 at 9:51am revealed Resident #2's PCP had signed an FL-2 on 02/23/24.

Telephone interview with a pharmacy technician at Resident #2's chosen pharmacy on 03/13/24 at 3:35pm revealed:
-The most recent FL-2 the pharmacy had on file was dated 02/22/22, which was faxed to the pharmacy on 02/28/22.
-The pharmacy had made multiple attempts to get an updated FL-2 from the facility for Resident #2, which were unsuccessful.
-The expectation was that the facility provided the pharmacy with an updated FL-2 annually.

Interview with the Wellness Coordinator (WC) on 03/15/24 at 2:55pm revealed:
-Point Click Care (PCC) tracked when evaluations were due, which included FL-2's.
-Staff had go into the evaluations for each resident when in PCC to see which evaluations were due to that resident.
-PCC did not always populate a trigger when an evaluation was due.
-Once PCC flagged a trigger that an FL-2 was due, the task would stay flagged in PCC until the task was completed.

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-She did not know why PCC did not flag a trigger that Resident #2's FL-2 needed to be completed.
-The facility relied completely on PCC to track when a FL-2's was due as the facility had no other system in place.
-She was made aware on 02/21/24 that Resident #2's FL-2 had not been updated since 02/22/22.
-She completed an updated FL-2 for Resident #2 that was signed by his PCP on 02/23/24.
-Since being hired by facility in November 2023, she had not checked in PCC to see if Resident #2 had a current FL-2.
-FL-2's should be completed yearly or when there was a change in the level of care.

Interview with the DRC on 03/15/24 at 4:11pm revealed:
-Resident FL-2's could be completed by any clinical staff, which included a medication aide, the WC, the Assistant Director of Resident Care (ADRC), or the DRC.
-PCC generated a trigger when an FL-2 was due.
-The task would remain triggered until it was cleared meaning the task was completed or the was no longer at facility.
-Staff had to look under the evaluations in PCC for each individual resident to see what tasks triggered as being due.
-She did not know why PCC did not trigger that Resident #2's FL-2 was due.
-The facility depended solely on PCC to track when a FL-2 was due as the facility had no other system in place.
-The expectation was that FL-2's be completed annually.

Interview with the Administrator on 03/15/24 at 4:43pm revealed:
-The clinical staff (DRC, ADRC, or WC) were responsible for completing resident FL-2's.

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D 235	Continued From page 4 -She was not aware Resident #2's last FL-2 was completed 02/22/22 prior to the new FL-2 being completed on 02/23/24. -She expected FL-2's to be completed annually.	D 235		
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: FOLLOW-UP TO TYPE B VIOLATION Non-compliance continues with increased severity resulting in residents placed at substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur. THIS IS A TYPE A1 VIOLATION Based on interviews, and record reviews, the facility failed to ensure referral and follow up with healthcare providers to meet the routine and acute health care needs of 3 of 6 sampled residents (#3, #4, and #6) including the facility showed neglect in treating the resident's swollen wrist (02/02/24 when swelling was noticed and the resident complained of pain and stiffness, 02/09/24 when primary care physician (PCP) observed redness and swelling, and 02/12/24, a delay in x-ray results confirming the fracture wrist to PCP) a delay of 10 days for treatment of a fractured right wrist (#3), delay in contacting the resident's PCP to report the resident yelled out in pain after a fall (#4), and failed to refer a resident with bipolar disorder, major depressive disorder, and anxiety disorder to a mental health provider	D 273		

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after the resident's PCP ordered the services (#6).

The findings are:
1. Review of Resident #3's current FL2 dated 02/23/24 revealed:
-Diagnoses included dementia, atherosclerosis, hypertension, depression, gastro-esophageal reflux disease without esophagitis, allergic rhinitis, and vitamin D deficiency.
-Resident #3 was constantly disoriented.
-Resident #3 required assistance with bathing.
-Resident #3 was semi-ambulatory.

Review of Resident #3's accident/incident (A/I) report dated 02/01/24 at 9:26am revealed:
-The resident was walking down the hall without her walker, stumbled and fell landing on her right side.
-No injuries observed at time of incident.
-Emergency Medical Services (EMS) called.

Review of Resident #3's 02/01/24 EMS after visit summary revealed:
-The reason for the visit was a fall with uncertain cause.
-Her diagnosis was a fall.
-Her imaging consisted of CT scan of the cervical spine without contrast, CT scan of the head without contrast, portable chest x-ray and ECG 12 lead.
-The imaging did not show any concerning findings.
-She was discharged back to the facility.
-No documentation of an x-ray of her arm or wrist.

Review of Resident #3's electronic progress note dated 02/02/24 at 8:46am revealed the medication aide (MA) observed swelling to the

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resident's right wrist and she complained of pain and stiffness.

Review of Resident #3's accident/incident (A/I) report dated 02/09/24 revealed:
-The resident reported to the primary care provider (PCP) that her wrist was sore and swollen.
-The right wrist was red and swollen and the provider ordered a mobile x-ray of the right wrist.
-The provider orders were to send the resident to hospital for stabilization of right wrist.

Review of Resident #3's radiology report dated 02/10/24 revealed an intra-articular distal radial fracture (fracture of the bone that extends into the wrist).

Review of Resident #3's 02/12/24 EMS revealed:
-The reason for the visit was due to a wrist injury.
-Her diagnosis was a closed fracture of distal end of right radius, unspecified fracture morphology, initial encounter.
-Her imaging consisted of x-ray wrist right posteroanterior, lateral, and oblique.
-She was given ibuprofen (Motrin) tablet (pain medication).
-A shoulder immobilizer or splint was provided for the injury.
-The recommendations were to follow-up with orthopedic surgeon.
-She was discharged back to the facility.

Interview with the MA on 03/14/24 at 9:53am revealed on 02/09/24 she became aware of the resident's swollen arm/wrist, and she reported it to the Wellness Coordinator (WC).

Interview with the primary care provider (PCP) on 03/15/24 at 9:08am revealed:

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-The PCP saw Resident #3 during her rounds on 02/09/24 and observed the right wrist was swollen and red.
-She ordered a mobile x-ray of the right wrist for 02/10/24.
-The radiology report was faxed to the facility first.
-On 02/10/24, the facility e-faxed the report to the PCP, but she did not receive the e-fax until Monday morning, 02/12/24 because she was not on call that weekend.

-On 02/12/24, the PCP read the report and gave orders to send the resident to the hospital to secure the arm.
-She was unaware if the facility called the on-call service number.
-The facility had the number to the on-call service line which is 24/7.
-The facility should call the on-call service with any report needing attention after hours.
-The resident was diagnosed with an intra-articular distal radial fracture and if left untreated it could continue to cause pain.
-When the resident moved the arm, she was in pain and used facial grimace to show she was in pain.
-The PCP did not know why the staff would not have noticed the facial grimace and pain when the arm was moved during her activities for daily living (ADLs).

Interview with the Wellness Coordinator (WC) on 03/15/24 at 9:43am revealed:
-She became aware of Resident #3's wrist injury on 02/09/24 when the MA reported it.
-The resident's wrist being left untreated could cause it to become worse and cause more pain.
-On 02/10/24, she was off and reviewed her emails when she found the radiology report, she then forwarded the report to the PCP.

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-She was unaware that the PCP was off.
-She should have forwarded the report to the on-call service, it was not on her mind at that time because she was off.
-The facility used an e-fax system to receive orders for residents, and only the managers had access to it.
-There was not a procedure for when a manager was off who would be next in line to be responsible to review any e-fax that came in.

Interview with the Director of Resident Care (DRC) on 03/15/24 at 11:48am revealed:
-On 02/01/24, she was walking down the hall and saw Resident #3 fall.
-The resident was complaining about her right wrist and could not extend her right leg.
-She called EMS for the resident and requested that they check her wrist.
-She returned with no findings concerning her wrist.
-There was no back-up if someone was off from work and an e-fax came in.
-Only managers had access to e-fax and were responsible for reviewing.
-She was unaware that the on-call service was not contacted on 02/10/24.
-The purpose for immediate treatment for the resident was to assist with the healing process.

Interview with the Administrator on 03/15/24 at 4:27pm revealed:
-She was unaware that her WC was off when she forwarded the e-fax to the PCP on 02/10/24.
-The WC should have contacted the on-call provider.
-The manager on duty are responsible and should have checked the e-fax.
-The e-fax went to all managers and the manager on duty.

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-There was no system in place to follow-up with e-faxes; although the on-call staff should have contacted the on-call provided.

2. Review of Resident #4's current FL2 dated 03/11/24 revealed:
-Diagnoses included dementia and abdominal pain.
-Resident #4 was intermittently disoriented.
-Resident #4 required assistance with bathing and dressing.
-Resident #4 was ambulatory.

Review of Resident #4's previous FL2 dated 03/28/23 revealed:
-Diagnosis included dementia, paroxysmal atrial fibrillation, hypertension, falls, thoracic compression fracture, and anxiety.
-Resident #4 was intermittently disoriented.
-Resident #4 was semi-ambulatory.
-Resident #4 required assistance with bathing.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 03/29/23.

Review of Resident #4's electronic progress notes dated 02/29/24 revealed at 3:09pm, the resident was sent out to the hospital after it was passed on to this medication aide (MA) that the resident stated she wanted to kill herself, the resident was transported to the hospital.

Review of Resident #4's emergency department (ED) after visit summary dated 02/29/24 revealed:
-The reason for visit was listed as "follow-up Medical Problem- Minor".
-The diagnoses were normal exam, dementia and other chronic pain
-There was a signed electronic prescription for

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hydrocodone-acetaminophen 5-325mg, take 1 tablet two times daily as needed for pain for up to 4 days.
-The resident was to follow-up with her primary care provider (PCP).

Review of Resident #4's electronic progress notes dated 03/01/24 revealed:
-At 4:29am, Resident #4 woke up yelling that she was in bad pain and that her left side was hurting, the resident then stated to the supervisor that she needed to go to the doctor.
-At 8:00am, hydrocodone-acetaminophen 5-325, 1 tablet every 12 hours as needed for pain was administered (hydrocodone is a narcotic analgesic used to treat moderate to moderately severe pain).
-At 8:08am, hydrocodone-acetaminophen 5-325 was documented as effective and a follow-up pain scale was documented as 4 out of 10, with 10 being the most severe pain.
-At 10:05pm, hydrocodone-acetaminophen 5-325mg 1 tablet every 12 hours as needed was documented as administered.

Review of Resident #4's electronic progress notes dated 03/02/24 revealed:
-At 3:18am, the personal care aide (PCA) reported that a resident went in Resident #4's room and called emergency medical services (EMS) because Resident #4 was having pain, Resident #4 went to the hospital by EMS on 03/01/24 and was now back in the facility with a diagnosis of back pain.
-At 8:54am, hydrocodone-acetaminophen 5-325mg 1 tablet every 12 hours as needed for pain was administered.
-At 12:12pm, hydrocodone-acetaminophen 5-325mg was documented as effective and a follow-up pain scale was documented as 0 out of

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10.

Review of Resident #4's incident reports revealed there was no incident report dated 03/01/24.

Review of Resident #4's emergency department (ED) after visit summary (AVS) dated 03/01/24 revealed:
-The reason for the visit was back pain.
-The diagnosis was fall with no injury, subsequent encounter.
-The discharge instructions listed no acute traumatic injury.

Review of Resident #4 hospital medical record dated 03/01/24 revealed:
-Resident #4 arrived at the emergency department at 7:47pm via EMS.
-The chief complaint was listed as back pain, the resident reported that she fell, she did not remember where, how or details of the fall, she personally called EMS from the facility for this back pain, she resided in the locked memory care side, no injuries were noted by EMS, staff denied any resident falls or knowledge of EMS arrival.
-History of Present Illness (HPI), Resident #4 was brought in by EMS from the facility after calling EMS and reported she fell and had back pain, when EMS arrived, the facility staff reported no knowledge of a fall, the resident had a past medical history of advanced dementia and was evaluated in the ED five times over the past week with similar complaints and negative workups, the resident was alert and oriented x 1 and repeated over and over that she fell and needed pills, there was no obvious traumatic injury, when asked the resident reported that she was walking through the city and fell and requested pills.
-A CT scan of the cervical spine without contrast was performed and revealed no evidence of an

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acute fracture and multiple levels of degenerative changes in the cervical spine.
-A CT of the head without contrast was performed and revealed no evidence of an acute intracranial abnormality.
-A portable chest x-ray was performed and revealed no evidence of acute cardiopulmonary disease.
-The differential diagnosis and additional work-up revealed, Resident #4 presented with a chief complaint of a fall, however there was no specific report of a fall, the resident was well known to the department for several visits over the past week for similar complaint, past medical history of advanced dementia and resided at the facility on a memory ward, overall presentation was consistent with her baseline mentation with no acute traumatic injuries, there was low suspicion given workups, exam and history for intracranial hemorrhage, severe traumatic brain injury, cervical spine fracture, intrathoracic fracture or injuries, vital signs were stable and the resident was in no apparent distress.

Review of Resident #4's electronic progress notes dated 03/03/24 revealed:
-At 10:10pm, upon arrival to start "my" shift, the resident stated she was having pain in her chest and her abdomen.
-The resident was escorted to her room by two resident assistants and helped to her bed, vital signs taken, BP 168/90, P 78 and R 16.
-EMS transported the resident to the local hospital.
-The PCP was notified.
-The Wellness Coordinator (WC) was notified.
-Her responsible party (RP) was notified.

Review of Resident #4's ED AVS dated 03/03/24 revealed:

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

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-The reason for visit was back pain.
-The diagnosis was back pain, unspecified back pain laterality, unspecified chronicity.
-The discharge instructions were to follow-up with PCP in 1 week.

Review of Resident #4's hospital medical record dated 03/03/24 revealed:
-The chief compliant was generalized back pain.
-HPI, Resident #4 presented with back pain, restlessness, and dementia.
-Her mental status was baseline.
-There was no additional imaging documented as performed.
-The ED course and decision making were ongoing back pain likely from osteopenia, no obvious fractures on recent imaging, no tenderness today, Lidocaine patch and acetaminophen given, she was stable for discharge back to facility.

Review of Resident #4's electronic progress note dated 03/04/24 revealed:
-At 1:15pm, the resident was complaining of abdominal pain and pain all over.
-EMS was called and transported Resident #4 to the local hospital.
-The care manager, her PCP and RP were notified.
-Hydrocodone-acetaminophen was administered before leaving.

Review of Resident #4's hospital AVS dated 03/12/24 revealed:
-Resident #4 was admitted to the hospital on 03/04/24 and discharged on 03/12/24.
-The discharge diagnosis was a closed L3 vertebral fracture.

Review of Resident #4's hospital discharge

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summary dated 03/12/24 revealed:
-Hospital course, the resident presented to the ED on 03/04/24 from the facility, she complained of right sided back pain and abdominal pain, she had multiple ED visits for abdominal pain, she was noted to have a L3 transverse process fracture on CT scan. Her labs were unremarkable. She was seen this morning and complained of pain in her right back and left lower quadrant. She was doing ok today with no new complaints. She was able to ambulate with a walker with minimal stand by assistance. She would be discharged back to the facility today.
-She was diagnosed with a closed L3 vertebral fracture, neurosurgery was consulted, the Physicians Assistant (PA) reviewed the imaging and diagnosed an L3 transverse process fracture, no brace or surgery were recommended, only pain management.
-A CT scan of the abdomen and pelvis was preformed on 03/04/2 and revealed a non-displaced right-sided L3 transverse process fracture.
-She was diagnosed with chronic low back pain, Oxycodone, acetaminophen, and Lidocaine patches were prescribed to take on a scheduled basis.

Telephone interview with a medication aide (MA) on 03/15/24 at 9:06am revealed:
-She worked the night shift on 03/01/24.
-On 03/01/24, one of the PCAs told her Resident #4 was "yelling" in pain.
-She evaluated Resident #4 on 03/01/24 and she had calmed down but complained of left abdominal pain.
-She asked Resident #4 if she wanted to go to the ED and Resident #4 said no.
-She thought she probably gave Resident #4 something for pain on 03/01/24 and if the pain

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medication did not help then she planned to send her to the ED.
-She thought she re-evaluated Resident #4 around 5:30am on 03/01/24 and she had settled down.
-She did not call Resident #4's primary care provider (PCP) or RP because Resident #4 had settled down.

Interview with a PCA on 03/15/24 at 2:22pm revealed:
-She worked the 2:00pm to 10:00pm shift on 03/01/24 in the special care unit (SCU).
-Resident #4 did not have a fall on 03/01/24 that she was aware of.
-No one reported a fall for Resident #4 on 03/01/24.
-About 2:40pm on 03/01/24, Resident #4 complained of right-side abdominal pain and said she was concerned she had appendicitis.
-She reported this to the Assistant Director of Resident Care (ADRC).
-Resident #4 did not want to go to the dining room because she was not feeling well.
-She left Resident #4's door cracked so she could keep an eye on her.
-Resident #4 could be heard moaning from her room.
-She was certain she had notified the evening MA of Resident #4's continued complaints of pain.
-Resident #4 had a cell phone and another resident had gone in and out of Resident #4's room several times.
-She was not aware Resident #4 or the other resident had called EMS until EMS arrived at the facility and reported that a resident had called complaining of pain.

Interview with the ADRC on 03/15/24 at 2:31pm revealed:

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D 273	Continued From page 16 -Resident #4 had several recent ED visits for complaints of abdominal and back pain and usually would be returned to the facility within about 2 hours. -Resident #4 did not have a fall on 03/01/24. -She did not know why the ED AVS listed a fall on 03/01/24. -Resident #4 had orders for acetaminophen, ibuprofen, and hydrocodone for pain and was being treated with medication for her pain. -She was certain she administered acetaminophen to Resident #4 on 03/01/24 around 2:00pm. -She checked on Resident #4 frequently, she slept, would wake up agitated, complain of pain and go right back to sleep. -She did not contact Resident #4's PCP because she was being treated for pain with medication. -She did not know why Resident #4, or another resident called EMS aside from the fact they had dementia. -She had already left the facility for the day when the resident called EMS on 03/01/24. Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:17am revealed: -She was on call for the facility on 03/01/24. -She received a call from the facility in the evening on 03/01/24 that EMS arrived at the facility unbeknownst to the staff after receiving a call from Resident #4's cell phone. -She later spoke to Resident #4's RP and was told there had been a call made to EMS from Resident #4's cell phone. -She did not know why a call was made to EMS from Resident #4's cell phone. -There should have been documentation in Resident #4's progress notes by the MA, of the residents' complaints of pain and any interventions.	D 273		

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Interview with the Administrator on 03/14/24 at 3:09pm revealed:
-The residents were monitored based on their individual needs by the PCAs and/or MAs.
-On 03/01/24, she received a phone call sometime between 7:30pm and 9:30pm from the DRC, that Resident #4 and another resident had called EMS from Resident #4's cell phone.
-She was told staff was not aware EMS had been contacted by Resident #4 until they arrived at the facility.
-She did not know why the resident called EMS.
-She expected there to be documentation in the progress notes by the MAs of the residents' condition, complaints and any interventions that were put in place, and contact with the PCP for Resident #4.

Attempted telephone interview with the MA on duty for 03/01/24 evening shift on 03/15/24 at 9:08am was unsuccessful.

Attempted telephone interview with Resident #4's RP on 03/13/24 at 11:32am was unsuccessful.

3. Review of Resident #6's current FL-2 dated 03/06/24 revealed:
-Diagnoses included bipolar disorder, major depressive disorder, anxiety disorder and Alzheimer's disease.
-The resident's level of care was assisted living (AL).
-The resident was ambulatory and intermittently disoriented.

Review of Resident #1's primary care provider (PCP) visit note dated 08/25/23 revealed:
-The resident's diagnoses included anxiety disorder, bipolar disorder, major depressive

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disorder, and dementia.
-The resident's family requested a referral for mental health services due to the resident struggling with a new diagnosis of dementia.
-The resident was also struggling because her dog had to leave the facility and had to reside with her family member.
-The resident was tearful during the PCP's visit.
-The PCP wrote a referral for mental health services in the resident's progress note and provided facility staff with an order to refer her to mental health services.

Review of Resident #6's record on 03/12/24 revealed there were no notes from a mental health provider.

Interview with Resident #6 on 03/12/24 at 9:10am revealed:
-She had been feeling "fine."
-She denied feeling sad or down.
-She felt nervous sometimes.
-She did not remember being seen by a mental health provider.

Interview with Resident #6's family member on 03/13/24 at 8:30am revealed:
-Resident #6 had a diagnosis of bipolar disorder, depression, anxiety, and Alzheimer's.
-Resident #6 had a difficult time coping with her diagnosis of Alzheimer's, she was tearful at times due to her confusion.
-The family member requested a referral to mental health services in August 2023 due to Resident #6's increase in depression and anxiety when her dog had to be moved from the facility.
-The family member spoke with the resident's primary care physician (PCP) in August 2023 to share his concerns about the resident's increase in depression and anxiety.

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D 273	Continued From page 19 -The family member met with the Administrator in August 2023 to complete required paperwork for Resident #6 to be referred to a mental health provider. -The family member was contacted by the Administrator and facility social worker to resign the paperwork to complete the referral for mental health services in September 2023. -Resident #6 still had not seen a mental health provider at the facility for an evaluation or for outpatient therapy. -The family member did not know why the facility had not referred Resident #6 for mental health services. Review of Resident #6's neuropsychologist evaluation summary dated 01/26/24 revealed the resident's diagnoses included moderate dementia with a history of bipolar disorder, depression, and anxiety. Interview with the Director of Resident Care (DRC) on 03/14/24 at 9:51am revealed: -Resident #6 had not been seen by a mental health provider because there was not an order or referral from the resident's primary care physician (PCP). -She forgot that Resident #6's PCP wrote an order for the resident to be seen by a mental health provider several months ago. -The facility had changed their contract to a new mental health provider for the facility and the referral for Resident #6 was accidentally missed. -The resident had not been referred to a mental health provider. -The medication aide (MA), Assistant Director of Resident Care (ADRC), the Wellness Coordinator (WC), the DRC or the Administrator were able to make the referral to a mental health provider for Resident #6 as ordered by the Resident's PCP.	D 273		

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Interview with the Administrator on 03/14/24 at 10:15am revealed:
-Resident #6's PCP ordered mental health services in August 2023 or September 2023.
-The facility changed mental health providers and the referral for Resident #6 was overlooked by staff.
-The WC, ADRC, or DRC should have referred Resident #6 to a mental health provider after the PCP ordered the services.
-Staff should have contacted a mental health provider in the community if a mental health service provider was not providing services at the facility to ensure the resident began mental health services.

Interview with Resident #6's PCP on 03/15/24 at 9:08am revealed:
-She completed an order for mental health services for Resident #6 in August 2023.
-She ordered mental health services for the resident due to the resident's difficulty adjusting to a new diagnosis of Alzheimer's disease, her dog having to leave the facility, and help with coping with depression and anxiety.
-She was not aware that the facility had not referred Resident #6 to a mental health provider until today (03/15/24).
-The facility should have referred Resident #6 to a mental health provider in August 2023.
-The facility was responsible for referring the resident to a mental health provider to ensure the resident received services she ordered.
-There had been a change in the facility's contracted mental health service providers, but the facility was still responsible for ensuring Resident #6 was referred to a mental health provider.
-Resident #6 would benefit from mental health

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services with possible changes in her medications to help decrease her depression and anxiety.

____

The facility failed to meet the acute health care needs of a resident who was seen in the local emergency department (ED) for a fractured right wrist two days after a radiology report was sent to the facility and the facility failed to notify the primary care provider (PCP) on call services (#3), failed to contact the PCP or emergency medical services (EMS) for a resident who resided on the Special Care Unit (SCU) who complained of back pain and abdominal pain, yelled out in pain and she or another resident contacted EMS by using their cellular telephone, and the facility was not aware that EMS was notified of the resident's complaint of pain until EMS arrived at the facility (#4) and was found to have a lumbar fracture after another ED visit resulting in hospitalization on 03/04/24, and failed to refer a resident with a diagnosis of bipolar disorder, major depressive disorder, and anxiety to a mental health provider after the resident's PCP ordered the referral in August 2023 (#6). The facility's failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/15/24 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 14, 2024.

D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support	D 278		

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D 278	Continued From page 22 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or	D 278		

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D 278	Continued From page 23 drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by:	D 278		

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Based on observations, record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 2 of 6 sampled residents (#2, #4) with LHPS tasks for applying and removing a leg brace, medication administration through injection, collecting and testing of finger stick blood samples (#2), and for ambulation using assistive devices that required physical assistance (#2, #4).

The findings are:

1. Review of Resident #2's current FL-2 dated 02/23/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease, atherosclerosis and coronary artery disease, Ogilvie syndrome, type 2 diabetes mellitus with other diabetic kidney complication, hypertension, secondary polycythemia, malignant neoplasm of bronchus and lung, polyneuropathy, and rash.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident's level of care was assisted living.

Review of Resident #2's current care plan dated 10/12/23 revealed:
-The resident required supervision during toileting.
-The resident was independent with ambulation but may use cane, walker, wheelchair independently.
-There was no documentation that indicated Resident #2 required subcutaneously injectable medications, finger stick blood sugar checks (FSBS), wore a leg brace, and needed physical assistance with ambulation.

Review of Resident #2's medication orders dated

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12/08/23 revealed:
-There was an order to check the resident's blood glucose daily.
-There was an order for Lantus Subcutaneous Solution 100 unit/ml inject 10 units subcutaneously at bedtime.

Review of a communication note from Resident #2's Primary Care Provider (PCP) dated 12/18/23 revealed the resident needed an ankle-foot orthoses (AFO) brace to assist with drop foot of left greater right foot to improve gait stability and overall ease of gait.

Review of Resident #2's current Licensed Health Professional Support (LHPS) Initial and Quarterly Evaluation dated 03/12/24 revealed:
-The date of last evaluation was 02/28/22.
-The resident's LHPS personal care tasks included applying and removing ace bandages, ted hoses, binders, and braces, and splints; ambulation using assistive devices that requires physical assistance; medication administration through injections; and collecting and testing of fingerstick blood samples.
-The LHPS evaluation was electronically signed on 03/12/24.

Review of Resident #2's LHPS Initial and Quarterly Evaluation dated 02/28/22 revealed:
-Resident #2 initial move in was 02/28/22.
-There were no LHPS personal care tasks noted.
-The LHPS evaluation was electronically signed on 03/04/22.

There were no other LHPS Evaluations provided for Resident #2.

Refer to the interview with the Director of Resident Care (DRC) on 03/15/24 at 4:11pm.

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Refer to the interview with the Administrator on 03/15/24 at 4:43pm.

2. Review of Resident #4's current FL2 dated 03/11/24 revealed:
-Diagnoses included dementia and abdominal pain.
-Resident #4 was intermittently disoriented.
-Resident #4 required assistance with bathing and dressing.
-Resident #4 was ambulatory.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 03/29/23.

Review of Resident #4's Resident Evaluation Care Plan completed by the Assistant Director of Resident Care (ADRC) on 11/30/23 and signed by Resident #4's primary care provider (PCP) on 11/30/23 revealed the resident required a walker as an assistive device for ambulation.

Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation revealed:
-Date of last evaluation was listed as 04/11/23.
-Under Personal Care Tasks Currently present, the letter "m" was checked for ambulation using assistive devices that requires physical assistance and if skilled tasks are identified, re-evaluate resident quarterly, yes was checked.
-Under review of health status and care provided, resident uses a walker was checked.
-The LHPS evaluation was signed electronically by the Director of Resident Care (DRC) on 03/12/24.

Review of Resident #4's previous LHPS

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evaluation revealed:
-Under Personal Care Tasks Currently present, no tasks were selected.
-The LHPS evaluation was electronically signed by the DRC on 04/11/23.

There were no other LHPS evaluations provided for Resident #4.

Observation of Resident #4 on 03/14/24 at 9:55am revealed she was ambulating in the hallway of the special care unit (SCU) using a walker.

Refer to interview with the DRC on 03/15/24 at 4:11pm.

Refer to interview with the Administrator on 03/15/24 at 4:43pm.

____

Interview with the DRC on 03/15/24 at 4:11pm revealed:
-She was responsible for completing the LHPS evaluations for the residents.
-LHPS evaluations were to be completed within 30 days of the residents'' admission and on a quarterly basis or when there was a change in the residents' condition.
-There was no trigger in the facility's electronic charting system to alert her when the LHPS evaluations were due.
-She knew she was behind on some of the residents' LHPS evaluations.
-The only way to check to see when the LHPS evaluations were due was to check each resident's electronic record individually.

Interview with the Administrator on 03/15/24 at 4:43pm revealed:

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D 278	Continued From page 28 -She thought LHPS evaluations were done within 30 days of a resident's admission and every 6 months. -The DRC was responsible for completing the LHPS evaluations. -She expected the DRC to complete the required LHPS assessments within the timeframe they were due to maintain compliance.	D 278		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure transportation was available to transport residents to medical appointments resulting in 5 of 11 sampled residents (#2, #7, #8, #9, and #10) not having transportation to medical appointments. The findings are: Review of the facility's transportation policy for	D 321		

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medical appointments revealed:
-The facility provides transportation on Monday, Tuesday, and Wednesday for medical appointments.
-Residents needed to schedule medical appointments 72 hours or more in advance through the front desk due to only a limited number of appointments.
-The facility provides transportation in a 15-mile radius.
-If it is out of the 15-mile radius, a charge will be applied to your account.

1. Review of Resident #2's current FL-2 dated 02/23/24 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerosis, coronary artery disease, Ogilvie syndrome, type 2 diabetes with other diabetic kidney complication, hypertension, secondary polycythemia, malignant neoplasm of bronchus and lung, and polyneuropathy.

Interview with Resident #2 on 03/13/24 at 10:38am revealed:
-The facility did not have a transportation driver and had not provided transportation to the residents since October 2023.
-He relied on his Power of Attorney (POA) to provide him transportation to medical appointments, outings, and shopping on Monday and Friday, when the POA was off of work.
-The facility provided transportation to Resident #2 to medical appointments, outings, and shopping prior to October 2023.
-The resident had paid for a cab on several occasions to take him shopping when his POA was not available, which was an extra expense.
-The resident would like for the facility to provide transportation to the residents.
-The facility advertised transportation was

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provided, which was one of the reasons he chose the facility.

Telephone interview with Resident #2's POA on 03/13/24 at 5:58pm revealed:
-The facility did not have a transportation driver and had not provided transportation to the residents since around November 2023.
-Prior to November 2023, the facility provided Resident #2 transportation to medical appointments, outings, and shopping.
-Since November 2023, she had provided Resident #2 with transportation to medical appointments, shopping, and outings, on Mondays and Fridays, which were her days off of work.
-Since November 2023, there was an occasion where she had to take a ½ day off of work to take Resident #2 to a medical appointment on a Tuesday, since there was no appointment available on Monday or Friday.
-Losing a ½ day of pay was an expense she endured due to the facility not providing transportation.
-Resident #2 had taken a cab to medical appointments and shopping, which cost him extra money when she was not available.
-The POA felt it was not fair that Resident #2 had to pay cab fare for transportation because the facility did not have a driver to provide transportation and felt the resident should have been reimbursed.

Refer to interview with a personal care aide (PCA) on 03/15/24 at 1:56pm.

Refer to interview with a second PCA on 03/15/24 at 2:06pm.

Refer to interview with the Activity Director (AD)

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D 321	Continued From page 31 on 03/15/24 at 2:10pm. Refer to interview with the Administrator on 03/15/24 at 2:18pm. 2. Review of Resident #7's current FL2 dated 09/18/23 revealed diagnoses included congestive heart failure, atrial fibrillation, type 2 diabetes, muscle weakness, hypertension, restless leg syndrome and anemia. Interview with Resident #7 on 03/14/24 at 9:23am revealed: -He was admitted to the facility in the late summer of 2023. -His family members picked the facility for him because one of the amenities was that the facility provided transportation to medical appointments for the residents. -He was provided transportation for the 1st 6 weeks of his stay at the facility. -After the 1st six weeks, transportation was no longer provided due to the facility not having a driver. -Family members made all of his appointments and took him to all of his appointments. -The lack of transportation to his medical appointments was a hardship because his family members still worked and had to take time off from their jobs to take him to his medical appointments. -His family members voiced frustration with this because the facility advertised that medical appointment transportation was provided for the residents. -He had not missed any appointments but he had many appointments. -He saw a cardiologist, a kidney specialist, a dermatologist, his PCP and was previously going to a wound clinic.	D 321		

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-He had been told the facility was actively searching for a replacement driver.
-It had been many months since the facility had provided transportation for his medical appointments.

Refer to interview with a personal care aide (PCA) on 03/15/24 at 1:56pm.

Refer to interview with a second PCA on 03/15/24 at 2:06pm.

Refer to interview with the Activity Director (AD) on 03/15/24 at 2:10pm.

Refer to interview with the Administrator on 03/15/24 at 2:18pm.

3. Interview with a resident on 03/12/24 at 9:20am revealed:
-She was admitted to the facility on 11/21/23.
-The facility had not transported residents to medical appointments since she was admitted to the facility.
-She needed the facility transportation services for her medical appointments but there was not a driver for the van.
-She had to contact members of her church and family members to take her to her medical appointments.
-It was inconvenient for her, her family, and friends at her church to coordinate transportation for her medical appointments because transportation to medical appointments was an amenity the facility was supposed to offer.

Refer to interview with a personal care aide (PCA) on 03/15/24 at 1:56pm.

Refer to interview with a second PCA on 03/15/24

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at 2:06pm.

Refer to interview with the Activity Director (AD) on 03/15/24 at 2:10pm.

Refer to interview with the Administrator on 03/15/24 at 2:18pm.

4. Review of Resident #10's current FL-2 dated 11/02/23 revealed diagnoses included cardiac pacemaker, bradycardia, atrial fibrillation, heart disease with heart failure, morbid obesity, depression, asthma, and aortic valve stenosis.

Interview with Resident #10 on 03/13/24 at 11:13am revealed:
-The facility had not had a transportation driver since November 2023.
-Residents were told that they had hired a driver, but she not seen a driver.
-Some residents had to take a taxi to appointments because the facility did not have a transportation driver.
-Residents had discussed this issue of transportation in the resident council meeting several times, the only person from administration that attended the resident council meetings was the Activity Director (AD).

Refer to interview with a personal care aide (PCA) on 03/15/24 at 1:56pm.

Refer to interview with a second PCA on 03/15/24 at 2:06pm.

Refer to interview with the Activity Director (AD) on 03/15/24 at 2:10pm.

Refer to interview with the Administrator on 03/15/24 at 2:18pm.

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5. Interview with a resident on 03/12/24 at 10:08am revealed:
-She was admitted to the facility in the fall of 2023.
-Transportation has never been provided to her since she has resided at the facility.
-She wanted to go and vote in the 2024 US primaries elections on 03/05/24 but the bus was not available, and she did not go.
-She was told the facility needed a driver for the bus.

Refer to interview with PCA on 03/15/24 at 1:56pm.

Refer to interview with a second PCA on 03/15/24 at 2:06pm.

Refer to interview with the Activity Director (AD) on 03/15/24 at 2:10pm.

Refer to interview with the Administrator on 03/15/24 at 2:18pm.

Interview with a PCA on 03/15/24 at 1:56pm revealed:
-The facility had not had a driver for the facility van since November 2023.
-The facility used the facility van to transport a few residents because those residents did not have a family member to take them to their appointments.
-She observed the Administrator drive a resident last week to a medical appointment.
-The facility did not have an individual hired as a transporter for residents.

Interview with a second PCA on 03/15/24 at 2:06pm revealed:

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D 321	Continued From page 35 -The facility had a bus used to take residents on outings and to medical appointments. -The facility did not currently have a driver for the facility bus and had been without a driver for several months. Interview with the Activity Director (AD) on 03/15/24 at 2:10pm revealed: -She was qualified to drive the transportation van. -The front desk completed the appointment calendar. -The Administrator and she could drive the transportation van. -If the resident resided in the special care unit (SCU) another employee had to ride with the resident. -Two residents were transported to appointments this week. -No outings for activities had been scheduled since there was not a transportation driver. Interview with the Administrator on 03/15/24 at 2:18pm revealed: -There was not a transportation driver, they had hired 3 people since the transportation driver left last year, but none of them started in the position. -The admission packet discussed that the resident must request transportation to appointments. -Appointments were scheduled on Monday, Tuesday, and Wednesday for a 15-mile radius if further than 15 miles there was a charge. -There was not a transportation log maintained and the front desk had the appointment calendar.	D 321		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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D 338	Continued From page 36 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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous B Violation was not abated. Based on interviews and record reviews, the facility failed to protect 3 of 7 residents (#2, #5 and #11) from physical, verbal, and mental abuse by a staff member resulting in a resident reporting he was fearful of a staff person and did not feel safe when the staff person entered his room and tried to force him out of bed to attend breakfast (#11), a resident who reported that staff were mentally and verbally disrespectful towards him and ignore him (#2), and a resident with a diagnosis of multiple sclerosis (MS) who had to walk a distance from the facility van with his rollator to enter a medical facility (#5). The findings are: Review of the facility's abuse, neglect, and exploitation prohibition and prevention program policy dated 09/01/19 revealed: -The purpose of the policy was to provide a mechanism for the prompt identification, investigation, and reporting of any allegation or complaint of abuse, neglect or exploitation whether made by a resident, family or staff member, visitor, or another person. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish.	D 338		

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D 338	Continued From page 37 -Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish, this includes verbal abuse, physical abuse, and mental abuse. -Willful, as used in the facility's definition of abuse, means the individual must have acted deliberately-not that the individual must have intended to inflict injury or harm. -Physical abuse was defined as unconsented physical touching, including (but not limited to) hitting, slapping, pinching, kicking, physical restraint, or corporal punishment of any kind. -Injury of unknown source was an injury that was not observed by anyone, and the occurrence of which cannot be explained by the resident. -Every resident has the right to be free from verbal, sexual, physical, and mental abuse. -The facility was responsible for taking reasonable, appropriate steps to ensure that each resident is free from abuse, neglect, and exploitation by anyone, including but not limited to staff. -Prompt, thorough investigations are conducted in response to complaints or allegation of abuse, neglect, and/or exploitation, and all proper and required notifications are made to the proper individuals and authorities according to applicable state and federal regulations. -Residents and staff are protected during incident investigations by ensuring reports are made without fear of retaliation and that anonymous reports are investigated. -The Administrator is responsible for the oversight and implementation of the Abuse, Neglect, and Exploitation Prohibition and Prevention Program. -The facility has a zero-tolerance policy with regard to abuse, neglect, and exploitation. -In responding to any allegation of abuse of a resident, the first priority is to protect the resident	D 338		

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and to prevent further potential abuse the following steps may be taken: if the allegation involves an employee, the employee is immediately removed from contact with the resident and may be suspended, pending the outcome of the investigation, the Administrator or his/her designee personally meets with any involved resident and/or family member to reassure him/her and determine placement that is best for the resident's safety, in the event of physical abuse allegations, the Director of Nursing/Resident Services Director or designee immediately arranges for a physical examination of the resident.
-The physical examination of the resident is conducted by an appropriately trained/licensed professional and the time, date, and person completing the examination are recorded in the medical record.
-The resident is monitored for 72 hours post allegation.
-All allegations of abuse are promptly investigated by the Administrator who is ultimately responsible for initiating and overseeing the investigation process.
-Documentation of the investigation findings are maintained on applicable forms or reports.
-The Administrator keeps the resident and his/her representative informed of the progress of the investigation.
-When the investigation is complete, the resident and his/her representative are informed of the results and correction action is taken.
-If an allegation involves abuse, notification must occur immediately but no later than 24 hours.
-The facility should maintain documentation in the resident's medical record of the identified signs/symptoms and allegation of abuse, assessment of the resident's condition, immediate interventions implemented, notification

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of the resident's physician, and notification of the family or responsible party for the resident.

1. Review of Resident #11's current FL2 dated 11/10/23 revealed diagnoses included diabetes, cervical disc disease, enlarged prostate, hypertension, coronary artery disease, hyperlipidemia, cholecystitis.

Interview with Resident #11 on 03/15/24 at 11:00am revealed:
-The personal care aide (PCA) got mad when he requested that she turn off both the lamp and the light, she turned off one and not the other.
-The PCA got mad when he told her that he did not feel like going to breakfast.
-Breakfast started at 7am, and it was too early for him.
-The PCA insisted that he go to breakfast and became rough through using force.
-The PCA grabbed his legs and turned them to a point where he did not have another choice but to get up.
-The PCA said to him, "you are going" and proceeded to force him out of bed by attempting to pull his legs out of the bed.
-He fought a little bit but then gave in.
-He stated that, "it feels like a rape scene, I feel humiliated, and I do not have control of my life."
-When he did not go to breakfast, the Administer came to him and said, "I'm getting ambiguous about you", which his understanding was should she keep him at the facility or discharge him.
-Three days prior while using the restroom, the medication aide (MA) walked in around 8:30am and made a gesture for him to take his medications. He said, "what the "expletive" are you doing?" The MA said, "take them." He said, "don't ever come in here like that again."
-He was afraid of retaliation if he mentioned what

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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 338	Continued From page 40 happened to him and that he would be discharged. Interview with the PCA on 03/15/24 at 2:01pm revealed: -She came to work at 6:00am and breakfast was scheduled for 7:00am. -She entered his room about 7:25am. -She asked him if he was ready for breakfast and sometimes, he would say his legs hurt or that he did not feel well. -When he refused to go to breakfast, she would return later and ask if he was ready to go to breakfast then. -She did not force him out of bed or have an altercation with him. Interview with the Administrator on 03/15/24 at 4:27pm revealed: -She was unaware of an incident with the MA and with the PCA. -The staff tried to get the resident to go to breakfast because he was a diabetic and she did not want his blood sugar to get low. -The facility did a 24 hour/ 5-day report and investigated and notified the Department of Social Services (DSS) with findings of any abuse or neglect. -She walked around the community and visited with the residents to check on them often. -She told the residents that they could come to her with issues or complaints, and she left her business card with work cell phone number for easy access. -Resident Rights training was implemented often "every single day" because she used issues as teachable moments. -She would be working on getting someone to implement resident rights training to staff.	D 338		

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D 338	Continued From page 41 2. Review of Resident #2's current FL-2 dated 02/23/24 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerosis, and coronary artery disease, ogilvie syndrome, type 2 diabetes mellitus with other diabetic kidney complication, hypertension, secondary polycythemia, malignant neoplasm of bronchus and lung, polyneuropathy, and rash. Review of Resident #2's move in record form revealed an admission date of 02/28/22. Interview with Resident #2 on 03/13/24 at 10:38am revealed: -About 2-3 weeks ago, the Director of Resident Care (DRC) licked her tongue at him and said "hey trouble" as she walked towards him while he sat at the entrance of the building and read the newspaper. -Resident #2 replied to the DRC by saying that was not an adult thing to say and do. -The DRC spoke to him for the first time since the incident on 03/12/24 when she brought him a snack. -He felt like the DRC was being vindictive by not speaking to him, as she had seen him throughout the building on multiple occasions. -Resident #2 indicated the Administrator had given him the cold shoulder for about 3 months by not speaking to him, which was why he had not shared his concerns regarding the DRC. -Resident #2 indicated the Administrator would put her head down to keep from speaking to him when she saw him in the hallway. -Resident #2 felt that the Administrator's behavior towards him was due to concerns regarding his care which were addressed with her in the past by him and/or his Power of Attorney's (POA). Second interview with Resident #2 on 03/14/24 at 1:17pm revealed:	D 338		

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-He did not like the DRC's comment of "hey trouble" and her licking her tongue at him.
-He did not like that the DRC and Administrator would not speak to him.
-Resident #2 indicated that he was more upset with the Administrator's behavior of not speaking to him, as he held her to a higher standard than the DRC.
-Staff should treat residents with dignity and respect even if they had concerns about the care being provided.
-He felt that staff not speaking showed a lack of character and was unprofessional.

Interview with the Administrator on 03/15/24 at 4:43pm revealed:
-She had an open-door policy and wanted residents to make her aware of any concerns.
-She was always available to residents, as she had given out her business card which listed her cell phone to residents in the past, giving them access to her at all times.
-She expected all staff, including herself, to treat all residents with dignity and respect.
-Resident Rights training was on-going she would address concerns upon acknowledgement.

3. Review of Resident #5's current FI-2 dated 12/12/23 revealed diagnoses included multiple sclerosis (MS), chronic diastolic heart failure, atrial fibrillation, hypertension, and post-traumatic stress syndrome.

Review of Resident #5's admission packet revealed:
-The facility provided transportation on Monday, Tuesday, and Wednesdays for doctor appointments.
-Residents had to schedule their appointments 72 hours or more in advance through the front desk

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for the facility to transport because of the limited number of appointments.
-The facility operates within a 15-mile radius and if out of that 15 miles a charge would be applied to their account.

Review of Resident #5's Emergency Department (ED) After Visit Summary dated on 02/22/24 revealed:
-A diagnosis of atrial fibrillation.
-Resident #5 was to follow up with his cardiologist.

Review of facility appointment calendar on 03/15/24 revealed a cardiologist appointment was scheduled for Resident #5 on 03/11/24 at 2:30pm.

Interview with Resident #5 on 03/13/24 at 1:08pm revealed:
-The facility van transported him to his cardiologist appointment on 03/11/24.
-It was a follow up appointment for atrial fibrillation from when he was seen in the ED (02/22/24).
-He had to walk using his rotator a long distance from the facility van to the cardiologist office entrance and he felt like this was difficult for him because of his MS and having to use a rollator to walk.
-He was not able to see the cardiologist that day due to the appointment had been canceled.
-He did not know who canceled the appointment.

Interview with the Activity Director on 03/15/24 at 2:10pm revealed:
-She was qualified to drive the transportation van.
-The front desk maintains the appointment calendar.
-The Administrator and her could drive the

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transportation van.

Interview with the Administrator on 03/15/24 at 11:00am revealed:
-She drove Resident #5 to his cardiologist appointment.
-A personal care aide (PCA) rode on the van to cardiologist appointment with Resident #5.
-She was not able to pull the van up to the entrance of the cardiologist's office building and get the ramp open and had to park on the side of the building.
-Resident #5 had to walk about 100 feet from the facility van to the cardiologist's office building entrance.
-She said that Resident #5 had complained to her about how far he had to walk.
-She was unaware until they arrived at the appointment and informed by the office staff that Resident #5 canceled his appointment.

Attempted telephone interview with the contracted facility primary care provider on 03/14/24 at 12:48pm was unsuccessful.

____

The facility failed to ensure all residents were treated with respect and dignity and residents were free from physical, verbal, and mental abuse. The facility's failure resulted in a resident being pulled by his legs by a staff member who forced him to get out of bed to attend breakfast and caused the resident to feel he was in a "rape scene" and a medication aide violated the resident's privacy by attempting to administer him medication while he was in the restroom (#11), a resident who felt that he was ignored and bullied by the Administrator and the Director of Resident Care (DRC) (#2), and a resident with a diagnosis of Multiple Sclerosis (MS) and post-traumatic stress disorder (PTSD) who was transported to

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D 338	Continued From page 45 the cardiologist appointment by facility staff on the facility van and dropped off in the parking lot and had to walk a distance with his rollator to the entrance of the cardioligist's office (#5). This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/15/24 for this violation.	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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#10, #12, #13) observed during the medication pass including errors with a medication used to treat and prevent blood clots, a medication used to treat allergies, a medication used to treat heartburn, and a vitamin supplement for the eyes (#10), a medication used to help digest food (#12), a medication used to treat blood clots, a medication used to treat leg pain, and a medication used to treat gastroesophageal reflux (#13); and for 1 of 6 residents (#2) sampled for	D 358		

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record review for a medication used to treat asthma.

The findings are:

1. The medication error rate was 21% as evidenced by the observation of 7 errors out of 32 opportunities during the morning medication pass on 03/12/24.

a. Review of Resident #10's current FI-2 dated 11/02/23 revealed diagnoses included cardiac pacemaker, bradycardia, atrial fibrillation, heart disease with heart failure, morbid obesity, depression, asthma, and aortic valve stenosis.

Review of Resident #10's current physician order sheet dated 03/13/24 revealed an order for Eliquis 5mg, two times daily. (Eliquis is a blood thinner used to treat and prevent blood clots).

Observation of the morning medication pass on 03/12/24 revealed Eliquis 5mg was administered to Resident #10 at 8:34am when she received her other medications.

Review of Resident #10's March 2024 electronic medication administration records (eMARs) revealed:
-There was an entry for Eliquis 5mg, one tablet two times daily, scheduled at 7:00am and 7:00pm.
-Eliquis was documented as administered 03/01/24 through 03/12/24 at 7:00am and 03/01/24 through 03/11/24 at 7:00pm.

Interview with Resident #10 on 03/13/24 at 11:13am revealed she normally received her morning medications after breakfast between 8:30am to 9:30am.

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Interview with the first medication aide (MA) on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what to do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCA).
-There was one MA scheduled for the first floor

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D 358	Continued From page 48 and one MA scheduled for the second floor, this was determined by census. -On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes. -Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall. -She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor. Interview with the ADRC on 03/14/24 at 9:30am revealed: -MAs should notify management when medications were administered late for assistance. -MAs had been educated to ask for help when medications were administered late. -First floor staff reported to the WC and the second floor reported to her. -Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.) -On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am. Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed: -MAs should have asked for help when medications were administered late. -All the medication carts' start times were different, which allowed time for the medications to be passed. -MAs were staffed related to the census and need.	D 358		

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-There were two MAs scheduled per shift.
-The WC scheduled the staff.

Interview with the Administrator on 03/14/24 at 10:40am revealed:
-She thought that the MAs were trained on what to do when medications were administered late.
-MAs should have asked for help when medications were administered late.
-There were 2-3 MAs scheduled per shift, 2 was the minimal staffing.

Attempted telephone interview with the facility's contracted primary care provider (PCP) on 03/14/24 at 11:10am was unsuccessful.

b. Review of Resident #10's current physician order sheet dated 03/13/24 revealed an order for Ipratropium 0.06% 2 puffs each nostril, three times daily. (Ipratropium is used to treat allergies.)

Observation of the morning medication pass on 03/12/24 revealed Ipratropium 0.06% was administered to Resident #10 at 8:34am when she received her other medications.

Review of Resident #10's March 2024 eMARs revealed:
-There was an entry for Ipratropium 0.06% 2 puffs each nostril, three times daily scheduled at 7:00am, 1:00pm, and 7:00pm.
-Ipratropium was documented as administered 03/01/24 through 03/12/24 at 7:00am and 03/01/24 through 03/11/24 at 1:00pm and 03/01/24 through 03/11/24 at 7:00pm.

Interview with Resident #10 on 03/13/24 at 11:13am revealed she normally received her morning medications after breakfast between

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8:30-9:30am.

Interview with the first medication aide (MA) on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what to do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCAs).

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-There was one MA scheduled for the first floor and one MA scheduled for the second floor, this was determined by census.
-On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes.
-Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall.
-She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor.

Interview with the ADRC on 03/14/24 at 9:30am revealed:
-MAs should notify management when medications were administered late for assistance.
-MAs had been educated to ask for help when medications were administered late.
-First floor staff reported to the WC and the second floor reported to her.
-Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.)
-On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am.

Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed:
-MAs should have asked for help when medications were administered late.
-All the medication carts' start times were different, which allowed time for the medications to be passed.
-MAs were staffed related to the census and

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need.
-There were two MAs scheduled per shift.
-The WC scheduled the staff.

Interview with the Administrator on 03/14/24 at 10:40am revealed:
-She thought that the MAs were trained on what to do when medications were administered late.
-MAs should have asked for help when medications were administered late.
-There were 2-3 MAs scheduled per shift, 2 was the minimal staffing.

Attempted telephone interview with the facility's contracted PCP on 03/14/24 at 11:10am was unsuccessful.

c. Review of Resident #10's current physician order sheet dated 03/13/24 revealed an order for Omeprazole 40mg, two times daily. (Omeprazole is used to treat heart burn.)

Observation of the morning medication pass on 03/12/24 revealed Omeprazole 40mg was administered to Resident #10 at 8:34am when she received her other medications.

Review of Resident #10's March 2024 eMARs revealed:
-There was an entry for Omeprazole 40mg, two times daily scheduled at 7:00am and 7:00pm.
-Omeprazole was documented as administered 03/01/24 through 03/12/24 at 7:00am and 03/01/24 through 03/11/24 at 7:00pm.

Interview with Resident #10 on 03/13/24 at 11:13am revealed:
-She was on medication for heartburn.
-The medication worked better in the morning if taken before breakfast.

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

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-Breakfast was served at 7:30am.

Interview with the first medication aide (MA) on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what to do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCAs).

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-There was one MA scheduled for the first floor and one MA scheduled for the second floor, this was determined by census.
-On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes.
-Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall.
-She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor.

Interview with the ADRC on 03/14/24 at 9:30am revealed:
-MAs should notify management when medications were administered late for assistance.
-MAs had been educated to ask for help when medications were administered late.
-First floor staff reported to the WC and the second floor reported to her.
-Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.)
-On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am.

Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed:
-MAs should have asked for help when medications were administered late.
-All the medication carts' start times were different, which allowed time for the medications to be passed.
-MAs were staffed related to the census and

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need.
-There were two MAs scheduled per shift.
-The WC scheduled the staff.

Interview with the Administrator on 03/14/24 at 10:40am revealed:
-She thought that the MAs were trained on what to do when medications were administered late.
-MAs should have asked for help when medications were administered late.
-There were 2-3 MAs scheduled per shift, 2 was the minimal staffing.

Attempted telephone interview with the facility's contracted PCP on 03/14/24 at 11:10am was unsuccessful.

d. Review of Resident #10's current physician order sheet dated 03/13/24 revealed an order for Pressor Vision, two times daily. (Pressor Vision is used as a supplement for the eyes.)

Observation of the morning medication pass on 03/12/24 revealed Pressor Vision was administered to Resident #10 at 8:34am when she received her other medications.

Review of Resident #10's March 2024 eMARs revealed:
-There was an entry for Pressor Vision, two times daily scheduled at 7:00am and 7:00pm.
- Pressor Vision was documented as administered 03/01/24 through 03/12/24 at 7:00am and 03/01/24 through 03/11/24 at 7:00pm.

Interview with Resident #10 on 03/13/24 at 11:13am revealed she normally received her morning medications after breakfast between 8:30-9:30am.

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Interview with the first medication aide (MA) on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what to do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCAs).
-There was one MA scheduled for the first floor

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and one MA scheduled for the second floor, this was determined by census.
-On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes.
-Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall.
-She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor.

Interview with the ADRC on 03/14/24 at 9:30am revealed:
-MAs should notify management when medications were administered late for assistance.
-MAs had been educated to ask for help when medications were administered late.
-First floor staff reported to the WC and the second floor reported to her.
-Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.)
-On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am.

Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed:
-MAs should have asked for help when medications were administered late.
-All the medication carts' start times were different, which allowed time for the medications to be passed.
-MAs were staffed related to the census and need.

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D 358	Continued From page 58 -There were two MAs scheduled per shift. -The WC scheduled the staff. Interview with the Administrator on 03/14/24 at 10:40am revealed: -She thought that the MAs were trained on what to do when medications were administered late. -MAs should have asked for help when medications were administered late. -There were 2-3 MAs scheduled per shift, 2 was the minimal staffing. Attempted telephone interview with the facility's contracted PCP on 03/14/24 at 11:10am was unsuccessful. e. Review of Resident #12's current FI-2 dated 11/28/23 revealed: -Diagnoses included chronic pancreatitis, cirrhosis of the liver, pulmonary fibrosis, type 2 diabetes, vitamin B12 deficiency, and anemia. -There was an order for Creon delayed release 6000-19000 units, two times daily scheduled at 7:00am and 7:00pm. (Creon is used to help digest food.) Observation of the morning medication pass on 03/12/24 revealed Creon was administered to Resident #12 at 9:10am when he received his other medications. Review of Resident #12's March 2024 eMARs revealed: -There was an entry for Creon 6000-19000 units, two times daily scheduled at 7:00am and 7:00pm. -Creon was documented as administered 03/01/24 through 03/12/24 at 7:00am and 03/01/24 through 03/11/24 at 7:00pm. Interview with Resident #12 on 03/13/24 at	D 358		

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2:30pm revealed he had loose stools daily.

Interview with the first medication aide (MA) on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what to do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCAs).

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D 358	Continued From page 60 -There was one MA scheduled for the first floor and one MA scheduled for the second floor, this was determined by census. -On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes. -Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall. -She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor. Interview with the ADRC on 03/14/24 at 9:30am revealed: -MAs should notify management when medications were administered late for assistance. -MAs had been educated to ask for help when medications were administered late. -First floor staff reported to the WC and the second floor reported to her. -Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.) -On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am. Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed: -MAs should have asked for help when medications were administered late. -All the medication carts' start times were different, which allowed time for the medications to be passed. -MAs were staffed related to the census and	D 358		

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need.
-There were two MAs scheduled per shift.
-The WC scheduled the staff.

Interview with the Administrator on 03/14/24 at 10:40am revealed:
-She thought that the MAs were trained on what to do when medications were administered late.
-MAs should have asked for help when medications were administered late.
-There were 2-3 MAs scheduled per shift, 2 was the minimal staffing.

Telephone interview with the facility's contracted pharmacist on 03/14/24 at 10:55am revealed it was important to administer Creon at mealtimes because it helped to digest food and would be less effective when administered after meals.

Telephone interview with the Resident #12's primary care provider (PCP) on 03/14/24 at 10:55am revealed Resident #12's Creon, when administered late, could cause diarrhea due to food not being absorbed correctly.

f. Review of Resident #13's current FI-2 dated 03/12/24 revealed diagnoses included atrial fibrillation, stroke, coronary artery disease, and osteoporosis.

Observation of the morning medication pass on 03/12/24 revealed Gabapentin 100mg was administered to Resident #13 at 8:43am when she received her other medications. (Gabapentin is used to treat pain.)

Review of Resident #13's March 2024 eMARs revealed:
-There was an entry for Gabapentin 100mg, three times daily scheduled at 7:00am, 1:00pm, and

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7:00pm.
-Gabapentin 100mg was documented as administered on 03/12/24 at 7:00am and 03/11/24 at 1:00pm, and 03/11/24 at 7:00pm.

Interview with Resident #13 on 03/13/24 at 3:45pm revealed she was not experiencing any pain.

Interview with the first MA on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what you should do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications

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were administered over one hour late.
-Management should have been notified if medications were administered late.
-MAs had been educated on what to do if medications were administered late.
-She did the schedule for nursing staff which included MAs and personal care aides (PCAs).
-There was one MA scheduled for the first floor and one MA scheduled for the second floor, this was determined by census.
-On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes.
-Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall.
-She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor.

Interview with the ADRC on 03/14/24 at 9:30am revealed:
-MAs should notify management when medications were administered late for assistance.
-MAs had been educated to ask for help when medications were administered late.
-First floor staff reported to the WC and the second floor reported to her.
-Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.)
-On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am.

Interview with the Director of Resident Care

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(DRC) on 03/14/24 at 10:00am revealed:
-MAs should have asked for help when medications were administered late.
-All the medication carts' start times were different, which allowed time for the medications to be passed.
-MAs were staffed related to the census and need.
-There were two MAs scheduled per shift.
-The WC scheduled the staff.

Interview with the Administrator on 03/14/24 at 10:40am revealed:
-She thought that the MAs were trained on what to do when medications were administered late.
-MAs should have asked for help when medications were administered late.
-There were 2-3 MAs scheduled per shift, 2 was the minimal staffing.

Telephone interview with the facility's contracted pharmacist on 03/14/24 at 11:00am revealed if Gabapentin was administered too far apart the pain could increase or if administered to close together it could increase sedation.

Attempted telephone interview with the facility's contracted PCP on 03/13/24 at 11:10am was unsuccessful.

g. Review of Resident #13's current FI-2 dated 03/12/24 revealed diagnoses included atrial fibrillation, stroke, coronary artery disease, and osteoporosis.

Observation of the morning medication pass on 03/12/24 revealed Eliquis 2.5mg was administered to Resident #13 at 8:43am when she received her other medications (Eliquis is used to treat or prevent blood clots).

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Review of Resident #13's March 2024 eMARs revealed:
-There was an entry for Eliquis 2.5mg, two times daily scheduled at 7:00am and 7:00pm.
-Eliquis was documented as administered on 03/12/24 at 7:00am and 03/11/24 at 7:00pm.

Interview with the first MA on 03/14/24 at 10:55am revealed:
-Medication administration began first with the residents with diabetes on the first floor and then medications were administered on the right hall and then the left hall.
-MA staffing was one MA on the first floor and one MA on the second floor.
-There has not been any education provided on what you should do when medications were administered late.

Interview with the second MA on 03/14/24 at 10:00am revealed:
-She administered medications on the Special Care Unit (SCU) first and then on the Assisted Living (AL) side.
-There had not been any education related to what to do if medications were administered late.
-There was not anyone to call or pull to help administer medications.
-She just continued to administer the medications until completed.
-She did not notify the provider when medications are administered late.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-MAs should document a progress note on the reason medications were administered late.
-MAs should notify the provider if medications were administered over one hour late.

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D 358	Continued From page 66 -Management should have been notified if medications were administered late. -MAs had been educated on what to do if medications were administered late. -She did the schedule for nursing staff which included MAs and personal care aides (PCAs). -There was one MA scheduled for the first floor and one MA scheduled for the second floor, this was determined by census. -On the first floor the right hall medication administration time started at 7:00am and on the first-floor left hall medication administration time started at 8:00am and 9:00am except for the residents diagnosed with diabetes. -Staff started the medication administration with residents diagnosed with diabetes and then continued the first-floor right hall and then first-floor left hall. -She was responsible for the first floor and the Assistant Director of Resident Care (ADRC) was responsible for the second floor. Interview with the ADRC on 03/14/24 at 9:30am revealed: -MAs should notify management when medications were administered late for assistance. -MAs had been educated to ask for help when medications were administered late. -First floor staff reported to the WC and the second floor reported to her. -Normal practice was one MA on first floor and one MA on second floor for both shifts (6:00am-6:00pm and 6:00pm-6:00am.) -On the second floor the medications were scheduled for administration in the AL at 7:00am and SCU at 8:00am and 9:00am. Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:00am revealed:	D 358		

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D 358	Continued From page 67 -MAs should have asked for help when medications were administered late. -All the medication carts' start times were different, which allowed time for the medications to be passed. -MAs were staffed related to the census and need. -There were two MAs scheduled per shift. -The WC scheduled the staff. Interview with the Administrator on 03/14/24 at 10:40am revealed: -She thought that the MAs were trained on what to do when medications were administered late. -MAs should have asked for help when medications were administered late. -There were 2-3 MAs scheduled per shift, 2 was the minimal staffing. Attempted telephone interview with the facility's contracted PCP on 03/14/24 at 11:10am was unsuccessful. 2. Review of Resident #2's current FL-2 dated 02/23/24 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerosis and coronary artery disease, type 2 diabetes mellitus with other diabetic kidney complication, and hypertension. a. Review of a physician's order sheet form for Resident #2 dated 12/08/23 revealed there was an order for Gabapentin 300mg 1 capsule three times a day for leg pain (Gabapentin is used to treat nerve pain). Review of Resident #2's current FL-2 dated 02/23/24 revealed there was an order for Gabapentin 300mg 1 tablet three times a day.	D 358		

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Review of Resident #2's February 2024 electronic medication administration record (eMARs) revealed:
-There was an entry for Gabapentin 300mg 1 capsule three times daily for leg pain, scheduled at 9:00am, 1:00pm, and 9:00pm.
-Gabapentin 300mg was documented as administered on 02/01/24-02/16/24 and 02/20/24-02/29/24 at 9:00am.
-On 02/17/24, 02/18/24, and 02/19/24 at 9:00am there was an "O" above the medication aides (MAs) initials.
-Gabapentin 300mg was documented as administered on 02/01/24-02/15/24 and 02/20/24-02/29/24 at 1:00pm.
-On 02/16/24 at 1:00pm there was a 5 above the MA initials.
-On 02/17/24, 02/18/24, and 02/19/24 at 1:00pm there was an "O" above the MA initials.
-Gabapentin 300mg was documented as administered on 02/01/24-02/15/24, 02/17/24, and 02/19/24-02/29/24 at 9:00pm.
-On 02/16/24 and 02/18/24 at 9:00pm there was an "O" above the MA initials.
-Per the chart codes on the eMAR, O=Other/See progress notes and 5=Hold/See progress notes.

Review of Resident #2's progress notes revealed:
-On 02/16/24, at 2:01pm it was documented that Gabapentin 300mg needed to be ordered.
-On 02/16/24, at 9:42pm it was documented that Gabapentin 300mg was not available.
-On 02/17/24, at 10:19am it was documented that Gabapentin 300mg was on order.
-On 02/17/24, at 12:07pm it was documented that Gabapentin 300mg was on order.
-On 02/18/24, at 12:10pm and 12:14pm it was documented that Gabapentin 300mg was on order.
-On 02/18/24, at 7:43pm it was documented that

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Gabapentin 300mg was ordered.
-On 02/19/24, at 12:36 pm it was documented that the Wellness Coordinator (WC) spoke to a local pharmacy to fill and send the resident's Gabapentin.
-On 02/19/24, at 2:18pm it was documented that Gabapentin 300mg was on order.

Review of prescription history for Resident #2 from 11/01/23 to 02/22/24 revealed:
-Gabapentin 300mg capsule (270 capsules) were filled on 11/29/23.
-Gabapentin 300mg capsule (90 capsules) were filled on 02/19/24.

Interview with Resident #2 on 03/13/24 at 10:38am revealed:
-He had an order for Gabapentin due to leg pain, which was to be administered three times daily.
-He missed several doses of Gabapentin in February 2024 as the medication was not on hand.
-His Gabapentin was on auto refill from the pharmacy and therefore should have never run out.
-His Power of Attorney (POA) picked up the Gabapentin and brought it to the facility, as the pharmacy he used only delivered medications to the facility on Thursdays.
-The facility found his blister pack of Gabapentin after the POA had brought in medications, which meant he had not run out of medications after all.
-He didn't have any increased leg pain from missed doses of Gabapentin but felt he needed the medication to lessen the chance of increased pain.

Telephone interview with Resident #2's POA on 03/13/24 at 5:58pm revealed:
-She was not sure of the date that Resident #2

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D 358	Continued From page 70 called her to let her know he was out of Gabapentin, as the facility never called her to make her aware. -Resident #2's medication was on auto refill from the pharmacy, which meant they should have never run out. -She picked up Resident #'2 Gabapentin from the pharmacy on 02/19/24 and took the medication to the facility between 1:00pm-2:00pm, since the pharmacy the resident used only delivered medications to the facility on Thursdays. -On 02/19/24, the Administrator told the POA the facility could not locate Resident #2's Gabapentin, as his medication could have been sent home with another resident who had signed out of the facility. Interview with a MA on 02/23/24 at 11:45am revealed: -Resident #2 had been out of Gabapentin a few days in February. -If a resident's medication was not available, the MA was responsible for calling the pharmacy to get the medication ordered. -The MAs were expected to document in the resident's progress note when the medication was not on hand to be administered and when pharmacy was called about getting the medication reordered. -She did not call the pharmacy about Resident #2's Gabapentin, as she assumed another MA had called. -She did not check Resident #2's progress notes to see if Resident #2's Gabapentin had been reordered. Interview with the Wellness Coordinator (WC) on 03/15/24 at 11:00am revealed: -She was not aware Resident #2 had been out of Gabapentin until 02/21/24.	D 358		

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D 358	Continued From page 71 -Since Resident #2 did not use the facility's contracted pharmacy, his POA was responsible for making sure his medications were in the building. -Staff had to call Resident #2's POA at times to have her pick up his medications, as his pharmacy only delivered medications to the facility on Thursdays. -Resident #2's POA had refused to pick up his medications at times that were needed before Thursday, which meant the resident would not have medication on hand to be administered. -Residents had been ordered medications due to medical need. -Residents should not run out of medications and medications should be administered as ordered. Interview with the Director of Resident Care (DRC) on 02/21/24 at 11:45am revealed: -Resident #2 was to be given Gabapentin three times daily according to his order. -Resident #2's POA made her aware on 02/19/24 that the resident had missed Gabapentin on 02/16/24-02/19/24, as the medication had run out. -Resident #2 should not have been out of Gabapentin due to the last order being filled in November 2023 (for a 90-day supply). -Resident #2's POA picked up the resident's Gabapentin from the pharmacy and delivered the medication to the facility on 02/19/24, since the resident's chosen pharmacy only delivered medications to the facility on Thursdays. -The MA should have called the pharmacy to reorder Resident #2's Gabapentin prior to 02/19/24. -She expected residents to have medications available to be administered as ordered. Interview with the Administrator on 02/21/24.	D 358		

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-Resident #2's POA made her aware that Resident #2 had been out of Gabapentin for several days on 02/19/24.
-The facility could not locate Resident #2's Gabapentin, as it could have been sent home with another resident who had signed out of the facility.
-She did not know why the MA did not call the pharmacy to have Resident #2's Gabapentin reordered prior to 02/19/24.
-The facility was ultimately responsible for ensuring medications were in the building to be administered as ordered.

Telephone interview with the Clinic Coordinator at Resident #2's primary care provider (PCP) office on 03/15/24 at 9:51pm revealed:
-Resident #2 was seen on 11/28/23 by his PCP.
-On 11/28/23, the PCP wrote an order for Gabapentin 300mg 1 three times daily (270 capsules).
-Due to the 11/28/23 order, Resident #2's Gabapentin should not have run out 02/16/24.
-On 02/19/24, a refill request was received from the pharmacy.
-On 02/19/24, an order was written for Gabapentin 300mg 1 three times daily (270 capsules).
-The facility did not call Resident #'2's PCP during the time of 02/16/24-02/19/24 to report the resident was out of Gabapentin.
-Resident #2 had been ordered Gabapentin for nerve pain.
-The nurse indicated that Resident #2 could have had increase pain, nausea, or headaches due to missed doses of Gabapentin.
-She would expect the facility to have medications on hand for residents and to administer as ordered.

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Telephone interview with a pharmacy technician at Resident #2's chosen pharmacy on 03/13/24 at 3:35pm revealed:
-Resident #'2's order for Gabapentin 300mg 1 three times daily was originally ordered on 06/22/23.
-The pharmacy filled 270 capsules of Gabapentin 300mg on 11/29/23, which were delivered to the facility on 11/30/24, as the pharmacy only delivered medications to the facility on Thursdays.
-The pharmacy filled 90 capsules of Gabapentin 300mg on 02/19/24, which were picked up by Resident #1's POA.
-Resident #2 should not have run out of Gabapentin on 02/16/24.
-She expected medication to be available and administered as ordered.

b. Review of a physician's order sheet form for Resident #2 dated 12/08/23 revealed there was an order for Montelukast Sodium 10mg 1 tablet at bedtime (Montelukast Sodium is a medication used to treat asthma).

Review of Resident #2's current FL-2 dated 02/23/24 revealed there was an order for Montelukast Sodium 10mg 1 tablet at bedtime.

Review of Resident #2's February 2024 eMARs revealed:
-There was an entry for Montelukast Sodium 10mg 1 tablet at bedtime, scheduled at 8:00pm.
-Montelukast Sodium 10mg was documented as administered on 02/01/24-02/25/24 and 02/29/24.
-On 02/26/24, 02/27/24, and 02/28/24 there at 8:00pm was a "O" above the MA initials.
-Per the chart codes on the eMAR, O=Other/See progress notes.

Review of Resident #2's progress notes revealed:

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-On 02/26/24 at 7:57pm it was documented that Montelukast Sodium 10mg was on order.
-On 02/27/24 at 9:07pm it was documented that Montelukast Sodium 10mg was on order.
-On 02/28/24 at 8:28pm it was documented that Montelukast Sodium 10mg was on order.

Review of prescription history for Resident #2 from 11/01/23 to 02/22/24 revealed the pharmacy filled Montelukast Sodium (90 capsules) on 12/26/23.

Interview with the Wellness Coordinator (WC) on 03/15/24 at 11:00am revealed:
-She was not aware Resident #2 did not have Montelukast on hand until 03/12/24
-Residents should not run out of medications and medications should be administered as ordered.
-Residents were ordered medications due to medical need.

Interview with the Director of Resident Care (DRC) on 03/13/24 at 2:39pm revealed:
-She was not aware Resident #2's Montelukast was not available 02/26/24-02/28/24.
-She expected residents to have medications available to be administered as ordered to residents.

Interview with the Administrator on 03/13/24 at 5:10pm revealed:
-She was not aware Resident #2 was out of his Montelukast on 02/26/24-02/28/24.
-She expected medications to be in the building and to be administered as ordered.

Telephone interview with the clinic coordinator at Resident #2's Primary Care Provider's (PCP) office on 03/15/24 at 9:51pm revealed:
-The resident was ordered Montelukast Sodium

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10mg 1 daily at bedtime on 09/25/23 for allergies and coughing.
-She would expect the facility to have medications on hand for residents and the medications to be administered as ordered.

Telephone interview with a pharmacy technician at Resident #2's chosen pharmacy on 03/13/24 at 3:35pm revealed:
-Resident #2's PCP wrote order on 09/25/23 for Montelukast Sodium 10mg 1 every night.
-On 12/26/23, the pharmacy filled Montelukast Sodium 10mg 1 every night (90 capsules), which should have been available to Resident #2 on 02/26/24-02/28/24.
-Resident #2 would not have had an outcome by missed doses other than allergies would have gotten worse or sinuses inflamed.
-She expected medication to be available and administered as ordered.

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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

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medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure the electronic medication administration records were accurate for 3 of 9 sampled residents (#2, #5, and #13) including medications to treat a viral infection (#2), and hypertension (#5, #13).

The findings are:

1. Review of Resident #5's current FL-2 dated 12/12/23 revealed:
-Diagnoses included multiple sclerosis, hypertension, atrial fibrillation, and chronic diastolic heart failure.
-There was an order for Metoprolol ER 25mg once per day (an extended-release medication used for hypertension).

Review of the physician's order sheet for Resident #5 dated 12/15/23 revealed an order for Metoprolol Tartrate 25mg one time per day (an extended-release medication used for hypertension).

Observation of Resident #5's medications on hand on 03/13/24 at 4:25pm revealed that there was a medication card for Metoprolol Succinate Extended Release (ER) 25mg dispensed on 02/24/24 for Resident #5.

Review of Resident #5's February 2024 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Tartrate 25mg, one time a day scheduled for 7:00am.
-Metoprolol Tartrate 25 mg was documented as administered on 02/01/24 through 02/13/24 and 02/15/24 through 02/29/24.
-On 02/14/24 the eMAR was documented with an "o" (other/see progress note) for 7:00am and there was not any documentation in the progress note.

Review of Resident #5's March 2024 eMAR revealed:
-There was an entry for Metoprolol Tartrate 25mg, one time a day scheduled for 7:00am.
-Metoprolol Tartrate 25 mg was documented as administered on 03/01/24 through 03/12/24.

Interview with medication aide (MA) on 03/14/24 at 10:55am revealed:
-She had been educated that you compared the eMAR to the medication before administering.
-She was unsure why she did not compare the eMAR and medication before administering.
-When an "o" was placed on the eMARs the medication was not administered and the reason should be documented in the progress note.
-She had forgotten to document the reason Metoprolol was not administered in a progress note for Resident #5.

Interview with the facility's contracted pharmacist on 3/14/24 at 11:55am revealed:
-Resident #5 had only been dispensed Metoprolol Succinate ER 25mg per provider order.
-The facility staff entered the information on their eMARs.

Interview with the Wellness Coordinator (WC) on

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

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03/14/24 at 9:13am revealed:
-The WC, Assistant Director of Resident Care (ADRC), and Director of Resident care (DRC) entered orders onto the eMARs.
-The facility was in the process of training the MAs to enter orders.

Interview with the ADRC on 03/14/24 at 9:30am revealed:
-The ADRC, WC, and DRC entered orders onto the eMARs.
-MAs entered orders onto the eMARs and then the WC, ADRC, or DRC confirmed the orders were correct.
-She performed weekly medication cart audits.
-The DRC performed bimonthly medication cart audits with her.

Interview with the DRC on 03/14/24 at 10:00am revealed:
-The DRC, WC, and ADRC entered orders onto the eMARs.
-MAs entered orders onto the eMARs and then they were confirmed by management.
-Order tracking forms were completed by the staff that entered the orders, then the second reviewer checked the orders to make sure they were correct, then the DRC reviewed the orders by the second day.

Interview with the Administer on 03/14/24 at 10:40am revealed orders were entered by management onto the eMARs and then the prescription or orders were faxed to the pharmacy.

Attempted interview with the facility's contracted primary care provider (PCP) on 03/14/24 at 12:48pm was unsuccessful.

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2. Review of Resident #13's current FL-2 dated 03/12/24 revealed:
-Diagnoses included atrial fibrillation, stroke, hypertension, and coronary artery disease.
-There was an order for Metoprolol 75mg one time per day (a medication used for hypertension).

Observation of Resident #13's medications on hand on 03/12/24 at 10:49am revealed that there was a medication card for Metoprolol Succinate ER 25mg take 3 a day (75mg) dispensed on 03/08/24 for Resident #13.

Review of Resident #13's March 2024 eMAR revealed:
-There was an entry for Metoprolol Tartrate 25mg give 3 one time a day scheduled for 7:00am.
-Metoprolol Tartrate 75 mg was documented as administered on 03/12/24.

Interview with the medication aide (MA) on 03/14/24 at 10:55am revealed:
-She had been trained that you compared the eMAR to the medication before administering.
-She had forgotten to compare the eMAR and medication before administering.
-Supervisors entered the orders onto the eMARs.

Interview with the facility's contracted pharmacist on 3/13/24 at 10:20am revealed:
-Resident #13 had only been dispensed Metoprolol Succinate ER 25mg since admission.
-The facility staff entered the information onto their eMARs.

Interview with the Wellness Coordinator (WC) on 03/14/24 at 9:13am revealed:
-The WC, ADRC, and DRC entered orders onto the eMARs.

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D 367	Continued From page 80 -The facility was in the process of training the MAs to enter orders. Interview with the ADRC on 03/14/24 at 9:30am revealed: -The ADRC, WC, and DRC entered orders onto the eMARs. -MAs entered orders on the eMARs and then the WC, ADRC, or DRC confirmed the orders were correct. -She performed weekly medication cart audits. -The DRC performed bimonthly medication cart audits with her. Interview with the DRC on 03/14/24 at 10:00am revealed: -The DRC, WC, and ADRC entered orders on the eMARs. -MAs entered orders on the eMARs and then they were confirmed by management. -Order tracking forms were completed by the staff that entered the orders, then the second reviewer checked the orders to make sure they were correct, then the DRC reviewed the orders by the second day. Interview with the Administer on 03/14/24 at 10:40am revealed orders were entered by management into the eMARs and then the prescription or orders were faxed to pharmacy. Attempted interview with the facility's contracted primary care provider (PCP) on 03/14/24 at 11:10am was unsuccessful. 3. Review of Resident #2's current FL-2 dated 02/23/24 revealed: -Diagnoses included chronic obstructive pulmonary disease, atherosclerosis and coronary artery disease, Ogilvie syndrome, type 2 diabetes	D 367		

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mellitus with other diabetic kidney complication, hypertension, secondary polycythemia, malignant neoplasm of bronchus and lung, polyneuropathy, and rash.

Review of a communication sheet from Resident #2's primary care provider (PCP) dated 01/31/24 revealed:
-The resident had an ongoing rash.
-The PCP ordered Valacyclovir 1000mg 1 tablet twice daily for 7 days, 14 tablets.
-The PCP sent the antiviral medication prescription to local pharmacy.

Review of Resident #2's February 2024 electronic medication administration record (eMARs) revealed:
-There was an entry for Valacyclovir 1000mg tablet 1 tablet twice daily for 14 days scheduled for 9:00am and 9:00pm.
-There was documentation Valacyclovir 1000mg was administered 02/02/24-02/08/24 , 02/10/24-02/12/24, and 02/14/24-02/15/24 at 9:00am
-On 02/09/24 and 02/13/24, there was a "O" above the medication aides (MA) initials on 02/09/24 and 02/13/24 at 9:00am.
-There was documentation Valacyclovir 1000mg was administered 02/01/24-02/08/24 and 02/14/24 at 9:00pm.
-On 02/09/24-02/13/24 there was a "O" above the MA initials on 02/09/24 and 02/13/24 at 9:00pm.
-Per the chart codes on the eMAR, O=Other/See progress notes.

Review of prescription history for Resident #2 revealed a quantity of 14 tablets of Valacyclovir was ordered and filled on 01/31/24.

Telephone interview with a pharmacy technician

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D 367	Continued From page 82 at Resident #2's chosen pharmacy on 03/13/24 at 3:35pm revealed: -Resident #2's PCP ordered Valacyclovir 1000mg 1 tablet twice daily for 7 days (14 tablets) on 01/31/24. -A total of 14 tablets of Valacyclovir were filled on 01/31/24. -The Valacyclovir order was delivered to the facility on 02/01/24, which was a Thursday and the only day the pharmacy delivered to the facility. Interview with a medication aide (MA) on 03/14/24 revealed: -Resident #2 had an order for Valacyclovir for itching but she could not remember how many days the medication was ordered. -She documented on the eMAR after she observed that a resident took the medication. -Upon review of the February eMAR, the MA indicated there was no stop date for the Valacyclovir. -Upon review of the Valacyclovir order dated 01/31/24, she did not know why she documented she administered Valacyclovir on 02/10/24-02/12/24 at 9:00am, as those days were beyond the 7 days of the medication order. -The MA looked at the electronic medication system and could see the order was entered on 01/31/24 by the Wellness Coordinator (WC) for 14 days. Interview with the WC on 03/15/24 at 11:00am revealed: -Orders could be entered into the electronic medication system by a MA, WC, Assistant Director of Resident Care (ADRC) or the Director of Resident Care (DRC) but would not populate to the eMAR until verified by the WC, ADRC or DRC. -On 01/31/24 she entered Resident #2's order for	D 367		

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D 367	Continued From page 83 Valacyclovir into the electronic medication system, which was then added to the February eMAR. -She saw 14 and put in 14 days, which was the number of tablets to be administered for 7 days. -The pharmacy only dispensed 14 tablets of Valacyclovir to the facility. -She was not aware the MAs had documented the medication was administered beyond the 7 days. -Even with the order entered wrong there were only 14 tablets to administer for 7 days, as the medication was ordered twice daily for Resident #2. -Random eMARs were reviewed weekly by the WC, ADRC or the DRC to look for holes on the eMARs such as missed medications. -She had not reviewed any resident's eMARs for accuracy including Resident #2. Interview with the DRC on 03/14/24 at 1:25pm revealed: -Resident #2 was ordered Valacyclovir for itching to be administered 7 days. -She was not aware the Valacyclovir was documented it was administered beyond the 7 days. -The eMAR documentation should reflect that medications were administered as ordered. Interview with the Administrator on 03/13/24 at 5:10pm revealed medications should not be documented as given if they were not administered.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and	D 451		

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Incidents
(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of accident/incidents that required emergency medical evaluation for 2 of 5 sampled residents (#3, #4) who both sustained falls requiring transport to the local hospital by emergency medical services (EMS).

The findings are:

Review of the facility's Incident Reporting and Investigation Policy with an effective date of 05/20/22 revealed:
-Under Policy Guidelines: Incidents occurring in the community or on the community property are reported immediately to the observing team member's supervisor or manager on duty. An internal incident report is completed for any incident that occurs. Incidents are reported to the resident's representative/family member and physician.
-Reportable Incidents are reported to the applicable state licensing agency in accordance with, within the timeframes prescribed by, and using any forms required by, applicable state laws and regulations. Incidents are promptly and thoroughly investigated.
-Under Provisions and Procedures:
a. Post-Incident Evaluation, immediately following

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D 451	Continued From page 85 an incident, a determination is made by staff that are present as to whether the individual shows signs of injury. First aid or notification of Emergency Medical Services will occur as necessary. The injured person is not left unattended unless it is necessary to summon assistance. The resident's primary physician is notified for further direction, If the attending physician is not available, an alternate physician is notified (i.e. on call physician), If necessary, arrangements are made to transport the injured person to a hospital. b. Additional Notifications: One the urgent needs of the injured person are addressed; immediate notification is made to the appropriate person in charge (including the Executive Director and/or the Director of Resident Care. If the incident involves a resident, the responsible party/family member is promptly notified by phone. If the responsible party is not available, continued attempts are made to reach them at reasonable intervals and these attempts are documented in the resident record. The Executive Director or designee is responsible to notify the following internal and external individuals and or agencies of all Reportable Incidents: appropriate agencies as required by state-specific regulations, the Director of Operations and Director of Clinical, who then will notify his/her supervisor if needed, Corporate Risk Management as needed, Director of Clinical for infectious outbreaks and as needed. c. Incident Report: An Incident Report is completed for all incidents in the Incident Reporting System during the shift that the incident occurred, which includes the date, time, and exact location of the incident, the surrounding circumstances/details, names, phone numbers and statements of witnesses, the date/time the physician and family/personal representative	D 451		

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were contacted, the outcome of the evaluation and first aid rendered, the plan of response to the incident, the signature, date and title of the team member preparing the Incident Report, triggered evaluations are completed, immediate interventions provided and changes to the care/service plan. The person entering the incident report should ensure there is a witness statement for any team member who witnessed the incident. The Executive Director and Director of Resident Care reviews all Incident Reports for completeness and accuracy and determines, in consultation with the Director of Operations and Director of Clinical as needed, if the situation needs to be reported to a state agency and/or other applicable regulatory agency.
-Additional Documentation: In addition to completing the Incident Report, the facts and circumstances of any incident involving a resident is documented in the resident's record. Documentation occurs following the incident and not more than 24 hours after the incident, The Executive Director is ultimately accountable for all follow-up and investigations, and to ensure that documentation is completed. If a resident is involved in the incident, the resident should also have a follow-up progress note within 72 hours of the incident.

1. Review of Resident #3's current FL2 dated 02/23/24 revealed:
-Diagnoses included dementia, atherosclerosis, hypertension, depression, gastro-esophageal reflux disease without esophagitis, allergic rhinitis, and vitamin D deficiency.
-Resident #3 was constantly disoriented.
-Resident #3 required assistance with bathing.
-Resident #3 was semi-ambulatory.

Review of Resident #3's electronic progress

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notes dated 02/01/24 at 11:13am revealed, the resident was sent to the emergency department (ED) due to a fall in the hallway; the primary care provider (PCP) and power of attorney (POA) was made aware.

Review of Resident #3's accident/incident (A/I) report dated 02/02/24 at 9:26am revealed:
-The resident was walking down the hall without her walker, stumbled and fell landing on her right side.
-No injuries observed at time of incident.
-Emergency Medical Services (EMS), POA, and PCP were called.

Review of Resident #3's 02/01/24 emergency department (ED) after visit summary (AVS) revealed:
-Resident #3's reason for visit was a fall with uncertain cause.
-Resident #3's diagnosis was a fall.
-Resident #3 had imaging that consisted of cat scan of the cervical spine without contrast, cat scan of the head without contrast, portable chest x-ray and ECG 12 lead.
-The imaging did not show any concerning findings.
-Resident #3 was discharged back to the facility.

Review of Resident #3's electronic progress notes dated 02/02/24 at 8:46am revealed the MA observed swelling to the resident's right wrist and she complained of pain and stiffness.

Review of Resident #3's A/I report dated 02/09/24 revealed:
-The resident reported to the PCP that her wrist was sore and swollen.
-The right wrist was red and swollen and the provider ordered a mobile x-ray of the right wrist.

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-The PCP orders were to send the resident to hospital for stabilization of right wrist.

Review of Resident #3's radiology report dated 02/10/24 revealed an intra-articular distal radial fracture.

Review of Resident #3's 02/12/24 ED AVS revealed:
-Resident #3's reason for visit due to a wrist injury.
-Resident #3's diagnosis was a closed fracture of distal end of right radius, unspecified fracture morphology, initial encounter.
-Resident #3 had imaging that consisted of x-ray wrist right PA lateral and oblique.
-Resident #3 was given ibuprofen (Motrin) tablet).
-A shoulder immobilizer or splint was provided for the injury.
-Follow up with orthopedic surgeon.
-Resident #3 was discharged back to the facility.

Interview with the Wellness Coordinator (WC) on 03/15/24 at 9:43am revealed:
-On 02/01/24, she did not send an accident and incident report to Department of Social Services (DSS) because there were no injuries per the ED discharge summary.
-Per the fall policy, she should notify the PCP, POA and complete an accident and incident report to the DSS in 24 hours if there are any injuries.

Interview with the Director of Resident Care (DRC) on 03/15/24 at 11:48am revealed:
-She did not send an A/I report to DSS because the resident returned to the facility with no injuries.
-Per the fall policy, implement the PCP order when the resident returned.

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-MA completed the A/I report, then the DRC or the Administrator signed and acknowledged the report.
-The report goes to DSS once the discharge summary comes from the hospital only if an injury had been noted.

Interview with the local Department of Social Services Adult Home Specialist (AHS) on 03/15/24 at 12:20pm revealed:
-The facility was responsible for faxing incident reports to DSS for any incidents that happened which required more than first aid.
-She had not received an A/I report for Resident #3's fall on 02/01/24.
-The A/I Report the facility used did not have an area on the form for staff to document notification to the local department of social services or method of notification.

Refer to the second interview with the DRC on 03/15/24 at 4:00pm.

Refer to the interview with the Administrator on 03/15/24 at 4:27pm.
2. Review of Resident #4's current FL2 dated 03/11/24 revealed:
-Diagnoses included dementia and abdominal pain.
-Resident #4 was intermittently disoriented.
-Resident #4 required assistance with bathing and dressing.
-Resident #4 was ambulatory.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 03/29/23.

Review of Resident #4's electronic progress notes dated 02/22/24 revealed:

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-At 2:34pm, Acetaminophen 325mg, 2 capsules were administered for pain related to a wedge compression fracture of the thoracic spine.
-At 4:47pm, the resident was out of the facility.

Review of Resident #4's 02/22/24 emergency department (ED) after visit summary (AVS) revealed:
-Resident #4's reason for visit was a fall.
-Resident #4's diagnosis was a fall.
-Resident #4 had imaging that consisted of CT scan of the cervical spine without contrast, CT of the head without contrast, portable chest x-ray and x-ray of the pelvis.
-The imaging did not show any concerning findings.
-Resident #4 was discharged back to the facility.

Review of Resident #4's resident record revealed there was no incident and accident report dated 02/22/24.

Interview with the medication aide (MA) on 03/13/24 at 2:53pm revealed:
-A/I reports were to be completed whenever a resident fell, whether they were sent to the emergency department (ED) or not.
-A/I reports should contain a description of the event, observations of any injuries, who was contacted, including the primary care provider (PCP), the resident's responsible party (RP), members of the management team, and any interventions put into place.
-The MAs or the care managers were responsible for completing the A/I reports.
-The MAs were also responsible for completing a progress note on the resident in the electronic medical record whenever there was a fall.
-She did not know why she did not complete an A/I report for Resident #4's 02/22/24 fall.

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	HAL065045	A. BUILDING: ______ B. WING ______	R-C 03/15/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-She did not why she did not enter a progress note for Resident #4's 02/22/24 fall.

Interview with the Assistant Director of Resident care (ADRC) on 03/13/24 at 3:03pm revealed:
-Anytime a resident had a fall or injury, an A/I report was to be done.
-The MAs were responsible for completing the A/I reports.
-The A/I report should include a description of what occurred, a description of any injuries and who was notified.
-The MA should complete a progress note as well with a description of what occurred, any injuries, interventions and who was contacted.
-She did not know why an A/I report had not been completed for Resident #4's fall on 02/22/24.
-She did not know why there was no progress note entered for Resident #4 after her 02/22/24 fall.
-There should have been an A/I report completed and a progress note entered after Resident #4's 02/22/24 fall.

Interview with the Director of Resident Care (DRC) on 03/14/24 at 10:17am revealed:
-If a resident had a fall that required anything beyond first aid rendered by the facility, an A/I report should be completed.
-The MAs or the care managers were responsible for completing the A/I reports.
-The A/I reports should include a description of what occurred, observations of any injuries, documentation of interventions and documentation of who was notified, such as family, PCP and management.
-The MAs and or care managers were expected to document in the progress notes as well with a description of what occurred, observations of injuries and any interventions and who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL065045	A. BUILDING: ______ B. WING ______	R-C **03/15/2024**

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contacted.
-There should have been an A/I report completed for Resident #4's 02/22/24 fall.
-There should have been a progress note entered for Resident #4's fall on 02/22/24.

Interview with the local DSS Adult Home Specialist (AHS) on 03/15/24 at 12:20pm revealed:
-The facility was responsible for faxing incident reports to DSS for any incidents that happened which required more than first aid.
-She had not received an incident report for Resident #4's fall on 02/22/24.
-The Accident/Incident Report the facility used did not have an area on the form for staff to document notification to the local department of social services or method of notification.

Refer to second interview with the DRC on 03/15/24 at 4:27pm.

Refer to interview with the Administrator on 0315/24 at 4:27pm.

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Second interview with the DRC on 03/15/24 at 4:00pm revealed:
-She was trained by the Administrator on reporting of A/Is.
-The MAs or the care managers were responsible for completing A/I reports.
-She was not familiar with the facility's policy on reporting A/Is to the county Department of Social Services (DSS).
-She thought A/I reports were sent to the county DSS only if the resident sustained a significant injury such as sutures or a broken bone.

Interview with the Administrator on 03/15/24 at 4:27pm revealed:

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 451	Continued From page 93 -An A/I report should be completed for any fall requiring more than first aid rendered at the facility. -The MAs, care managers or herself completed the A/I reports. -The A/I report contained a description of the event that occurred, documentation of any injuries and interventions, notification of family, PCP, and management. -A/I reports should have been completed for Resident #3's fall on 02/01/24 and Resident #4's fall on 02/22/24 and a copy should have been sent to the PCP and the county DSS.	D 451		