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D 000	Initial Comments The Adult Care Licensure Section conducted a Follow-Up Survey on 06/05/23-06/08/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the environment was clean and free of hazards related to oxygen tanks not being secured in a resident's room and the cleanliness of the residents' wall air-conditioner/heater units and overhead bathroom exhaust vents. 1. Review of the facility's oxygen policy dated September 2021 revealed: -Oxygen tanks must be secured in a stand or to the wall in the room and portable oxygen tanks must be attached to the wheelchair or walker in a secure manner. -All staff were to follow safety requirements regarding oxygen. -Oxygen tanks shall be secured upright at all times to prevent falling over and secured in a manner to prevent tanks from being dropped or from striking violently against each other. -Tanks would not be stored near radiators or	D 079		

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D 079	Continued From page 1 other heat sources. Observation of a resident's room on 06/05/23 at 8:21am revealed: -There was a large oxygen tank in the resident's room sitting on the floor next to the heater; the heater was off. -The oxygen tank was sitting on the floor and was not secured in a rack, cart or to the wall. -The oxygen tank gauge indicated the tank was empty. -There was a second smaller oxygen tank on the floor in the shared area entering the resident's room. -The second oxygen tank did not have a gauge on it and had a green tag on it indicating it was full. -The second oxygen tank was not secured to a rack, cart or to the wall. -There was a third small oxygen tank in a bag sitting on the seat of the resident's walker; the bag was attached to the walker. Second observation of the resident's room on 06/05/23 at 10:13am revealed: -The large oxygen tank had been removed from the room. -The smaller full tank was in the bag with the oxygen tank that had a regulator gauge on it. Interview with the resident who resided in the room on 06/05/23 at 8:21am revealed: -The larger of the oxygen tanks came from the hospital. -The oxygen tank was empty and waiting for someone to pick it up. -The smaller of the oxygen tanks had not been used. -She did not know anything about securing the two oxygen tanks.	D 079		

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-She knew the empty tanks were placed on the floor next to the door to the room.
-When the staff brought a new tank to her room, they left it on the floor next to the door until she used it; sometimes staff would place it in the bag on her walker with the tank she was using.

Interview with a personal care aide (PCA) on 06/05/23 at 8:54am revealed:
-The resident changed her own portable oxygen tanks and placed her own nasal cannula in without assistance.
-She told the staff when she needed a new oxygen tank.
-Staff would place the full oxygen tank on the floor next to the door.
-After the resident changed the gauges on the tanks, she would place the empty tank on the floor next to the door.
-Staff would pick the tank up and return it to the oxygen room.
-There were not racks or any way to secure the empty or full oxygen tanks in the resident's room.

Interview with a second PCA on 06/06/23 at 3:38pm revealed:
-It was not uncommon for the resident to have an empty or full oxygen tank on the floor in her room by the door.
-The tanks were never in a rack, just on the floor.
-The resident would tell her when to take it out of the room.

Interview with a medication aide (MA) on 06/06/23 at 1:45pm revealed:
-The resident who resided in the room had an oxygen concentrator she used when in her room and a portable oxygen tank for when she left her room.
-The resident would let staff know she needed a

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full tank because her portable oxygen tank was almost empty.
-The staff had keys to the oxygen storage room and would get a new tank for the resident.
-The full tank would be left on the floor next to the door in her room.
-The tanks were not supposed to be on the floors, but the resident requested the full tanks before the tank in use was empty.
-Staff had explained to the resident about not leaving the oxygen tanks on the floor but she would get upset and staff would give in to her.
-Most of the time she carried the extra tank on her walker in the bag with the tank she was using.
-The facility did not have racks to secure the tanks in the residents' rooms.

Interview with the Resident Care Coordinator (RCC) on 06/08/23 at 12:52am revealed:
-There were no racks because oxygen tanks were not allowed in residents' rooms if they were not being used.
-She thought the tanks were not allowed because they could get knocked over or punctured.
-The PCAs had told her the resident wanted to keep an extra tank in her room.
-She had explained to the resident she could not have an unsecured oxygen tank in her room, but the resident said she was afraid of running out of oxygen and not having a tank available.
-The resident also had an oxygen concentrator in her room.

Interview with the Administrator on 06/08/23 at 5:20pm revealed:
-The PCAs were responsible for monitoring the oxygen level available in the portable oxygen tanks and for switching them over when the tank was empty.
-The resident should not have changed the

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oxygen tanks herself; the staff should have changed the tanks.
-The empty oxygen tanks should have not been left in the resident's room and never on the floor; the empty oxygen tanks should have been taken out of her room and stored in the oxygen room.
-The full oxygen tanks should have been in use and in a bag attached to the resident's walker.
-There should never be full and unsecured oxygen tank on the floor in the resident's room.
-Unsecured oxygen tanks were a safety concern because she thought they could explode.

2. Observation of resident rooms on 06/05/23 between 8:10am-8:15am revealed there was a build-up of dirt and debris inside the wall heater/air-conditioning units in resident rooms 405, 501, 503, 505, 508, and 509.

Observation of resident rooms on 06/05/23 between 8:10am-8:15am and 12:15pm-12:23pm revealed there was a build-up of dirt in the overhead bathrooms exhaust vents in resident rooms 405, 501, 504, 509, 603, and 605.

Interviews with the residents in rooms observed on 06/05/23 at various times between 8:11am-3:15pm revealed:
-The residents had not seen anyone clean the inside of their wall units, just the outside.
-The residents had not seen anyone clean the overhead vents in their bathrooms.

Interview with a housekeeper in the assisted living (AL) on 06/05/23 at 8:18am revealed:
-When he cleaned resident rooms he cleaned, the commode and the floors, wiped down stains on the walls, and took out the trash.
-That was all that he cleaned.

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Interview with another AL housekeeper on 06/07/23 at 8:09am revealed:
-She was taught to clean the overhead bathroom vent by the previous Maintenance Director.
-She told the previous Maintenance Director she would need something to be able to reach the overhead vent, but nothing had been provided.
-The front of the wall units had been removed and cleaned.
-She had not noticed the inside of the air-conditioner units.

Interview with a housekeeper in the memory care unit (MCU) on 06/06/23 at 11:30am revealed:
-He was trained to clean the resident rooms by the previous Maintenance Director.
-The wall units had been "deep cleaned about one month ago."
-The front of the units had been removed and were pressure washed.
-He wiped off the wall units daily.
-It was impossible to get behind the screen area to clean any dirt with the supplies they had to use.
-He cleaned the overhead exhaust fans last week with his duster.
-To clean the overhead vents, he "really" needed a step ladder.
-He told a manager, (he could not recall who), that he needed a step ladder to clean the overhead vents.
-He was told the step ladder was in an outside storage building and no one had a key to the building.

Interview with another MCU housekeeper on 06/06/23 at 3:34pm revealed:
-She cleaned the overhead bathroom vents when she noticed they needed cleaning.
-She cleaned two rooms, 109 and 110, overhead vents yesterday, 06/05/23.

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D 079	Continued From page 6 -She used a broom but "could not get to it good." -A lot of dust fell out of the overhead vent in the bathroom of room 110. Interview with the Administrator on 06/07/23 at 9:40am revealed: -The Maintenance Director was no longer working at the facility, and they were in the process of hiring a new Maintenance Director; he left about two weeks ago. -The PCAs and housekeeping staff had been taking the fronts off the wall units and washing the vents outside when the weather was nice so the units could dry. -She expected the housekeeping staff to clean the wall units to the best of their ability but did not know how the inside of the units could be cleaned. -She told the housekeeping staff to clean the overhead vents in the bathroom. -She could not recall when, but it was recently that she told the housekeeping staff to clean the vents; she did not specify overhead vents. -The storage building was not locked and could be accessed if needed for supplies. -She was not aware a stepladder was needed to effectively clean the overhead vents.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state	D 125		

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D 125	Continued From page 7 occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 3 sampled staff (Staff B) passed the written medication aide examination within 60 days of completing the medication clinical skills validation. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) on 02/24/23. -Staff B completed medication clinical skills validation on 03/13/23. -Staff B completed the 5-hour and 10-hour medication aide training on 06/17/21. -There was no documentation that Staff B had successfully passed the written MA examination within 60 days of completing the medication clinical skills validation. Review of residents' April 2023 electronic medication administration record (eMAR) revealed there was documentation Staff B administered medication on 4 of 30 days in April 2023. Review of residents' May 2023 eMAR revealed there was documentation Staff B administered medication 9 of 31 days.	D 125		

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D 125	Continued From page 8 Review of residents' June 2023 eMAR from 06/01/23 to 06/05/23 revealed there was documentation Staff B administered medications on 1 of 5 days. Telephone interview with Staff B on 06/08/23 at 3:34 pm revealed: -Staff B had not taken the MA examination. -Staff B was aware she was outside of her 60-day timeframe from the date of medication clinical skills validation. -She had scheduled to take the MA examination the week of 06/12/23. Interview with the Area Clinical Director (ACD) on 06/08/23 at 3:35 pm revealed: -Staff B had been informed of a 60-day timeframe to complete the MA examination once she completed the medication clinical skills validation. -Staff B was responsible for scheduling her MA examination. -She could not find documentation Staff B took the MA exam. Interview with the Business Office Manager (BOM) on 06/08/23 at 3:45 pm revealed: -The care manager was responsible for ensuring that staff received the appropriate training. -The BOM, ACD, and Resident Care Coordinator (RCC) worked together to make Staff B aware of certification issues. -She and the ACD made Staff B aware she had 60 days to take her MA exam. Interview with the RCC on 06/08/23 at 4:05 pm revealed: -Staff B was responsible for setting up an appointment to take the MA exam. -Staff B was notified after completing her	D 125		

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D 125	Continued From page 9 medication skills checklist that she had 60 days to take and pass the MA exam. Interview with Administrator on 06/08/23 at 4:20 pm revealed: -The RCC sent an email to the ACD informing her who needed training. -The RCC was responsible for reminding staff about MA exam. -It was Staff B's responsibility to schedule and pass the MA exam. -Staff B must be pulled off the medication cart immediately.	D 125		
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 A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 4 sampled residents (#11) related to the failure to immediately send the resident to the emergency department (ED) for further evaluation for a injury to the resident's arm and a delayed evaluation of a change in condition. The findings are: Review of Resident #11's current FL-2 dated	D 273		

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01/1/23 revealed:
-Diagnoses included dementia, depression, coronary artery disease, cerebrovascular accident, and degenerative disc disease.
-She was constantly confused.
-She was semi-ambulatory.
-She was incontinent of bowel and bladder.
-She could verbally communicate her needs.
-She needed personal care assistance with bathing and dressing.

Review of Resident #11's emergency department (ED) summary dated 06/04/23 revealed:
-The X-ray results dated 06/04/23 revealed anterior right shoulder dislocation (the head of the arm bone was moved forward in front of the socket).
-Pulmonary Emboli (blood clots) noted in all 5 lobes of the lungs.
-Suspect right rib fractures.
-Blunt, chest trauma with bruising to the right arm, torso, abdomen, breasts, shoulder that the facility staff noticed this morning, 06/04/23.
-Resident #11's daughter indicated she was notified three days ago of an incident that occurred at the facilty 4 days ago when Resident #11 was agitated and required physical restraint.
-Question whether injury occurred then as bruising to shoulder/arm/chest wall area with areas of purple and yellow bruising which would seem consistent with injury a few days ago.
-Resident #11 was sedated and attempted reduction of the right shoulder in the ED but was unsuccessful.
-Orthopedist was consulted and advised to admit Resident #11 to the hospital and attempt reduction of the right shoulder in the operation room (OR) on Monday, 06/06/23.

Review of Resident #11's operative note dated

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06/05/23 revealed:
-The dislocation was at least a week ago.
-Attempted reduction of the right shoulder in the ED was unsuccessful.
-Resident #11 was taken to the OR to attempt to reduce the right shoulder.
-Resident #11 could not be intubated due to the pulmonary emboli.
-An attempt was made to externally rotate the shoulder while providing traction was unsuccessful.
-Attempts were made to massage the humeral head back toward the glenoid (the socket joint of the shoulder joint that meets the humeral head) was unsuccessful.
-The attempt to reduce the shoulder was aborted in order to prevent additional injury.

Review of Resident #11's hospital discharge summary dated 06/07/23 revealed Resident #11 was discharged home with a family member on hospice care.

Interview with the Memory Care Manager (MCM) on 06/05/23 at 8:40am revealed:
-Resident #11 was sent to the hospital on Sunday, 06/04/23.
-She received a phone call from the Resident Care Coordinator (RCC) that Resident #11 had bruising and she was sending her to the hospital.
-She did not have a fall; she had some type of "bruising disorder."
-Her family member was familiar with the bruising and how easily Resident #11 bruised.

Interview with a medication aide (MA) on 06/06/23 at 5:38pm revealed:
-Resident #11 was taken to the hospital on Sunday, 06/04/23.
-She had bruising on her right shoulder, right arm,

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right breast, and right side.
-No one knew how Resident #11 received the bruising.
-She called the hospital on Sunday evening, 06/04/23, to see how Resident #11 was and she was told Resident #11 had a dislocated shoulder.

Interview with a personal care aide (PCA) on 06/07/2023 at 9:10 am revealed:
-She worked 3rd shift in the Memory Care Unit (MCU).
-Resident#11 had a lot of bruises and a fractured shoulder.
-Resident # 11 was put in the shower, but everyone knew Resident# 11 got bed baths.
-The PCAs would bathe, change, and dress Resident #11 in the bed, then put her into a wheelchair and take her to eat in the dining area.

Interview with a second PCA on 06/07/23 at 3:54pm revealed:
-She worked second shift in the MCU.
-It took two PCAs to give Resident #11 a bath or to change her adult incontinence brief because the resident could be combative.
-Resident #11 was not bathed in the shower because she was combative.
-Resident #11 was bathed while in bed or from the sink while sitting in the bathroom.
-She worked second shift on Friday, 06/02/23, and Resident #11 was in her room the entire shift and did not come to the dining room for dinner.
-Resident #11 did not come out of her room on Saturday, 06/03/23, and did not eat dinner.
-She reported for her second shift on Sunday, 06/04/23, and was told at the shift change report that Resident #11 had bruises on her arm and was sent to the hospital.
-The MCM told her today, 06/07/23 that Resident #11 was not returning to the facility; Resident #11

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had a broken shoulder, her bed was stripped, and he belongings were gone.
-The PCAs were required to log the residents' Activities of Daily Living (ADLs) in the electronic system every day.
-She would log ADLs as completed for other PCAs because not every PCA could log into the electronic system.

Telephone interview with a third PCA on 06/07/23 at 4:22pm revealed:
-She worked with Resident #11 on first shift on Tuesday 05/30/23 and noticed Resident #11 was favoring her right shoulder but did not notice any bruising.
-She and another PCA got Resident #11 out of bed on 05/30/23 and transferred her to the wheelchair at 11:00am.
-Resident #11 did not "fight" or resist getting out of bed on 05/30/23, like she normally would.
-She took Resident #11 to the dining room for lunch between 11:30am and 12:00pm.
-Resident #11 laid her head on the dining room table and would not eat lunch.
-Resident #11 was returned to her room and transferred back to her bed.
-Resident #11 did not "fight" with the staff when being transferred to bed, which was unusual.
-Resident #11 was moaning and groaning when she was transferred to bed.
-The MA assisted during the transfer and was aware of Resident #11 favoring her right shoulder, moaning, and groaning and that she did not eat lunch.
-She cared for Resident #11 on first shift on Wednesday, 05/31/23.
-Resident #11 was out of bed in the wheelchair and dressed in a long sleeve shirt when she arrived to work.
-Resident #11 continued to favor her right side on

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05/31/23.
-On Saturday, 06/03/23, Resident #11 did not get out of bed and go to the dining room.
-Resident #11 did not eat breakfast or lunch on Saturday.
-She noticed Resident #11 had bruising on her right breast, right side, and right arm from the right shoulder to right hand with swelling of the right arm and hand.
-She reported the bruising and swelling to the MA; the MA and other PCAs stated Resident #11 had "been like this for several days" and management was aware of the bruising and swelling.
-On Sunday, 06/04/23, Resident #11 continued to stay in bed, not eating, and bruising her right arm.
-She reported Resident #11's condition to the weekend manager on-call who was the Resident Care Coordinator (RCC).
-The RCC sent Resident #11 to the ED.

Interview with a fourth PCA on 06/07/23 at 4:27pm revealed:
-She worked second shift in the MCU.
-She was trained to stay calm when a resident became combative and to calmly speak to the resident and hold their hands.
-On Sunday, 06/04/23, she was told by the second shift MA Resident #11 had been sent to the hospital because she had bruises on her arm.
-On Friday, 06/02/23 Resident #11 stayed in her bed and did not get up, even to go to the dining room.
-She was sleeping because she checked her adult brief at about 3:30pm.
-She changed Resident #11's brief about a week before and noticed skin tears on the top of her feet; Resident #11's skin tore very easily.
-Resident #11 became combative during showers about two to three months ago and required two

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staff to bathe her so she was changed to a bed bath or a bath from the sink.
-She would swing her arms during a shower but one staff could give her a bed bath or a sink bath because she remained calm.
-Resident #11 was scheduled to be bathed on Tuesdays, Thursdays, and Saturdays on second shift.
-She worked second shift on Monday, 05/29/23, and Resident #11 was her normal self.
-She did not work again until second shift on Friday, 06/02/23, and Resident #11 slept the entire shift.
-She had to place her arm around Resident #11's waist to assist her to stand and pivot while standing; Resident #11 could hold on to the grab bar for stability once standing on 05/29/23.
-She did not know about Resident #11's ability to stand or pivot on 06/02/23 because Resident #11 stayed in bed.

Telephone interview with a second MA on 06/07/23 at 5:58pm revealed:
-She was the MA on the MCU on 06/02/23, 06/03/23, and 06/04/23.
-Resident #11 was out of bed to the wheelchair on Friday, 06/02/23.
-She noticed Resident #11 cradle her right arm in her lap, rub her right upper arm with her left hand, and grab her right hand and squeeze it with her left hand.
-She asked the MCM if she was aware of Resident #11's bruising, not eating, and staying in bed and the MCM stated she was aware.
-She would lay on her left side, facing the wall when she was placed in the bed; she normally laid on her right side when in the bed.
-She saw the bruising on Resident #11 on her right shoulder, right breast, right side, right arm, hand, and right shoulder on 06/03/23.

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-She noticed Resident #11 favoring her right side.
-She stayed in bed and slept a lot over the weekend.
-She drank some water and tea but did not eat over the weekend.
-She noticed Resident #11 grab her right arm with her left hand when the staff provided personal care.
-She did not know what happened to Resident #11 and no one else seemed to know either.

Telephone interview with a PCA on 06/08/23 at 4:12am revealed:
-She was told by a MA on 05/30/23, Resident #11 was having pain in her right arm when the arm was moved.
-She assessed Resident #11 like she did all of her residents when she made rounds at the beginning of her shift, on 05/30/23 around 11:45pm-12:00am.
-When she left on Tuesday morning, 05/30/23, the resident did not have any bruising and when she returned on 3rd shift on 05/30/23 the resident had bruises.
-Resident #11 had a bruise "about the size of a hand" on the top of her arm, and 3 small bruises on her back near her rib cage.
-She told the MCM the morning of 05/31/23 as soon as the MCM came in.
-She did not get Resident #11 out of bed before she left on 05/31/23 because the resident was in pain.
-When Resident #11 was rolled over she seemed to be in pain.
-She told the MCM she thought Resident #11's arm was broken and the MCM stated the PCP would get an X-ray when she saw her on 05/31/23.
-When she worked again on Saturday night, 06/03/23, she was told Resident #11 was worse.

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-When she went in to assess Resident #11, the resident was "bruised from her shoulder blade all the way down to her fingertips, all the way down her ribcage, even down to the resident's adult incontinence brief in the back and there was some bruising on her leg."

Interview with a second PCA on 06/08/23 at 8:50am revealed:
-She worked on Tuesday 05/30/23 and assisted another PCA with Resident #11.
-She told the MA on 05/30/23 that Resident #11 did not look or act herself.
-Resident #11 normally pulled her clothing and her hair when getting out of bed, but she did not do this on 05/30/23.
-She was taken to the dining room for lunch but did not eat.
-She laid her head on the dining room table, and she was taken back to her room and put to bed.
-When Resident #11 got her back to her room, Resident #11 pointed to her bed and said, "can I get in there."
-She stood in front of her and placed Resident #11's arms around her waist like she had done many times before, but Resident #11 would not hold her grip.
-She would drop her right arm like she did not have any strength in her right arm.
-She noticed Resident #11 rubbing her right arm from shoulder to elbow after she was in bed.

Telephone interview with a third PCA on 06/08/23 at 9:37am and 10:22am revealed:
-When she came into work on 05/30/23, she was told Resident #11 had not been out of bed all day, but no one knew why other than the resident was not feeling good.
-When she attempted to get Resident #11 out of bed, the resident was holding her arm saying,

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"Ouch, ooh-wee."
-She went and got the MA and asked her to come in and see Resident #11.
-Resident #11's arm was just hanging; she was not moving it.
-Resident #11 did not seem like herself on the three days she worked with her, Tuesday, Wednesday, and Thursday, 05/30/23-06/01/23..
-She had to transfer Resident #11 by her waist because the resident's arm was still hurting.
-A [named] PCA told her she gave Resident #11 a shower by herself on 05/30/23, and the resident had not complained of arm pain.
-The [named] PCA had left when she did rounds with Resident #11.

Telephone interview with a MA on 06/08/23 at 3:44am revealed:
-When she came in on 05/30/23 around 7:00pm, she was told by a staff person had taken Resident #11 to the shower by herself.
-Resident #11 required 2 staff for her showers.
-Resident #11 was laying in her bed.
-Resident #11 had redness and bruising on her right arm, left arm, and her back toward the right side.
-She tried to notify the MCM that night, 05/30/23, but she did not hear from her until the next morning 05/31/23.
-She asked the MCM about sending Resident #11 out and she was told no, the PCP was coming in and would see Resident #11 that afternoon, 05/31/23.
-On 05/31/23, when the PCA went in to change the resident, Resident #11 "oohed and aahed" like she was hurting, so she told the PCA not to get the resident up.
-She asked the MCM if she should do an incident report and the MCM told her no.
-She did not work with Resident #11 again before

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D 273	Continued From page 19 the resident was sent to the hospital on 06/04/23. Interview with a second MA on 06/08/23 at 9:20am revealed: -A PCA told her on Tuesday, 05/30/23 about Resident #11 not eating and laying her head on the dining room table. -She spoke to Resident #11 and asked her how she was feeling, but Resident #11 asked to be put her in the bed. -She assisted the PCAs with transferring Resident #11 back to bed. -Resident #11 was holding her right hand and rubbing her right arm. -Resident #11 would grip her right fingers as if she was holding pressure on them. -Resident #11 said "ouch" when she was placed in the bed. -She asked the PCA to get the MCM to come and assess her. -The MCM maneuvered her right arm and Resident #11 would "draw back" and tensed up. -The MCM assessed her and said she was fine. -She did not call the PCP, because she reported the changes in Resident #11 to her manager, the MCM. -The MCM added Resident #11 to the list to be seen on Wednesday by the PCP, who came every Wednesday. -Resident #11 was normally combative when being transferred but she was not on Tuesday, 05/30/23. -On Wednesday, 05/31/23, Resident #11 was seated in the wheelchair when she arrived at work. -A PCA from the third shift reported Resident #11 was holding her right shoulder when she got out of bed. -She spoke with the MCM again about Resident #11 on Wednesday, 05/31/23.	D 273		

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-The MCM stated the PCP would be in the facility today, 05/31/23.
-On Thursday, 06/01/23, Resident #11 was up in the wheelchair.
-The PCA reported Resident #11 had bruising on her chest on 06/01/23.
-She assessed Resident #11 and noticed bruising on her right arm, right shoulder, and right breast.
-The MCM took pictures of the bruises on Thursday, 06/01/23, and said she was going to send the pictures to the PCP.
-When she returned to work on Monday, 06/05/23, Resident #11 was at the hospital.
-She called the hospital to check on Resident #11 and she was told she had a dislocated shoulder and they tried to "fix" the shoulder, but they were unable to.
-She did not know how Resident #11's right shoulder became dislocated and how she had bruises over her right shoulder, right arm, right breast, and right side.

Telephone interview with a third MA on 06/08/23 at 10:06am revealed:
-She saw Resident #11 on 05/30/23 when the PCA asked her to see Resident #11 because she was complaining of arm pain.
-Resident #11 was laying on her side in the fetal position with her arm up and her hands at her ear.
-Resident #11 was asleep so she was trying to be gentle and not wake the resident up but looked at the resident's arm up to the elbow.
-She did not report to the next shift anything about Resident #11's complaints of arm pain.

Telephone interview with Resident #11's family member on 06/07/23 at 12:46pm revealed:
-She received a phone call on Thursday, 06/01/23, from the MCM.

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D 273	Continued From page 21 -The MCM reported Resident #11 had bruises on her right arm. -She went to the facility on 06/02/23 and Resident #11 was sitting in her wheelchair at the dining room table. -Resident #11 had a long sleeve shirt on, and the MCM pulled Resident #11's shirt down from the shoulder to show her the bruising on the right shoulder. -The MCM did not know how the bruising occurred. -She received a telephone call from the RCC on Sunday, 06/04/23, in the early afternoon. -The RCC reported that Resident #11 was not eating or drinking and was being sent to the ED. -When she arrived at the ED, she was told Resident #11 had a right dislocated shoulder. -Resident #11 had bruising from her shoulder to her waist on her right side, on her right arm, and her right breast. -The ED physician attempted to reduce the right shoulder dislocation in the ED, but he was unsuccessful. -On Monday, 06/05/23, an Orthopedic Surgeon attempted to reduce the dislocation in the operating room but was unsuccessful. -The Orthopedic Surgeon reported the right shoulder had been dislocated too long to be reduced. -The hospital was discharging Resident #11 today, 06/07/23, on hospice care. -She was taking Resident #11 home with her. -Resident #11 was ambulatory about 2 months ago; she had been in a wheelchair since. -Resident #11 would get out of bed to the wheelchair with the assistance of the PCA daily. -Two weeks ago, when she visited, Resident #11 was talking and laughing. -Resident #11 had a good appetite until the week she went to the hospital.	D 273		

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D 273	Continued From page 22 Interview with the MCM on 06/07/23 at 3:45pm revealed: -The RCC telephoned her on Sunday, 06/04/34, to report she was sending Resident #11 to the hospital because she had bruising on her stomach, right breast, right shoulder, armpit, arm, and hand, and she was crying and complaining of pain. -She received a second telephone call from the RCC on Sunday evening, 06/04/23, who reported Resident #11 had a right dislocated shoulder -She did not know how Resident #11's arm was bruised or became dislocated. -A MA notified her of the bruise on Resident #11's arm on Tuesday, 05/30/23. -On Wednesday 05/31/23, the bruise on her upper right arm had spread toward her right shoulder, under her arm in her armpit, and down her right side. -On Thursday 06/01/23, the bruising spread to her right breast and down toward her rib cage. -She thought Resident #11 got out of bed to the wheelchair on Wednesday and Thursday. -Resident #11 did not act like she was in pain on Wednesday or Thursday. -She did notice Resident #11 favoring her right side. -Resident #11's PCP saw Resident #11 on Wednesday; the MCM did not report anything to the PCP on Thursday or Friday. -The first time Resident #11 complained of pain was on Sunday, 06/04/23, to her knowledge. -It would take 2 to 3 PCAs/MAs to provide care to Resident #11; bathing, dressing, incontinent care, and transferring to a wheelchair. -Prior to Tuesday, 05/30/23, Resident #11 could touch her feet to the floor but she could not bear weight; the staff would hold her up and place her in the wheelchair.	D 273		

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-Prior to Tuesday, 05/30/23, Resident #11 would swing at the PCAs and pull clothing and hair when transferring from bed to wheelchair and during her shower.
-Resident #11's showers were done on Tuesday, Thursday, and Saturday on the second shift.

Interview with the MCM on 06/08/23 at 1:05pm revealed:
-On Wednesday, 05/31/23, someone came to me and told me Resident #11's bruising was worse.
-She looked at Resident #11's right arm but did not touch it.
-The facility staff did not tell her Resident #11 complained of discomfort when she was transferred.
-Resident #11's PCP stated Resident #11 bruised easily.
-She did not call Resident #11's PCP on Friday to inform the PCP that Resident #11's bruising had spread.
-She texted Resident #11's PCP on Friday, 06/02/23, and the PCP ordered a UA and an antibiotic.
-The bruise on Friday had increased from a deck of cards to 5-6 inches.
-She called Resident #11's family member on 06/01/23 and told Resident #11's family member about the bruising.
-Resident #11's family member came to the facility on Friday, 06/02/23, to see Resident #11.
-She showed Resident #11's family member the bruise on her right shoulder.
-Resident #11's family member attempted to feed Resident #11 on Friday, 06/03/23; she took a few spoonfuls of food, and a few sips of water.
-Resident #11 did had a change in her mental status; she just was not herself.
-Resident #11 was not aggressive toward the staff when providing personal care as she had

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been earlier in the week.
-She did not tell the Administrator about the bruising on Resident #11.
-She did not complete an incident report regarding Resident #11 bruising.
-She should have completed an incident report.
-She should have told the Administrator about the bruising of Resident #11.
-The Administrator was made aware of Resident #11 on the Monday, 06/05/23.
-The Administrator was told Resident #11 was admitted to the hospital, had a right dislocated shoulder and the bruising had spread.
-She told the Administrator she did not know what happened to Resident #11.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/0823 at 2:35pm revealed Resident #11 did not take any medications that would increase bleeding time and ultimately cause bruising.

Interview with Resident #11's PCP on 06/07/23 at 2:01pm revealed:
-She saw Resident #11 on 05/31/23.
-Resident #11 had a bruise on her right upper arm about 5 inches in length, a skin tear on her right middle finger, a 1-inch skin tear on her left lower shin, and a 2-inch skin tear on her left foot.
-The facility staff did not know what happened to Resident #11.
-It looked like Resident #11 hit her arm on something.
-The left lower leg looked like it may have been scraped on the foot pedal of the wheelchair.
-Resident #11 could have tried to stand and go to the bathroom and fell.
-Resident #11 would not be able to get up off the floor by herself.
-She would get aggravated when the staff

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provided personal care.
-She assessed Resident #11's arm on Wednesday, 05/31/23.
-She manipulated her right arm, and she denied any pain.
-Resident #1 was transferred to the hospital on Sunday, 06/04/23 because the bruising on her right arm had extended to her right shoulder and her chest and her right hand and arm had become swollen.
-She was notified Resident #11 had a dislocated right shoulder.

Telephone interviews with Resident #11's PCP on 06/08/23 at 3:29pm and 5:11pm revealed:
-The MCM reached out to her on Tuesday afternoon, 05/30/23, and told her that resident #11 had a skin tear and a bruise.
-She did not recall anyone telling her Resident #11 had complained of arm pain before her assessment on 05/31/23.
-Resident #11 was assessed and did not grimace or indicate she had any pain in her arm on 05/31/23.
-Resident #11 was up and out of bed when she saw her.
-Resident #11 complaining of arm pain was a significant change and she should have been notified.
-If she had been notified, she would have ordered an X-ray immediately or sent the resident to the hospital to be evaluated.
-She was not aware Resident #11 was not getting out of bed and was not eating starting on Friday, 06/02/23; that was a change in the resident.
-She would have expected to have been notified and she would have sent the resident to the hospital on Friday, 06/02/23.

Interview with the Administrator on 06/08/23 at

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D 273	Continued From page 26 1:47pm revealed: -She received a text Sunday night, 06/04/23, from the MCM, that Resident #11 was transferred to the hospital because of bruises and a dislocated shoulder. -The MCM did not know how the bruising and dislocated shoulder happened. -She was informed by the MCM sometime between 05/30/23 to 06/02/23 that Resident #11 had bruising around her breast; she could not remember the exact date. -The MCM did not specify if the bruising was around the right or left breast. -The MCM did not mention Resident #11 was in pain. -If the facility staff knew Resident #11 was in pain, they should notify the MCM. -The MAs and MCM should have documented in the progress note the day-to-day changes in Resident #11. -An incident report should have been completed when the bruise was noted and was of unknown origin. -She would have expected staff to notify Resident #11's PCP of any changes with Resident #11. _____ The facility failed to contact the PCP and send a resident to the hospital for evaluation (#11) immediately after an accident that resulted in the resident having a dislocated shoulder that was not able to be repaired because it had been in the dislocated position for an extended period of time. The resident also had a change in her condition, including staying in bed, experiencing pain in her left arm, and not eating for several days and the PCP was not notified. This failure resulted in serious physical injury, pain and serious neglect to the resident and constitutes an Unabated Type A1 Violation. _____	D 273		

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D 273	Continued From page 27 The facility provided a plan of protection for this violation on 06/08/23 in accordance with G.S. 131D-34.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 2 of 3 sampled residents (#1, #3) including administration of oxygen (#1); and a discontinued order for anti-embolism stockings for a resident (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 05/24/23 revealed: -Diagnoses included hypertension with heart disease, acute respiratory distress, chronic obstructive respiratory failure, chronic respiratory failure and unsteadiness on feet. -There was an order to apply anti-embolism knee high stockings apply to both legs every morning and remove at bedtime. Observation of Resident #3 on 06/05/23 at 9:59am revealed: -She did not have anti-embolism stockings on her	D 276		

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legs.
-Her left leg was wrapped in gauze with an ace bandage over the gauze.
-She had two pairs for white open toed anti-embolism stockings in her top dresser drawer.

Observation of Resident #3 on 06/07/23 at 8:0am revealed:
-She had white closed toed anti-embolism stocking on both legs.
-Her left leg was wrapped with gauze and a bandage and had the anti-embolism stocking applied over the wrap.

Review of after visit report from Resident #3's primary care provider (PCP) dated 05/24/23 revealed there was an order to discontinue Resident #3's anti-embolism stockings.

Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for anti-embolism knee high stockings apply to both legs every morning and remove at bedtime scheduled at 8:00am and 8:00pm.
-Resident #3's anti-embolism knee high stockings were documented as applied every morning from 05/01/23 to 05/31/23; on 05/30/23 there was documentation Resident #3 was not available.
-There was documentation Resident #3 did not have her anti-embolism stocking on at bedtime on 05/24/23.
-There documentation on 05/30/23 at 8:00am Resident #3's legs were wrapped.
-Based on the documentation on the eMAR Resident #3's anti-embolism stockings had been applied six times in May 2023 after they were discontinued by the physician.

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D 276	Continued From page 29 Review of Resident #3's June 2023 eMAR from 06/01/23 to 06/07/23 revealed: -There was an entry for anti-embolism knee high stockings apply to both legs every morning and remove at bedtime scheduled at 8:00am and 8:00pm. -There was documentation Resident #3's anti-embolism stockings were applied and removed on 05/01/23, 06/04/23 and applied on 06/07/23. -Based on the documentation on the eMAR Resident #3's anti-embolism stockings had been applied three times in June 2023, after they were discontinued by the physician. Interview with Resident #3 on 06/05/23 at 9:59am revealed: -She wore anti-embolism stockings on both legs most days. -Sometimes staff did not put them on her. -She had sores on both of her feet but the one on her left foot was worse and the right foot was almost healed. -The Home Health Nurse had wrapped her left leg about a week ago. -Her anti-embolism stockings were still applied to her legs with the bandage on it. -Her anti-embolism stockings were kept in her top dresser drawer. Interview with Resident #3 on 06/07/23 at 8:08am revealed: -The MA had applied her anti-embolism stocking on her because her feet had sores on them. -They applied them over her wrapped foot. -Her feet did not hurt her and neither did the stockings. Telephone interview with the Pharmacist from the	D 276		

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facility's contracted pharmacy on 06/05/23 at 3:16pm revealed:
-Resident #3 had an active order for anti-embolism stocking applied every morning and removed every evening.
-There was no discontinued order for the stockings.

Second telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/07/23 at 9:53am revealed:
-Resident #3 had an active order for active order for anti-embolism stocking applied every morning and removed every evening.
-There was no discontinued order for the stockings.

Telephone interview with a representative from Resident #3's primary care provider's (PCP) office on 06/06/23 at 10:45am revealed Resident #3's anti-embolism stockings had been discontinued after discussion with the Home Health Nurse on 05/24/23.

Second interview with Resident #3's PCP on 06/07/23 at 2:05pm revealed:
-Resident #3's anti-embolism stockings were discontinued once she was referred to Home Health due to venous stasis ulcers on her bilateral lower extremities.
-She and the Home Health Nurse agreed Resident #3 should not have anti-embolism stockings applied to because she had ulcers.
-Anti-embolism stockings compressed the leg and could aggravate the ulcers on Resident #3's legs if applied.

Telephone interview with Resident #3's Home Health Nurse on 06/06/23 at 10:54am revealed:
-Resident #3's anti-embolism stockings had been

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discontinued on 05/24/23 because she had venous stasis ulcers on both feet.
-She did not want Resident #3 to have anti-embolism stockings applied over her ulcers.
-She wrapped Resident #3's left foot because of an open ulcer.
-The ulcer on her right foot was closed.

Second telephone interview with Resident #3's Home Health Nurse on 06/07/23 at 9:48am revealed:
-Resident #3's order for anti-embolism stockings had not been reactivated; they were still discontinued.
-Resident #3 should not have anti-embolism stockings applied because she did not have an order for anti-embolism stockings and her left leg was wrapped due to a venous stasis ulcer.

Interview with a medication aide (MA) on 06/06/23 at 1:45pm revealed:
-When something was discontinued the PCP would leave the order for the MAs and they would fax the order to the pharmacy.
-The pharmacy would remove the discontinued medication or treatment from the eMAR.
-Sometimes the pharmacy made mistakes and left the discontinued order on the eMAR.

Interview with a second MA on 06/07/23 at 2:25pm revealed:
-She had applied Resident #3's anti-embolism stockings in the morning on 06/07/23.
-She applied them over the wrapping on her left leg and on her right leg.
-Resident #3 had a current order for the anti-embolism stockings because it was still active on the eMAR.
-She applied them because she followed the order on the eMAR.

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-The other MAs or the RCC should have verbally told her Resident #3's anti-embolism stockings had been discontinued.
-Resident #3's anti-embolism stockings should have been removed from her room if they had been discontinued.
-She would not have applied them if she had known they were discontinued.

Interview with the Resident Care Coordinator (RCC) on 06/08/23 at 12:39pm revealed:
-The MAs were supposed to apply anti-embolism stockings in the morning and removed them in the evenings.
-Resident #3's anti-embolism stockings were discontinued on 05/24/23; she sent the order to the pharmacy.
-The pharmacy was supposed to remove the anti-embolism stockings from the eMAR.
-She verbally told the staff Resident #3's anti-embolism stockings were discontinued on 05/25/23; she also wrote it on the twenty-four-hour report.
-She caught staff applying the stockings after they had been discontinued.
-She had not looked at the eMAR to see if the order was still active.
-Resident #3's anti-embolism stockings were discontinued because the Home Health Nurse was wrapping one of her feet and the other had a tender spot.
-She would resend the discontinued order to the pharmacy.

Interview with the Administrator on 06/08/23 at 4:38pm revealed:
-The RCC was responsible for scanning all discontinued medication orders to the pharmacy.
-When the pharmacy received the discontinue order, they removed the order from the eMAR.

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-The RCC was responsible for monitoring the eMAR to ensure discontinued orders were done.
-Resident #3's anti-embolism stockings should not have been applied once they were discontinued.
-The stockings should have been removed from her room.
-Staff should have followed the correct orders.

Attempted telephone interview with Resident #3's Power of Attorney (POA) on 06/06/23 at 10:42am was unsuccessful.
2. Review of Resident #1's current FL-2 dated 05/10/23 revealed diagnoses of chronic obstructive pulmonary disease (COPD) and obstructive sleep apnea.

Review of Resident #1's signed physician's order dated 05/03/23 revealed there was an order for oxygen 2 liters a minute continuous while awake, may use as needed, not required at meals or when out of room.

Review of Resident #1's Licensed Health Professional Services (LHPS) assessment dated 05/23/23 revealed:
-Resident #1 had an oxygen concentrator.
-Resident #1's oxygen flow rate was ordered as 2 liters.
-Resident #1 demonstrated donning and removing the nasal cannula.
-The facility staff was to manage the equipment.

Observation of Resident #1's oxygen concentrator on 06/05/23 at 8:47am revealed the oxygen concentrator was set at 1 liter per minute.

Interview with Resident #1 on 06/05/23 at 8:48am revealed:
-She used oxygen because of COPD.

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D 276	Continued From page 34 -She was on 2 liters of oxygen. -She used her oxygen when she was in her room and at night when sleeping. -She did not have any complaints of shortness of breath. -She walked to the dining room for each meal without her oxygen and did not have any shortness of breath. Observation of Resident #1's oxygen concentrator on 06/06/23 at 11:24am revealed the oxygen concentrator was set at 1 liter per minute. Interview with Resident #1 on 06/06/23 at 11:24am revealed: -She breathed better since she started the oxygen. -She never checked the oxygen concentrator. -She placed her nasal cannula on when she returned to her room. -The oxygen concentrator was never turned off. Interview with a Medication Aide (MA) on 06/06/23 at 1:44pm revealed: -She did not know how many liters of oxygen Resident #1 received. -She knew there was an entry on the electronic medication administration record (eMAR) for oxygen that she signed that Resident #1 received oxygen. -She did not check Resident #1's oxygen concentrator to see how many liters the concentrator was set. -She did not know Resident #1 was to receive 2 liters of oxygen and the concentrator was set at 1 liter of oxygen. -She needed to check the oxygen concentrator to make sure it was set at 2 liters of oxygen before she signed the eMAR.	D 276		

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D 276	Continued From page 35 Interview with a second MA on 06/06/23 at 5:38pm revealed: -She knew Resident #1 had an order for oxygen but did not know how many liters she was on. -She had not looked at Resident #1's oxygen concentrator to see how many liters of oxygen it was set on. -She did not know she needed to check Resident #1's oxygen concentrator to see how many liters it was on. Interview with a third MA on 06/07/23 at 9:15am revealed: -She knew Resident #1 had an order for oxygen. -She did not know how many liters of oxygen Resident #1 was ordered. -She did not look at Resident #1's oxygen concentrator. -She would check Resident #1 to ensure she had her nasal cannula on when she was in her room. -She did not know Resident #1 was ordered 2 liters of oxygen and was receiving 1 liter of oxygen. -She needed to check the oxygen concentrator to ensure Resident #1 was receiving 2 liters of oxygen. Interview with Resident #1's Primary Care Provider (PCP) on 06/07/23 at 2:01pm revealed: -Resident #1 was ordered oxygen 2 liters continuously while in her room to decrease the worsening of her COPD. -It was necessary for Resident #1 to have oxygen at 2 liters because of the COPD diagnosis. -Resident #1 had not complained of shortness of breath. -Long-term oxygen use of 1 liter was not useful; Resident #1 could have worsening of COPD.	D 276		

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D 276	Continued From page 36 Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -Resident #1 had an order for oxygen 2 liters. -Resident #1 would wear oxygen when she was in her room. -She had not noticed Resident #1 with shortness of breath when ambulating in the hallway or in the dining room. -She did not check Resident #1's oxygen concentrator to ensure it was set at 2 liters. -She did not know Resident #1's oxygen concentrator was set at 1 liter. -The MAs should check Resident #1's oxygen concentrator to ensure it was set at 2 liters before they signed the eMAR. Interview with the Administrator on 06/08/23 at 3:31pm revealed: -Resident #1 received 2 liters of oxygen. -She did not know Resident #1's oxygen concentrator was set at 1 liter. -Resident #1 may experience shortness of breath. -She expected the MAs to check Resident #1's concentrator each shift to ensure Resident #1 received 2 liters of oxygen.	D 276		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure all residents were provided with napkins at each meal.

The findings are:

Observation of the lunch service meal in the 300-hall dining room in the Memory Care Unit (MCU) on 06/05/23 at 11:32am revealed:
-There were no napkins on the dining room table for the lunch service meal.
-A visitor went to the kitchenette and pulled paper towels from the dispenser and gave each resident a paper towel.

Interview with the visitor on 06/05/23 at 11:35am revealed:
-She visited the facility several times a week.
-She noticed the residents did not have napkins so she got the residents a paper towel from the kitchenette.
-The residents did not always have napkins so she would give them a paper towel from the kitchenette.

Observations of the dining room on the 300-hall in the MCU on 06/06/23 at 7:37am and 11:40am revealed there were paper towels placed on the dining room tables for the residents to use as napkins at the breakfast and lunch service meals.

Telephone interview with a family member on 06/06/23 at 6:05pm revealed:
-The residents have not had napkins in two weeks.

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-The medicationn aides (MA) rarely placed napkins on the table.
-She had gotten paper towels from the paper towel dispenser in the kitchenette and given them to all the residents several times in the past month.
-She knew another visitor who had gotten paper towels from the dispenser and given them to the residents.
-The paper towels were too rough to be used as napkins.

Interview with a personal care aide (PCA) on 06/06/23 at 11:42am revealed:
-Napkins for the residents usually came on the food cart with the meals.
-The kitchen staff was responsible for placing the napkins on the food cart.
-When napkins were not on the food cart, he would use hand towels from the dispenser in the kitchenette.
-There were no napkins to give the residents yesterday or today.
-The kitchen staff would keep extra napkins in the kitchenette cabinets, but there were no napkins in the cabinets yesterday or today.
-He did not ask the dietary aide (DA) for napkins.
-He should have asked the dietary aide for napkins.

Interview with a DA on 06/06/23 at 3:16pm revealed:
-She was responsible for beverages and silverware.
-Sometimes she put extra napkins on top of the food cart, but just "every now and then."
-There were plenty of napkins on the side table in the kitchen.
-No one in the MCU had asked her for napkins.

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Observation of the side table in the main kitchen on 06/06/23 at 3:18pm revealed a large number of napkins.

Interview with the Dietary Manager (DM) on 06/06/23 at 3:19pm revealed:
-The DAs were responsible for silverware and napkins.
-She had taken extra packs of napkins to the MCU, to both the men's dining room and the women's dining room.
-She expected the MCU staff to have called the kitchen and asked for napkins.

Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed:
-There were napkins in the facility for the residents.
-The dietary staff would place packs of napkins in the cabinets in the kitchenette for the PCAs to give the residents at mealtimes.
-She did not know the residents in the dining room on the 300-hall were given hand towels to use at mealtimes.
-The PCAs should ask the dietary staff for napkins if there were not any in the cabinets in the kitchenette.

Interview with the MCM on 06/07/23 at 8:50am revealed:
-The PCAs were responsible for making sure all the residents received every thing they needed at meals, including napkins.
-She would have expected the PCAs to request additional napkins.
-She thought a paper towel could be used as a napkin if napkins were not available.

Interview with the Administrator on 06/06/23 at 3:22pm revealed:

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D 286	Continued From page 40 -The PCAs and the dietary staff worked as a team to provide the residents with what they needed at meals. -She did not know the residents in the MCU did not have napkins at every meal. -She expected the staff to follow the regulation to ensure all residents had a complete place setting at meals, which included napkins.	D 286		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 2 sampled residents (#2) who had an order for a mechanical soft diet with ground meats. The findings are: Review of Resident #2's current FL-2 dated 09/14/22 revealed diagnoses included dementia, failure to thrive, acute kidney injury, and dehydration. Review of Resident #2's signed physician order dated 11/23/22 revealed an order for a mechanical soft entire meal, meats chopped. Review of the facility's menu and diet extensions therapeutic diet menu for lunch dated 06/05/23	D 310		

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revealed:
-The menu for the lunch meal service was spaghetti and meat sauce, buttered zucchini, garlic bread, and a brownie.
-The mechanical soft diet was listed as all items soft, and bite-sized, and the bread was to be soaked and the brownie moistened.

Review of the facility's recipe guide for a baked roll revealed:
-Rolls should be pre-soaked/gelled until gelled through the entire thickness; well moistened rolls cut into bite-size pieces were allowed on an individual basis.
-In brackets, it was documented moistened with syrup, jelly, margarine, or butter.

Observation of the lunch meal service on 06/05/23 from 11:52am to 12:25pm revealed:
-Resident #2 was served spaghetti with a tomato sauce, zucchini, a biscuit, and a brownie.
-The bread was not moistened and was not cut into bite-sized pieces.
-The brownie was not moistened and was not cut into bite-sized pieces.

Review of the facility's menu and diet extensions therapeutic diet menu for lunch dated 06/06/23 revealed:
-The menu for the lunch meal service was apple and onion pork, mashed potatoes, corn, collard greens, baked roll, and mandarin oranges.
-The mechanical soft diet was listed as all items soft, and bite-sized, the corn was to be substituted with a soft bite-sized vegetable, and the bread was to be moistened.

Observation of the lunch meal service on 06/06/23 from 11:40am-12:18pm revealed:
-Resident #2 was served chopped barbecue,

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creamed potatoes, turnip greens, corn, and a roll.
-The roll was not moistened or cut into bite size pieces and the corn was not substituted with a soft bite-sized vegetable.
-Resident #2 coughed while eating her meal and as she stood to leave the dining room she coughed again.
-Resident #2 ate 100% of the meal provided.

Interview with Resident #2 on 06/06/23 at 12:19pm revealed:
-She had problems with chewing because her teeth were "really little."
-Today, 06/06/23, at lunch, she had a problem chewing her bread.
-She did not have any problems with anything else today at lunch, 06/06/23.
-She did not chew her corn; she just mixed it with her creamed potatoes and swallowed.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 06/06/23 at 1:43 revealed:
-Resident #2 was ordered a mechanical soft diet because she had difficulty chewing her food and swallowing, dysphagia, and a history of pocketing her food.
-If Resident #2 was experiencing coughing during meals, it could indicate she was having problems with swallowing.
-She was concerned about Resident #2 choking and pocketing food.
-It was "definitely an issue if Resident #2 was not being served a mechanical soft diet as ordered."

Telephone interview with Resident #2's family member on 06/06/23 at 2:09pm revealed:
-Resident #2 had a nice set of dentures, but the dentures had been lost.
-Not having dentures caused Resident #2 to have

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D 310	Continued From page 43 a problem with chewing her food and swallowing. Interview with a personal care aide (PCA) on 06/07/23 at 8:42am revealed: -Meals were prepared by the dietary staff and brought to the memory care unit (MCU) by the dietary staff; the PCAs served the meals at the table. -Chopped meals were covered with a brown top and regular meals were covered with a white top. -Resident #2 was served a chopped plate. -She knew what a chopped plate looked like once the top was removed, because everything was chopped, even the bread. -A mechanical soft and a chopped plate were the same diets. -She did not know if a resident on a chopped diet could have corn. -She did not notice Resident #2's roll was not cut or moistened. Interview with the Memory Care Manager (MCM) on 06/07/23 at 8:50am revealed: -Mechanical soft meals in the MCU were covered with a brown top, and placed on the right side of the warmer. -The PCAs knew what type of meal each resident received because she told them when there were any changes in the diet orders. -Resident #2 was ordered regular, chopped meats and a mechanical soft diet. -The PCAs would be able to visually see if a meal was chopped or not but would not know if certain foods should be substituted or if bread should be moistened; dietary was responsible for that. Interview with the Dietary Manager on 06/07/23 at 9:22am revealed: -Resident #2 was on a mechanical soft diet. -A mechanical soft diet meant that the food was	D 310		

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cut up and moistened.
-Bread should be moistened and cut up.
-Bread could be moistened with milk, such as breakfast bread, or juice from a vegetable at another meal.
-Once moistened, the bread should also be cut up into bite-sized pieces.
-Corn was to be substituted with field peas for mechanical soft diets.
-The cook had a diet list to use as a guide for preparing meals and plates.
-Resident #2's diet was listed as mechanical soft with chopped meats, regular, and the word "regular" was in all capital and bold lettering.
-She thought the cook may have confused the diet because of the way the word regular was stood out.

Interview with a cook on 06/07/22 at 9:32am revealed:
-Resident #2's meals were prepared as a mechanical soft diet with chopped meats.
-Resident #2's food was cooked soft and cut up when needed, even bread was cut up.
-He moistened the bread by using tongs to dip the bread in hot water and then put the bread on a plate and cut the bread into bite-sized pieces.
-Mechanical soft meals could not have corn so he substituted it with peas and/or snaps.
-If Resident #2 had a regular plate, it was because the PCA gave the resident the wrong tray.

Interview with the Administrator on 06/07/23 at 9:40am revealed:
-The kitchen staff was responsible for preparing meals based on the diet list.
-Meals were delivered to the MCU with different colored lids to help the staff know which plate belonged to which residents.

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D 310	Continued From page 45 -She expected the residents to receive their meals as ordered by the provider and that the meal had been prepared correctly. -She expected the MCU staff to deliver the correct meal to the resident.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with dignity and respect during the morning medication pass including administration of an inhaler, eye drops, obtaining a fingerstick blood sugar, and administration of insulin in the dining room during the breakfast service meal in the Memory Care Unit (MCU) and related to a resident eating in her room because staff did not change her portable oxygen tanks (#3). The findings are: 1. Observation of the medication pass on 06/06/23 between 7:35am and 8:05am revealed: -The Medication Aide (MA) positioned the medication cart in the hallway in front of the 300-hall dining room. -There were 12 residents seated in the dining room for the breakfast service meal. -The MA prepared 6 pills, one inhaler, and a glucometer for a fingerstick blood sugar check (FSBS). -The MA approached a dining room table with 3	D 338		

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residents eating breakfast.
-The MA told one of the residents she had her medication, handed her the cup of pills and a cup of water.
-The resident stopped eating and took the pills with water.
-The MA then administered 2 puffs of an inhaler to the same resident.
-The MA gave the resident a cup of water and asked her to rinse her mouth, then gave her an empty, plastic cup to spit into.
-The MA tore a paper towel into and handed it the same resident and administered eye drops.
-The MA checked the same resident's FSBS and returned to the medication cart.
-The resident resumed eating.
-The MA prepared an insulin pen for administration, and returned to the dining room table.
-The MA asked the same resident to remove her jacket and administered the insulin.
-After the insulin was administered, the resident donned her jacket and resumed eating breakfast.
-The MA maneuvered the medication cart to the hallway in front of the 200-hall dining room.
-The MA prepared 3 pills, cough syrup and an eye drop for a resident.
-The MA approached a table with 3 residents, 2 of the 3 were being fed by PCAs.
-The PCA stopped feeding a resident so the MA could administer the resident her pills, cough syrup and eye drops.

Interview with a MA on 06/07/23 at 8:50am revealed:
-She had always administered medication in the dining rooms during mealtimes.
-She heard that medications needed to be administered in the resident's room.
-In the Memory Care Unit (MCU) the residents did

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not stay in their rooms during the day.
-The residents were either in the dining room or the living room so they could be watched by the staff.
-She administered medications while the residents were in the living room and the dining room.

Interview with a second MA on 06/07/23 at 9:15am revealed:
-She administered medications to residents in the living room and dining room.
-She administered pills, eye drops, injections and checked fingerstick blood sugars in the living room and dining room.

Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed:
-The MA should not be administering medications in the dining room during mealtimes.
-The MA should administer medications before or after mealtimes.
-She had not seen the MAs administer medications in the dining room during mealtimes.
-She noticed the MA administering medications during breakfast this morning, 06/06/23.
-She did not say anything to the MA today after she observed her administering medications in the dining room at breakfast.
-The residents should be able to eat their meals without stopping to take medications.

Interview with the Administrator on 06/08/23 at 3:31pm revealed:
-The MAs should not administer medications in the dining room while the residents were eating.
-The residents may be enjoying their meal and should not be interrupted.
-She expected the MAs to administer medications before or after the breakfast service meal, not

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during.
2. Review of Resident #3's current FL-2 dated 05/24/23 revealed:
-Diagnoses included hypertension with heart disease, acute respiratory distress, chronic obstructive respiratory failure, chronic respiratory failure and unsteadiness on feet.
-There was an order for 3 liters of continuous oxygen via nasal cannula.

Observation of Resident #3 on 06/05/23 at 9:59am revealed:
-She was served her breakfast tray in her room.
-She was using an oxygen concentrator.
-She had a portable tank of oxygen in a bag on her walker; the gauge indicated the tank was empty.

Review of Resident #3's care plan dated 09/07/22 revealed:
-She needed limited assistance with toileting and grooming.
-She needed extensive assistance with dressing.

Review of the facility' oxygen policy dated September 2021 revealed:
-Care staff should periodically check remaining volume in the resident's oxygen tank and advise the Resident Care Coordinator (RCC) if the level was low.
-Unlicensed staff may be trained to have knowledge of oxygen equipment.
-Unlicensed staff were aware of how the equipment [oxygen tanks] works.
-Unlicensed staff may assist the resident with attaching tubing or replacing the tubing.
-Unlicensed staff may assist the resident with applying the nasal cannula by inserting the prongs gently into the resident's nostrils and securing the tubing around the ears and under

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the chin and sliding the adapter to adjust the fit.
-Unlicensed staff may assist the resident with turning on the oxygen tank.
-The RCC or designee monitored the resident's ongoing ability to operate the equipment in accordance with the physician's orders.

Observations of Resident #3 on 06/06/23 at 9:49am and 12:30pm revealed:
-She had a breakfast tray in her room on a folding table.
-She was served her lunch in her room.
-She had her oxygen concentrator on and had the nasal cannula under her nose.
-She demonstrated how far her tubing on the concentrator was by lifting it up and waving it up and down.
-There was approximately eight to ten feet of tubing on the concentrator.
-There was a portable tank of oxygen in a bag on her walker; the regulator indicated it was empty.
-There was approximately four to five feet of tubing with a nasal cannula on the portable oxygen tank.
-Her oxygen tubing was under her shirt and she wanted to have it run on top of her shirt, but she did not know how to remove the nasal cannula and run the tubing on the outside.

Interview with Resident #3 on 06/05/23 at 10:06am revealed:
-She could not walk around without the use of her oxygen.
-Because her [portable] oxygen tank was empty she could not walk around and had to stay in her room.

Interview with Resident #3 on 06/06/23 at 9:49am revealed:
-She did not eat breakfast today, 06/06/23 or

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dinner the night before in the dining room.
-She preferred to eat her meals in the dining room and not in her room.
-She could not go to the dining room because the oxygen concentrator tubing was too short to reach the dining room.
-She could not use the portable oxygen tank in the dining room because the tubing was too short.
-She thought the last time she ate in the dining room was before she went to the hospital on 05/31/23.
-Her clothing was on top of the tubing for the oxygen concentrator and she wanted it out from under her shirt.
-She did not know how to move the tubing from under her shirt or how to remove the nasal cannula.
-She knew the portable oxygen tank was empty, but she did not know how to change the empty tank to the full tank.

Interview with Resident #3's primary care provider (PCP) on 06/07/23 at 2:15pm revealed:
-Resident #3 told her she was eating in her room.
-She thought it was because the resident was not feeling good.
-In the past she had seen Resident #3 eating with her oxygen tube on in the dining room.
-She seemed a little off mentally since her last visit to the hospital on 05/31/23, probably because of decreased oxygen.
-She may have struggled with operating her portable oxygen tanks since her return from the hospital.
-She needed her oxygen while eating.
-She preferred to see the residents eating in the dining room.

Interview with a personal care aide (PCA) on

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06/05/23 at 8:54am revealed:
-Resident #3 changed her own portable oxygen tanks and placed her own nasal cannula in without assistance.
-She told the staff when she needed a new oxygen tank.
-Resident #3 usually ate her meals in the dining room, but she had been eating in her room the past few days.
-She did not know why Resident #3 was eating in her room now.
-Resident #3 had been more confused since returning from the hospital on 05/31/23.

Interview with a second PCA on 06/06/23 at 3:38pm revealed:
-Resident #3 always ate her meals in the dining room while she was using the portable oxygen tanks.
-The past few days she had been eating her meals in her room.
-Resident #3 had two tanks on her walker; one was in use and the other was full.
-Resident #3 changed her own oxygen tanks and applied her own nasal cannula.
-Resident #3 let the staff know when her oxygen tank was almost empty; she could read the gauges herself.
-She never checked on Resident #3's oxygen tank because the resident kept up with it.
-Resident #3 had been more confused and irritable since her return from the hospital last week.

Interview with a medication aide (MA) on 06/05/23 at 5:14pm revealed:
-Resident #3 could change out her own oxygen tanks.
-She could apply the nasal cannula without help.
-She let the staff know when her [portable]

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oxygen tank was empty.
-She was alert and oriented and could do it by herself.
-Resident #3 was not eating in her room because she was not feeling well.

Interview with a second MA on 06/06/23 at 1:45pm revealed:
-Resident #3 had an oxygen concentrator she used when in her room and a portable oxygen tank for when she left her room.
-Resident #3 ate in her room when she did not feel good.
-She had not been feeling good and her foot was wrapped so she was eating in her room this week.
-Resident #3 let the MAs or PCAs know when her portable oxygen tank was almost empty, and she needed a new one.
-The PCAs or the MAs would bring the full portable oxygen tank to Resident #3 and she would change out the regulator gauge herself.
-Resident #3 could read the gauge on the portable tank and tell when she needed a new one and she could set the new one up.
-The portable oxygen tank had tubing and a nasal cannula on it; Resident #3 knew how to change everything on her own.
-Since she returned from the hospital on 05/31/23 she was more confused and did not know how to put on her nasal cannula.

Interview with the Resident Care Coordinator (RCC) on 06/08/23 at 12:52am revealed:
-Resident #3 used her portable oxygen tanks when she ate her meals in the dining room.
-She knew Resident #3 had not been eating in the dining room the last couple of days, because the staff reported because she did not feel well.
-She had observed Resident #3 had increased

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D 338	Continued From page 53 paranoia and was worried about running out of oxygen since her hospital visit on 05/31/23. -She had also noticed Resident #3 had been "fiddling" with things more since 05/31/23. -The PCP had reported on 06/07/23 Resident #3 had increased confusion. -She changed over Resident #3's portable oxygen tank today, 06/08/23 before lunch and she ate in the dining room. -She had also applied Resident #3's nasal cannula for her. Interview with the Administrator on 06/08/23 at 5:20pm revealed: -Resident #3 always ate in the dining room and always had her portable oxygen tank with her and on. -The PCAs were responsible for monitoring the oxygen level available in the portable oxygen tanks and for switching them over when the tank was empty. -The PCAs were supposed to assist Resident #3 with putting her nasal cannula on before going to the dining room. -The MA should have found out why Resident #3 was not eating in the dining room and reported the reason to the RCC.	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	D 358		

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and procedures.

This Rule is not met as evidenced by:
FOLLOW UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 4 of 5 residents (#2, #7, #8, #9) observed during the morning medication pass including errors with the administration of an eye drop (#2); an ointment and cream (#7); an inhaler (#8); and ointment and cream (#9); and for 3 of 6 sampled residents for record review including errors with a muscle relaxant and two inhalers (#1); a diuretic for congestive heart failure, a supplement, and a medication used in a nebulizer (#3); and an eye drop (#2).

The findings are:

Review of the facility's medication administration preparation and general guidelines policy revised in November 2018 revealed:
-If medication with a current, active order could not be located on the medication cart, the medication room or the facility, the pharmacy was contacted.
-Medications were administered in accordance with written orders of the prescriber.

1. The medication error rate was 23% as evidenced by the observation of 7 errors out of 30 opportunities during the 8:00am medication pass on 06/06/23.

a. Review of Resident #8's current FL-2 dated

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D 358	Continued From page 55 05/24/23 revealed diagnoses of dementia, hypertension, asthma, and diabetes. Review of Resident #8's physician orders dated 05/24/23 revealed: -There was an order for Symbicort 80-4.5mg (used to treat asthma) inhale 2 puffs twice daily with spacer, rinse mouth with water and expectorate after use. -There was an order for albuterol sulfate (used to treat shortness of breath or wheezing caused by asthma) inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. Observation of the medication pass for Resident #8 on 06/06/23 at 7:33am revealed: -The Medication Aide (MA) removed the albuterol inhaler from the top drawer of the medication cart. -The MA administered 2 puffs of albuterol inhaler to Resident #8. -The MA returned the albuterol inhaler to the medication cart. -The MA did not administer Symbicort inhaler to Resident #8 during the 8:00am medication pass on 06/06/23. Review of Resident #8's June 2023 electronic medication administration record (eMAR) on 06/06/23 revealed: -There was an entry for Symbicort 80-4.5mg inhale 2 puffs twice daily with spacer, rinse mouth with water and expectorate after use with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Symbicort was administered during the 8:00am medication pass on 06/06/23. -There was an entry for albuterol sulfate 90mcg inhale 2 puffs every 6 hours as needed for	D 358		

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shortness of breath and wheezing.
-There was no documentation albuterol sulfate was administered during the 8:00am medication pass on 06/06/23.

Observation of Resident #8's medication on hand on 06/06/23 at 9:45am revealed there was not a Symbicort inhaler 80-4.5mg available for administration on the medication cart.

Interview with the MA on 06/06/22 at 1:44pm revealed:
-She documented on the eMAR that she administered Symbicort to Resident #8.
-She did not realize she gave Resident #8 the albuterol inhaler instead of the Symbicort inhaler.
-She performed her three checks but made a mistake.
-She was nervous because she was being observed during the medication pass and she was trying to do everything right.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/06/23 at 3:38pm revealed:
-Resident #8 had an order for Symbicort inhaler 2 puffs twice daily with spacer.
-The spacer helped the resident inhale the medication when they could not take a deep breath to inhale the medication.
-One Symbicort inhaler was last dispensed on 04/03/23.
-The Symbicort inhaler consisted of two medications, a steroid and a bronchodilator, used to open the airway and made it easier to breath.
-The albuterol inhaler was to be used as a rescue inhaler in case the resident was having shortness of breath or wheezing.

Interview with Resident #8's Primary Care

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Provider (PCP) on 06/07/23 at 2:01pm revealed:
-Resident #8 was ordered Symbicort inhaler 2 puffs twice daily for COPD.
-Symbicort inhaler was a long-acting steroid.
-The MAs should administer Symbicort inhaler as ordered so Resident #8 would get the best results from the medication.

Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed:
-The MA should read the instructions on the prescription label three times and compare it to the eMAR.
-The MA should not click "prep" on a medication on the eMAR if the medication was not on the medication cart and available for administration.
-The MA had to take her time and read to make sure she was administering the correct medication.

Interview with the Administrator on 06/08/23 at 3:31pm revealed the MA should have verified the inhaler that she administered prior to administering the inhaler.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

Refer to the interview with the MCM on 06/06/23 at 2:49pm.

Refer to the interview with the MCM on 06/07/23 at 8:41am.

Refer to the interview with the Administrator on 06/08/23 at 3:31pm.

b. Review of Resident #2's current FL-2 dated 09/14/22 revealed diagnoses included dementia

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and failure to thrive.

Review of Resident #2's physician orders dated 04/26/23 revealed there was an order for Systane 0.04 - 0.03% (used to treat burning and irritation due to dryness of the eye) instill 1 drop in each eye four times daily.

Observation of the medication pass for Resident #2 on 06/06/23 at 7:55am revealed:
-The Medication Aide (MA) prepared 2 pills to administer to Resident #2.
-The MA administered the 2 pills to Resident #2.
-The MA did not administer Systane eye drops to Resident #2 during the 8:00am medication pass on 06/06/23.

Review of Resident #2's June 2023 electronic medication administration record (eMAR) on 06/06/23 revealed:
-There was an entry for Systane eye drops instill one drop in each eye four times daily with a scheduled administration time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was documentation Systane eye drops were administered during the 8:00am medication pass on 06/06/23.

Observation of Resident #2's medication on hand on 06/06/23 at 9:45am revealed there was a box of 29 single use Systane eye drops available on the medication cart for administration.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/23 at 2:51pm revealed the pharmacy had not dispensed Systane eye drops for Resident #2; they only profiled the information.

Interview with Resident #2 on 06/06/23 at

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12:19pm revealed:
-She got eye drops once a day, every day; she could not say what time.
-Her eyes itched at times.
-She tried not to rub her eyes but sometimes she did.

Interview with the MA on 06/06/23 at 1:44pm revealed:
-She did not recall seeing Resident #2's eye drops pop up on the eMAR for administration this morning.
-She did not administer Resident #2's eye drops this morning.
-She did not know how her initials were on the eMAR as administering Resident #2's eye drops at 8:00am.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 06/06/23 at 1:43pm revealed she had signed Resident #2's Systane eye drops on 11/23/22 as part of her medication management, but Resident #2's Oncologist had ordered the eye drops.

Telephone interview with a Registered Nurse (RN) at Resident #2's Oncologist office on 06/06/23 at 2:55pm revealed:
-Resident #2's Systane eye drops were ordered as part of her chemotherapy treatment.
-One of the side effects of the type of chemotherapy Resident #2 was receiving was dryness and blurred vision, and the Systane eye drops were ordered to help with these side effects.
-If Resident #2 was not administered the eye drops as ordered, the resident would continue to experience dry eyes and blurred vision.
-She did not know if the chemotherapy could also cause itching, but everyone could be affected

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D 358	Continued From page 60 differently. Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -She administered Resident #2 her eye drops this morning at shift change. -Resident #2 was rubbing her eyes, so she administered the eye drops while the MAs were counting narcotics. -She did not sign the eMAR that she administered the eye drops on 06/06/23. -When the MA was passing medications this morning, she would have clicked "prep" on the eMAR and it would have documented her initials. -She did not know why the MA could not see the entry for eye drops on the eMAR since her initials were signed. Interview with the Administrator on 06/08/23 at 4:20pm revealed she was not aware Resident #2's eye drops had not been administered as ordered based on the documentation and the medications on hand. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. Refer to the interview with the MCM on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm c. Review of Resident #7's current FL-2 dated 09/14/22 revealed diagnoses included dementia, hypertension, and osteoporosis.	D 358		

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D 358	Continued From page 61 Review of Resident #7's physician's order dated 05/10/23 revealed there was an order for hydrocortisone cream 1% (used to treat itching and irritation) apply to reddened spots on back twice daily. Review of Resident #7's physician's order dated 04/20/23 revealed there was an order for zinc oxide 22% (used to treat diaper rash) to reddened skin breakdown on left buttock three times daily with incontinence changes. Observation of the medication pass for Resident #7 on 06/06/23 at 7:45am revealed the Medication Aide (MA) did not administer hydrocortisone cream or zinc oxide to Resident #7 during the 8:00am medication pass on 06/06/23. Review of Resident #7's June 2023 electronic medication administration record (eMAR) on 06/06/23 revealed: -There was an entry for hydrocortisone cream 1% apply topically to reddened spots on back twice daily with a scheduled time of 8:00am and 8:00pm. -There was documentation hydrocortisone was administered during the 8:00am medication pass on 06/06/23. -There was an entry for zinc oxide 22% to reddened skin breakdown on left buttock three times daily with incontinence changes with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation zinc oxide was administered during the 8:00am medication pass on 06/06/23. Observation of Resident #7's medication on hand	D 358		

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D 358	Continued From page 62 on 06/06/23 at 9:45am revealed there was an opened tube of hydrocortisone cream and an opened tube of zinc oxide available on the medication cart for administration. Interview with the MA on 06/06/22 at 1:44pm revealed: -She did not apply hydrocortisone cream or zinc oxide to Resident #7 this morning during the 8:00am medication pass. -She did sign off on the hydrocortisone cream and the zinc oxide when she administered pills to Resident #7. -She would apply the hydrocortisone cream when Resident #7 returned to her room after breakfast. -She would apply the zinc oxide when the personal care aide (PCA) provided incontinent care to Resident #7. -She signed off on the eMAR because it was scheduled for 8:00am and she could not apply the hydrocortisone cream and zinc oxide until Resident #7 had finished breakfast and she had finished the medication pass. Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -The MA should not document on the eMAR that a medication has been administered if it had not. -The MA should document the medication was administered after she administered the medication. Interview with the Administrator on 06/08/23 at 3:31pm revealed the MA should document on the eMAR after the medication has been administered, not before. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.	D 358		

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D 358	Continued From page 63 Refer to the interview with the MCM on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm. d. Review of Resident #9's current FL-2 dated 07/20/22 revealed diagnoses included Alzheimer's disease, hypothyroidism, major depression disorder, and traumatic subdural hemorrhage, and edema. Review of Resident #9's physician's order dated 05/24/23 revealed there was an order for bacitracin ointment (used to treat minor skin injuries) apply to wound daily. Review of Resident #9's physician's order dated 05/31/23 revealed there was an order for triple antibiotic ointment (used to treat minor skin infections) apply to wound on right arm every other day. Observation of the medication pass for Resident #9 on 06/06/23 at 7:55am revealed the Medication Aide (MA) did not administer bacitracin ointment or triple antibiotic ointment to Resident #9 during the 8:00am medication pass on 06/06/23. Review of Resident #9's June 2023 electronic medication administration record (eMAR) on 06/06/23 revealed: -There was an entry for bacitracin ointment apply topically to affected areas daily with a scheduled administration time of 8:00am.	D 358		

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D 358	Continued From page 64 -There was documentation bacitracin ointment was administered during the 8:00am medication pass on 06/06/23. -There was an entry for triple antibiotic ointment apply to wound on right arm every other day with a scheduled administration time of 8:00am. -There was documentation triple antibiotic ointment was administered during the 8:00am medication pass on 06/06/23. Observation of Resident #9's medication on hand on 06/06/23 at 9:45am revealed there was an opened tube of bacitracin ointment and an opened tube triple antibiotic ointment available on the medication cart for administration. Interview with the MA on 06/06/22 at 1:44pm revealed: -She did not apply bacitracin ointment or triple antibiotic ointment to Resident #9 this morning when she administered her pills, cough syrup, and eye drops. -She signed off on the bacitracin ointment and the triple antibiotic ointment when she administered pills, cough syrup, and eye drops to Resident #9. -She would apply the bacitracin ointment and the triple antibiotic ointment to Resident #9 when she performed wound care. -She signed off on the eMAR because it was scheduled for 8:00am and she could not perform wound care until Resident #9 had finished breakfast and she had finished medication pass. Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -The MA should not document on the eMAR that a medication has been administered if it had not. -The MA should document the medication was administered after she administered the medication.	D 358		

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D 358	Continued From page 65 Interview with the Administrator on 06/08/23 at 3:31pm revealed the MA should document on the eMAR after the medication has been administered, not before. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. Refer to the interview with the MCM on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm. 2. Review of Resident #1's current FL-2 dated 05/10/23 revealed diagnoses of chronic obstructive pulmonary disease (COPD), obstructive sleep apnea (OSA), congestive heart failure (CHF), diabetic neuropathy, and morbid obesity. a. Review of Resident #1's physician order dated 05/31/23 revealed there was an order for cyclobenzaprine 5mg (used to relax muscles) at bedtime. Review of Resident #1's June 2023 electronic medication administration record (eMAR) from 06/02/23 to 06/04/23 revealed: -There was an entry for cyclobenzaprine 5mg at bedtime scheduled at 8:00pm. -There was documentation cyclobenzaprine 5mg was administered from 06/02/23 to 06/04/23. -There was no documentataion cyclobenzaprine 5mg was administered on 05/31/23 or 06/01/23,	D 358		

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D 358	Continued From page 66 and there was no exception documented. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/0823 at 2:35pm revealed: -The pharmacy had an order dated 05/31/23 for cyclobenzaprine 5mg at bedtime -Cyclobenzaprine was used for muscle spasms. -The pharmacy dispensed 12 cyclobenzaprine 5mg on 05/31/23. -The resident would receive effects from the medication in 30 minutes to one hour and it would last 6 to 8 hours. Observation of Resident #1's medications on hand on 06/06/23 revealed: -There was a blister pack of 12 cyclobenzaprine 5mg tablets available for administration. -The prescription label read one tablet at bedtime. -The dispensed date was 05/31/23. -The pharmacy dispensed 12 tablets. Interview with Resident #1 on 06/06/23 at 11:24am revealed: -The Primary Care Provider (PCP) ordered a muscle relaxant for her legs. -Her legs hurt and spasm every night and kept her awake. -She had not received the muscle relaxant for her legs. -The MA told her the pharmacy had not sent the medication. Interview with Resident #1 on 06/07/23 at 8:31am revealed: -She received the medication for the muscle spasms and leg pain last night at bedtime. -Last night, 06/06/23, was the first night she had received the medication for the muscle spasms and leg pain.	D 358		

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D 358	Continued From page 67 -She slept good last night, 06/06/23, because her legs did not spasm or hurt during the night. Interview with a MA on 06/06/23 at 5:38pm revealed: -Resident #1 complained of muscle spasms and pain in her legs, and her PCP ordered a new medication. -Resident #1 kept asking for the medication for her leg pain and spasm but it was not in the facility to administer. -She was told by the previous MA that the medication had not been delivered from the pharmacy. -She did not look for the medication since the previous MA told her the medication had not been delivered. -She accidentally signed the eMAR that the medication was administered, but she did not recall administering the medication. -She did not know the medication was on the medication cart for administration. Interview with Resident #1's PCP on 06/07/23 at 2:01pm revealed: -She saw Resident #1 today, 06/07/23. -Resident #1 had a diagnosis of peripheral neuropathy causing pain and muscle spasms in her legs. -Resident #1 complained that the muscle spasms and pain in her legs were keeping her from sleeping. -Resident #1 requested a muscle relaxant to help with the muscle spasms and leg pain so she could sleep. -She ordered cyclobenzaprine 5mg at bedtime on 05/31/23. -The medication was not working, so she discontinued cyclobenzaprine today, 06/07/23, and ordered a different medication.	D 358		

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-There was documentation on the eMAR Resident #1 had received the medication nightly since 06/02/23.
-She did not know Resident #1 had not received the medication until 06/06/23.
-She did not know the medication had been in the facility and available for administration since 06/01/23.
-Resident #1 continued to have muscle spasms and pain in her legs during the week when the medication was in the facility and available for administration.
-She expected the MAs to administer medications as ordered.

Interview with the Memory Care Memory (MCM) on 06/06/23 at 2:49pm revealed:
-The MA did not look for the medication on the medication cart.
-The medication was in a blister pack on the medication cart.
-She did not approve the medication for administration until the medication was in the facility.
-If the entry was displayed on the eMAR for the MA to see, then the MA would know the medication was on the medication cart.
-The medication was dispensed from the pharmacy in a blister pack until it could be placed in the multi-dose pack.

Interview with the MCM on 06/07/23 at 8:31am revealed:
-She checked the medication cart on 06/02/23 to see if cyclobenzaprine 5mg had been received from the pharmacy.
-She saw the medication on the medication cart, so she approved the medication for administration on 06/02/23.
-The medication was received in the facility on

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06/01/23.
-She should have approved the medication on the EMAR on 06/01/23 so the MAs could start administering the medication on 06/01/23.
-The MA did not look to see if the medication was on the medication cart.
-Resident #1 should have been receiving cyclobenzaprine 5mg since 06/02/23, but it was not administered until 06/07/23.

Interview with the Administrator on 06/08/233 at 3:31pm revealed the MAs needed to ensure they were administering a medication before they signed the eMAR that it had been administered.

Refer to the interview with the MCM on 06/06/23 at 2:49pm.

Refer to the interview with the MCM on 06/07/23 at 8:41am.

Refer to the interview with the Administrator on 06/08/23 at 3:31pm.

b. Review of Resident #1's physician's order dated 05/02/23 revealed there was an order for Symbicort inhaler (used to treat COPD) 2 puffs twice daily.

Review of Resident #1's physician's order dated 05/17/23 revealed there was a clarification order to administer Symbicort inhaler 2 puffs twice daily, rinse mouth with water and spit after use.

Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/02/23 to 05/31/23 revealed:
-There was an entry for Symbicort inhaler 160-4.5mcg 2 puffs twice a day with an administration time of 8:00am and 8:00pm.

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-There was documentation Symbicort inhaler 2 puffs was administered twice daily from 05/02/23 to 05/17/23 at 8:00am.
-There was a second entry for Symbicort inhaler 160-4.5mg 2 puffs twice daily rinse mouth with water and spit after use.
-There was documentation Symbicort inhaler 2 puffs was administered twice daily from 05/18/23 to 05/31/23.
-There was no documentation that Symbicort inhaler was administered on 05/14/23 at 8:00pm; there was no exception documented.

Review of Resident #1's June 2023 eMAR from 06/01/23 to 06/05/23 revealed:
-There was an entry for Symbicort inhaler 160-4.5mcg 2 puffs twice a day with an administration time of 8:00am and 8:00pm.
-There was documentation Symbicort inhaler 2 puffs was administered twice daily from 06/01/23 to 06/05/23 at 8:00am.

Telephone interview with the pharmacy technician on 06/06/23 at 3:38pm revealed:
-The pharmacy had an order for Symbicort inhaler 2 puffs twice daily.
-The pharmacy dispensed one Symbicort inhaler on 05/12/23.
-One Symbicort inhaler had 120 inhalations and would last 30 days if administered 2 puffs twice daily.

Telephone interview with the Pharmacist for the facility's contracted pharmacy on 06/08/23 at 2:35pm revealed:
-Symbicort inhaler was a scheduled, preventive inhaler.
-Symbicort inhaler consisted of two medications, a steroid and a bronchodilator, used to open the airway and made it easier to breath.

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D 358	Continued From page 71 Observation of medication on hand for Resident #1 on 06/05/23 revealed: -There was an open box with a Symbicort inhaler inside with an open date of 05/02/23. -The opened Symbicort inhaler had 38 of 120 inhalations remaining and available for administration. -There was a second box of Symbicort inhaler dispensed on 05/12/23 that was unopened. Interview with Resident #1 on 06/06/23 at 11:24am revealed: -She was administered the Symbicort inhaler two or three times a day. -She used the Symbicort inhaler when the MA brought it to her. -She did not have any shortness of breath since she was admitted to the facility on 05/01/23. Interview with a Medication Aide (MA) on 06/06/23 at 1:44pm revealed: -She administered Symbicort inhaler to Resident #1 as ordered. -She did not give the inhaler to Resident #1; she administered the inhaler to Resident #1. -Resident #1 had not complained of shortness of breath. -She had not observed Resident #1 with shortness of breath. -She did not know why the inhaler had more inhalations in it than it was supposed to. Interview with a second MA on 06/06/23 at 5:38pm revealed: -She administered Symbicort inhaler to Resident #1. -She did not know why there were still using a Symbicort inhaler that should be empty. -It appeared that Resident #1 was not being	D 358		

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D 358	Continued From page 72 administered the Symbicort inhaler as ordered. Interview with a third MA on 06/07/23 at 9:15am revealed: -Resident #1 received Symbicort inhaler twice daily. -She had administered Symbicort inhaler to Resident #1. -She would hand the Symbicort inhaler to Resident #1 and let her administer the medication to herself. -Resident #1 had never refused the Symbicort inhaler. -She had never forgotten to administer the Symbicort inhaler to Resident #1. -She did not know Resident #1 was being administered Symbicort from an inhaler that was opened on 05/02/23 and that should be empty. Interview with Resident #1's Primary Care Provider (PCP) on 06/07/23 at 2:01pm revealed: -Resident #1 was ordered Symbicort inhaler 2 puffs twice daily for COPD. -Symbicort inhaler was a long-acting steroid. -The MAs should administer Symbicort inhaler as ordered so Resident #1 would get the best results from the medication. Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -She did not know why the MAs were using an inhaler that was opened on 05/02/23. -The inhaler should have been completed about a week ago and the MAs should have started using a new inhaler. Interview with the Administrator on 06/08/23 at 3:31pm revealed: -It appeared Resident #1 had not been administered her Symbicort inhaler as ordered.	D 358		

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D 358	Continued From page 73 -She expected the MAs to administer medications as ordered. Refer to the interview with the MCM on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm c. Review of Resident #1's signed physician's order dated 05/17/23 revealed: -There was an order to discontinue albuterol inhaler (used to treat shortness of breath or wheezing) 1 puff every 4 hours. -There was an order for albuterol inhaler 2 puffs every 6 hours while awake at 8:00am, 2:00pm, and 8:00pm. Review of Resident #1's May 2023 electronic medication administration record (eMAR) from 05/19/23 to 05/31/23 revealed: -There was an entry for albuterol inhaler 90mg 2 puffs every 6 hours while awake with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation albuterol inhaler 2 puffs were administered three times daily from 05/19/23 to 05/31/23. Review of Resident #1's June 2023 eMAR from 06/01/23 to 06/05/23 at 8:00am revealed: -There was an entry for albuterol inhaler 90mg 2 puffs every 6 hours while awake with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -There was documentation albuterol inhaler 2 puffs were administered three times daily from	D 358		

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D 358	Continued From page 74 06/01/23 to 06/05/23 at 8:00am. Interview with the pharmacy technician on 06/06/23 at 3:38pm revealed: -The pharmacy had an order for albuterol inhaler 2 puffs every 6 hours while awake. -The pharmacy scheduled the albuterol inhaler at 8:00am, 2:00pm and 8:00pm. -The pharmacy dispensed one albuterol inhaler on 05/12/23. -One albuterol inhaler had 200 inhalations and would last 33 days if administered 2 puffs three times a day as scheduled. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/08/23 at 2:35pm revealed albuterol inhaler was a rescue inhaler used to open the airways and allow the resident to breathe easier. Observation of medication on hand for Resident #1 on 06/05/23 revealed: -There was a box with an albuterol inhaler inside. -The box had a prescription label that read "inhale 2 puffs every 6 hours while awake, 8:00am, 2:00pm, and 8:00pm. -There was an open date of 05/19/23 written on the albuterol inhaler box. -There were 180 of 200 puffs remaining in the albuterol inhaler. Interview with Resident #1 on 06/06/23 at 11:24am revealed: -She was administered an albuterol inhaler. -She did not know how often she received the albuterol inhaler. -She used the albuterol inhaler when the MA brought it to her. Interview with a Medication Aide (MA) on	D 358		

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D 358	Continued From page 75 06/06/23 at 1:44pm revealed: -She administered the albuterol inhaler to Resident #1 as ordered. -She did not give the inhaler to Resident #1; she administered the inhaler to Resident #1. -Resident #1 had not complained of shortness of breath. -She had not observed Resident #1 with shortness of breath -She did not know why the inhaler had more inhalations in it than it was supposed to. Interview with a second MA on 06/06/23 at 5:38pm revealed: -She administered the albuterol inhaler to Resident #1. -She did not know why there were only 20 inhalations missing from the albuterol inhaler if it was opened on 05/19/23. -It appeared that Resident #1 was not being administered the albuterol inhaler as ordered. Interview with a third MA on 06/07/23 at 9:15am revealed: -Resident #1 received the albuterol inhaler three times daily. -She had administered the albuterol inhaler to Resident #1. -She would hand the albuterol inhaler to Resident #1 and let her administer the medication to herself. -Resident #1 had never refused the albuterol inhaler. -She had never forgotten to administer albuterol inhaler to Resident #1. -She did not know why there were more inhalations documented as administered than there were missing from the inhaler. Interview with Resident #1's Primary Care	D 358		

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Provider (PCP) on 06/07/23 at 2:01pm revealed:
-Resident #1 was ordered the albuterol inhaler 2 puffs every 6 hours while awake.
-Albuterol inhaler was a short-acting medication.
-The MAs should administer albuterol inhaler as ordered to Resident #1.

Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed she did not know why there were only 20 inhalers missing from the inhaler and documented 49 times as administered since the inhaler was opened.

Interview with the Administrator on 06/08/23 at 3:31pm revealed:
-It appeared Resident #1 had not been administered her albuterol inhaler as ordered.
-She expected the MAs to administer medications as ordered.

Refer to the interview with the MCM on 06/06/23 at 2:49pm.

Refer to the interview with the MCM on 06/07/23 at 8:41am.

Refer to the interview with the Administrator on 06/08/23 at 3:31pm.

3. Review of Resident #3's current FL-2 dated 05/24/23 revealed diagnoses included hypertension with heart disease, acute respiratory distress, chronic obstructive respiratory failure, chronic respiratory failure and unsteadiness on feet.

a. Review of Resident #3's current FL-2 dated 05/24/23 revealed an order for spironolactone (a diuretic used to treat high blood pressure) 12.5mg once daily.

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D 358	Continued From page 77 Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for spironolactone 25mg take half a tablet to equal 12.5mg once daily at 8:00am. -Spironolactone 12.5mg was documented as administered once daily from 04/01/23 to 04/20/23. -There was a second entry for spironolactone 25mg take half a tablet to equal 12.5mg once daily at 8:00am. -Spironolactone 12.5mg was documented as administered once daily from 04/21/23 to 04/30/23. -There were no other entries for spironolactone 12.5mg. Review of Resident #3's May 2023 eMAR revealed: -There was an entry for spironolactone 25mg take half a tablet to equal 12.5mg once daily at 8:00am. -Spironolactone 12.5mg was documented as administered once daily from 05/01/23 to 05/29/23 and on 05/31/23. -On 05/30/23 spironolactone 12.5mg was documented as not administered because the resident unavailable. Review of Resident #3's June 2023 eMAR from 06/01/23 to 06/05/23 revealed: -There was an entry for spironolactone 25mg take half a tablet to equal 12.5mg once daily at 8:00am. -Spironolactone 12.5mg was documented as administered once daily from 06/01/23 to 06/04/23.	D 358		

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D 358	Continued From page 78 Observation of Resident #3's medication on hand on 06/05/23 at 2:31pm revealed: -Ten half tablets of spironolactone 12.5mg were dispensed in a single dose card on 04/19/23. -There were seven half tablets available for administration in the single dose card. -Seven half tablets of spironolactone 12.5mg was dispensed in a multidose package on 05/25/23. -There were no half tablets available for administration from the multidose package. Based on the dispense dates on the medication cards the single dose card of spironolactone should not have been available for administration. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/08/23 at 2:00pm revealed: -Resident #3 had an active order for spironolactone 12.5mg once daily; the order was dated 04/19/23. -Ten doses of spironolactone 12.5mg were dispensed on 04/19/23; five whole 25mg tablets were dispensed as ten half 12.5mg tablets to equal the ten doses. -The ten half tablet doses of spironolactone 12.5mg were dispensed in a single dose package on 09/19/22. -The ten doses were dispensed into a single medication package because the order was written between cycle fill and packaging of the multidose packages for the facility. -On 04/28/23, 05/04/23, 05/11/23, 05/18/23 and 05/25/23 seven doses of spironolactone were dispensed in seven-day multidose packages. -The ten doses in the single dose package dispensed on 04/19/23 should have been administered and completed by the start of the multidose package dispensed on 04/28/23; this would have begun the cycle fill for the	D 358		

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spironolactone for Resident #3.
-Spironolactone was a diuretic used to treat edema by decreasing swelling which would help to lower blood pressure.
-If Resident #3 was not administered her spironolactone 12.5mg as ordered she could have experienced increased swelling and her blood pressure might not be lowered.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 06/07/23 at 8:38am revealed:
-Resident #3 had congestive heart failure (CHF) and needed a medication to control edema.
-She had been on another medication to reduce fluid in the body, but she had been on it for such a long time she was at risk for becoming resistant to the medication, so she ordered the spironolactone as an extra defense for her CHF.
-If Resident #3 missed enough doses of her spironolactone she would eventually have exasperation of her CHF.
-Resident #3's blood pressures were monitored and remained within parameters.
-She expected Resident #3's orders to be followed by the staff.

Interview with a medication aide (MA) on 06/06/23 at 1:45pm revealed:
-Resident #3 did not refuse her medications.
-When there was an order change or a new order the PCP would leave the order for the MAs or the Resident Care Coordinator (RCC) would fax the new order to the pharmacy.
-If the order was between cycle fills the pharmacy would dispense the medication in a single dose package until it could be included in the multidose package on the next cycle fill.
-The eMAR would indicate there was a medication not in the multidose package with it

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was scanned.
-Single dose packages needed to be scanned and appeared in blue on the eMAR for administering.
-The pharmacy would place a sticker on the multidose package that read dispensed separately if a medication was usually dispensed in the multidose package but was left out for some reason.
-She was not sure about a single dose package of spironolactone for Resident #3 from April 2023; she relied on the eMAR when she administered medications.

Interview with a second MA on 06/07/23 at 2:25pm revealed:
-Resident #3 did not refuse her medications.
-She pulled the medication cards from the medication cart and scanned them and then she compared them to the eMAR before administering them.
-She did not remember seeing a single dose card for Resident #3's spironolactone from April 2023; she recalled it being in the multidose package.
-If there had been a single dose card, she would have administered it to Resident #3 because she followed the eMAR.

Interview with the RCC on 06/08/23 at 1:04pm revealed:
-New medication orders were faxed to the pharmacy and the pharmacy placed the order on the eMAR.
-If the new order was between cycle fills, they dispensed the medication in a single dose card.
-On the next cycle fill they included the medication in the multidose package.
-The MAs were supposed to administer the medication in the single dose card until it was used.

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D 358	Continued From page 81 -If there was a single dose card of spironolactone from 04/19/23 with seven half tablets available for administration it looked like staff were not reading the eMAR and the medication was not administered. -The MAs were just "clicking" on the medication on the eMAR. -The MAs should have been looking at all the medication cards and then the eMAR; not just the multidose packages. Interview with the Administrator on 06/08/23 at 4:25pm revealed: -The MAs needed to administer medication as ordered; they needed to follow the eMAR. -The medication cards were supposed to be scanned and then checked against the order on the eMAR. -Staff could "click" on a medication without scanning and it would appear as if the medication had been administered when it was not. -The single dose card should have been administered and then the multidose card. Refer to the interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm. b. Review of Resident #3's current FL-2 dated 05/24/23 revealed an order for levalbuterol (used to treat chronic obstructive pulmonary disease (COPD) 1.25mg/3ml inhale one 3ml vial via nebulizer once daily after lunch.	D 358		

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Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for levalbuterol 1.25mg/3ml inhale one 3ml vial via nebulizer once daily after lunch scheduled at 2:00pm.
-Resident #3's levalbuterol 1.25mg/3ml was documented as administered from 05/01/23 to 05/29/23 and on 05/31/23.
-On 05/30/23 levalbuterol 1.25/3ml was documented as not administered because the resident was not available.
-There was an entry for levalbuterol 1.25mg/3ml inhale one 3ml vial via nebulizer every four hours as needed (PRN) for shortness of breath.
-There was documentation levalbuterol 1.25mg/3ml was not administered PRN during the month of May 2023.
-Thirty vials of levalbuterol were documented as administered in May 2023.

Review of Resident #3's June 2023 eMAR from 06/01/23 to 06/05/23 revealed:
-There was an entry for levalbuterol 1.25mg/3ml inhale one 3ml vial via nebulizer once daily after lunch scheduled at 2:00pm.
-Resident #3's levalbuterol 1.25mg/3ml was documented as administered from 06/01/23 to 06/05/23.
-There was an entry for levalbuterol 1.25mg/3ml inhale one 3ml vial via nebulizer every four hours as needed (PRN) for shortness of breath.
-There was documentation levalbuterol 1.25mg/3ml was not administered PRN during the month of June 2023.
-Five vials of levalbuterol were documented as administered in June 2023.

Observation of Resident #3's medication on hand on 06/05/23 at 2:31pm revealed:

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-A box of twenty-five vials of levalbuterol 1.25mg/3ml were dispensed on 01/09/23.
-There was a large orange sticker covering the label on the box; the only information visible was the pharmacy, Resident #3's name and the dispense date.
-The orange sticker had Resident #3's name, the name of the medication and the dosage but not the frequency.
-The directions on the sticker read see eMAR and was dated 03/01/23.
-There was an open foil pouch inside the box with nine vials available for administration; the foil pouch had a partial sticker with Resident #3's name and the medication name and dosage.
-There was an open sticker on the foil pouch, but the sticker was not dated.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/05/23 at 3:16pm revealed:
-Resident #3 had an active order for levalbuterol 1.25mg/3ml once daily dated 12/30/22.
-A 25-day supply of Resident #3's levalbuterol 1.25mg/3ml was last dispensed on 01/29/23.
-Levalbuterol was not on a cycle fill and the facility would need to reorder when needed.
-Levalbuterol was used to dilate lungs and provide relief with breathing for COPD or other obstructions of breathing.
-If not administered as ordered possible outcomes could be general difficulty breathing, decreased breathing, discomfort when breathing and lower oxygen stats.

Interview with Resident #3 on 06/05/23 at 10:06am revealed:
-She had a nebulizer machine that she used about every other day.
-The staff set it up for her.

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D 358	Continued From page 84 -The last time she had used it was before she went to the hospital on 05/31/23. -Her breathing was better after she used it. Interview with Resident #3 on 06/06/23 at 9:49am revealed: -She was administered her nebulizer treatment yesterday evening, 06/05/23 around 5:00pm. -She was usually administered her nebulizer treatments before dinner but not every day; she did not know how often she was supposed to be administered her breathing treatment. -Her breathing was usually okay if she did not move around much. -Her breathing was better after she received her breathing treatment. Interview with a medication aide (MA) on 06/06/23 at 1:45pm and 4:15pm revealed: -Resident #3 had an order for a nebulizer treatment after lunch and as needed. -Resident #3 refused her nebulizer treatments if she was participating in an activity. -She had administered Resident #3 her nebulizer treatment PRN once; she did not recall when. -Resident #3 would not ask for her nebulizer treatment. -She set the nebulizer machine up for Resident #3 including placing the vial of medication in the nebulizer. -She would watch Resident #3 use the nebulizer; she would stay in the area and check on her while she did the treatment. -The vials for the nebulizer were not on cycle fill and had to be reordered by the MAs when there were about ten left in the box. -Medication was reordered through the eMAR. -Depending on the time of day it was ordered it would take the pharmacy about two days to dispense the medication.	D 358		

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-She could not say how long one box of Resident #3's levalbuterol would last because it depended on how many vials were in a box and how many times she used the nebulizer.
-Cart audits were done on third shift.
-She saw the orange sticker on Resident #3's box of levalbuterol; the Resident Care Coordinator (RCC) placed the sticker on the box; 03/01/23 was the date the box was opened.
-She did not know what the orange sticker meant or why it was on the box; she thought the box was Resident #3's PRN levalbuterol and was just being used up.
-She realized on 06/05/23 Resident #3 did not have a box of scheduled levalbuterol on the medication cart, so it was reordered, and she administered Resident #3 her nebulizer treatment by using the levalbuterol from the box dispensed on 01/09/23.
-She was told there was an insurance issue with reordering Resident #3's levalbuterol.
-She thought the scheduled levalbuterol had been reordered since 01/09/23.

Interview with a second MA on 06/07/23 at 2:25pm revealed:
-Resident #3 did not refuse her medications.
-Resident #3 had an order for levalbuterol at 2:00pm; she administered it to her.
-Levalbuterol had to be reordered by the MAs because it was not on a cycle fill from the pharmacy.
-Medications could be reordered through the eMAR; it was easy to do.
-She did not know why there was levalbuterol still on the medication cart from January 2023.
-She administered Resident #3 the levalbuterol because she followed the eMAR.

Telephone interview with a representative from

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the billing department at the facility's contracted pharmacy on 06/07/23 at 9:53am revealed:
-The facility requested a refill for Resident #3's levalbuterol on 06/05/23 at 6:00pm.
-Resident #3's levalbuterol was dispensed on 06/06/23 at 9:00am.
-Resident #3's primary insurance rejected the payment for the levalbuterol, but her secondary insurance covered the cost.
-She did not contact the facility about insurance issues because the billing department at the pharmacy always processed payments through the primary and then the secondary insurance for residents.
-There was no delay in Resident #3's medication being dispensed due to insurance coverage.
-The last time Resident #3's levalbuterol had been processed for billing was for three dispenses in January 2023; all three went through her secondary insurance company for payment.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 06/07/23 at 8:49am revealed:
-Resident #3 had an order for levalbuterol once daily and an order for PRN for shortness of breath.
-Resident #3 had breathing issues including COPD.
-The levalbuterol worked better in a nebulizer because she was also on 3 liters continuous oxygen which opened her lungs and allowed the levalbuterol to go deeper into her lungs for better treatment.
-Resident #3 was sent to the hospital on 05/31/23 for exasperation of her COPD.
-Resident #3 had increased problems with her breathing over the previous couple of weeks.
-She did not think Resident #3's exasperation of her COPD on 05/31/23 was due to not receiving

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her levalbuterol as ordered.
-She was notified by the RCC about an insurance issue and not being able to refill the levalbuterol on 06/05/23; her office was not notified prior to 06/05/23.

Interview with the RCC on 06/06/23 at 4:27pm revealed:
-Third shift did the cart audits.
-The MAs reordered medication when it was on the last row or about ten doses left to administer.
-Resident #3's levalbuterol was not on a cycle fill and needed to be reordered when it was almost out.
-Resident was ordered levalbuterol PRN and then a schedule dosage was added at some point.
-She ran out of the scheduled levalbuterol, so she instructed the staff to use the PRN levalbuterol until more was dispensed.
-Resident #3 should have had two boxes of levalbuterol on the medication cart; one box for her scheduled dose and one for her PRN dose.
-The box with the orange sticker was originally Resident #3's PRN levalbuterol.
-The MA had placed the orange sticker on the levalbuterol box; she was supposed to have placed the order change sticker on the box.
-The date of 03/01/23 was the dispense date for the levalbuterol from the pharmacy.
-She realized the week before that Resident #3 had been administered all her scheduled levalbuterol.
-She reordered more from the pharmacy on 06/02/23 but the pharmacy notified her there was an issue with the insurance payment and the refill on the levalbuterol might be a delayed in dispensing.
-She notified Resident #3' PCP today, 06/06/23 about the issue with the insurance and the chance Resident #3 might run out of the

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levalbuterol.
-She had attempted to reorder the levalbuterol again on 06/05/23 but was told again that it was not going to be refilled because of insurance issues.
-She could not tell if Resident #3 had missed any doses of levalbuterol, but the medication should not have lasted from a January 2023 dispensing until 06/02/23 if it had been administered correctly.
-She wondered what medication Resident #3 had been administered in her nebulizer all this time.
-She had recently administered Resident #3 her nebulizer and she had seen her using her nebulizer.
-She did not pay attention to how much levalbuterol Resident #3 had on hand until 06/02/23; she could not scan the box because the sticker covered the instructions and said see eMAR for directions.
-It saddened her to think Resident #3 had not received her levalbuterol as ordered because she had so many breathing issues.

Interview with the Administrator on 06/08/23 at 5:20pm revealed:
-Resident #3's vials of levalbuterol would not have lasted from a dispensing in January 2023 to June 2023.
-She could not explain what had happened and why there were nine vials available for administration on 06/05/23 from January 2023.
-Resident #3 had breathing issues and her nebulizer treatment should be administered as ordered by the physician.
-Staff should follow medication orders and documentation on the eMAR.

Refer to the interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm.

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Refer to the interview with the MCM on 06/07/23 at 8:41am.

Refer to the interview with the Administrator on 06/08/23 at 3:31pm.

c. Review of Resident #3's current FL-2 dated 05/24/23 revealed an order for potassium chloride (used to prevent low potassium) 20mEg once daily.

Review of an after-visit report from Resident #3's primary care provider (PCP) dated 04/19/23 revealed there was an order to discontinue the potassium chloride 20mEg once daily.

Review of after visit report from Resident #3's primary care provider (PCP) dated 05/24/23 revealed there was a second order to discontinue the potassium chloride 20mEg once daily.

Review of Resident #3's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for potassium chloride 20mEg once daily scheduled at 8:00am.
-There was documentation potassium chloride was administered from 04/01/23 to 04/26/23.
-There was documentation on the eMAR Resident #3's potassium chloride was discontinued on 04/26/23.

Review of Resident #3's May 2023 eMAR revealed:
-There was an entry for potassium chloride 20mEg once daily scheduled at 8:00am.
-There was documentation potassium chloride was administered from 05/18/23 and 05/19/23, and 05/21 to 05/29/23 and on 05/31/23.

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D 358	Continued From page 90 -On 05/19/23 potassium chloride was documented as not administered because it was on hold. -On 05/30/23 potassium chloride was documented as not administered because the resident was not available. Review of Resident #3's June 2023 eMAR from 06/01/23 to 06/06/23 revealed: -There was an entry for potassium chloride 20mEg once daily scheduled at 8:00am. -There was documentation potassium chloride was administered from 06/01/23 to 06/06/23. Observation of Resident #3's medication on hand on 06/05/23 at 2:31pm revealed: -Seven tablets of potassium chloride 20mEg were dispensed in a multidose package on 05/25/23. -The order on the multidose package was potassium chloride 20mEg once daily scheduled at 8:00am. Telephone interview with the Pharmacist from the facility's contracted pharmacy on 06/05/23 at 3:16pm revealed: -Resident #3 had an active order for potassium chloride 20mEg once daily dated 12/28/22. -Resident #3 did not have a discontinued order for the potassium chloride. -Resident #3's potassium chloride was dispensed on a cycle fill. -Seven tablets were dispensed in a multidose package on 05/18/23, 05/25/23 and 06/01/23. -Resident #3 was most likely ordered potassium chloride because she was on another medication that depleted potassium from the blood, but she was also ordered a medication that retained potassium in the blood. -Risk associated with high blood potassium included increased heart rate and tremors.	D 358		

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D 358	Continued From page 91 Telephone interview with Resident #3's PCP on 06/07/23 at 8:49am and 2:05pm revealed: -Resident #3 had congestive heart failure (CHF). -She was ordered a diuretic that depleted her of potassium, so she had been ordered the potassium chloride to replace the depleted amount. -She had ordered a new medication on 04/19/23 for Resident #3 that helped her retain potassium, so she discontinued the order for potassium chloride 20mEg once daily. -She had written a second order on 05/24/23 to discontinue the potassium chloride when she realized it was still appearing on her medication list in the eMAR when she reviewed it remotely. -She had monitored Resident #3's potassium chloride and her levels were normal; her recent potassium level on 05/17/23 was 4.4 mEq/L which was within the normal range of 3.7 to 5.0. -If Resident #3 continued to be administered the potassium chloride she could become hyperkalemic (higher than normal levels of potassium in the bloodstream) -She expected orders for Resident #3's to be followed by the facility. Interview with a medication aide (MA) on 06/06/23 at 1:45pm revealed: -When a medication was discontinued the PCP would leave the order for the MAs and they would fax the order to the pharmacy. -If the order was between cycle fills the MAs or the Resident Care Coordinator (RCC) would put a sticker on the multidose package indicating the medication was discontinued. -When the multidose package with the discontinued medication was scanned the eMAR would no longer show the medication. -The medication should be removed from the	D 358		

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multidose package and discarded by the MA.
-She did not recall Resident #3's potassium chloride being discontinued.
-Sometimes the pharmacy made mistakes and left medications in the multidose packages and left the discontinued order on the eMAR.
-She did not recall Resident #3's potassium chloride being discontinued but she relied on the eMAR when administering medications.

Interview with a second MA on 06/07/23 at 2:25pm revealed:
-Resident #3 did not refuse her medications.
-She thought Resident #3 had an order for potassium chloride, but she could not say for sure; she could not recall everyone's medications.
-The RCC sent discontinued medication orders to the pharmacy.
-Once a medication was discontinued it was removed from the multidose package and the eMAR by the pharmacy.
-When she scanned the multidose packages the eMAR would indicate which medications were still active.
-She followed the eMAR when she administered Resident #3 her medication.

Interview with the RCC on 06/08/23 at 1:04pm revealed:
-When the facility received a discontinued order she or the MAs scanned the order to the pharmacy.
-The staff who sent the discontinued order placed a discontinued sticker on the multidose package.
-If the medication continued to be dispensed and was on the eMAR the MAs were to let her know and she would resend the order to the pharmacy.
-In the beginning of May 2023, the pharmacy had a computer issue and all the discontinued medications reappeared on the eMAR.

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-She had gone through the orders and the eMAR and removed all the orders that had been discontinued and reappeared.
-Resident #3's potassium chloride must have been one of the medications that reappeared on the eMAR and she missed it.

Interview with the Administrator on 06/08/23 at 4:38pm revealed:
-The RCC was responsible for scanning all discontinued medication orders to the pharmacy.
-When the pharmacy received the discontinue order, they removed the order from the eMAR.
-If the medication was still in the multidose package a discontinued sticker was placed on the package.
-The RCC was responsible for monitoring the eMAR to ensure discontinued orders were done.
-She was not sure why Resident #3's potassium chloride had continued to be administered.
-She expected staff to administer medications as ordered.

Refer to the interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm.

Refer to the interview with the MCM on 06/07/23 at 8:41am.

Refer to the interview with the Administrator on 06/08/23 at 3:31pm.

4. Review of Resident #2's current FL-2 dated 09/14/22 revealed diagnoses included dementia, failure to thrive, acute kidney injury, and dehydration.

Review of Resident #2's physician order dated 10/11/22 revealed an order for Systane hydration

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(used to help restore moisture to dry eyes) one drop in each eye four times daily; resident was starting Blenrep (used in the treatment of adults with relapsed or refractory multiple myeloma) for myeloma.

Review of Resident #2's signed physician order dated 11/23/22 revealed an order for Systane preservative-free (PF) 0.4-0.3% eye drops instill one drop in each eye four times daily.

Review of Resident #2's June 2023 electronic medication administration record (eMAR) for 06/01/23-06/07/23 revealed:
-There was an entry for Systane (PF) 0.4-0.3% eye drops instill one drop in each eye four times daily with a scheduled administration time of 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-Systane PF was documented as administered on 06/01/23-06/04/23 at 8:00am, 12:00pm, 4:00pm, and 8:00pm and 06/05/23 at 8:00am.
-There were 17 doses documented as administered.

Observation of Resident #2's medication on hand on 06/05/23 at 11:02am revealed:
-There was a box of Systane PF hydration lubricant eye drops; the box did not have a pharmacy label.
-There was an orange sticker with the resident's name and a handwritten note as opened on 06/01/23.
-There were 29 of 30 individual vials available for administration.

Interview with the medication aide (MA) on 06/05/23 at 11:02am revealed:
-She administered Resident #2's Systane eye drops this morning and was going to be administering the 12:00pm dosage soon.

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-The orange sticker labeled as opened 06/01/23 meant that was when the box would have been opened and the first dose used.
-The box did not have a pharmacy label because Resident #2's family member provided the medication over the counter (OTC).

Interview with the same MA on 06/06/23 at 11:24am revealed:
-She had administered the last vial of Resident #2's Systane on 06/01/23 at 12:00pm and asked for a new box to be used for the 4:00pm dose.
-She did not apply the sticker and did not know which MA did, but it should have been whoever signed off on the 4:00pm dose on 06/01/23.

Interview with another MA on 06/06/23 at 3:34pm revealed:
-Resident #2 was administered eye drops, she thought once on her shift, at 12:00pm.
-Resident #2 had refused eye drops, but she would document the refusal.
-She did not recall Resident #2 refusing eye drops since the new box was opened on 06/01/23.
-The MA who pulled the new box of eye drops was responsible for putting the sticker on the box and dating when the box was first used.
-She did not know why there were more vials documented as administered than had been used from the box, "maybe sometimes they just were not given."

Interview on 06/06/23 at 4:34pm with the MA who initialed the 4:00pm dose on 06/01/23 revealed:
-She did not recall if she opened the box of eye drops for Resident #2 or not.
-When a new box was opened the MA was responsible for putting a sticker on the box and dating it for the date the box was opened; it would

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be used the first time when the sticker was dated.

Based on observations, reviews, and interviews, Resident #2 was not administered the Systane eye drops as ordered as there should have been 15 doses administered after the box of Systane eye drops was opened on 06/01/23 for the 4:00pm administration and only 1 vial was missing from the 30 vials dispensed.

Telephone interview with Resident #2's eye doctor on 06/06/23 at 10:39am revealed:
-He did not order Resident #2's Systane eye drops but only continued the order.
-If Resident #2's Systane eye drops were not administered as ordered, the resident would have increased irritation with her eyes.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/23 at 2:51pm revealed the pharmacy had not dispensed Systane eye drops for Resident #2; they only profiled the information.

Interview with Resident #2 on 06/06/23 at 12:19pm revealed:
-She got eye drops once a day, every day; she could not say what time.
-She had a problem with seeing, her vision was "blurry."
-Her eyes itched at times.
-She tried not to rub her eyes but sometimes she did.

Telephone interview with Resident #2's family member on 06/06/23 at 2:09pm revealed:
-Part of Resident #2's treatment for cancer was eye drops.
-Resident #2 was supposed to get Systane eye drops four times a day.

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-Resident #2 had to have the eye drops, because it was an important part of her treatment.

Telephone interview with a Registered Nurse (RN) at Resident #2's Oncologist office on 06/06/23 at 2:55pm revealed:
-Resident #2's Systane eye drops were ordered as part of her chemotherapy treatment.
-One of the side effects of the type of chemotherapy Resident #2 was receiving was dryness and blurred vision, and the Systane eye drops were ordered to help with these side effects.
-If Resident #2 was not administered the eye drops as ordered, the resident would continue to experience dry eyes and blurred vision.
-She did not know if the chemotherapy could also cause itching, but everyone could be affected differently.

Interview with the Memory Care Manager (MCM) on 06/07/23 at 8:58am revealed:
-A sticker was placed on the medication when opened if the medication did not have a label to be able to write an opened date.
-If Resident #2's Systane eye drops were labeled as opened on 06/01/23, there should have been more than one vial missing from the box.
-She was concerned Resident #1's eye drops had not been administered as ordered because the resident's eyes could have gotten worse.

Interview with the Administrator on 06/08/23 at 4:20pm revealed:
-She was not aware Resident #2's eye drops had not been administered as ordered based on the documentation and the medications on hand.
-She expected Resident #2's eye drops to be administered as ordered.

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D 358	Continued From page 98 Refer to the interview with the MCM on 06/06/23 at 2:49pm. Refer to the interview with the MCM on 06/07/23 at 8:41am. Refer to the interview with the Administrator on 06/08/23 at 3:31pm. _____ Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:49pm revealed: -The Medication Aides (MA) should administer medications as ordered. -If the MAs could not find the medication on the medication cart after the medication had been approved on the electronic medication administration record (eMAR), the MA should notify the MCM or the Pharmacy. -She expected the MAs to administer medications as ordered. Interview with the MCM on 06/07/23 at 8:41am revealed: -The medication cart audits were completed by the MCM, Resident Care Coordinator (RCC) and the MA every week on Tuesday. -The medication carts were last audited on 05/30/23. -She printed the physician's orders and gave them to the MAs. -The MAs would compare the medications on the medication cart to the medications listed on the physician's order. -The MAs looked to see that all the medications were in the multi-dose pack (MDP). -Opened medications were dated when opened such as, eye drops, inhalers and insulin pens. -If a medication was not in the MDP, the MA should look for a blister pack. -If the medication was not on the medication cart,	D 358		

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the MA should notify the MCM or RCC and call the pharmacy.
-The MAs should administer all medications as ordered.

Interview with the Administrator on 06/08/23 at 3:31pm revealed:
-The MAs should administer medications as ordered.
-If the MAs could not find a medication on the medication cart, they should notify the MCM or RCC.
-The MAs should document on the eMARs after the medication was administered.
-The MCM, RCC and MAs completed medication cart audits weekly on Tuesday.
-The MCM, RCC, and MAs printed the physician orders and compared the medication listed on the physician orders to the medication on the medication cart.
-If there was a medication listed on the physician orders but not on the medication cart, the pharmacy should be contacted.
-The multi-dose packs arrive on Thursday and third shift places them on the medication cart on Monday evening to start Tuesday morning.
-When a new medication order was written the MCM or RCC would fax the order to the pharmacy.
-The pharmacy would enter the medication onto the eMAR.
-The medication would be delivered the next day in a blister pack with enough medication to get the resident on cycle fill.
-Once the medication was on the medication cart, the MCM or RCC would approve the medication on the eMAR, making it visible to the MAs, and the MAs could start administering the medication.

_____
The facility failed to ensure medications were

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D 358	Continued From page 100 administered as ordered for 4 resident observed during the 8:00am medication pass and 3 sampled residents, including a resident (#8) who had a diagnosis of asthma and was not administered a scheduled inhaler; a resident (#1) who was ordered a muscle relaxant for muscle spasms and leg pain, which was keeping her awake at night and 2 inhalers for COPD that were not administered as scheduled; a resident (#3) with congestive heart failure who had a new order for a diuretic and missed seven doses while also administered potassium chloride that had been discontinued and a nebulizer treatment that was not administered as scheduled; and a resident (#2) who was receiving a chemotherapy treatment that caused blurry vision and dry eyes and was experiencing blurred vision and eye irritation had been administered her eye drops as ordered. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/05/23 for this violation.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 371		

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failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who popped a pill into her bare hand prior to administration and who administered 2 eye drops, checked a fingerstick blood sugar and administered insulin and failed to wash her hands with soap and water before and after donning and doffing gloves.

The findings are:

Review of the facility's medication administration preparation and general guidelines policy revised in November 2018 revealed:
-The person administering medication should adhere to good hand hygiene prior to handling any medication, after coming in contact with a resident and before and after administration of ophthalmic medications.
-Hand hygiene was performed before putting on and upon removal of examination gloves for administration of ophthalmic and injectable medications.
-Hand Sanitization was done when returning to the mediation cart or to the preparation area.

Review of the facility's glucometer policy dated September 2021 revealed hand hygiene should be performed immediately after removal of gloves and before touching other medical supplies intended for use on other persons.

Observation of the Medication Aide (MA) administering medications during the 8:00am morning medication pass on 06/06/23 revealed:
-The MA initiated preparing medications for administration to a resident.
-The MA prepared 6 pills, an eye drop, gathered a glucometer for a fingerstick blood sugar check, and an insulin pen.

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D 371	Continued From page 102 -The MA popped 5 pills from the multi-dose pack directly into the medication cup and popped one pill from a blister pack directly into her bare hand and placed it in the medication cup. -The MA donned gloves and administered the eye drops, removed the gloves, donned a second set of gloves, and performed a fingerstick to check a blood sugar reading, removed gloves, donned a third set of gloves, and administered an insulin injection and removed gloves. -The MA returned to the medication cart, placed the glucometer, insulin pen and eye drops on the medication cart and proceeded to prepare medication for the next resident. -She did not use hand sanitizer or wash her hands between donning and doffing gloves or before preparing medication for the next resident. Interview with the MA on 06/06/23 at 1:44pm revealed: -The MAs could not keep the hand sanitizer on top of the medication cart in the Memory Care Unit (MCU). -The hand sanitizer was kept in a drawer. -She usually kept her personal hand sanitizer in her pocket, but she forgot it today. -She forgot to look in the medication cart and use the hand sanitizer that was on the medication cart. -She did not wash her hands after donning and doffing gloves. -She would wash her hands when she finished passing medications from one medication cart before starting the second medication cart. -She felt rushed with the number of medications she had to administer and did not stop to wash her hands. -She should have popped the pill in the cup and not in her hand. -She usually popped pills in the medication cup.	D 371		

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D 371	Continued From page 103 -She was nervous and forgot to pop the pill in the medication cup. Interview with the Memory Care Manager (MCM) on 06/06/23 at 2:39pm revealed: -The MAs should wear gloves when administering eye drops, checking blood sugars and administering insulin. -The MAs should wash their hands after removing gloves. -The MAs did not have to wash their hands before donning gloves. -The MA should wash their hands after administering medications to each resident. -The hand sanitizer was kept on each medication cart for the MAs to use. -The MA should pop pills in the medication cup and not in their hands. Interview with the Administrator on 06/08/23 at 3:31pm revealed: -The MA should wash her hands before donning and after removing gloves. -There was hand sanitizer on the medication carts for the MAs. -The MAs need to wash their hands with soap and water after administering medication to 3 residents.	D 371		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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D 438	Continued From page 104 This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of resident injuries for 1 of 1 resident (#11) who had injuries of unknown origin and then six days later required hospitalization and was diagnosed with a dislocated shoulder. The findings are: Review of Resident #11 current FL-2 dated 01/18/23 revealed: -Diagnoses included dementia, depression, coronary artery disease, cerebrovascular accident, and degenerative disc disease. -She was constantly confused. -She was semi-ambulatory. -She was incontinent of bowel and bladder. -She could verbally communicate her needs. -She needed personal care assistance with bathing and dressing. Telephone interview with a personal care aide (PCA) on 06/08/23 at 4:12am revealed: -She was told on 05/30/23, Resident #11 was having pain in her right arm when the arm was moved. -When she left on Tuesday morning, 05/30/23, the resident did not have any bruising and when she returned on 3rd shift on 05/30/23 the resident had bruises. -Resident #11 had a bruise "about the size of a hand" on the top of her arm, and 3 small bruises on her back near her rib cage.	D 438		

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D 438	Continued From page 105 -She told the Memory Care Manager (MCM) the morning of 05/31/23 as soon as the MCM came in when Resident #11 was rolled over she seemed to be in pain. -She did not get Resident #11 out of bed before she left on 05/31/23 because the resident was in pain. -She told the MCM to come to see Resident #11. -She told the MCM she thought Resident #11's arm was broken and the MCM stated the primary care provider (PCP) would get an X-ray when she saw her on 05/31/23. Interview with a medication aide (MA) on 06/06/23 at 5:38pm revealed: -Resident #11 was taken to the hospital on Sunday, 06/04/23. -She had bruising on her right shoulder, right arm, right breast, and right side. -No one knew how Resident #11 received the bruising. -She called the hospital on Sunday evening, 06/04/23, to see how Resident #11 was and she was told Resident #11 had a dislocated shoulder. Interview with another MA on 06/08/23 at 9:20am revealed: -A PCA told her on Tuesday, 05/30/23 about Resident #11 not eating and laying her head on the dining room table. -She spoke to Resident #11 and asked her how she was feeling, Resident #11 asked to be put in the bed. -She assisted the PCAs with transferring Resident #11 back to bed. -Resident #11 was holding her right hand and rubbing her right arm. -Resident #11 would grip her right fingers as if she was holding pressure on them. -Resident #11 said "ouch" when she was placed	D 438		

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in the bed.
-She asked the PCA to get the MCM to come and assess her.
-The MCM maneuvered her right arm and Resident #11 would "drawback" and tensed up.
-The MCM assessed her and said she was fine.
-She did not call the Primary Care Provider (PCP) because she reported Resident #11 to her manager the MCM.
-The MCM added Resident #11 to the list to be seen on Wednesday, 05/31/23, by the PCP, who came every Wednesday.
-Resident #11 was normally combative when being transferred but she was not on Tuesday, 05/30/23.
-On Wednesday, 05/31/23, Resident #11 was seated in the wheelchair when she arrived at work.
-A PCA from the third shift reported Resident #11 was holding her right shoulder when she got out of bed.
-She spoke with the MCM again about Resident #11 on Wednesday, 05/31/23.
-The MCM stated the PCP would be in the facility today, 05/31/23.
-On Thursday, 06/01/23, Resident #11 was up in the wheelchair.
-The PCA reported Resident #11 had bruising on her chest.
-She assessed Resident #11 and noticed bruising on her right arm, right shoulder, and right breast.

Interview with Resident #11's PCP on 06/07/23 at 2:01pm revealed:
-She saw Resident #11 on 05/31/23.
-Resident #11 had a bruise on her right upper arm about 5 inches in length, a skin tear on her right middle finger, a 1-inch skin tear on her left lower shin, and a 2-inch skin tear on her left foot.
-The facility staff did not know what happened to

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Resident #11.
-Resident #1 was transferred to the hospital on Sunday, 06/04/23 because the bruising on her right arm had extended to her right shoulder and her chest and swelling in her right hand and arm.
-She was notified Resident #11 had a dislocated right shoulder.

Interview with the MCM on 06/07/23 at 3:45pm revealed:
-The RCC telephoned her on Sunday to report she was sending Resident #11 to the hospital because she had bruising on her stomach, right breast, right shoulder, armpit, arm, and hand, she was crying and complaining of pain.
-She received a telephone call from the Resident Care Coordinator (RCC) on Sunday evening, 06/04/23, who reported Resident #11 had a right dislocated shoulder
-She did not know how Resident #11's arm was bruised or became dislocated.
-A MA notified her of the bruise on Resident #11's arm on Tuesday, 05/30/23.
-On Wednesday 05/31/23 the bruise on her upper right arm had spread toward her right shoulder, under her arm in her armpit, and down her right side.

Interview with the MCM on 06/08/23 at 1:05pm revealed:
-On Wednesday, 05/31/23, someone came to me and told me Resident #11's bruising was worse.
-She looked at Resident #11's right arm but did not touch it.
-The facility staff did not tell her Resident #11 complained of discomfort when she was transferred.

Interview with the Administrator on 06/08/23 at 1:47pm revealed:

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D 438	Continued From page 108 -She was responsible for initiating notification of the HCPR. -She received a text message from the MCM on Sunday night, 06/08/23 around 10:15pm letting her know Resident #11 had a dislocated shoulder and bruises. -She asked the MCM how the resident got a dislocated shoulder and the MCM replied she did not know but the resident resisted care a lot. -The MCM had told her sometime between Tuesday, 05/30/23 and 06/02/23, that Resident #11 had discoloration on her upper breast area; she did not know which side. -No one had reported to her Resident #11's arm was hurting. -Resident #11's family had told someone at the facility the resident would get discoloration on her skin. -When bruising was first noticed on Resident #11, whoever saw the bruise should have told the MCM. -If it happened any other time, she expected staff to let her know by telling her or texting her. -A bruise of an unknown origin should have had an incident and accident report completed. -She did not know Resident #11 had complained of arm pain last week, the week of 05/29/23. -She would have expected staff to notify Resident #11's PCP of any changes with Resident #11. - She had initiated a HCPR for Resident #11 on 06/06/23. -She knew she had 24 hours to initiate an HCPR report after discovering the injuries with unknown causes. -She had not initiated an HCPR report for Resident #11 last week because she was told the resident had skin discoloration, not bruises. -She had not assessed Resident #11 when she was told about the resident.	D 438		

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D 438	Continued From page 109 The facility failed to ensure an injury of unknown origin to a resident (#11) was reported to the HCPR and did not initiate the 24-hour report within 24-hours for the resident when the resident had a skin tear and bruise, and it was not known how the injury occurred, resulting in being sent to the hospital where it was determined the resident's shoulder was dislocated. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 06/08/23.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and 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 an incident/accident that required emergency medical evaluation for 1 of 2 sampled residents (#2) who had a fall and was transported to the local hospital by emergency medical services (EMS). The findings are:	D 451		

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Review of the facility's guidelines for incident reporting dated September 2021 revealed:
-Incident reports must be completed for accidents and incidents in the facility.
-Incident reports should be completed for any incident involving a resident, or incident involving a resident and staff.
-Incident reports should be sent to the Department of Social Services (DSS) within 48 hours if the resident received medical intervention greater than first aid.

Review of Resident #5's FL-2 dated 05/02/23 revealed:
-Diagnoses included leukocytosis, depression, hypertension, neuropathy, and glaucoma.
-Resident #5 was intermittently confused.
-Resident #5 was semi-ambulatory

Review of Resident #5's incident and accident report dated 05/25/23 revealed:
-Resident #5 was observed laying on the floor on her side.
-Resident #5 reported to staff she fell out of bed.
-Resident #5 exhibited and/or complained of pain after the fall, to her left shoulder.
-Resident #4 was transported to a local hospital.

Review of Resident #5's progress notes revealed:
-On 05/25/23, at 5:15am, Resident #5 was transported to the hospital for a fall.
-The primary care provider (PCP) was notified, the responsible party was notified, and an incident and accident report was completed.

Interview with the Adult Home Specialist (AHS) at the county DSS on 06/06/23 at 8:39am revealed:
-She received incidents and accident reports by fax from the facility.

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-She filed all the incident and accident reports received in the facility's file.
-She had not received an incident and accident report on Resident #5, dated 05/25/23.

Interview with a medication aide (MA) on 06/06/23 at 4:30pm revealed the MAs completed incident reports and the managers, Memory Care Manager (MCM), or the Resident Care Coordinator (RCC) were responsible for faxing the report to the DSS.

Interview with the MCM on 06/07/23 at 8:58am revealed:
-The MCM and/or the RCC was responsible for faxing completed incident and accident reports to DSS.
-Once the incident and accident report was completed by the MA, the report was given to the Administrator to review and sign off that it was ready to fax.
-She did not recall if Resident #5's incident and accident report had been faxed.
-All faxed incident and accident reports were given to the Administrator to be filed.
-Faxed incident and accident reports would have the confirmation sheet confirming that the fax was successful.

Interview with the Administrator on 06/07/23 at 9:40am revealed:
-The managers were responsible for faxing completed incident and accident reports to the AHS at the local DSS.
-The incident and accident report for Resident #5 dated 05/25/23 would have been considered reportable.
-Completed incident and accident reports were scanned into the computer system and the paper copy was filed in the incident and accident

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D 451	Continued From page 112 notebook in her office. -She did not see the incident and accident report scanned into the computer system or in the notebook. Second interview with the Administrator on 06/07/23 at 12:41pm revealed: -She had checked with the RCC and the RCC did not have a copy of the incident and accident report for Resident #5 dated 05/23/23. -She had not been able to locate a copy of the fax confirming the incident and accident report for Resident #5 had been sent to DSS.	D 451		