STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032109	A. BUILDING: _____ B. WING _____	R 03/21/2024

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SEASONS AT SOUTH POINT	1002 EAST HIGHWAY 54 DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and Department of Social Services conducted an annual and follow-up survey with a complaint investigation with an exit date of March 21, 2024.	D 000		
D 260	10A NCAC 13F .0802(b) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to revise the care plan after a change in condition for 1 of 6 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 02/09/24 revealed: -Diagnoses included dementia, major depression, and cystitis. -Resident #2 was semi-ambulatory and used a walker. Review of Resident #2's record revealed an assessment and care plan completed on 02/22/24 by the Wellness Director (WD) revealed: -Resident #2 required supervision for transfers. -Resident #2 was independent with ambulation. -Resident #2 required supervision for toileting, bathing and hygiene. -Resident #2 used a walker. Review of an incident report dated 02/26/24	D 260		

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D 260	Continued From page 1	D 260		

revealed:
-Resident #2 was sent to the emergency department on 02/26/24 for right hip pain.
-She had a history of right hip fracture with replacement.
-She did not recall falling.
-She returned to the facility the following day on 02/27/24 with a diagnosis of right femur displacement.
-Follow up notes included Resident #2 would be assisted with her activities of daily living with 2 people until fully healed.

Review of an orthopedic consult dated 02/26/24 revealed:
-No surgical intervention indicated.
-Weight bearing as tolerated to right lower extremity with a walker.
-Recommend physical and occupational therapy.

Review of Resident #2's record revealed:
-The most recent care plan available for review was 02/22/24
-There was no updated care plan available for review.

Interview with Resident #2 on 03/19/24 at 4:00pm revealed:
-She had pain in her right hip that came and went.
-She stated she could not walk right now.

Observation of Resident #2 in the therapy gym on 03/19/24 at 4:10pm revealed:
-Resident #2 was sitting in a wheelchair.
-Resident #2 completed sit to stand exercises with the Physical Therapist (PT).

Interview with a personal care aide (PCA) on 03/19/24 at 3:15pm revealed:

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D 260	Continued From page 2 -Resident #2 walked with a walker independently prior to going to the hospital a couple of weeks ago. -Resident #2 was now in a wheelchair and not walking. -Resident #2 required extensive assistance now with toileting, bathing, dressing and toileting. Interview with the PT on 03/19/24 at 4:10pm revealed: -Resident #2 was being seen by PT for strengthening and mobility. -Resident #2 was ambulating with a walker and was more mobile prior to the right femur displacement. -Resident #2 was not walking now. -PT was working on standing and strengthening. -Resident #2 was now using a wheelchair. Interview with the WD on 03/19/24 at 3:45pm revealed: -Resident #2 did have a change in condition; she was not using a wheelchair and not walking. -He was responsible for completing the assessments and care plans. -He did not update the care plan for Resident #2. -Resident #2 should have an updated care plan due to her change in mobility and activities of daily living status.	D 260		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION	D 273		

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Based on observations, interviews, and record reviews, the facility failed to refer 2 of 7 sampled residents (#1 and #7), who needed their toenails trimmed, to a podiatrist.

The findings are:

1. Review of Resident #1's current FL-2 dated 07/04/23 revealed:
-Diagnoses included Alzheimer's disease, diabetes mellitus, and peripheral vascular disease.
-Resident #1 required assistance with bathing and dressing.

Review of Resident #1's care plan dated 10/06/23 revealed:
-The care plan was signed by the Wellness Director (WD) on 10/06/23.
-The care plan was signed by the Primary Care Provider (PCP) on 10/26/23.
-The level of assistance Resident #1 required for activities of daily living had not been completed.

Review of the facility's podiatry services schedule for 03/28/24 revealed Resident #1 was not on the schedule to be seen.

Observation of Resident #1's toenails on 03/20/24 at 8:49am revealed:
-The first toenail on her left foot had grown one inch past the end of the toe; it was turned toward the inside of her second toe.
-The second toenail on her left foot had grown out three-fourths an inch past the end of the toe and was turning toward the first toe.
-The third toenail on her left foot had grown over the end of the toe, curved over the end of the toe, and was growing toward the underside of the

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second toe.
-The fourth toenail on her left foot had grown past the end of the toe, had curved toward the third toe, and was pressed against the top left side of the toe.
-The first toenail on her right foot had grown one inch past the end of the toe; it was turned toward the inside of her second toe.
-The second toenail on her right foot had grown over the end of the toe, curved over the end of the toe, and pressed the underside of the toe.
-The third toenail on her right foot had grown out one-fourth an inch past the end of the toe and was pressed against the third toe.
-The fourth toenail on her right foot had grown past the end of the toe, had curved toward the third toe, and was pressed against the top right side of the toe.
-The fifth toenail on her right foot was pressed against the top of the fourth toe.
-Resident #1's skin was dark and crusty between her toes and underneath the toes on her right foot.
-All of Resident #1's toenails were thick and brownish/gray.
-Resident #1's feet were dry and scaly.

Interview with Resident #1 on 03/20/24 at 8:46am revealed:
-Her toenails needed to be cut.
-Her toenails hurt if she walked a lot.
-She had not told anyone her toenails needed to be cut.

Interview with a personal care aide (PCA) on 03/20/24 at 9:02am revealed:
-She had assisted Resident #1 with showers and dressing.
-Resident #1's feet were "really" dry and had an odor at times.

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-Resident #1's toenails were "really" long.
-Resident#1's toenails could only be cut by a nurse or a podiatrist.
-She had notified the WD that Resident #1's toenails needed to be cut (she did not recall the date).
-She thought the WD was going to trim the resident's toenails between podiatry visits.

Interview with a medication aide (MA) on 03/20/24 at 9:35am revealed:
-If a PCA noticed a resident's toenails needed to be cut, the PCA should tell the WD, or if they told her, she would tell the WD.
-A PCA told her when he put Resident #1's sock on, the resident's toenails were long and needed to be cut and she would tell the WD.

Telephone interview with Resident #1's family member on 03/19/24 at 11:25am revealed:
-Resident #1's toenails were so long that the resident was having difficulty walking.
-She saw Resident #1's toenails at the hospital on 03/15/24.
-The facility added podiatry services at the facility she thought in the fall of 2023, and she asked to have Resident #1 seen by podiatry.
-She had assumed Resident #1 was seen by podiatry.
-She was going to make Resident #1 an appointment to have her toenails cut because "something needed to be done."
-Resident #1 was diabetic and her feet needed to be assessed.

Telephone interview with a representative with the facility's contracted podiatry services on 03/20/24 at 3:31pm revealed Resident #1 was not enrolled in their services and had not been seen by a podiatrist with their company.

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D 273	Continued From page 6 Interview with the WD on 03/20/24 at 5:02pm revealed he was not aware Resident #1's toenails needed to be cut. Interview with the Administrator on 03/20/24 at 4:36pm revealed he was not aware Resident #1's toenails needed to be cut; if he had known he would have made an appointment immediately. Refer to the interview with the PCP on 03/21/24 at 12:57pm Refer to the interview with the WD on 03/20/24 at 5:02pm. Refer to the interview with the Administrator on 03/20/24 at 4:36pm. 2. Review of Resident #7's current FL-2 dated 01/25/24 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes, and hypertension. -Resident #1 required assistance with bathing, feeding, and dressing. Review of Resident #7's care plan dated 10/06/23 revealed: -The care plan was signed by the WD on 10/06/23. -The care plan was signed by the PCP on 10/26/23. -The level of assistance Resident #7 required for activities of daily living had not been completed. Review of the facility's podiatry services scheduled for 03/28/24 revealed Resident #7 was not on the schedule to be seen. Observation of Resident #7's toenails on 03/21/24	D 273		

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D 273	Continued From page 7 at 4:21pm revealed: -The first toenail on her left foot had grown one inch past the end of the toe; it was turned toward the top of her second toe. -The second toenail on her left foot had grown over the end of the toe and was pressing into the bottom of the toe. -The third toenail on her left foot was broken and jagged. -The fourth toenail had grown one-fourth an inch past the end of the toe. -In between Resident #7's toes on her left foot, was a dark brown, dried, crusty substance. -The first toenail on her right foot had grown one inch past the end of the toe; it was turned toward the top of her second toe. -The second toenail on her right foot had grown over the end of the toe, curved over the end of the toe, and was pressing into the underside of the toe. -The fourth toenail on her right foot had grown over the end of the toe and was pressing into the bottom of the toe. -The third and fifth toenails on her right foot were broken and jagged -There was a blister on the top of Resident #7's second toe on the right foot. -All of Resident #7's toenails were thick and brownish/gray. -Resident #7's feet were dry and scaly. -Resident #7's feet had a foul odor when her socks were removed. Interview with Resident #7 on 03/20/24 at 4:25pm revealed: -Her feet hurt because of her toenails. -Sometimes it would hurt to walk. Interview with a PCA on 03/20/24 at 4:25am revealed staff put a wider shoe on Resident #7	D 273		

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D 273	Continued From page 8	D 273		

because the shoe gave the resident more room because the resident's toenails needed to be cut.

Interview with another PCA on 03/20/24 at 9:02am revealed:
-Resident #7's toenails were "really" long.
-She had notified the WD that Resident #7's toenails needed to be cut (she did not recall the date).

Interview with a MA on 03/21/24 at 10:01am revealed:
-Resident #1 said "ouch" when she was putting the resident's sock on.
-She recalled telling the WD that Resident #7's toenails were long in the past couple of weeks but did not recall the date.

Interview with a second MA on 03/20/24 at 9:35am revealed:
-She had seen Resident #7's toenails and had told the WD on 03/08/24 that the resident's toenails needed to be cut.
-The WD replied "okay."

Telephone interview with a representative with the facility's contracted podiatry services on 03/20/24 at 3:31pm revealed Resident #7 was not enrolled in their services and had not been seen by a podiatrist with their company.

Interview with the WD on 03/20/24 at 5:02pm revealed:
-He was not aware Resident #7's toenails needed to be cut until today, 03/20/24.
-He had looked at Resident #7's toenails today, 03/20/24, and was concerned about a blister on the resident's big toe

Interview with the Administrator on 03/20/24 at

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D 273	Continued From page 9 4:36pm revealed he was not aware Resident #7's toenails needed to be cut; if he had known he would have made an appointment immediately. Attempted telephone interview with Resident #7's family member on 03/20/24 at 10:50am was unsuccessful. Refer to the interview with the PCP on 03/21/24 at 12:57pm Refer to the interview with the WD on 03/20/24 at 5:02pm. Refer to the interview with the Administrator on 03/20/24 at 4:36pm. _____ Interview with the PCP on 03/21/24 at 12:57pm revealed: -Residents should have a routine podiatry examination every three months. -If toenails were not trimmed, the toenails could cut into the residents' skin. -Residents could develop wounds on their feet and diabetics would have delayed healing and possibly the need for antibiotics. -Long toenails could increase the risk of falls because toes provided balance and long toenails could change the balance. -Residents with dementia may not report pain. Interview with the WD on 03/20/24 at 5:02pm revealed: -PCAs could not cut the resident's toenails so they let him know when a resident's toenails needed to be cut. -Family members also came to him to let him know when their family members' toenails needed to be cut. -He had trimmed residents' toenails before to	D 273		

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"hold over" until the next podiatry visit.
-He was concerned about diabetic residents whose toenails needed to be trimmed because long toenails could lead to an injury and an open wound could lead to further risks.

Interview with the Administrator on 03/20/24 at 4:36pm revealed:
-Diabetic residents' foot care would be taken care of by a podiatrist.
-The WD was responsible for making appointments with the podiatrist.
-The WD may have the PCAs look at the residents' feet to see if the resident would need to be added to the podiatry list.
-If the PCA or MA saw that a resident needed foot care, they should let the WD know.
-The WD should make an appointment for the resident or if an immediate need the WD could contact the family to see if the family member could get an appointment sooner.

_____

The facility failed to ensure 2 of 2 diabetic residents (#1 and #7), who needed their toenails trimmed, were referred to a podiatrist, which resulted in both residents having long, thick toenails that were painful and put the residents at risk for injuries to their feet and because the residents had a diagnosis of diabetes an injury could put the residents at increased risk of infection. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/20/24 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 21,

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D 273	Continued From page 11 2024.	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, record reviews and interviews, the facility failed to implement physician's orders for 3 of 6 sampled residents (#1, #3, and #5) related to an order for parameters for low finger stick blood sugar (FSBS) (#1), for Thromboembolism-deterrent (TED) hose (#1, #3) and dressing changes (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 07/04/23 revealed: -Diagnoses included Alzheimer's disease, diabetes mellitus, and peripheral vascular disease. -Resident #1 required assistance with bathing and dressing. Review of Resident #1's care plan dated 10/06/23 revealed: -The care plan was signed by the Wellness Director (WD) on 10/06/23. -The care plan was signed by the Primary Care Provider (PCP) on 10/26/23.	D 276		

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-The level of assistance Resident #1 required for activities of daily living had not been completed.

a. Review of Resident #1's signed physician's orders dated 07/04/23 revealed:
-Check Resident #1's finger stick blood sugar (FSBS) once daily.
-The order included the directions to call the PCP if the residents' FSBS was less than 60.
-The order also included the directions to give Resident #1 orange juice with a tablespoon of sugar if the resident could swallow.
-If the resident was nonresponsive and could not swallow, call emergency medical services (EMS).

Review of Resident #1's March 2024 electronic medication administration record (eMAR) for 03/15/24 revealed:
-There was an entry to check Resident #1's FSBS once daily scheduled at 6:30am.
-If Resident #1's FSBS was less than 60 call EMS.
-If Resident #1's FSBS was less than 60, give orange juice and one tablespoon of sugar.
-Resident #1's FSBS was documented as 55 on 03/15/24.

Review of Resident #1's incident report dated 03/15/24 at 6:30am revealed:
-Resident #1's FSBS was 55.
-EMS was called.
-When EMS arrived, Resident #1's FSBS was 36.

Review of Resident #1's EMS report dated 03/15/24 revealed Resident #1's FSBS had a reading of 36 when checked by EMS.

Interview with Resident #1 on 03/20/24 at 8:46am revealed:
-Staff checked her FSBS but she could not recall

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how often.
-She did not recall having any low FSBS.
-She did not recall having a low FSBS and going to the hospital.

Interview with a medication aide (MA) on 03/21/24 at 2:42pm revealed:
-When she woke Resident #1 up on 03/15/24, the resident was "not right."
-"It was like Resident #1's right side was not working."
-When she checked Resident #1's FSBS, the result was 55 and she immediately called EMS.
-Resident #1 did not have anything to eat or drink before EMS arrived.
-She "probably" should have given Resident #1 orange juice.
-She knew there was an order to give Resident #1 orange juice with sugar.
-She did not have any orange juice because the kitchen was locked.
-She had a key to the kitchen, but the refrigerator was locked, and she did not have a key to the refrigerator.

Interview with the PCP on 03/21/24 at 12:57pm revealed:
-She was not notified when Resident #1's finger stick blood sugar (FSBS) was 55 on 03/15/24.
-She expected the order to give orange juice and sugar to be followed when Resident #1's FSBS was less than 60.
-She was concerned Resident #1 was not given orange juice because the resident's FSBS from the time called EMS until EMS arrived could drop even further.
-The outcome could have been "horrible" because if Resident #1's FSBS dropped too low the resident could go into a coma.
-Resident #1's FSBS would have come back to

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normal if she had been given orange juice as ordered.

Interview with the WD on 03/21/24 at 3:49pm revealed:
-He expected the MA to follow the order when Resident #1's FSBS was less than 60.
-The MA should have given Resident #1 orange juice with sugar per order.
-It was unnecessary to send Resident #1 out without knowing if the orange juice would have brought the resident's FSBS up.

Interview with the Administrator on 03/21/24 at 5:05pm revealed:
-He expected the MA to call the PCP when Resident #1's FSBS was less than 60 per the order.
-He expected the MA to give Resident #1 orange juice and sugar per order.
-Sending Resident #1 to the hospital may have been avoided had the MA given the resident orange juice and sugar.

b. Review of Resident #1's PCP order dated 11/16/23 revealed an order for Thromboembolism-deterrent (TED) hose, apply the stockings in the morning and remove in the evenings.

Observation of Resident #1 at various times on 03/19/24 and 03/20/24 revealed the resident was not wearing TED hose.

Review of Resident #1's March 2024 eMAR for 03/01/24 -03/19/24 revealed there was no entry to apply TED hose for Resident #1; there was no documentation TED hose had been applied.

Interview with Resident #1 on 03/20/24 at 8:46am

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revealed she did not know what TED hose were and she did not know if she was supposed to wear TED hose.

Interview with a MA on 03/20/24 at 2:42pm revealed:
-Resident #1 did not wear TED hose.
-She had never applied TED hose on Resident #1.
-She had noticed swelling in Resident #1's legs and encouraged the resident to elevate her legs.

Interview with a second MA on 03/20/24 at 4:16pm revealed:
-Resident #1 did not wear TED hose.
-She had never applied TED hose on Resident #1.
-She had never seen TED hose in Resident #1's room.
-If Resident #1 had an order for TED hose, it would have been on the eMAR.

Interview with a third MA on 03/20/24 at 2:42pm revealed she had never seen Resident #1 wear TED hose.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/20/24 at 3:22pm revealed:
-Resident #1 had an order that was received on 11/16/23 to apply TED hose in the mornings and remove the TED hose in the evening.
-Resident #1's TED hose measurement form was faxed to the facility.
-The pharmacy was not able to send TED hose for Resident #1 without measurements.
-TED hose were used to help with swelling and to prevent deep vein thrombosis.

Telephone interview with Resident #1's family

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member on 03/20/24 at 3:57pm revealed:
-Resident #1 had swelling in her ankles and feet.
-Resident #1 did not have an order for TED hose that she knew about.
-She thought Resident #1 had swelling in her ankles and feet because of sitting but never reclining because the resident had sundowning and was always up.
-No one had ever mentioned a concern about Resident #1's feet/ankles swelling so she had never brought it up with staff.

Interview with the PCP on 03/21/24 at 12:57pm revealed:
-She ordered TED hose for Resident #1 due to edema (swelling).
-Resident #1 would not elevate her legs which would have helped with the edema.
-If Resident #1's edema was not controlled the resident could develop cellulitis over time.
-She liked to stay ahead of the edema to prevent the use of diuretics in a resident with memory loss due to incontinence and a "host of other issues."
-Edema could also flare up neuropathy which could put the resident at a higher risk for falls.

Interview with the WD on 03/21/24 at 3:49pm revealed:
-When the pharmacy received orders for TED hose, the pharmacy would then send a form for measurements.
-The staff obtain the measurements per the form and fax the form back to the pharmacy.
-He was not aware Resident #1 had an order for TED hose.
-If Resident #1 was not wearing her TED hose as ordered, the resident could experience swelling.
-He was not aware Resident #1 had swelling in her legs.

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D 276	Continued From page 17 Interview with the Administrator on 03/20124 at 5:05pm revealed: -Resident #1 was identified as needing TED hose and the order was not followed through. -Resident #1 could have an exacerbation of the condition the TED hose was ordered. -He expected the order for Resident #1's TED hose to be faxed to the pharmacy and the TED hose to be applied once they were received. 2. Review of Resident #3's current FL-2 dated 08/17/23 revealed diagnoses Alzheimer's disease, bilateral pneumonia, dementia with agitation, hyperlipidemia, and depression. Review of Resident #3's signed physician order dated 01/11/24 revealed there was an order to apply TED hose to bilateral legs at 8:00am and remove at 8:00pm. Review of Resident #3's care plan dated revealed: -The care plan was signed by the Primary Care Provider (PCP) on 12/14/23. -The performance codes for Resident #3's activities of daily living had not been completed. Observation of Resident #3 at various times on 03/19/24 and 03/20/24 revealed the resident was not wearing TED hose. Review of Resident #3's January 2024 electronic medication administration record (eMAR) from 01/11/24 to 01/31/24 revealed: -There was no entry to apply TED hose to bilaterally leg at 8:00am and remove at 8:00pm. -There was no documentation TED hose were applied to Resident #3's bilateral legs.	D 276		

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D 276	Continued From page 18 Review of Resident #3's care plan dated 10/06/23 revealed: -The care plan was signed by the Primary Care Provider (PCP) on 12/14/23. -The performance codes for Resident #3's activities of daily living had not been completed. Interview with the Pharmacist at the facility's contracted pharmacy on 03/21/24 at 9:11am revealed: -The pharmacy did not receive an order for TED hose for Resident #5. -The pharmacy did supply TED hose to the facility's once the measurements were obtained by the facility staff and faxed to the pharmacy. -The order for TED hose would be entered on the eMAR once the TED hose was shipped to the facility. Interview with a medication aide (MA) on 03/21/24 at 1:15pm revealed: -She did not know Resident #3 had an order for TED hose. -She had not noticed and swelling in Resident #3 feet or ankles. -The Wellness Director (WD) received all new orders and faxed the new orders to the pharmacy. Interview with Resident #3's PCP on 03/21/24 at 1:27pm revealed: -She wrote the order for Resident #3 for TED hose on 01/11/24 and gave the order to the WD to be faxed to the pharmacy. -She preferred the residents to wear TED hose instead of administering diuretics which could lead to skin breakdown since Resident #3 was incontinent. -Resident #3 was having swelling of his feet and ankles.	D 276		

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-She did not know the TED hose had not been received from the pharmacy and applied to Resident #3 as ordered.
-She expected orders to be follow orders as written.

Interview with the WD on 03/21/24 at 3:49pm revealed:
-When the pharmacy received orders for TED hose, the pharmacy would send a form to obtain Resident #3's measurements.
-The MAs obtained the measurements, completed the form, and faxed the form back to the pharmacy.
-He did not know Resident #3 had an order for TED hose.
-He was not aware Resident #3 had swelling in his legs.
-Resident #3 could have increased swelling in his legs if he did not wear the TED hose as ordered.

Interview with the Executive Director (ED) on 03/21/24 at 5:08pm revealed:
-The order for TED hose for Resident #3 should have been faxed to the pharmacy by the MA or WD.
-The Ted hose were ordered for Resident #3 for a reason and if the order was not followed Resident #3 could have an exacerbation of the reason the TED hose were ordered.
-He expected new orders to be faxed to the pharmacy when received and followed as ordered.

Attempted telephone interview with Resident #3's family member on 03/21/24 at 2:00pm was unsuccessful.

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

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interviewable.

3. Review of Resident #5's current FL-2 dated 12/13/23 revealed diagnoses of dementia, hypertension, hyperlipidemia, and glaucoma.

Review of Resident #5's record revealed there was no care plan to review.

Review of Resident #5's hospital Emergency Department summary dated 03/15/24 revealed:
-Resident #5's was seen in the Emergency Department due to a fall.
-Resident #5 was diagnosed with a skin tear to his left upper extremity.
-There were instructions for Resident #5's left arm to be cleaned and re-dressed with xeroform gauze and wrapped in coban.
-Resident #5's dressing to the wound on the left arm should be changed every 24 to 48 hours.
-Dressing supplies were provided by the Emergency Department.

Observation of Resident #5 on 03/19/24 at 9:02am revealed:
-Resident #5 had a bulky dressing wrapped with coban to his left arm.
-The padding under the coban extended about 1 inch from the coban and was visible.
-There was no date on the dressing.

Observation of Resident #5 on 03/20/24 at 11:45am revealed:
-Resident #5 had a bulky dressing wrapped with coban on his left arm.
-The padding under the coban extended about 1 inch from the coban and was visible.
-There was no date on the dressing.

Observation of Resident #5 on 03/21/24 at

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D 276	Continued From page 21 11:15am revealed: -Resident #5 had a dressing wrapped with coban to his left arm; the dressing change was dated 03/21/24. -There was no visible padding noted from under the coban. Review of Resident #5's electronic progress notes from 03/15/24 to 03/20/24 revealed there was no documentation Resident #5's left arm dressing had been re-dressed. Review of Resident #5's March 2024 electronic medication administration record (eMAR) from 03/16/24 to 03/21/24 revealed: -There was no entry for a dressing change every 24 - 48 hours to Resident #5's left arm. -There was no documentation that a dressing change for Resident #5 had occurred. Telephone interview with Resident #5's family member on 03/20/24 at 4:00pm revealed: -She visited Resident #5 on the afternoon of 03/15/24. -She requested Resident #5 be sent to the Emergency Department for treatment to his left arm. Interview with a medication aide (MA) on 03/21/24 at 9:29am and 11:25am revealed: -Resident #5 was sent to the Emergency Department o 03/15/24, for a large skin tear to his left arm as requested by Resident #5's family, and Resident #5 returned to the facility the same day. -She had not changed Resident #5's dressing to his left arm. -She had not seen orders to change Resident #5's dressing to his left arm. -She did not know Resident #5 had orders to	D 276		

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change the dressing to his left arm.
-The Wellness Director (WD) was responsible for changing Resident #5's dressing.
-The WD changed the dressing to Resident #5's left arm today, 03/21/24.
-Today was the first time Resident #5's dressing was changed since the Emergency Department visit on 03/15/24.

Interview with the WD on 03/21/24 at 3:49pm revealed:
-Resident #5 was seen in the Emergency Department on 03/15/24 because of a skin tear to his left arm.
-The WD saw the Emergency Department discharge summary on 03/19/24.
-He changed Resident #5's dressing on 03/19/24 and 03/21/24.
-Resident #5 did not have a dressing change on 03/16/24, 03/17/24, or 03/18/24.
-The MAs could not change the dressing to Resident #3's left arm; it was out of their scope of practice.
-He did not know if the dressing change order was faxed to the pharmacy.
-He did not document the dressing change was done on 03/19/24 or 03/21/24.
-The MA working Resident #5's hall would have received the Emergency Department's discharge summary.
-The MA would fax Resident #5's Emergency Department's discharge summary to the pharmacy.
-The pharmacy would update Resident #5's eMAR with the new orders for dressing changes received from the Emergency Department for Resident #5.

Interview with the Executive Director (ED) on 03/21/24 at 5:08pm revealed:

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D 276	Continued From page 23 -The MA should review the Emergency Department discharge summary and fax it to the pharmacy. -The WD would review the Emergency Department discharge summary the next day. -If the Emergency Department visit was over the weekend, the WD would review the discharge summary the following Monday. -The WD would see that the Emergency Department discharge summary was faxed to the pharmacy. -The WD would place the Emergency Department discharge summary in the PCPs box for review. -If the MA had questions regarding the orders on the Emergency Department discharge summary, the MA should call the WD for guidance. -He was concerned the resident did not get the needed treatment as ordered in a timely manner. -He expected the staff to review the Emergency Department discharge summary and take the necessary action to ensure the orders were followed through. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300	D 283		

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D 283	Continued From page 24 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to unsealed bags of food in the freezer. The findings are: Observation of the walk-in freezer on 03/19/24 at 9:15am revealed: -There were two opened bags of fries on the third shelf of the freezer. -There was one opened bag of chicken nuggets on the third shelf of the freezer. -There was one opened bag of hushpuppies on the third shelf of the freezer. Interview with a cook on 03/19/24 at 9:45am revealed: -He did not have anyway of sealing the bags once they were opened. -He would twist the opening around to attempt to close the bag, but it did not keep the bag of food closed. -He did not have any twist ties or rubber bands to close the open bags of food. Interview a second cook on 03/20/24 at 10:45am revealed:	D 283		

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D 283	Continued From page 25 -He did not know there were opened bags of frozen food in the freezer. -The food was have freezer burn and would have to be thrown away. -He used the clear, clingy wrap to secure bags of food that he had opened. -He did not use twist ties to secure the opened bags of food. Interview with the Dietary Manager (DM) on 03/20/24 at 9:14am revealed: -He did not realize there were opened bags of food in the freezer. -The dietary staff should have re-sealed the bags with a twist tie. -He thought there were twist ties in the kitchen to close opened bags of food. -He did not look in the freezer each day to see if the bags of food were sealed. Interview with the Executive Director (ED) on 03/20/24 at 10:21am revealed: -He expected the food in the freezer to be properly stored to prevent freezer burn. -He made rounds in the kitchen daily but did not go in the freezer on a daily basis. -He had not noticed the opened bags of food in the freezer.	D 283		
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 mealtime table service included a place setting consisting of a knife, fork, and spoon.

The findings are:

Observation of the breakfast meal service on 03/19/24 at 8:47am revealed:
-The residents were served a bowl of cereal and two slices of bacon.
-The residents were provided with only a spoon.
-The residents were not provided a fork or a knife.
-Multiple residents were observed picking up slices of bacon with their fingers.

Observation of the lunch meal service on 03/19/24 at 12:00pm revealed:
-The place setting consisted of a napkin, a spoon, and a fork.
-The meal consisted of either chicken tenders or boned chicken drumettes, coleslaw, french fries, and a biscuit.
-There were 46 place settings with a fork and a spoon; there were no knives on the tables.
-One resident used his fingers to hold the chicken tender in place while he used the side of the spoon to cut pieces of the chicken; he was unsuccessful and picked the chicken tender up with his fingers.
-Another resident attempted to cut her chicken with her fork and was unsuccessful; she picked

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 286	Continued From page 27 the chicken tender up with her fingers. . Observation of the breakfast meal service on 03/20/24 at 8:08am revealed: -The place setting consisted of a spoon and a fork. -The menu consisted of scrambled eggs, a sausage patty, and a biscuit. -There were 46 place settings with a fork and a spoon; there were no knives on the tables. -One resident used his spoon to unsuccessfully attempt to cut the sausage patty; he picked the sausage patty up with his fingers. -Another resident used a fork to unsuccessfully attempt to cut the sausage patty; she picked the sausage patty up with her fingers. Interview with the dietary cook on 03/20/24 at 9:02am revealed: -The dietary staff was responsible for placing the place setting on the table. -The place setting consisted of a spoon and fork, but no knife. -He had been told by the previous Dietary Manager (DM) that the knives were dangerous, and someone could get hurt. -He had never placed knives on the tables, and no one had instructed him to place knives on the table. Interview with the DM on 03/20/24 at 9:14am revealed: -The resident's place setting consisted of a fork and a spoon. -He was told by the staff that the knives disappeared; residents will take the knives to their room. -He did not realize the residents required a complete setting of silverware. -He had seen residents successfully cut meat	D 286		

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D 286	Continued From page 28 with a fork. -He served meats that were tender and did not require a knife for cutting. Interview with the Executive Director (ED) on 03/20/24 at 10:21am revealed: -Residents like to take utensils to their room from the dining room. -A knife could be used to harm another resident or staff member. -He had not noticed residents attempting to cut their food with a fork or spoon.	D 286		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an accurate listing of residents with physician-ordered therapeutic diets was available for the guidance of the food service staff. The findings are: Observation of the dietary list in the kitchen on	D 309		

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D 309	Continued From page 29 03/19/24 at 9:28am revealed: -The dietary list consisted of the resident's photo with a diet listed underneath the photo. -The dietary list was posted on a bulletin board on the wall next to the walk-in refrigerator. -The dietary list was not visible to the cook plating the food. -There was no date on the dietary list. Interview with the cook on 03/20/24 at 9:02am revealed: -The Dietary Manager (DM) was responsible for updating the dietary list. -He thought the dietary list was updated about 3 weeks ago. -He did not know the dietary list was incorrect. -He knew which residents were on special diets; he did not refer to the dietary list. Interview with the DM on 03/20/24 at 9:14am revealed: -The Wellness Director (WD) was responsible for updating the dietary list. -He did not know when therapeutic diets were ordered or changed. -He did not know the last time the dietary list was updated. -He did not know the dietary list was not up to date. -He acquired the dietary list when he started employment about 2 months ago. Interview with the Marketer on 03/20/24 at 10:15am revealed: -He managed all the admission paperwork. -He made a copy of the diet order and gave it to the DM when there was a new admission. -The WD managed diet orders written after the resident was admitted to the facility.	D 309		

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D 309	Continued From page 30 Interview with the WD on 03/20/24 at 9:56am revealed: -Diet orders were part of the admission paperwork. -The marketer for the facility handled all the admission paperwork. -The marketer would make a copy of the diet order and give it to the DM. -He received diet orders changed after a resident was admitted to the facility. -He would make a copy of the diet order and give the copy to the DM. -The DM was responsible for updating the dietary list in the kitchen. Interview with the Executive Director (ED) on 03/20/24 at 10:21am revealed: -The DM was to update the dietary list in the kitchen. -The Marketer or the WD would give the DM the diet order and the DM would update the dietary list. -He did not realize the dietary list was not updated for staff to reference. -He expected the dietary list to be updated with each new diet order.	D 309		
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, record reviews, and interviews, the facility failed to ensure therapeutic	D 310		

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diets were served as ordered for 3 of 4 sampled residents with a diet order for a level 3 soft chew (#1, #8) and finger foods (#4).

The findings are:

Review of the weekly menu for the week of 03/17/24 to 03/23/24 revealed:
-The lunch meal to be served for the regular diet on 03/19/24 was baked ravioli, green beans, bread sticks, apple crisp, and beverage of choice.
-The breakfast meal to be served for the regular diet on 03/19/24 was juice of choice, egg of choice, sausage link, cereal of choice, toast, beverage of choice, milk of choice, jelly, margarine, creamer, salt, and pepper.

1. Review of Resident #1's current FL-2 dated 07/04/23 revealed diagnoses included Alzheimer's disease, diabetes mellitus, and peripheral vascular disease.
Observation of the lunch meal in the main dining room on 03/19/24 at 12:12pm revealed:
-Resident #1 was served 2 drumettes, ½ cup of slaw, French fries, a biscuit, and apple crisp.
-Resident #1 ate two bites from 1 drumette, ¼ of the slaw, 100% of the French fries, ½ of the biscuit and 100% of the apple crisp.

Review of the therapeutic diet menu for the week of 03/17/24 to 03/23/24 revealed:
-The lunch meal to be served for the level 3 soft chew diet on 03/19/24 was baked ravioli, green beans, bread sticks, applesauce, and beverage of choice.
-The breakfast meal to be served for the level 3 soft chew diet on 03/20/24 was juice, scrambled egg, ground sausage, cereal of choice with milk, beverage of choice, jelly, margarine creamer, salt, and pepper.

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D 310	Continued From page 32 Observation of the breakfast meal in the main dining room on 03/20/24 at 8:32am revealed: -Resident #1 was served a sausage patty, scrambled eggs, and a biscuit. -Resident #1 ate ½ of the sausage patty, 100 % of the scrambled eggs and biscuit. Review of Resident #1's primary care provider (PCP) after-visit summary dated 12/12/23 revealed: -Resident #1's family member had contacted the PCP to discuss concerns about Resident #1's eating. -Resident #1 had several teeth removed, most noticeably 4 or 5 on the bottom row in the front making it difficult to bite, especially meat. -The family member thought Resident #1 had a weight loss. -The family member requested Resident #1's food be cut into smaller pieces so the resident could chew it. -She wrote an order to please cut Resident #1's food into small bite-size pieces to help with food consumption. Review of the facility's diet order form dated 12/14/23 revealed: -Resident #1 was to be on a no-added salt diet with texture as soft and bite-sized. -Soft bite-sized was to be 15mm x 15mm pieces; soft, tender, and moist. Telephone interview with Resident #1's family member on 03/21/24 at 11:39am revealed: -She requested Resident #1's food be cut into bite-size pieces because Resident #1 had a lot of teeth pulled, "the teeth where you would bite." -She thought food with bones would be hard for Resident #1 to bite the meat off and would need	D 310		

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to be cut.

Interview with Resident #1's PCP on 03/21/24 at 12:57pm revealed:
-Resident #1's diet was ordered to be cut up so the resident could chew better.
-If Resident #1 was not able to chew her food, the resident could experience weight loss.
-Resident #1 was diabetic and if Resident #1 did not eat it increased the resident's risk of hypoglycemia, which she just experienced (03/15/24).

Refer to the interview with the dietary cook on 03/20/24 at 8:26am.

Refer to the interview with the DM on 03/20/24 at 9:14am.

Refer to the interview with the WD on 03/20/24 at 9:56am.

Refer to the interview with the Administrator on 03/20/24 at 10:21.

2. Review of Resident #8's current FL-2 dated 02/07/23 revealed diagnosis included dementia.

Review of Resident #8's signed physician diet order dated 02/09/24 revealed there was an order for a level 3 soft chew diet.

Review of the therapeutic diet menu for the week of 03/17/24 to 03/23/24 revealed:
-The lunch meal to be served for the level 3 soft chew diet on 03/19/24 was baked ravioli, green beans, bread sticks, applesauce, and beverage of choice.
-The breakfast meal to be served for the level 3 soft chew diet on 03/20/24 was juice, scrambled

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egg, ground sausage, cereal of choice with milk, beverage of choice, jelly, margarine creamer, salt, and pepper.

Observation of the lunch meal in the main dining room on 03/19/24 at 12:12pm revealed:
-Resident #8 was served 2 chicken tenders, ½ cup of slaw, French fries, a biscuit, and apple crisp.
-Resident #8 did not eat any chicken tenders or apple crisp, ¾ of the slaw, 100% of the French fries, 3/4 of the biscuit.

Observation of the breakfast meal in the main dining room on 03/20/24 at 8:32am revealed:
-Resident # 8 was served a sausage patty, scrambled eggs, and a biscuit.
-Resident #8 ate 100% of his meal.

Interview with Resident #8's Primary Care Provider (PCP) on 03/21/24 at 1:27pm revealed:
-Resident #8 was on a soft chew diet because he has a history of choking on his food.
-She expected Resident #8 to be served a soft chew diet.

Interview with the Dietary Manager (DM) on 03/21/24 at 9:00am revealed:
-He was not aware of guidance for a level III soft chew diet.
-He used what knowledge he had and researched online.
-The food was chopped and cooked in water to soften the food.

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

Refer to the interview with the dietary cook on 03/20/24 at 8:26am.

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D 310	Continued From page 35 Refer to the interview with the DM on 03/20/24 at 9:14am. Refer to the interview with the WD on 03/20/24 at 9:56am. Refer to the interview with the Administrator on 03/20/24 at 10:21. 3. Review of Resident #4's current FL-2 dated 02/12/23 revealed diagnoses of encephalopathy and dementia. Review of the Resident #4's facility's diet order form dated 07/23/23 revealed there was an order for finger foods. Review of the therapeutic diet menu for the week of 03/17/24 to 03/23/24 revealed: -The lunch meal to be served for the finger food diet on 03/19/24 was baked ravioli, green beans, bread sticks, applesauce, and beverage of choice. -The breakfast meal to be served for the finger food diet on 03/20/24 was juice, scrambled egg, ground sausage, cereal of choice with milk, beverage of choice, jelly, margarine creamer, salt, and pepper. Observation of the lunch meal service on 03/19/24 at 12:10pm revealed: -Resident #4 was served chopped chicken, chopped broccoli and two scoops of mashed potatoes. -A slice of apple pie was served for dessert. -Resident #4 did not receive any bread. -Resident #4 was fed his entire meal by a personal care assistant (PCA). -Resident #4 consumed 100% of his meal.	D 310		

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D 310	Continued From page 36 Observation of the breakfast meal service on 03/20/24 at 8:38am revealed: -Resident #4 was served scrambled eggs, a sausage patty, and a biscuit. -The Dietary Manager served Resident #8 his plate and cut the sausage patty and biscuit into bite size pieces. -Resident #4 was fed his meal by a PCA. -Resident #4 ate ½ of his biscuit and sausage and ¾ of his eggs. Interview with the PCA on 03/19/24 at 12:20pm revealed: -Resident #4 had to be helped to eat. -Resident #4 could feed himself finger food but with stuff that was served on his meal tray, he needed help. -She did not know what diet Resident #4 was on. Interview with the DM on 03/20/24 at 9:14am revealed: -Resident #4 was served a soft diet because the staff had been feeding him. -He did not realize Resident #4 did not have an order for a soft diet. Interview with Resident #4's PCP on 03/21/24 at 12:57pm revealed: -Resident #4 was on a finger food diet so he could feed himself. -She was not aware Resident #4 could no longer feed himself finger food. -If she had been told, she would have updated his dietary order. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable. Refer to the interview with the dietary cook on	D 310		

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D 310	Continued From page 37 03/20/24 at 8:26am. Refer to the interview with the DM on 03/20/24 at 9:14am. Refer to the interview with the WD on 03/20/24 at 9:56am. Refer to the interview with the Administrator on 03/20/24 at 10:21. _____ Interview with the dietary cook on 03/20/24 at 8:26am revealed: -He had worked at the facility long enough to know which residents were on a special diet. -There are only four residents with special diets ordered. -The four special diets were prepared, the plate covered with a lid and the resident's name was on the lid to identify the special diet was to be given to a specific resident. -The remainder of the plates were a regular diet. -He did not know what a therapeutic menu was. -He did not use a therapeutic menu when preparing therapeutic diets. -He did not know if there was a therapeutic menu available. -The Dietary Manager (DM)wrote out menus for each day. Interview with the DM on 03/20/24 at 9:14am revealed: -The therapeutic menu was kept in a notebook in the kitchen. -The cooks did not use the therapeutic menu. -He was taught about the therapeutic menu and to refer to it as needed. -Therapeutic meals were prepared based on his knowledge of what the diet order was. -The diet orders should be followed as ordered.	D 310		

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D 310	Continued From page 38 -Resident #4 was served a soft diet because the staff had been feeding him. -He did not realize Resident #4 did not have an order for a soft diet. Interview with the WD on 03/20/24 at 9:56am revealed: -Diet orders were part of the admission paperwork. -The marketer for the facility handled all the admission paperwork. -The marketer would make a copy of the diet order and give it the DM. Interview with the Administrator on 03/20/24 at 10:21am revealed: -Meals should be served as ordered by the PCP. -He was concerned a resident may get the incorrect diet and not be able to eat the food or have swallowing difficulties.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 6 sampled residents (#11) regarding an order for finger stick blood sugar (FSBS).

The findings are:

Review of Resident #11's current FL-2 dated 12/28/23 revealed:
-Diagnoses included Alzheimer's disease, muscle weakness, and atrial fibrillation.
-There was no order to check Resident #11's FSBS.

Review of Resident #11's January 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check the resident's FSBS three times daily scheduled at 7:00am, 11:30am, and 4:30pm.
-There was documentation Resident #11's FSBS was checked three times daily from 01/09/24-01/31/24.
-There was documentation that Resident #11 was out of the facility from 01/01/24-01/08/24.

Review of Resident #11's February 2024 eMAR revealed:
-There was an entry to check the resident's FSBS three times daily scheduled at 7:00am, 11:30am, and 4:30pm.
-There was documentation Resident #11's FSBS was checked three times daily from 02/01/24-02/29/24.
-There was documentation of exceptions on 02/06/24 at 4:30pm, 02/08/24 at 7:00am, 11:30am, and 4:30pm and on 02/27/24 at 11:30am.

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D 344	Continued From page 40 Review of Resident #11's March 2024 eMAR from 03/01/24-03/19/24 revealed: -There was an entry to check the resident's FSBS three times daily scheduled at 7:00am, 11:30am, and 4:30pm. -There was documentation Resident #11's FSBS was checked three times daily from 03/01/24-03/19/24. Telephone interview with a pharmacist from the facility's contract pharmacy on 03/20/24 at 10:57am revealed: -Resident #11's order for FSBS was dated 01/18/23 for 30 days. -The order was entered into the eMAR system with a start date of 01/19/23 and an end date of 02/17/23. -Continuing to check Resident #11's FSBS when there was no order, could cause the resident to have pain when being stuck when he did not need to be stuck. Telephone interview with a representative from the facility's contracted pharmacy on 03/20/24 at 11:42am revealed: -Resident #11's order for FSBS three times daily was not entered into the eMAR system by the pharmacy. -A [named] facility staff had put the entry into the eMAR system for Resident #11's FSBS three times daily on 08/03/23. -If there was an order for Resident #11 to have FSBS, the facility staff should have sent the order to the pharmacy to be entered into the system. Telephone interview with the [named] staff on 03/21/24 at 3:26pm revealed: -Resident #7's toe was bleeding, and she notified the resident's family member.	D 344		

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-The family member asked what Resident #7's FSBS had been running.
-She looked at Resident #7's eMAR and did not see where the resident's FSBS was being checked.
-She reviewed Resident #7's record and saw an order from a hospitalization she thought was in July 2023, but she could not recall the date.
-She thought the order had been overlooked and added the order to the eMAR.

Review of Resident #7's hospital discharge summary dated 06/30/23 revealed:
-There were multiple sections with information.
-The first section was to start a new medication.
-The second section was related to changes in medication.
-The third section was to continue the medications listed.
-Under the third section blood glucose diagnostic strips (FSBS test strips) were listed with direction to use three times daily as instructed.

Review of Resident #7's hospital discharge summary dated 09/15/23 revealed:
-The first section was active outpatient medications; blood glucose diagnostic strips were not listed.
-The second section was for new, changed or discontinued medications; blood glucose diagnostic strips were not listed.

Review of Resident #7's hospital discharge summary dated 01/05/24 revealed there was no documentation related to FSBS for the resident in the start taking these medications section, the continue taking these medications section, or the stop taking these medications section.

Interview with a medication aide (MA) on

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03/20/24 at 2:55pm revealed:
-She checked Resident #11's FSBS three times daily when she worked.
-She knew to check Resident #11's FSBS three times daily because it was on Resident #11's eMAR.
-The MA did not put orders in the eMAR system.

Interview with a second MA on 03/20/24 at 3:00pm revealed:
-Resident #11 had the order to check his FSBS before breakfast, dinner, and at bedtime.
-Resident #11's eMAR directed the MAs to check Resident #11's FSBS three times per day.
-The pharmacy inputs orders into the eMAR.
-Resident #11 complained of having to have his FSBS checked because it usually took two pricks to get blood to be able to check the resident's FSBS.

Interview with Resident #11 on 03/20/24 at 3:07pm revealed:
-The MAs checked his FSBS three times a day some days, but not every day.
-He did not mind his FSBS being checked once a day, but he did not think it needed to be done three times a day.
-The end of his fingers hurt on the days his FSBS was checked three times a day.
-He did not need his FSBS checked three times per day.

Telephone interview with Resident #11's family member on 03/20/24 at 3:46pm revealed:
-He did not think Resident #11 had an active order to check his FSBS.
-Resident #11 was diabetic but the resident's A1C had been "really good" like at a 5, so no reason to make the resident bleed unnecessarily since the resident had been having to get blood

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D 344	Continued From page 43 transfusions for other reasons. [The hemoglobin A1C test tells you your average level of blood sugar over the past 2 to 3 months. (According to the American Diabetic a HbgA1C value less than 7.0 is a goal for diabetic residents with the normal range for HbA1C being 4 to 5.9)]. Interview with the Wellness Director (WD) on 03/21/24 at 3:49pm revealed: -The MA should review discharge papers and if there was something on the eMAR that was not on the discharge papers, the MA should contact the pharmacy for clarification. -If the pharmacy was not able to clarify the order, he expected the MA to contact him so he could assist with clarifying the order. Interview with the Administrator on 03/21/24 at 5:05pm revealed: -When a resident returned to the facility with hospital paperwork, the MA should contact the Primary Care Provider (PCP) and let them know what happened and go with their directives. -If paperwork was completed on a resident and it did not have a task listed, the MA should reach out to the PCP for clarification. Attempted telephone interview with Resident #11's PCP on 03/21/24 at 3:23pm was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

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D 358	Continued From page 44 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 sample residents (#9 and #10) observed during the morning medication pass including errors with a medication for mood (#9) and a supplement (#10); and for 4 of 6 sampled residents (#1, #3, #5, and #6) on record review, including two medications used to treat diabetes (#1); a supplement, and a blood pressure and cholesterol medication (#3); a medication for depression and two eye drops (#5); and a medication for memory loss (#6). The findings are: 1. The medication error rate was 7.6% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 03/20/24. a. Review of Resident #9's current FL-2 dated 05/02/23 revealed: -Diagnoses included dementia and hypertension. -There was an order for Seroquel (a medication used to treat abnormal mood and behavior) 50mg by mouth twice a day. Review of a signed physician's order dated 03/12/24 revealed an order to start Seroquel 12.5mg by mouth daily for anxiety and Seroquel 12.5mg by mouth at bedtime for insomnia.	D 358		

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D 358	Continued From page 45 Observation of the morning medication pass on 03/20/24 at 7:50am revealed: -The medication aide (MA) removed a bottle of Seroquel 25mg from the medication cart for Resident #9. -The MA compared the medication to the medication due for administration on the electronic medication administration record (eMAR). -The MA poured one Seroquel 25mg tablet into the medication cup. -The MA administered the medications to Resident #9 with a cup of water and resident consumed the medication. Review of Resident #9's March 1 - 20, 2024 eMAR revealed: -There was an entry for Seroquel 12.5mg by mouth every day for anxiety/agitation scheduled for 8:00am. -Seroquel 12.5mg was documented as administered at 8:00am on 03/20/24. Observation of medications on hand on 03/20/24 at 10:30am revealed: -There was a bottle of Seroquel 25mg. -There was a dispensed date of 11/07/23. -There was no Seroquel 12.5mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 03/20/24 at 9:42am revealed: -Resident #9 had an order for Seroquel 12.5mg daily and 12.5mg at bedtime. -The pharmacy did not provide Resident #'9's medications. -The facility sent orders to the pharmacy for Resident #9's profile only to be added to the eMAR.	D 358		

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D 358	Continued From page 46 Interview with the MA on 03/20/24 at 10:30am revealed: -She was aware the daily dose of Seroquel was 12.5mg. -She administered the residents' medications according to what was on the eMAR. -She did not realize she did not have Seroquel 12.5mg tablets available to administer to Resident #9. -The Wellness Director (WD) usually faxed orders to the pharmacy. -Resident #9 received medications from the Veterans Administration (VA) pharmacy. Attempted telephon interview with a representative VA pharmacy on 03/20/24 at 10:00am was unsuccessful. Interview with Resident #9's Mental Health Provider on 03/20/24 2:45pm revealed: -She visited Resident #9 for the first time on 03/12/24 in the facility. -She wanted to start to wean Resident #9 off Seroquel in an effort to reduce antipsychotic drug use. -She wrote new orders to decrease the Seroquel to 12.5mg in the morning and 12.5mg at bedtime to begin to titrate the medication down. -She left orders with the facility's WD for him to fax to the pharmacy to get the medication. -She was unaware Resident #9 had not received the correct dose. -She was worried there was a breakdown in the process of getting medications. -There was no negative outcome to the medication not being reduced as ordered. Interview with the WD on 03/20/24 at 10:45am revealed:	D 358		

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-He received Resident #9's new order from the provider on 03/12/24 and faxed it to the pharmacy.
-He did not recall sending the order to the VA pharmacy.
-He faxed orders to the facility's pharmacy but also expected MAs to fax orders to the pharmacy as well.
-He was not aware Resident #9 had not received the correct dose of Seroquel.
-He expected MAs to follow the physician's orders and if the correct medication dose was not available, to get in touch with the pharmacy and make him aware.

Based on observations, record review, and staff interviews, it was determined Resident #9 was not interviewable.

Refer to the interview with the WD on 03/21/24 at 3:49pm.

Refer to the interview with the Administrator on 03/21/24 at 5:08pm.

b. Review of Resident #11's current FL-2 dated 09/15/23 revealed diagnoses of gastrointestinal bleed, dementia, hypertension, atrial fibrillation, and diabetes mellitus.

Review of a signed new prescription summary dated 01/15/24 and electronically signed by a nurse practitioner (NP) in Resident #11's hematology clinic revealed a new order for vitamin B12 (a medication used to help prevent anemia) 1,000mcg by mouth daily.

Observation of the morning medication pass on 03/20/24 at 8:15am revealed:
-The (MA) removed several bottles of

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medications from the medication cart for Resident #11.
-The MA compared the medication labels to the medications due for administration on the eMAR.
-The MA did not have any vitamin B12 available for administration to Resident #11.

Review of Resident #11's March 1-20, 2024 eMAR revealed:
-There was an entry for vitamin B12 1,000mcg daily, scheduled at 8:00am.
-There was documentation vitamin B12 was administered 03/01/24 to 03/04/24 and 03/06/24 to 03/19/24.
-There was documentation vitamin B12 was not administered on March 5 and March 20, 2024, due to "pharmacy processing medication".

Observations of medications on hand for Resident #11 on 03/20/24 at 8:20am revealed Resident #11 did not have vitamin B12 available to administer.

Telephone interview with a representative from the facility's contracted pharmacy on 03/20/24 at 9:42am revealed:
-Resident #11 had an order for vitamin B12 1,000mcg daily.
-The pharmacy had not dispensed vitamin B12 for Resident #11.
-The facility faxed all orders for Resident#11 to the pharmacy for profile information only and so it got added to the eMAR.

Telephone interview with a representative from the VA pharmacy on 03/20/24 at 9:55am revealed:
-The pharmacy did not have a prescription order for vitamin B12 for Resident #11.
-The pharmacy had not dispensed vitamin B12

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D 358	Continued From page 49 for Resident #11. Interview with the MA on 03/20/24 at 8:20am revealed: -Resident #11 did not have any vitamin B12 available to administer. -Resident #11 received his medications from the VA pharmacy. -MAs and the WD were both responsible for faxing new orders to the pharmacy. -New medication orders were to be faxed to the facility's pharmacy and the VA pharmacy. -Sometimes Resident #11's family member brought in his medications. Telephone interview with a NP from Resident #11's hemotalogy clinic on 03/20/24 at 10:10am revealed: -Resident #11 was seen in the hematology clinic on 01/10/24. -Resident #11 was seen in the clinic due to anemia due to gastrointestinal bleeds. -Resident #11's vitamin B12 level was a little low so she prescribed vitamin B12 1,000mcg by mouth daily. -Vitamin B12 helped to treat anemia. -The new order was faxed to the facility's pharmacy. -She was not aware Resident #11 received his medications from the VA pharmacy. -She did not fax the new order for vitamin B12 1,000mcg daily to the VA pharmacy. -She was not aware Resident #11 had not received vitamin B12. -She followed Resident #11 closely and monitored his hemoglobin levels. -She would see him again in the clinic on 04/10/24. -Resident #11 had not experienced a negative outcome.	D 358		

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D 358	Continued From page 50 Interview with the WD on 03/20/24 at 10:45am revealed: -He was not aware Resident #11 had not received vitamin B12. -Both him and the MAs were responsible for faxing orders to the pharmacy. -If a resident received medications from the VA, orders should be faxed to the facility's pharmacy and the VA pharmacy. Based on observations, record review, and staff interviews, it was determined Resident #11 was not interviewable. Refer to the interview with the WD on 03/21/24 at 3:49pm. Refer to the interview with the Administrator on 03/21/24 at 5:08pm. 2. Review of Resident #5's current FL-2 dated 12/13/23 revealed diagnoses of glaucoma and depression. a. Review of Resident #5's current FL-2 dated 12/13/23 revealed there was an order for brimonidine 0.15% eye drops (used to lower eye pressure caused by open-angle glaucoma) one drop to each eye twice daily. Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for brimonidine 0.15% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation brimonidine was	D 358		

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administered twice daily from 01/01/24 at 8:00am to 01/11/24 at 8:00pm and from 01/12/24 at 8:00pm to 01/31/24 at 8:00pm.
-There was an exception documented on 01/12/24 at 8:00am; the exception was the medication was not available.

Review of Resident #5's February 2024 eMAR revealed:
-There was an entry for brimonidine 0.15% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation brimonidine was administered twice daily from 02/01/24 at 8:00am to 02/03/24 at 8:00pm; from 02/04/24 at 8:00pm to 02/12/24 at 8:00pm; and from 02/13/24 at 8:00pm to 02/29/24 at 8:00pm.
-There was an exception documented on 02/04/24 at 8:00am; the exception was resident refused.
-There was an exception documented on 02/13/24 at 8:00pm; the exception was medication not available.

Review of Resident #5's March 2024 eMAR from 03/01/24 to 03/19/24 revealed:
-There was an entry for brimonidine 0.15% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation brimonidine was administered twice daily from 03/01/24 at 8:00am to 03/15/24 at 8:00am and from 03/16/24 at 8:00am to 03/19/24 at 8:00am.
-There was an exception documented on 03/15/24 at 8:00pm; the exception was resident was out of the facility.

Observation of Resident #5's medication on hand

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on 03/19/24 at 10:37am revealed there was no brimonidine 0.15% eye drops available for administration.

Telephone interview with a representative of the facility's contracted pharmacy on 03/19/24 revealed:
-Resident #5 had an order for brimonidine instill one drop twice daily to each eye.
-The pharmacy had not dispensed the eye drops to the facility for Resident #5.
-The pharmacy was notified that Resident #5's family brought medications with when he was admitted to the facility on 12/20/23, and the pharmacy would be notified when medications needed to be dispensed.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

b. Review of Resident #5's current FL-2 dated 12/13/23 revealed there was an order for dorzolamide-timolol 2-0.5% eye drops (used to treat increased eye pressure caused by glaucoma) one drop to each eye daily.

Review of Resident #5's January 2024 eMAR revealed:
-There was an entry for dorzolamide-timolol 2-0.5% daily with a scheduled administration time of 8:00am.
-There was documentation dorzolamide-timolol was administered daily from 01/01/24 to 01/11/24 and from 01/13/24 to 01/31/24.
-There was an exception documented on 01/12/24: the exception was the medication was not available.

Review of Resident #5's February 2024 eMAR

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revealed:
-There was an entry for dorzolamide-timolol 2-0.5% daily with a scheduled administration time of 8:00am.
-There was documentation dorzolamide-timolol 2-0.5% was administered daily from 02/01/24 to 02/03/24 and from 02/05/24 to 02/29/24.
-There was an exception documented on 02/04/24; the exception was the resident refused.

Review of Resident #5's March 2024 eMAR from 03/01/24 to 03/19/24 revealed:
-There was an entry for dorzolamide-timolol 2-0.5% daily with a scheduled administration time of 8:00am.
-There was documentation dorzolamide-timolol was administered daily from 03/01/24 to 03/19/24.

Observation of Resident #5's medication on hand on 03/19/24 at 10:37am revealed there was no dorzolamide-timolol 2-0.5% eye drops available for administration.

Telephone interview with a representative of the facility's contracted pharmacy on 03/19/24 revealed:
-Resident #5 had an order for dorzolamide-timolol 2-0.5% instill one drop daily to each eye.
-The pharmacy had not dispensed the eye drops to the facility for Resident #5.
-The pharmacy was notified that Resident #5's family brought medications when he was admitted to the facility on 12/20/23, and the pharmacy would be notified when medications needed to be refilled.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

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D 358	Continued From page 54 Interview with a medication aide (MA) on 03/20/24 at 2:28pm revealed: -She knew Resident #5's eye drops were not available for administration. -She did not know where Resident #5's eye drops were; there were no eye drops in the refrigerator for Resident #5. -She had re-ordered Resident #5's eye drops from the facility's contracted pharmacy by clicking on the reorder tab on the eMAR. -She did not know why the eye drops were not delivered from the pharmacy. -She did not know the family brought Resident #5's medication to the facility from an outside pharmacy. -She had not called the pharmacy about Resident #5's eye drops and she had not told the Wellness Director (WD) the eye drops were not available. Interview with a second MA on 03/20/24 at 3:10pm revealed: -She administered eye drops to Resident #5. -She knew Resident #5's eye drops had run out. -Resident #5's family was to bring more eye drops to the facility. -She had not called Resident #5's family to bring more eye drops to the facility. -She worked the 7:00pm to 7:00am shift; she thought the MA on the 7:00am to 7:00pm shift called the family about bringing Resident #5's eye drops. Interview with a third MA on 03/21/24 at 10:20am revealed: -She administered medications to Resident #5. -She noticed Resident #5 did not have eye drops available for administration. -She did not remember when she noticed there were no eye drops available for administration.	D 358		

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-She tried to re-order the eye drops through the pharmacy, but the pharmacy never sent them.
-She did not speak to the WD about Resident #5's eye drops not being available.
-First shift staff should have contacted the family to see if the family would bring them.

Telephone interview with a representative at Resident #5's Ophthalmologist's office on 03/21/24 at 10:38am revealed:
-Resident #5 was seen in the Ophthalmologist office on 01/29/24.
-Resident #5 had a diagnosis of glaucoma and received eye drops for treatment.
-Resident #5's intra-ocular eye pressure was checked on 01/29/24 during the office visit.
-Resident #5's intra-ocular eye pressure in each eye was 24mmHg.
-Twenty-four was a high eye pressure considering Resident #5 was on multiple eye drops.
-Resident #5's ocular eye pressure should be no higher than low to mid-teens.
-Resident #5's ocular eye pressure on his visit from 10/23/23 was 8mmHg in his right eye and 7mmHg in his left eye.
-Resident #5's family member stated that Resident #5 had been admitted to an assisted living facility in December 2023 and she was concerned Resident #5 was not receiving his eye drops as ordered.
-If Resident #5 did not receive his eye drops as ordered Resident #5 could have significant damage to the optic nerve, cause poor peripheral vision and could possibly lead to blindness.

Telephone interview with Resident #5's family member on 03/20/24 at 4:00pm revealed:
-She brought Resident #5's eye drops to the facility when he was admitted in December 2023.
-She wanted to make sure the eye drops were

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always in the facility.
-She was concerned whether Resident #5 would be administered his eye drops.
-She had not brought any eye drops to the facility since Resident #5 was admitted.
-She received a phone call earlier today for the first time about Resident #5 needing eye drops.
-She called the pharmacy today and re-ordered eye drops for Resident #5.
-Each time she took Resident #5 to the ophthalmologist, Resident #5's eye pressure was checked.
-Resident #5's eye pressure was elevated when he saw the Ophthalmologist in January 2024.
-The Ophthalmologist stressed how important it was for Resident #5 to be administered his eye drops as ordered.
-She spoke with the WD and the MAs and stressed the importance of Resident #5 receiving his eye drops.
-She was concerned about Resident #5 not getting his eye drops.
-She did not want Resident #5 to go blind.

Interview with the WD on 03/20/24 at 3:45pm revealed:
-Resident #5 did not use the facility's contracted pharmacy.
-Resident #5's family brought his medication to the facility.
-He was not aware Resident #5 did not have 2 of his eye drops available for administration.
-The MA should have notified the family to bring more eye drops to the facility.
-Resident #5 needed his eye drops because he had glaucoma.

Interview with the Administrator on 03/20/24 at 4:49pm revealed:
-Resident #5's family used their pharmacy for

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Resident #5's medication instead of the facility's contracted pharmacy.
-The MAs were responsible for letting Resident #5's family member know when his eye drops were low so the family could bring additional medication to the facility.

Refer to the interview with the WD on 03/21/24 at 3:49pm.

Refer to the interview with the Administrator on 03/21/24 at 5:08pm.

_____

c. Review of Resident #5's current FL-2 dated 12/13/24 revealed there was an order for bupropion 150mg (used to treat anxiety) daily.

Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for bupropion 150mg to be administered.
-There was no documentation bupropion 150mg was administered.

Review of Resident #5's February 2024 eMAR revealed:
-There was no entry for bupropion 150mg to be administered.
-There was no documentation bupropion 150mg was administered.

Review of Resident #5's March 2024 eMAR from 03/01/24 to 03/19/24 revealed:
-There was no entry for bupropion 150mg to be administered.
-There was no documentation bupropion 150mg was administered.

Observation of Resident #5's medication on hand

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D 358	Continued From page 58 on 03/19/24 at 10:37am revealed: -There was a bottle of bupropion from an outside pharmacy on the medication cart. -The bottle had 208 bupropion tablets available for administration. -The bottle of bupropion was dispensed on 11/15/23 from an outside pharmacy. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/21/24 at 9:11am revealed: -The pharmacy received a faxed FL-2 for Resident #5 on 12/19/23. -The order for bupropion was not clear, so the pharmacy faxed a request to the facility to verify the strength for the bupropion. -The pharmacy did not hear back from the facility regarding the bupropion. -The bupropion was not added to the eMAR because the strength of the medication had to be verified. -Bupropion was used to treat depression and anxiety. -Resident #5 could have an increase in depression and anxiety if he did not receive the bupropion as ordered. Interview with a medication aide (MA) on 03/21/24 at 9:29am revealed: -She did not administer bupropion to Resident #5. -Bupropion was not on Resident #5's eMAR; she did not administer any medications that were not on the eMAR. -She had not noticed the bottle of bupropion for Resident #5 in the medication cart. -Resident #5 was admitted to the facility in December 2023 and his family brought his medications with him. -She did not know why the bottle of bupropion for Resident #5 was on the medication cart	D 358		

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-Resident #5 did not have any behaviors or outburst when she worked with him.

Interview with a second MA on 03/21/24 at 10:20am revealed:
-She did not administer bupropion to Resident #5.
-She did not know Resident #5 had an order for bupropion.
-She had noticed there was a bottle of bupropion 150mg for Resident #5 in the medication cart from an outside pharmacy, but she did not question why the bottle of bupropion was in the medication cart.
-She did not know if Resident #5's family brought the medication to the facility when he was admitted.
-She administered medications to Resident #5 based on the medications listed on the eMAR.
-She did not receive faxes from the pharmacy; she did not know who was responsible for receiving the faxed information from the pharmacy.

Interview with the Wellness Director (WD) on 03/21/24 at 3:49pm revealed:
-The marketer was responsible for faxing new admission information to the pharmacy.
-He did not realize bupropion was on the FL-2 and was not transcribed to the eMAR by the pharmacy.
-If the pharmacy had a concern about a medication on the FL-2, he would expect the pharmacy to notify the Primary Care Provider(PCP).
-He did not receive a request from the pharmacy regarding the dosage of bupropion.
-The pharmacy would have faxed a request to the facility and the receptionist would have placed the request in the basket on the desk.
-He would go through the papers in the basket

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and see if there were any request he needed to follow-up on.
-Resident #5 should have received the bupropion as ordered to help with anxiety.
-He had not seen Resident #5 with any behaviors related to increase in anxiety since admission.

Interview with the Administrator on 03/21/24 at 5:08pm revealed:
-If the pharmacy had questions about an order, they would call and speak to the MA or the WD.
-If the pharmacy sent a fax, the MA or WD were responsible for responding to the fax.
-The fax regarding bupropion the pharmacy sent should have been received by the MA working Resident #3's hall.
-The MA was responsible for obtaining and faxing the requested information to the pharmacy.
-The MA should compare each medication in the medication cart to the entries on the eMAR and if there was a discrepancy, the MA should notify the WD or the pharmacy.
-He expected the MA or WD to compare the FL-2 with the medications delivered to the facility from the pharmacy to ensure all medications were available for administration.

Attempted interview with Resident #5's PCP on 03/21/24 at 10:45am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable

Refer to the interview with the WD on 03/21/24 at 3:49pm.

Refer to the interview with the Administrator on 03/21/24 at 5:08pm.

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D 358	Continued From page 61 3. Review of Resident #1's current FL-2 dated 07/04/23 revealed diagnoses included Alzheimer's disease, diabetes mellitus, and peripheral vascular disease. a. Review of Resident #1's current FL-2 dated 07/04/23 revealed there was an order for Lantus (insulin used to treat diabetes) 18 units (u) at bedtime. Review of Resident #1's hospital discharge summary dated 03/16/24 revealed: -Resident #1 was seen in the emergency department for hypoglycemia. -Resident #1's Lantus order was decreased from 18u to 9u. Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/01/24-03/19/24 revealed: -There was an entry for Lantus 18u with a scheduled administration time of 8:00pm. -There was documentation Lantus 18u was administered at 8:00pm on 03/01/24-03/14/24 and 03/16/24-03/18/24. -There was an exception documented for 03/15/24 that Resident #1 was out of the facility. Review of Resident #1's finger stick blood sugar (FSBS) readings for 03/17/24-03/19/24 revealed: -Resident #1's FSBS were checked daily at 8:00am. -There was documentation Resident #1's FSBS was 69 on 03/17/24, 241 on 03/18/24, and 63 on 03/19/24. Observation of Resident #1's medications on hand on 03/19/24 at 12:02pm revealed: -There was a prescription bottle dispensed on	D 358		

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02/21/24 for Lantus 18u with the directions to administer 18u at bedtime.
-There was no label on the prescription bottle indicating any changes in the directions for the medication.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/20/24 at 10:57am revealed Resident #1's discharge summary dated 03/16/24 had not been received at the pharmacy until 03/19/24 with the directions to decrease Resident #1's Lantus from 18u to 9u.

b. Review of Resident #1's physician's order dated 01/11/24 revealed an order for Januvia (used to treat diabetes) 100mg daily.

Review of Resident #1's hospital discharge summary dated 03/16/24 revealed:
-Resident #1 was seen in the emergency department for hypoglycemia.
-Resident #1's Januvia was discontinued due to hypoglycemia.

Review of Resident #1's March 2024 eMAR from 03/01/24-03/19/24 revealed:
-There was an entry for Januvia 100mg with a scheduled administration time of 8:00am.
-There was documentation Januvia 100mg was administered at 8:00am on 03/01/24-03/14/24 and 03/16/24-03/19/24.
-There was an exception documented for 03/15/24 that Resident #1 was out of the facility.

Review of Resident #1's finger stick blood sugar (FSBS) readings for 03/17/24-03/19/24 revealed:
-Resident #1's FSBS were checked daily at 8:00am.
-There was documentation Resident #1's FSBS was 69 on 03/17/24, 241 on 03/18/24, and 63 on

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D 358	Continued From page 63 03/19/24. Observation of Resident #1's medications on hand on 03/19/24 at 12:02pm revealed there was a punch card dispensed on 03/07/24 for 28 tablets of Januvia 100mg; 18 tablets were remaining. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/20/24 at 10:57am revealed Resident #1's discharge summary dated 03/16/24 had not been received at the pharmacy until 03/19/24 with the directions to discontinue Resident #1's Januvia. Telephone interview with Resident #1's family member on 03/19/24 at 3:03pm revealed: -She went to the facility today, 03/19/24, to follow up on Resident #1's medications after her recent hospitalization. -The Wellness Director (WD) had to look for Resident #1's hospital discharge summary. -She confirmed with staff at the facility, that Resident #1 had her morning medications, including Januvia, on 03/19/24. -The WD removed Resident #1's Januvia from the medication cart today, 03/19/24. _____ Interview with Resident #1 on 03/20/24 at 8:49am revealed she did not know what medications she took. Interview with a medication aide (MA) on 03/21/24 at 2:42pm revealed: -She was working on 03/15/24 when Resident #1's finger stick blood sugar (FSBS) was 55. -She was not working on 03/16/24 when Resident #1 returned from the hospital. -She was not made aware of any changes in Resident #1's medications until 03/19/24.	D 358		

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D 358	Continued From page 64 Interview with a second MA on 03/21/24 at 10:01am revealed: -She did not recall seeing Resident #1's discharge summary with orders when the resident returned from the hospital. -She only checked the fax machine if someone told her to expect a fax. -She did not know there were changes made to Resident #1's medications when she was discharged from the hospital. -She administered Resident #1's medications per the eMAR after the resident returned from the hospital. Telephone interview with Resident #1's family member on 03/19/24 at 11:25am and 3:03pm revealed: -On 03/15/24, Resident #1's FSBS was so low they could not get the resident to come around. -She knew they made changes to Resident #1's diabetic medication due to the low FSBS, but she was not sure what the changes were. -She planned on going to the facility today, 03/19/24, to ensure the medication changes had been implemented. -The staff member who was working on Saturday, 03/16/24, when Resident #1 returned from the hospital told her she had seen Resident #1's new orders sent by the hospital; she did not know the name of the MA. Interview with the Primary Care Provider (PCP) on 03/21/24 at 12:57pm revealed she expected the staff to follow the discharge orders from the hospital until she was able to review Resident #1's discharge papers. Interview with the WD on 03/19/24 at 3:08pm revealed:	D 358		

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-He had not seen Resident #1's hospital discharge papers until today, 03/19/24, when Resident #1's family member asked him about the medication changes, and he pulled the discharge summary.
-New orders were sent to the pharmacy by whatever MA was working when the resident returned to the facility.
-He saw on Resident #1's hospital discharge summary the changes in the medications, but he had not seen an actual order.
-He did not know Resident #1's discharge summary could be sent to the pharmacy and used as an order because it was electronically signed.
-He would fax Resident #1's discharge papers to the pharmacy immediately.

Interview with the Administrator on 03/21/24 at 5:05pm revealed he was concerned the medication changes were not put in place as ordered by the hospital physician as there had been a reason for the changes.

Refer to the interview with the WD on 03/20/24 at 3:49pm.

Refer to the interview with the Administrator on 03/21/24 at 5:08pm.

4. Review of Resident #3's current FL-2 dated 02/06/24 revealed diagnoses of emesis, fever, and hypoxemia.

a. Review of Resident #3's current FL-2 dated 02/06/24 revealed there was no order for amlodipine 2.5mg (used to treat high blood pressure) daily.

Review of Resident #3's hospital discharge

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summary dated 02/06/24 revealed there were instructions to discontinue amlodipine 2.5mg

Review of Resident #3's February electronic medication administration record (eMAR) from 02/07/234 to 02/29/24 revealed:
-There was an entry for amlodipine 2.5mg daily with a scheduled administration time of 5:00pm,
-There was documentation amlodipine was administered daily from 02/07/24 to 02/29/24.

Review of Resident #3's March eMAR from 03/01/24 to 03/18/24 revealed:
-There was an entry for amlodipine 2.5mg daily with a scheduled administration time of 5:00pm.
-There was documentation amlodipine was administered daily from 03/01/24 to 03/18/24.

Observation of Resident #3's medication on hand on 03/19/24 at 10:47am revealed there was a bubble pack of 25 amlodipine 2.5mg available for administration.

Interview with a representative from the facility's contracted pharmacy on 03/19/24 at 3:53pm revealed:
-The pharmacy had an active order for amlodipine 2.5mg daily dated 09/14/23.
-The pharmacy did not have an order to discontinue amlodipine 2.5mg.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/20/24 at 3:15pm revealed:
-Amlodipine was used for high blood pressure.
-Resident #3's blood pressure could drop if he continued to take amlodipine when it was discontinued.

Interview with the Primary Care Provider (PCP)

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on 03/21/24 at 1:27pm revealed:
-She did not know Resident #3's amlodipine was discontinued when he returned from the hospital.
-If Resident #3 continued to take amlodipine after it was discontinued, it could lower his blood pressure.
-Amlodipine could have been discontinued because a side effect was swelling in the feet and ankles and Resident #3 did have swelling in his ankles and feet.

Interview with the Wellness Director (WD) on 03/21/24 at 3:49pm revealed if Resident #3's amlodipine was discontinued because his blood pressure was low, then the amlodipine could lower Resident #3's blood pressure more.

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

b. Review of Resident #3's FL-2 dated 2/6/24 revealed there was no order for rosuvastatin 5mg (used to lower cholesterol) daily.

Review of Resident #3's hospital discharge summary dated 02/06/24 revealed there were instructions to discontinue rosuvastatin 5mg.

Review of Resident #3's February eMAR from 02/07/234 to 02/29/24 revealed:
-There was an entry for rosuvastatin 5mg daily with a scheduled administration time of 8:00am.
-There was documentation rosuvastatin was administered from 02/09/24 to 02/29/24.
-There were exceptions documented on 02/07/24 and 02/08/24; the exceptions were the resident was out of the facility and the resident refused.

Review of Resident #3's March eMAR from

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D 358	Continued From page 68 03/01/24 to 03/18/24 revealed: -There was an entry for rosuvastatin 5mg daily with a scheduled administration time of 8:00am. -There was documentation rosuvastatin was administered from 03/01/24 to 03/18/24. Observation of Resident #3's medication on hand on 03/19/24 at 10:47am revealed there was a bubble pack of 22 rosuvastatin 5mg available for administration. Interview with a representative from the facility's contracted pharmacy on 03/19/24 at 3:53pm revealed: -The pharmacy had an active order for rosuvastatin 5mg daily dated 09/13/23. -The pharmacy did not have an order to discontinue rosuvastatin 5mg. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/20/24 at 3:15pm revealed rosuvastatin was used to lower cholesterol. Interview with the PCP on 03/21/24 at 1:27pm revealed she would expect the facility to follow the hospital discharge orders as written until she saw the resident. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. c. Review of Resident #3's FL-2 dated 02/06/24 revealed there was no order for vitamin D3 1000u daily (used as a supplement). Review of Resident #3's hospital discharge summary dated 02/06/24 revealed there were instructions to discontinue vitamin D3 1000units	D 358		

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daily.

Review of Resident #3's February eMAR from 02/07/234 to 02/29/24 revealed:
-There was an entry for vitamin D3 1000 units daily with a scheduled administration time of 8:00am.
-There was documentation vitamin D3 was administered daily from 02/09/24 to 02/29/24.
-There were exceptions documented on 02/01/24 and 02/08/24; the exceptions were the resident was out of the facility and the resident refused.

Review of Resident #3's March eMAR from 03/01/24 to 03/18/24 revealed:
-There was an entry for vitamin D3 1000 units daily with a scheduled administration time of 8:00am.
-There was documentation vitamin D3 was administered daily from 03/01/24 to 03/18/24.

Observation of Resident #3's medication on hand on 03/19/24 at 10:46am revealed there was a bubble pack of 22 vitamin D3 1000 units available for administration.

Interview with a representative from the facility's contracted pharmacy on 03/19/24 at 3:53pm revealed:
-The pharmacy had an active order for vitamin D3 1000u daily dated 09/13/23.
-The pharmacy did not have an order to discontinue vitamin D3.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/20/24 at 3:15pm revealed vitamin D3 was used as a supplement.

Based on observations, interviews, and record

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D 358	Continued From page 70 reviews it was determined Resident #3 was not interviewable. _____ Interview with a medication aide (MA) on 03/20/24 at 3:30pm revealed: -She did not review FL-2s when they were sent to the facility. -The WD was responsible for reviewing the updated FL-2 when a resident returned from the hospital. -The WD was responsible for faxing the updated FL-2 to the pharmacy. Interview with a second MA on 03/21/24 at 10:20am revealed: -The MAs received the hospital discharge summary and the updated FL-2 when a resident returned from the hospital. -She would leave the hospital discharge summary and the updated FL-2 for first shift staffto review and to fax to the pharmacy. -She did not know if the WD reviewed hospital discharge summary and the updated FL-2. Interview with a representative from the facility's contracted pharmacy on 03/19/24 at 3:53pm revealed: -The facility did not receive the hospital discharge orders or the updated FL-2 from Resident #3's hospitalization in February 2023. -If the pharmacy had received the hospital discharge orders of the updated FL-2 from Resident #3's they would have discontinued the medications as ordered. Interview with the PCP on 03/21/24 at 1:27pm revealed: -She should be notified each time a resident went to the hospital and returned to the facility. -She was not always notified when a resident	D 358		

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went to the hospital.
-She would be notified when she entered the facility on her next visit after a resident had returned from the hospital.
-Resident #3's family told the PCP Resident #3 had been in the hospital.
-She did not see Resident #3's discharge summary from 02/06/24; she would initial the hospital discharge summary after it was reviewed.
-She expected the facility to follow the hospital discharge orders as written until she saw the resident.

Interview with the WD on 03/21/24 at 3:49pm revealed:
-Resident #3 was in the hospital the first week of February 2024.
-He did not recall seeing a hospital discharge summary and the updated FL-2 for Resident #3 after his hospitalization.
-The MA working Resident #3's hall would have received the hospital discharge summary and the updated FL-2.
-The MA would fax Resident #3's hospital discharge summary and the updated FL-2 to the pharmacy.
-The pharmacy would update Resident #3's eMAR with any new orders received from the hospital.
-He did not know the hospital discharge summary and the updated FL-2 was not faxed to the pharmacy.
-The MA should have placed the hospital discharge summary and the updated FL-2 in the WD's box to be reviewed since there were changes to Resident #3's medications.
-He did not expect the MAs to understand the FL-2s.
-He expected the MAs to place FL-2s in the WD's

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box for him to review.

Interview with the Administrator on 03/21/24 at 5:08pm revealed:
-Resident #3 returned from a hospital stay and during the hospital stay had some changes to his medications they were pertinent to his care and he continued to received medications that were discontinued.
-He expected PCP orders to be followed by the MAs.

_____
Refer to the interview with the WD on 03/21/24 at 3:49pm.

Refer to the interview with the Administrator on 03/21/24 at 5:08pm.
5. Review of Resident #6's current FL-2 dated 07/06/23 revealed:
-Diagnoses included Alzheimer's disease, gastroesophageal reflux disease, osteoarthritis, hyperlipidemia, primary hypertension, abnormal gait, and irritability.
-There was an order for Memantine TAB HCL (used for memory loss) 10mg twice a day.

Review of Resident #6's January 2024 electronic medication administration record (eMAR) from 01/01/24-01/31/24 revealed:
-There was an entry for Memantine TAB HCL 10mg take one capsule twice a day.
-There was documentation Memantine TAB HCL 10mg was administered at 8:00am and 8:00pm on 01/01/24-01/31/24.

Review of Resident #6's February 2024 eMAR from 02/01/24-02/29/24 revealed:
-There was an entry for Memantine TAB HCL 10mg take one capsule twice a day.
-There was documentation Memantine TAB HCL

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10mg was administered at 8:00am and 8:00pm on 02/01/24-02/29/24.

Review of Resident #6's March 2024 eMAR from 03/01/24-03/19/24 revealed:
-There was an entry for Memantine TAB HCL 10mg take one capsule twice a day.
-There was documentation Memantine TAB HCL 10mg was administered at 8:00am and 8:00pm on 03/01/24-03/19/24.

Observation of medications on hand for Resident #6 on 03/19/24 at 12:51pm revealed:
-There were two medication cards with a dispensed date of 03/07/24 with 28 tablets in one card remaining and 28 tablets in the second card.
-There was one medication card with a dispensed date of 02/08/24 with 11 tablets remaining.
-There were 67 tablets of Memantine on hand.

Interview with a pharmacist at the facility's contracted pharmacy on 03/19/24 at 4:30pm revealed 56 tablets of Memantine TAB HCL were dispensed on 01/11/24, 02/08/24, and 03/07/24.

Telephone interview with Resident #6's neurologist on 03/20/24 at 2:49pm revealed:
-Resident #6 was prescribed Memantine TAB HCL 10mg to treat symptoms of Alzheimer's disease.
-There was no order to discontinue this medication.
-A negative outcome of not taking Memantine would be increased
confusion.
-He expected the facility to follow orders and give medication as prescribed.

Interview with personal care aide (PCA) on 03/20/24 at 3:24pm revealed she had not

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D 358	Continued From page 74 observed Resident #6 being more confused. Interview with another PCA on 03/20/24 at 3:25pm revealed she had not observed Resident #6 being more confused or acting any different. Interview with a medication aide (MA) on 03/21/24 at 10:16am revealed: -She administered Resident #6's medications using the eMAR and medications on hand. -She had not observed the resident being confused during the month of March 2024. Interview with the Wellness Director (WD) on 03/21/24 at 6:10pm revealed: -He was not aware Resident #6 had not received Memantine TAB HCL 10mg as ordered. -His expectations were that medication was given as ordered. Interview with the Administrator on 03/21/24 at 6:15pm revealed: -He was not aware Resident #6 had not received Memantine TAB HCL 10mg as ordered. -He was concerned the MAs were not following the physician's orders. -His expectation was that medications be given as ordered by the physician. Based on observations, interviews, and record review it was determined Resident #6 was not interviewable. Refer to the interview with the WD on 03/20/24 at 3:49pm. Refer to the interview with the Administrator on 03/21/24 at 5:08pm _____ Interview with the WD on 03/20/24 at 3:49pm	D 358		

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D 358	Continued From page 75 revealed: -The MAs should compare the medications on hand with the medications entered on the eMAR. -If a medication was not available to administer, the MA should call the pharmacy or the WD. -Medication cart audits were not done routinely. -He did a medication cart audit about 4 months ago. -MAs were not doing medication cart audits. -The pharmacy would audit the medication cart quarterly. -A representative from the corporate office did a medication cart audit in December 2023 to ensure the facility was in compliance with the state. Interview with the Administrator on 03/21/24 at 5:08pm revealed: -The MAs were not paying attention to what they were doing when administering medications. -The MAs appear to be administering medications from memory instead of looking at the eMAR. -The MAs were not being diligent when preparing the medications for administration. -He expected the MAs to pay attention to what they were doing when administering medications. -The MAs should look at the eMAR and compare a medication with each entry on the MAR to ensure the medication was administered. -The MAs should ensure the 6 rights are followed when administering medications. -If a medication was not on the medication cart and available for administration the MAs should call the pharmacy. -The MA should document why and when the pharmacy was contacted. -The MAs should alert the WD when there was a problem with any medication. _____	D 358		

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D 358	Continued From page 76 The facility failed to ensure eye drop medications for glaucoma were administered as ordered to Resident #5 resulting in the resident having increased intra-ocular eye pressure from 7mmHg and 8mmHg in October of 2023 to an increase in intra-ocular eye pressure of 24mmHg in January 2024, which increased the risk of optic nerve damage, peripheral vision loss and blindness, and changes were made as ordered to diabetic medication after the resident had been sent to the emergency department for hypoglycemia and whose FSBS was documented as 63 on 03/19/24 (#1). This failure resulted in substantial risk of harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on March 20, 2024 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED April 20, 2024.	D 358		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the medication room, which was located within the nurse's station, and the medication cart was locked when not under the direct supervision of a medication aide.	D 377		

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D 377	Continued From page 77 The findings are: Observation of the 100/200 hall nurses' station on 03/19/24 at 8:40am, 9:12am, and 2:20pm revealed: -The door into the nurses' station was unlocked. -The door to the medication room was propped open. -The refrigerator in the medication room was unlocked and contained medications. -There were multiple residents in the hallway and the television room. -The staff were bringing residents from the dining room to the television room. Observation of the 300/400 hall nurses' station on 03/19/24 at 4:20pm revealed: -The medication cart was sitting inside the nurse's station; the cart was not locked. -The door to the nurses' station was not locked. -The door to the medication room, where the refrigerator with medication was kept, was propped open. -There were no staff at the nurses' station or within the immediate site of the nurse's station. -There were two residents outside of the nurses' station, one resident was opening the door to the fire extinguisher; a personal care aide stopped the resident. Observation of the 300/400 hall-way medication room on 03/20/24 between at 7:45 and 12:45pm revealed: -The door to the nurse's station was unlocked. -The medication room door was propped open. -The refrigerator in the medication room was unlocked and contained medication. -There were several resident ambulating in the hallway outside the nurses' station and there was	D 377		

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D 377	Continued From page 78 no staff member in site. Observation of the 100/200 hall-way medication cart during the morning medication pass on 03/20/24 revealed: -The 100/200 hall-way medication cart was positioned outside the dining room. -Residents and staff walked by the medication cart multiple times. -At 8:39, the medication aide (MA) prepared medications for administration, entered the dining room, administered the medications while the medication cart was unlocked sitting in the hallway. -At 8:40am, a resident picked up a pudding cup from the top of the unlocked medication cart that was in the hallway at the dining room; the MA was not supervising the medication cart. -At 8:43am, the MA prepared medications for a second resident for administration, entered the dining room, administered the medications while the medication cart was unlocked sitting in the hallway. Interview with a MA on 03/20/24 at 2:17pm revealed: -The medication room was located inside the nurse's station. -The medication room door was always propped open. -The nurse's station door used to have a lock and the door would automatically lock each time it was closed. -The lock on the nurse's station door was changed about 2 months ago and would not lock now. -The medication room door remained propped open; that was what we were used to. -She did not realize she left the medication cart unlocked this morning when administering	D 377		

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D 377	Continued From page 79 medications. -She should have locked the medication cart before entering the dining room to administer medications. -She knew medications had to be secured and locked when not under the supervision of a MA. Interview with the (WD) on 03/20/24 at 3:45pm revealed: -Medication carts should be locked. -He knew the medication rooms were not locked because they were behind the nurse's station. -The door to the nurse's station should lock, so no one could get to the medication room. -He expected the MAs to ensure the medication cart and the medication room or the nurse's station was locked at all times to ensure medications were secure. Interview with the Administrator on 03/21/24 at 5:08pm revealed: -Medication carts should be locked, and narcotics should be doubled locked at all times. -The medications in the medication rooms should be locked at all times. -He was concerned a resident would get a medication they could be allergic to, take too much of a medication, or take another residents medication. -He expected all medication to be secured by locking the medication carts and the medication rooms.	D 377		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than	D 465		

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	HAL032109	A. BUILDING: _____ B. WING _____	R 03/21/2024

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one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 3 of 9 third shifts sampled between 01/13/24-03/17/24

The findings are:

Review of the facility's 2024 license from the Division of Health Service Regulation revealed the facility was licensed for a SCU with a capacity of fifty-one beds.

1. Review of the census dated 01/14/24 revealed there was an SCU census of 41 residents, which required 32.8 staff hours on the third shift.

Review of the Individual Employee Timecards dated 01/14/24 revealed 24 staff hours were provided on the third shift leaving the shift short 8.8 staff hours.

2. Review of the census dated 01/21/24 revealed there was an SCU census of 41 residents, which required 32.8 staff hours on the third shift.

Review of the Individual Employee Timecards dated 01/21/24 revealed 23 staff hours were provided on the third shift leaving the shift short 9.8 staff hours.

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D 465	Continued From page 81 3. Review of the census dated 03/09/24 revealed there was an SCU census of 46 residents, which required 36.8 staff hours on the third shift. Review of the Individual Employee Timecards and agency invoice dated 03/19/24 revealed 24 staff hours were provided on the third shift leaving the shift short 12.8 staff hours. Interview with a resident during the initial facility tour on 03/19/24 at 8:53am revealed the facility was short-staffed on weekends and it took longer to receive medications and get their meals. Interview with three staff members on 03/21/24 between 2:00pm-2:15pm revealed: -They were frequently short staffed. -When the facility was short staffed the residents may not get showers. -When the facility was short staffed the residents may not get changed as often. -When the facility was short staffed, the staff were short on doing rounds and responding to emergencies. -When the facility was short staffed, the staff may not be able to keep eyes on the residents. Interview with the Wellness Director on 03/21/24 at 3:49pm revealed: -He knew the third shift should be staffed with one staff member for every 10 residents. -The Administrator handled scheduling staff to work. -He had heard staff complain of being "shorthanded" when staff called out or were a no-show. Interview with the Administrator on 03/21/24 at 5:05pm revealed:	D 465		

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D 465	Continued From page 82 -He knew if there was a call out the SCU would be short-staffed. -The supervisor of the shift should notify him or the Wellness Director when a staff member did not show up for their shift. -He advised the Supervisor to call other staff members to see if someone could cover the shift. -The staff for the next shift may come in early to help cover some of the shift. -He offers bonuses to encourage staff to cover shifts. -When staff called out or was a no-show it was difficult to find coverage, even with agencies as well.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision	D 468		

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within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure that 6 of 6 sampled staff (Staff A, B, C, D, E and F) completed 6 hours of orientation on the nature and needs of the residents of a Special Care Unit (SCU) within the first weeks of employment and completed 20 hours of training specific to the population being served.

The findings are:

Review of the facility's current license dated 01/01/24 revealed the facility was licensed as an Alzheimer's/Dementia special care unit SCU with a capacity of 51 residents.

Review of the facility's current census tracking log revealed the census on 03/19/24 was 46 residents.

1. Review of Staff A, medication aide's (MA), personnel record revealed:
-She was hired on 08/01/23.
-There was no documentation of 6-hour of SCU training within the first week of hire.
-There was no documentation of 20 hours of SCU training within six months of hire.

Interview with Staff A on 03/21/24 at 4:25pm

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revealed she could not remember when, but she thought she had completed a course in dementia online.

Refer to the interview with the business operations manager (BOM) on 03/21/24 at 12:05pm.

2. Review of Staff B, personal care aide's (PCA), personnel record revealed:
-He was hired on 01/31/24.
-There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff B.
-There was no documentation of 20 hours of training specific to the population being served for Staff B.

Refer to the interview with the Business Office Manager (BOM) on 03/21/24 at 12:05pm.

Attempted telephone interview with Staff B on 03/21/24 at 1:32pm was unsuccessful.

3. Review of Staff C, MA's, personnel record revealed:
-She was hired on 11/21/23.
-There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff C.
-There was no documentation of 20 hours of training specific to the population being served for Staff C.

Refer to the interview with the BOM on 03/21/24 at 12:05pm.

Interview with Staff C on 03/21/24 at 3:30pm revealed she could not recall SCU training.

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D 468	Continued From page 85 4. Review of Staff D, PCA and MA's, personnel record revealed: -She was hired on 08/05/22. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff D. -There was no documentation of 20 hours of training specific to the population being served for Staff D. Refer to the interview with the BOM on 03/21/24 at 12:05pm. 5. Review of Staff E, MA's, personnel record revealed: -There was no documentation of a hire date. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff E. -There was no documentation of 20 hours of training specific to the population being served for Staff E. Refer to the interview with the BOM on 03/21/24 at 12:05pm. 6. Review of Staff F, PCA's, personnel record revealed: -She was hired on 02/28/24. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff F. -There was no documentation of 20 hours of training specific to the population being served for Staff F. Refer to the interview with the BOM on 03/21/24 at 12:05pm. Interview with the BOM on 03/21/24 at 12:05pm	D 468		

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D 468	Continued From page 86 revealed: -It was her responsibility to maintain all the personnel records. -She had not audited the personnel records. -She was unaware the 6-hour training and 20 hours of training documentation were not in their personnel files. -She did not request documentation from the Wellness Director (WD)of the staffs SCU training. -She was not aware all training was not completed in the staff files. special care training	D 468		