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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, a follow-up and a complaint investigation from 04/30/24 to 05/03/24. The Person County Department of Social Services initiated the complaint investigation on 04/08/24.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: Based on observations, review of labels, and interviews, the facility failed to ensure the environmental storage room containing hazardous materials was locked and not accessible to residents who were intermittently disoriented.. The findings are: Observation of the storage room on 04/30/24 at 10:57am revealed: -The door was not locked. -There were 8 large bottles of bleach; the material safety data sheet (MSDS) indicated minor redness and irritation with contact to skin.	D 056		

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D 056	Continued From page 1 -There were 16 cans of aerosol glass cleaner; the MSDS indicated minor redness and irritation with contact to skin. -Two bottles were labeled with a warning, avoiding contact with liquid concentrated product with eyes and skin. Observation of the same storage room on 05/01/24 at 8:10am and at 3:20pm revealed the door was not locked. Review of FL-2s for Residents #1, #2, #5 and #6 revealed the residents were intermittently disoriented. Interview with a housekeeper on 05/01/24 at 3:22pm revealed: -The door to the storage room was unlocked all day so housekeepers could get supplies. -Housekeepers did not have a key and that was why the door remained unlocked. -The Maintenance Director opened the door at 7:00am and the Housekeeping Supervisor locked the door at 5:00pm at the end of her shift. Interview with the Housekeeping Supervisor on 05/01/24 at 4:30pm revealed: -She was aware the storage room door was unlocked. -The door remained unlocked for housekeeping staff to get needed supplies throughout the day. -She was never told the door was to remain locked. -The Maintenance Director unlocked the door at 7:00am and she locked the door at 5:00pm before she left work. Interview with the Maintenance Director on 05/02/24 at 8:45am revealed: -He did not unlock the door at 7:00am daily.	D 056		

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D 056	Continued From page 2 -He was unsure why the door was unlocked. -The Housekeeping Supervisor may have left the door unlocked, but she was not supposed to. -The Housekeeping Supervisor was responsible for ensuring the door was locked. -The storage room was supposed to always be locked. -He locked the door when he found it unlocked. -He did not routinely check the door to ensure it was locked, because he was busy within the facility handling maintenance issues. Interview with the Administrator on 05/02/24 at 11:27am revealed: -The room was supposed to be locked so the residents could not get to the chemicals. -The residents could have been curious and got into the chemicals if the door was not locked. -Maintenance was responsible for keeping that door locked at all times.	D 056		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.	D 067		

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D 067	Continued From page 3 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 exterior exit doors were equipped with a sounding device that was audible throughout the facility when the door was opened and accessible to four residents (#1, #2, #5 and #6) residing in the facility who were intermittently disoriented and a resident who was disoriented and had a history of wandering (#6). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 120 beds. Review of the facility's census on 04/30/24 revealed there were 80 residents residing in the facility. Review of FL-2s for Residents #1, #2, #5 and #6 revealed the residents were intermittently disoriented. Observation of Residents #1, #2, and #5 at various times from 04/30/24 to 05/03/24 revealed Residents #1, #2, and #5 did not have Wander Guards on their wrists or ankles. (A Wander Guard is a system made to keep people who are disoriented, have dementia, or are at risk for wandering safe. The system relies on a bracelet that the individual wears, sensors that monitor doors, and technology that sends safety alerts to caregivers when the individual approaches a door.)	D 067		

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D 067	Continued From page 4 Observations of the facility on 04/30/24 at various times from 8:00am to 5:15pm revealed: -There were two exit doors on the sides of the front of the facility; each door had an interior push bar to exit and a key pad beside the door to disarm the alarm. -There were two doors on the opposite sides of the back residents' hallways; each door had an interior push bar to exit the facility and did not have key pads to disarm the alarm. -There was a main entrance located in the middle of the front of the facility with two sets of double glass doors. -At 8:00am, the main entrance door was unlocked, and an alarm did not sound when the survey team entered the facility. -There was a lobby area with sofas and chairs at the entrance of the facility; the front desk was not visible from main entrance or the lobby. -There was a desk facing into the interior hallway of the facility; no one at the front desk. -There was a window on the wall behind the desk that viewed the front lobby. -Residents, visitors and staff were observed entering and leaving the main entrance; no alarm sounded when the doors were opened. -At 10:40am, a company delivered a bed frame and a mattress to the facility; the delivery personnel freely entered and left the facility without the alarm sounding. -There was no receptionist at the front desk. -At 11:55am, the receptionist was in the dining room assisting with the lunch meal. -At 3:10pm, residents were observed exiting the facility through the front exit door to sit on the front porch without the door alarm sounding; there was no one at the front desk. -At 5:15pm, the survey team exited the facility; the door alarm did not sound.	D 067		

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Observation of the main entrance door on 05/01/24 at 8:00am revealed no alarm sounded when the survey team entered the facility.

Observations of the facility on 05/02/24 at various times from 7:30am to 7:00pm revealed:
-At 7:30am, the main entrance doors did not alarm when the survey team entered the facility.
-At 1:15pm, the main entrance doors did not alarm when the survey team left the facility.
-At 2:08pm, the main entrance doors did not alarm when the survey team returned to the facility.
-At 7:00pm, the main entrance doors did not alarm when the survey team left for the day.

Observations of the facility on 05/03/24 at 11:50pm and 1:30pm revealed:
-At 11:50am, the front door was not alarmed.
-There was no staff at the front desk; there were five residents seated in the lobby, two residents on the front porch.
-At 1:30pm, the front door was not alarmed.

Review of Resident #6's FL-2 dated 05/01/24 revealed:
-Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage.
-The recommended level of care was skilled nursing facility (SNF); documented beside other was memory care.
-Resident #6 was documented as ambulatory and intermittently disoriented.
-Resident #6 had wandering behaviors.

Review of Resident #6's FL2 dated 02/07/24 revealed:
-Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and

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subarachnoid hemorrhage.
-The recommended level of care was a SNF.
-Resident #6 was ambulatory and intermittently disoriented.

Review of Resident #6's care plan dated 01/03/24 revealed:
-He required limited assistance with grooming.
-He required extensive assistance with toileting, and ambulation.
-He required total assistance with bathing, dressing and transfers.
-He was ambulatory with the aid of a wheelchair.

Review of Resident #6's progress notes revealed:
-On 04/25/24 at 4:10pm, he was observed outside of the facility attempting to walk to a local store.
-The Resident Care Coordinator (RCC) and another staff could not redirect him back to the facility and escorted him to a local store and then back to the facility.
-On 04/26/24 at 5:59pm, Resident #6 eloped from the facility and walked to the local store; 911 was notified.

Observation of Resident #6 on 04/30/24 at 11:55am revealed:
-He was seated in the dining room.
-He did not have a Wander Guard fob on a lanyard around his neck.

Telephone interview with Resident #6's Power of Attorney (POA) on 04/30/24 at 6:08pm revealed:
-Resident #6 had wandered away from the facility two times the week before and was at a local store both times.
-The police were called both times and brought him back; the second time the police officer told him not to wander away again.

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-Resident #6 had dementia and had good days and bad days.

Interview with the facility's receptionist on 04/30/24 at 10:40am revealed:
-The front door was not locked from the inside or the outside of the building.
-Visitors could come and go through the main entrance without sounding an alarm or ringing a bell for entrance.
-Residents could go outside without sounding an alarm.

Interview with the RCC on 05/01/24 at 4:55pm revealed:
-Resident #6 eloped on 04/25/24 and 04/26/24.
-On 04/26/24, the front doors were alarmed that evening only at 7:30pm after visitation.
-The main entrance doors were not alarmed at night but were locked from the outside around 8:00pm.
-There was a receptionist at the front desk during the week days from around 8:00am to 3:30pm and then from 4:30pm to 6:30pm.
-The receptionist kept an eye on the front doors and if residents wandered.
-The receptionist was not always at the front desk.
-The remainder of the exterior doors were alarmed.
-There was a panel at the front desk that indicated which door alarm was activated.
-Any staff who heard the door alarms were supposed to check the panel and go to the door to check it; staff deactivated the alarm only after the door was checked.

Observation of the RCC on 05/01/24 at 4:55pm revealed:
-She opened a drawer to her desk and pulled out

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a fob for a Wander Guard.
-She removed the lanyard from around her neck and fastened the Wander Guard fob to the lanyard.
-She left the office with the lanyard and the fob.

Interview with the Administrator on 05/01/24 at 5:05pm revealed:
-She had not put a Wander Guard on Resident #6 after he eloped.
-The facility had Wander Guard fobs but did not have the wristbands.
-She tried to order wristbands but was unable to get them because they were out of stock.
-She and the RCC put a fob on a lanyard and placed it around Resident #6's neck because that was the only way she could put a Wander Guard on him without the wristband.
-She was going to contact a sister facility and see if they had wristbands for the Wander Guard fobs.

Observation of Resident #6 on 05/01/24 at 5:30pm revealed:
-He had a Wander Guard fob on a lanyard around his neck.
-He attempted to exit through the first set of double glass doors at the main entrance of the facility and the Wander Guard pendant made an alarming sound.
-A medication aide (MA) redirected Resident #6 back into the facility as he said he was "following other people going outside."

Interview with a personal care aide (PCA) on 05/03/24 at 12:20pm revealed:
-All the exterior doors were alarmed and would go off when a resident exited through them except the door to the main entrance, it was never on an alarm.
-There was a panel at the front desk that told staff

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which door alarm was going off.
-All the doors were red except for the front door which was at the top of the panel and was always green.
-The procedure was to physically go check the door when the alarm went off and once it was cleared then staff would go back to the panel and turn off the alarm.
-She had seen residents' FL-2s in their record and she knew of two named residents who were listed as intermittently disoriented and one named resident who was constantly disoriented.
-She had worked at other facilities with a secured special care unit and knew the exit doors should have been locked and alarmed because the residents at the facility were disoriented and confused.

Interview with a medication aide (MA) on 05/03/24 at 11:50am revealed:
-The receptionist was off and there was no staff at the front desk.
-The staff were all helping to check on things and answer the phone.

Observation of Resident #6 on 05/03/24 at 12:10pm revealed:
-He was seated in the dining room with other residents.
-He did not have a Wander Guard fob on a lanyard around his neck, wrist or ankles.

Telephone interview with the facility's evening shift receptionist on 05/03/24 at 1:50pm revealed:
-She worked 4 to 5 days a week from 6:00pm to 9:00pm; she did not work weekends.
-She stayed at the front desk most of the time but did leave to assist residents.
-There was no one at the front desk once she left until the next morning when the day shift

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receptionist came to work.
-The front door was not alarmed; it was only locked from the outside in the evenings around 6:30pm.
-The alarm for the front door could be activated but she had never been told by anyone to activate it.
-There was an alarm panel at the front desk; the light for the front doors was always green which indicated the door was not alarmed.
-The front door was not alarmed even after a resident eloped the week before.

Telephone interview with the RCC on 05/03/24 at 2:23pm revealed:
-She filled out the residents' FL-2s and the physician signed them.
-There were residents with a dementia diagnosis, but she did not know how many.
-She did not think any of the residents were consistently confused but there were a lot of residents who were intermittently disoriented, but she did not know how many had a Wander Guard.
-The residents who wore Wander Guards were identified as needing one because they had walked out of the facility in the past, so the Wander Guard was a way of monitoring them; she did not know how many.
-She was not aware the doors needed to be alarmed if a resident was disoriented.
-Resident #6 was equipped with a Wander Guard fob on 05/01/24.
-She did not have wristbands for the fob and there was no other way to attach the Wander Guard to Resident #6.
-She took off her personal lanyard she had around her neck and she attached the Wander Guard fob to the ring on the lanyard and hung it around Resident #6's neck.

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-She was not sure who was responsible for ordering the wristbands for the fobs.
-She had seen the fob on his neck yesterday, 05/02/24, in the morning and after lunch, because he showed it to her.
-She had not been told by staff that he did not have it or staff could not find it.

Telephone interview with the facility's day shift receptionist on 05/03/24 at 2:31pm revealed:
-There was a Wander Guard system at the facility but Resident #6 did not have one.
-The facility did not have wrist straps for the Wander Guard fobs.
-She tried to keep an eye on the residents and the front porch, but she would leave the desk to answer call bells, go to the bathroom or to run to do something somewhere else in the building.
-She walked around with the primary care provider (PCP) and took notes when she did rounds about a week ago.
-The front door was not alarmed during the day time; she did not know about the evenings or overnight.
-She had not been told to alarm the front door.

Interview with a second MA on 05/03/24 at 3:40pm revealed:
-The front door was never alarmed during the day.
-The only alarm was the residents who wore a Wander Guard.
-There were residents the staff had to keep an eye on because they tried to wander off the front porch or tried to go to the front porch but were not allowed because they tried to leave.

Interview with the Administrator on 05/03/24 at 3:50pm revealed:
-Some of the residents in the facility had a

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Wander Guard wrist band and would activate an alarm at the main entrance.
-The main entrance was always opened and not alarmed.
-The receptionist and staff kept an eye on residents but there was not always someone at the front desk monitoring the main entrance.
-There would be times when the staff would not know when a resident went past the door and left the property.
-It would not be good if a resident with dementia got out because of it could become a safety issue.
-There were some residents in the facility who had a dementia diagnosis and were intermittently confused.
-Some of the residents had been at the facility for a long time and they had declined.
-Residents were required to sign out even when they were just going to sit on the porch, but she could understand where a resident with dementia or confusion would not remember to sign out.
-She could not say why the doors were not locked; she had forgot the rule about the alarms.
-The doors to the main entrance should have been locked based on the residents' diagnosis and orientation.

Interview with the day shift Supervisor on 05/03/24 at 5:20pm revealed:
-There were no alarms on the front door; it was never alarmed.
-There was not always staff or a receptionist at the front desk to monitor the door.
-There were three named residents she was worried about because they tried to get out of the facility.
-At the shift change meeting on Saturday, 04/27/24 she was told to keep an eye on Resident #6 because he eloped the day before.

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D 067	Continued From page 13 -She was concerned about resident elopements without the staff's knowledge because of the busy highway out front. [Refer to Tag DO270, 10A NCAC 13F .0901(b) Personal Care and Supervision] _____ The facility failed to ensure the main entrance doors were secured and alarmed with an audible sounding device when the doors were opened to prevent residents who were intermittently disoriented or identified as wanderer including one resident who eloped twice (#6) by exiting without the staff's knowledge. On 04/25/24 a resident (#6) was observed by staff leaving the facility and on 04/26/24 he left the facility without staff knowledge and the police were contacted by someone in the local community. The facility's failure resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the	D 125		

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D 125	Continued From page 14 written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff who administered medications had successfully passed the state medication aide examination or completed the state-approved 5-hour,10-hour or 15-hour medication aide (MA) training courses and had a validated clinical skills checklist prior to administering medications to residents for 1 of 4 sampled staff (Staff F). The findings are: Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F was hired on 02/27/24 as a MA. -There was no documentation that Staff F had taken and passed the MA examination. -There was no documentation of a medication clinical skills validation checklist completed for Staff F. -There was no documentation that Staff F completed the state-approved 5-hour, 10-hour or 15-hour medication aide training. Observations of Staff F on 05/02/24 at various times between 8:00am and 2:00pm revealed Staff F was administering medications to the residents, including pills, insulin, inhalers, and obtaining fingerstick blood sugar checks.	D 125		

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D 125	Continued From page 15 Review of residents' March 2024 and April 2024 electronic medication administration records (eMAR) revealed: -There was documentation that Staff F administered medications to residents for 6 days on the first shift in March 2024. -There was documentation that Staff F administered medications to residents for 11 days on the first shift in April 2024. Observation of Resident #1's room on 05/02/24 at 9:08am during Resident #1's interview revealed: -The MA entered Resident #1's room with a glucometer and a Tresiba insulin (a long-acting insulin) pen. -The MA checked Resident #1's fingerstick blood sugar (FSBS) and the reading was 255. -The MA dialed up 45 units of Tresiba and administered the insulin to Resident #1. -There was no prescription label on the Tresiba insulin pen. Interview with the Staff F on 05/02/24 at 10:50am revealed: -She administered 45 units of Tresiba to Resident #1 this morning. -She was aware Resident #1 had an order for Tresiba 30 units every morning. -Resident #1's FSBS was 255 this morning. -She considered a FSBS reading of 255 high, and she thought Resident #1 needed more than 30 units of insulin. -She looked at the eMAR and the prescription label on the medications and if they were different, she would administer the medication as instructed on the prescription label because the eMAR was incorrect most of the time. -The prescription label was more accurate which was why she followed the prescription label instructions.	D 125		

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D 125	Continued From page 16 Interview with Staff F on 05/02/24 at 11:21am revealed: -She completed the medication administration class the second week in January 2024 at the local community college. -She was given a certificate showing she had completed the medication administration class. -She had taken the state-approved MA examination the week after she completed the medication administration class and passed the test. -She started working at the facility the first week of March 2024. -When she was hired the Business Office Manager (BOM) did not ask her for her certification verifying she had completed the medication administration class. -She was informed by the BOM that the facility could check her certification through the computer. -She shadowed a Supervisor for two days and then she administered medications while the Supervisor observed. -She did not work with a Registered Nurse (RN) and was not checked off on her clinical skills. -She had administered medications weekly since she started the first week of March 2024. Telephone interview with the Area Regional Director on 05/03/24 at 2:42pm revealed: -The BOM left about one month ago. -She and the Administrator were conducting the duties of the BOM. -She had not audited the personnel records. -There had been no new employees hired since she was assigned to this building. Interview with the Administrator on 05/03/24 at 5:22pm revealed:	D 125		

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D 125	Continued From page 17 -The previous BOM was responsible for obtaining the MA's certificate and verifying the MA had taken and passed the MA test. -The BOM would have scheduled the RN to verify the clinical skills for Staff F after she had been orientated to the medication cart by the Supervisor. -The BOM was responsible for auditing the personnel records to ensure they were compliant. -The personnel records were not being audited at this time. -The Area Regional Manager assumed the BOM responsibilities as of 04/01/24. _____ The facility failed to ensure Staff F who administered medications had successfully passed the state medication aide examination, completed the state-approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses and had the clinical skills validation completed before administering medications to residents which included the administration of insulin. This failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:	D 137		

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D 137	Continued From page 18 (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (F) had no substantiated findings on the North Carolina Health Care Personal Registry (HCPR) upon hire. The findings are: 1. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F was hired on 02/27/24. -There was no documentation a HCPR check was completed prior to hire. Interview with Staff F on 05/03/24 at 11:38am revealed: -She had worked at the facility since March 2024. -She did not know what a HCPR was. -She did not know if the facility checked the HCPR for her. Telephone interview with the Area Regional Director (ARD) on 05/03/24 at 2:42pm revealed: -The Business Office Manager (BOM) left about one month ago. -She and the Administrator were conducting the duties of the BOM. -She had not audited staffs' personnel records. -There had been no new employees hired since she was assigned to this facility. Interview with the Administrator on 05/02/24 at 4:38pm revealed: -She did not know an HCPR had not been done	D 137		

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D 137	Continued From page 19 for Staff F. -The previous BOM was responsible for checking the HCPR for all employees. -Staff F's HCPR should have been checked by the previous BOM. -The ARD was responsible for checking the HCPR for employees now.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (B and F) had a criminal background check completed upon hire. The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 10/10/23. -There was no signed consent for a criminal background check in her personnel record. -There was no documentation of a criminal background check in Staff B's personal record. Interview with Staff B on 05/02/24 at 2:05pm revealed: -She signed release papers to have a criminal	D 139		

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background check done when she was hired.
-She was told she would not be able to start work until her criminal background check was completed, but she did not remember who told her.
-She thought the criminal background check had been done since she was placed on the schedule to work.

Refer to the telephone interview with the Area Regional Director on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

2. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F was hired on 02/27/24.
-There was no signed consent for a criminal background check in her personnel record.
-There was no documentation of a criminal background check in Staff F's personal record.

Interview with Staff F on 05/03/24 at 11:38am revealed:
-When she was hired, the previous Business Office Manager (BOM) had her sign a paper so the facility could do a criminal background check.
-She did not know if the criminal background check had been done.

Refer to the telephone interview with the Area Regional Director on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

_____

Telephone interview with the Area Regional Director on 05/03/24 at 2:42pm revealed:
-She had not had any employee sign a release to

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D 139	Continued From page 21 have a criminal background check done. -The BOM left about one month ago. -She and the Administrator were conducting the duties of the BOM. -She had not audited the personnel records. -There had been no new employees hired since she was assigned to this building. Interview with the Administrator on 05/02/24 at 4:28pm revealed: -The previous BOM was responsible for doing a criminal background check on new employees. -She was not aware there were employees working who did not have a criminal background check completed prior to starting work. -The Area Regional Manager was working as the BOM until a new BOM was hired. _____ The facility failed to ensure criminal background checks were completed for Staff B and Staff F, prior to working in the facility, resulting in the facility being unaware if the staff had a criminal record. This failure was detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2024.	D 139		
D 140	10A NCAC 13F .0407(a)(8) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall:	D 140		

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D 140	Continued From page 22 (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure in accordance with G.S. 131D - 45 an examination and screening for the presence of controlled substances was completed for 3 of 6 sampled staff (B, C, F). The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B was hired on 10/10/23. -There was no documentation Staff B completed a drug screening when she was hired. Interview with Staff B on 05/02/24 at 2:05pm revealed: -She had worked at the facility for 6 months. -She did not have a drug screen prior to starting work at the facility. -The Resident Care Coordinator (RCC) mentioned she would need to do a drug screen, but she was never sent anywhere to do it. Interview with the RCC on 05/02/24 at 4:05pm revealed: -She may have mentioned to Staff B that she would need a drug screening, but she was not responsible for sending new employees to have their drug screening done. -The previous Business Office Manager (BOM)	D 140		

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was responsible for sending new employees to have their drug screening completed.
-She was not aware Staff B did not have a drug screening before she started work.

Refer to the telephone interview with the Area Regional Director on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

2. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 01/24/24.
-There was no documentation Staff C completed a drug screening when she was hired.

Attempted interview with Staff C on 05/02/24 at 2:30pm was unsuccessful.

Refer to the telephone interview with the Area Regional Director on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

3. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F was hired on 02/27/24.
-There was no documentation Staff F completed a drug screening when she was hired.

Interview with Staff F on 05/02/24 at 10:50am revealed:
-She was sent to the facility's contracted laboratory office to have a drug screen completed.
-She was told by the staff at the laboratory that they no longer did the drug screens for the facility.
-The laboratory staff asked her to have

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D 140	Continued From page 24	D 140		

management at the facility contact them.
-She returned to the facility and told the previous BOM the laboratory staff wanted to be contacted.
-She was not sent anywhere else to have a drug screen completed.

Refer to the telephone interview with the Area Regional Director on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

_____

Telephone interview with the Area Regional Director on 05/03/24 at 2:42pm revealed:
-She had not had any employee sign a release to have a drug screen completed.
-The BOM was responsible for ensuring new employees had a drug screen test prior to employment.
-She and the Administrator were conducting the duties of the BOM.
-She had not audited the personnel records.
-There had been no new employees hired since she was assigned to this building.

Interview with the Administrator on 05/02/24 at 4:28pm revealed:
-The previous BOM was responsible for sending new employees to the laboratory to have a drug screen completed prior to starting work.
-She was not aware there were employees working who did not have a drug screen completed prior to starting work.
-The Area Regional Manager was working as the BOM until a new BOM was hired.

_____

The facility failed to ensure drug screening were completed for Staff B, Staff C, and Staff F resulting in the facility not knowing if staff had findings of controlled substances. This failure was

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D 140	Continued From page 25 detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2024.	D 140		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.	D 161		

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D 161	Continued From page 26 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff B, and Staff F) had completed the competency evaluation and validation for Licensed Health Professional Support (LHPS) tasks for fingerstick blood sugar checks (FSBS), subcutaneous injections, and oxygen. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's hire date was 09/14/23. -There was no documentation of a LHPS competency validation. Interview with Staff A on 05/02/24 at 2:34pm revealed: -She had not completed the LHPS validation since she started working at the facility. -She used previous training and knowledge to complete tasks for residents. -Her MA duties included administering insulin when needed and checking residents' FSBS as ordered. Review of Resident #1's April 2024 eMAR revealed: -There was documentation Staff A administered insulin on 04/30/24. -There was no entry for Staff A to obtained a FSBS reading. Review of Resident #13's February 2024 electronic medication administration record (eMAR) revealed: -There was documentation Staff A obtained	D 161		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO ASSISTED LIVING OPCO LLC	5660 DURHAM ROAD ROXBORO, NC 27574

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fingerstick blood sugars (FSBS) readings on 02/17/24, 02/18/24 and 02/29/24.
-There was documentation Staff A administered insulin injections on 02/17/24, 02/18/24 and 02/29/24.

Review of Resident #13's March 2024 eMAR revealed:
-There was documentation Staff A obtained FSBS readings on 03/07/24, 03/08/24, 03/12/24, 03/13/24, 03/16/24, 03/17/24, and 03/18/24
-There was documentation Staff A administered insulin injections on 03/07/24, 03/08/24, 03/12/24, 03/13/24, 03/16/24, 03/17/24, and 03/18/24.

Review of Resident #13's April 2024 eMAR revealed:
-There was documentation Staff A obtained a FSBS reading on 04/30/24.
-There was documentation Staff A administered an insulin injection on 04/30/24.

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful.

Refer to the telephone interview with the Area Regional Director (ARD) on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B's hire date was 10/10/23.
-There was no documentation of a LHPS competency validation.

Interview with Staff B on 05/02/24 at 2:05pm revealed:

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-She did not know what an Licensed Health Professional Support (LHPS) check list was.
-She did not recall a Registered Nurse (RN) watching her obtain a FSBS or administering an insulin injection.
-She had obtained fingerstick blood sugars (FSBS) and given insulin injections.

Review of Resident #13's February 2024 electronic medication administration record (eMAR) revealed:
-There was documentation Staff B obtained fingerstick blood sugars (FSBS) readings on 02/03/24, 02/05/24, 02/08/24 and 02/09/24.
-There was documentation Staff B administered insulin injections on 02/03/24, 02/05/24, 02/08/24 and 02/09/24.

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful.

Refer to the telephone interview with the Area Regional Director (ARD) on 05/03/24 at 2:42pm.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

3. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F's hire date was 02/27/24.
-There was no documentation of a LHPS competency validation.

Observation of a medication pass on 05/02/24 at 9:08am revealed:
-The medication aide (MA) entered Resident #1's room with a glucometer and a Tresiba insulin (a long-acting insulin) pen.
-The MA obtained Resident #1's fingerstick blood

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sugar (FSBS) reading which was 255.
-The MA dialed up 45 units of Tresiba and administered the insulin to a resident.

Interview with Staff F on 05/04/24 at 10:50am revealed:
-She did not know what an Licensed Health Professional Support (LHPS) check list was.
-She worked with the Supervisor when administering insulin and obtaining fingerstick blood sugars (FSBS).
-She did not work with a Registered Nurse (RN) to check her skills for insulin injection and obtaining FSBSs.
-She had obtained FSBSs, given insulin injections, and had cared for a resident with oxygen.

Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed:
-There was documentation Staff F administered insulin injections on 03/21/24, 03/22/24, 03/26/24, 03/27/24, 03/30/24, and 03/31/24.
-There was no entry for Staff F to obtained a FSBS reading.

Review of a Resident #1's April 2024 eMAR revealed:
-There was documentation Staff F administered insulin injections on 04/01/24, 04/04/24, 04/05/24, 04/09/24, 04/19/24, 04/23/24, 04/24/24, 04/27/24, 04/28/24, and 04/29/24.
-There was no entry for Staff F to obtained a FSBS reading.

Review of Resident #1's May 2024 eMAR revealed:
-There was documentation Staff F obtained a FSBS reading of 255 on 05/02/24.

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D 161	Continued From page 30 -There was documentation Staff F administered an insulin injection on 05/02/24. Review of Resident #2's March 2024 eMAR revealed Staff F administered oxygen on 03/18/24, 03/21/24, 03/22/24, 03/26/24, 03/27/24, 03/30/24, 03/31/24. Review of Resident #2's April 2024 eMAR revealed Staff F administered oxygen on 04/01/24, 04/04/24, 04/05/24, 04/09/24, 04/10/24, 04/19/24, 04/23/24, 04/24/24, 04/27/245, 04/28/24, and 04/29/24. Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful. Refer to the telephone interview with the Area Regional Director (ARD) on 05/03/24 at 2:42pm. Refer to the interview with the Administrator on 05/03/24 at 5:22pm _____ Telephone interview with the Area Regional Director (ARD) on 05/03/24 at 2:42pm revealed: -The Business Office Manager (BOM) left about one month ago. -She and the Administrator were conducting the duties of the BOM. -She had not audited staffs' personnel records. -There had been no new employees hired since she was assigned to this facility on 04/01/24. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -She did not know there were MAs working who were not checked off for LHPS tasks. -The previous BOM was responsible for scheduling the RN for LHPS task check list for	D 161		

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D 161	Continued From page 31 new employees. -The BOM was responsible for auditing the personnel records to ensure they were compliant. -The personnel records were not being audited at this time. -The ARD assumed the BOM responsibilities as of 04/01/24. [Refer to the findings for Resident #1 in tag 276 10A NCAC 13F .0902(c)(3-4).] [Refer to the findings for Resident #1 in tag 358 10A NCAC 13F .1004(a).] The facility failed to ensure the staff were competency validated regarding fingerstick blood sugar checks and subcutaneous injections for Resident #1 who had a diagnosis of diabetes. The failure was detrimental to the health, safety, and welfare of Resident #1 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2024.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:	D 164		

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D 164	Continued From page 32 (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 3 of 4 sampled medication aides (Staff A, B, and F) completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's hire date was 09/14/23. -There was no documentation of training on diabetic care for residents.	D 164		

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Review of Resident #1's March 2024 electronic medication administration records (eMAR) revealed:
-There was documentation Staff A administered insulin in March 2024.
-There was no entry for Staff A to obtain a fingerstick blood sugar (FSBS) reading.

Review of Resident #1's April 2024 eMAR revealed:
-There was documentation Staff A administered insulin in April 2024.
-There was no entry for Staff A to obtained a FSBS reading.

Review of Resident #13's February 2024 eMAR revealed:
-There was documentation Staff A had obtained a FSBS reading in February 2024.
-There was documentation Staff A had administered insulin in February 2024.

Review of Resident #13's March 2024 eMAR revealed:
-There was documentation Staff A had obtained FSBS readings in March 2024.
-There was documentation Staff A administered insulin in March 2024.

Review of Resident #13's April 2024 eMARs revealed:
-There was documentation Staff A had obtained a FSBS reading in April 2024.
-There was documentation Staff A administered insulin in April 2024.

Interview with Staff A on 05/02/24 at 2:34pm revealed:
-She had been working at the facility as a MA since September 2023.

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D 164	Continued From page 34 -Her MA duties included administering insulin when needed and checking residents' FSBS as ordered. -Since she started working at the facility, she had not received any training related to care of diabetic residents. Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 4:05pm. Refer to the interview with the Administrator on 05/02/24 at 4:38pm. 2. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B's hire date was 10/10/23. -There was no documentation of training on diabetic care for residents. Review of Resident #13's February 2024 electronic medication administration record (eMAR) revealed: -There was documentation Staff B had obtained a fingerstick blood sugar reading (FSBS) in February 2024. -There was documentation Staff B had administered insulin in February 2024. Interview with Staff B on 05/02/24 at 2:05pm revealed: -She did not have diabetic training when she was hired. -No one told her she needed to have diabetic training. -She worked with resident who were diabetics. -She administered insulin and obtained fingerstick	D 164		

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blood sugar (FSBS) readings.

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 4:05pm.

Refer to the interview with the Administrator on 05/02/24 at 4:38pm.

3. Review of Staff F's, medication aide (MA), personnel record revealed:
-Staff F's hire date was 02/27/24.
-There was no documentation of training on diabetic care for residents.

Review of Resident #1's March 2024 electronic medication administration records (eMAR) revealed:
-There was documentation Staff F administered insulin in March 2024.
-There was no entry for Staff F to obtain a fingerstick blood sugar (FSBS) reading.

Review of Resident #1's April 2024 eMAR revealed:
-There was documentation Staff F administered insulin in April 2024.
-There was no entry for Staff F to obtained a FSBS reading.

Review of Resident #13's March 2024 eMAR revealed:
-There was documentation Staff F had obtained FSBS readings in March 2024.
-There was documentation Staff F administered insulin in March 2024.

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D 164	Continued From page 36 Review of Resident #13's April 2024 eMARs revealed: -There was documentation Staff F had obtained a FSBS reading in April 2024. -There was documentation Staff F administered insulin in April 2024. Interview with Staff F on 05/02/24 at 10:50am revealed: -She did not remember having diabetic training when she was hired. -She worked with resident who were diabetics. -She administered insulin and obtain (FSBS) readings. Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful. Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 4:05pm. Refer to the interview with the Administrator on 05/02/24 at 4:38pm. _____ Interview with the RCC on 05/02/24 at 4:05pm revealed: -The diabetic training was taught by the Nurse Consultant from the facility's contracted pharmacy. -The diabetic training was completed by the Nurse Consultant from the previous facility's contracted pharmacy. -The Nurse Consultant would give the diabetic training certificates to the BOM to file in the personnel records. Interview with the Administrator on 05/02/24 at 4:38pm revealed: -The Nurse Consultant from the facility's previous	D 164		

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D 164	Continued From page 37 consulting pharmacy completed the diabetic training. -She did not know there were staff working who had no documentation of completing diabetic training prior to administration medications and obtaining FSBS. [Refer to the findings for Resident #1 in Tag 276 10A NCAC 13F .0902(c)(3-4).] [Refer to the findings for Resident #1 in Tag 358 10A NCAC 13F .1004(a).] _____ The facility failed to ensure 3 of 4 sampled staff (A, B, and F) completed training on the care of residents with diabetes, resulting in the MAs not obtaining FSBS readings as ordered and administering the incorrect dosages of insulin to Resident #1 who had a diagnosis of diabetes. This failure resulted in substantial risk of physical harm for Resident #1 which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 164		
D 224	10A NCAC 13F .0702 (b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons:	D 224		

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D 224	Continued From page 38 (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner; (4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or (5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to initiate the discharge of 1 of 1 resident (#6) who was recommended for a higher level of care by the primary care provider (PCP).	D 224		

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D 224	Continued From page 39 The findings are: Review of Resident #6's FL2 dated 02/07/24 revealed: -Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage. -The recommended level of care was a skilled nursing facility (SNF). -Resident #6 was intermittently disoriented. Review of Resident #6's FL-2 dated 05/01/24 revealed: -Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage. -The recommended level of care was SNF; documented beside other was memory care. -Resident #6 was intermittently disoriented. -Resident #6 had wandering behaviors. Review of Resident #6 current care plan dated 02/07/24 revealed: -There was no documentation if the care plan was annual or a significant change in condition. -Resident #6 required extensive assistance dressing, was totally dependent for toileting, bathing, and grooming and required limited assistance with transfers. -Resident #6 was sometimes disoriented, was incontinent to bladder and bowel, and was ambulatory with a cane. Review of Resident #6's progress notes revealed: -On 01/30/24, the Resident Care Coordinator (RCC) attempted to contact Resident #6's power of attorney (POA) to discuss his care plan; this was the first attempt. -On 02/05/24, the RCC attempted to contact Resident #6's POA to discuss his care plan; this	D 224		

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was the second attempt.
-On 02/06/24, after multiple attempts the Supervisor on duty was able to convince the resident to take a bath.
-On 02/15/24, the RCC and the Administrator had a discussion with the resident about bathing and his body odor after a visitor complained.
-On 02/20/24, he refused to walk and sat in his walker to move around and asked staff to push him; he had no complaints of pain in his feet and legs.
-On 04/25/24 at 4:10pm, he was observed outside of the facility attempting to walk to a local store.
-The RCC and another staff could not redirect him back to the facility and escorted him to a local store and then back to the facility.
-On 04/26/24 at 5:59pm, Resident #6 eloped from the facility and walked to the local store; 911 was called.

Review of a notice to discharge dated 03/19/24 revealed:
-The notice of discharge was issued for Resident #6 on 03/19/24.
-The date of discharge was 04/19/24; 30 days after the date of the notice.
-The reason for the notice was "failure to pay the cost of services and accommodations by the payment due date".
-There was nothing else checked off under reason for the notice of discharge.
-The noticed was signed by the Administrator on 03/19/24.

Telephone interview with Resident #6's POA on 04/30/24 at 6:08pm revealed:
-Sometime around 03/18/24 the Administrator had given her a discharge notice for failure to pay with a discharge date of 04/19/24.

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-She had contacted another assisted living facility to possibly admit Resident #6.
-The new assisted living facility requested a new FL-2 because Resident #6's FL-2 was not current.
-The new assisted living facility visited Resident #6 at the current facility and did an assessment; she did not recall the date.
-The new assisted living facility told her they could not admit Resident #6 because he needed placement into a skilled [nursing] facility.
-The RCC at the current facility told the POA Resident #6 was on the "cusp" of needing to be in a skilled [nursing] facility.
-The Administrator told the POA Resident #6 needed to be in a skilled [nursing] facility; she did not recall the date.
-The week before Resident #6 wandered from the facility two times and was at a local store both times.
-The police were called both times and brought him back: the police officer talked to him about not wandering away again.
-Resident #6 had dementia, liver issues, low platelet counts, and behavior issues, and she was told by the RCC that he also had become incontinent to bladder and bowel.

Telephone interview with Resident #6's PCP on 05/02/24 at 3:10pm revealed:
-Resident #6 had increased dementia and behaviors in the last few months and he needed a higher level of care.
-She had signed an FL-2 in February 2024 with a recommendation for a SNF based on reports from staff about Resident #6's cognitive decline and behaviors.
-Resident #6 had increased falls, refused to bathe, and increased aggression.
-Resident #6 should have been discharged

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shortly after his level of care was changed on the FL-2 in February 2024.
-Resident #6 had eloped the week before.
-She was not told about the elopement when it happened.
-She was made aware of the elopement on 05/01/24 and she signed a new FL-2 with a recommendation for a SNF with a [secured] memory care unit.
-Elopement was a "red flag" and was an emergency situation.
-Resident #6 needed to be immediately discharged to a memory care unit for his safety.
-She was worried about him leaving and wandering onto the busy highway in front of the facility.
-Technically, Resident #6 should not have been at the facility when he eloped.

Interview with a personal care aide (PCA) on 05/03/24 at 12:15pm revealed:
-Resident #6 seemed to be more confused lately but then he had good days and he seemed just fine.
-Sometimes he would soil himself, he refused to take baths and refused to change clothes.
-He used to be mean to the staff and other residents, but he had gotten nicer over the past few weeks.

Interview with a medication aide (MA) on 05/03/24 at 3:40pm revealed:
-Resident #6 had changed over the last three months.
-He used to sit in the lobby but now he stayed in his room.
-He repeatedly asked the same questions.
-He did not like to take baths and refused to change his clothes.
-She had noticed a decline in him.

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D 224	Continued From page 43 Interview with the day shift Supervisor on 05/03/24 at 5:20pm revealed: -She had noticed a decline in Resident #6 in the past two to three months. -He did not recognize the staff like he used to. -He would soil himself and not care or recognize if he was soiled and smelled. -Staff were struggling to get him to bathe and to change his clothes. Interview with the RCC on 05/01/24 at 4:43pm revealed: -She typed everything on the FL-2s, and the PCP signed them. -Resident #6 was having issues with a low platelet count and because of the low platelet count, the PCP felt like the facility could not provide the care for him. -Some days Resident #6 would have a complete change from the day before and not be able to stand up on his own and would call for help or there would be a change in his mobility and he would not be able to ambulate anymore. -She did not know if it was due to his dementia or the low platelet count. -She discussed the need for a higher level of care for Resident #6 with the PCP and changed the FL-2 sometime in February 2024. -She usually discussed a recommendation for a higher level of care with the PCP first then the family before she completed a new FL-2. -She reached out twice to Resident #6's POA to do a care plan meeting to discuss the recommended higher level of care but was unable to reach her. -After the PCP signed the February 2024 FL-2 with the recommendation for the higher level of care, she gave it to the Administrator. -She spoke to the POA after Resident #6's first	D 224		

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elopement and explained the need for a higher level of care with a secured memory unit; she thought the POA understood the need.

Interview with the Administrator on 05/01/24 at 11:35am revealed:
-Resident #6 had been given a notice for discharge due to failure to pay on 03/19/24.
-Resident #6 had not moved from the facility because everyone [other facilities] who came to see him decided not to admit him; she did not know why.

Interview with the Administrator on 05/03/24 at 3:50pm revealed:
-The RCC filled out all resident FL-2s and the PCP signed them.
-She did not follow the FL-2 for residents; that was between the RCC and the PCP.
-The RCC filled out an FL-2 for Resident #6 in February 2024 with a recommendation for a SNF related to low blood platelet counts and his decline in health.
-She did not know if Resident #6's cognition decline was part of the reason for the recommendation for a SNF on his FL-2 in February 2024.
-She knew the FL-2s were only good for thirty days.
-The RCC sent Resident #6's FL-2 dated 02/07/24, to two other assisted living facilities.
-Resident #6 should have gone [admitted] to a SNF and now he needed a memory care facility.
-She did not know about Resident #6's recommended level of care to a SNF when she completed the notice of discharge for him on 03/19/24.
-She was only made aware of Resident #6's 02/07/24 FL-2 a few weeks ago.
-If she had realized Resident #6 was

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D 224	Continued From page 45 recommended for a SNF, she would have discharged him based on his recommended level of care. -The RCC did not let her know about the increased recommended level of care or Resident #6. -The RCC should have told her about the change in the recommended level of care when the PCP signed the FL-2. -Resident #6 should have ben discharged to a SNF before she gave the notice of discharge on 03/19/24; now he needed a memory care unit. _____ The facility failed to initiate the discharge of Resident #6 who had an FL-2 with a recommendation for a skilled nursing facility (SNF) on 02/07/24, and an FL-2 with a recommendation for a SNF and memory care unit on 05/01/24; the resident had delined in mental status and eloped twice from the facility. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2024.	D 224		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.	D 253		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 6 of 8 Residents (Residents #2, #4, #5, #6, #7 & #8).

The findings are:

1. Review of Resident #2's Resident Register dated 10/31/23 revealed:
-Resident #2 was admitted to the facility on 10/20/23.
-The Resident Register was not signed and dated by anyone on the last page.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm.

Refer to the interview with the Administrator on 05/01/24 at 4:00pm.

2. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension, chronic constipation, mild cognitive impairment, and anemia.

Review of Resident #4's record revealed:
-There was a resident face sheet with an admission date of 07/27/21.
-There was no completed Resident Register.

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D 253	Continued From page 47 Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm. Refer to the interview with the Administrator on 05/01/24 at 4:00pm. 3. Review of Resident #5's current FL2 dated 01/19/24 revealed diagnoses included unspecified anxiety disorder and major neurocognitive disorder to multiple etiologies with behavior disturbance. Review of Resident #5's resident record revealed: -There was a resident face sheet with an admission date of 03/16/22. -There was no completed Resident Register. Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm. Refer to the interview with the Administrator on 05/01/24 at 4:00pm. 4. Review of Resident #6's Resident Registered revealed: -There was no admission date on Resident #6's Resident Register. -Resident #6 had a Power of Attorney (POA). -The assessment was complete. -There were no signatures or dates on the last page of the Resident Register. Telephone interview with Resident #6's POA on 04/30/24 at 6:08am revealed Resident #6 was admitted to the facility sometime in November 2022. Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm.	D 253		

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D 253	Continued From page 48 Refer to the interview with the Administrator on 05/01/24 at 4:00pm. 5. Review of Resident #7's Resident Register revealed: -Resident #7 was admitted to the facility on 09/29/23. -Resident #7 had a power of attorney (POA). -There was only the front page to the Resident Register. -There was no assessment page. Telephone interview with Resident #7's POA on 04/30/24 at 9:52am revealed Resident #7's Resident Register was completed and signed a week prior to Resident #7's admission on 09/29/23. Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm. Refer to the interview with the Administrator on 05/01/24 at 4:00pm. 6. Review of the Resident #8's Resident Register dated 08/09/23 revealed: -Resident #8 was admitted to the facility on 08/09/23. -The assessment page was completed. -The Resident Register was not signed and dated by anyone on the last page. Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm. Refer to the interview with the Administrator on 05/01/24 at 4:00pm. _____ Interview with the Resident Care Coordinator (RCC) on 05/01/24 at 3:48pm revealed:	D 253		

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D 253	Continued From page 49 -The resident or their responsible party along with the Administrator were to complete the Resident Register with signatures within 72 hours of admission. Interview with the Administrator on 05/01/24 at 4:00pm revealed: -The Resident Register was part of the new admission packet. -The resident or resident's responsible party were to complete the Resident Resister with the Administrator at the time of admission. -The Business Office Manager (BOM) was responsible for auditing resident records but the facility had not had a BOM since August 2023. -She had not been doing record audits to ensure necessary paperwork was completed. -She had not set aside time to review all the new admission packets or records to make sure the Resident Register was reviewed and signed with 72 hours of the residents' admissions.	D 253		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision	D 270		

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for 1 of 1 sampled residents (#6) who had a diagnosis of Alzheimer's Disease, was intermittently disoriented and eloped from the facility without staff knowledge.

The findings are:

Review of the facility's Missing Person Plan revealed:
-The plan was not dated.
-The first action was to notify the facility staff to begin a 5-minute thorough search of the facility and the grounds.
-The second action was to notify the Administrator who would notify the rest of the staff to do a thorough 5-minute search of the exterior of the facility.
-If the resident was not located within the five-minute search the interior search would continue and the Administrator would advise selected individuals to conduct automobile searches of the area within a one-mile radius of the facility.
-If the resident was not located in 30 minutes the police, the family and the local Department of Social Services (DSS) should be notified.
-The Administrator would continue a coordinated search with the police and community resources until the resident was found.

Observation of the facility on 04/30/24 at 8:00am revealed:
-There was a main entrance located in the middle of the front of the facility with two sets of double glass doors; the doors were not locked and were not alarmed.
-The facility was located on a busy four-lane highway with a grassy medium (Hwy US 501/NC 57).
-The speed limit in front of the facility was 55

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miles an hour.
-Multiple large vehicles including tractor trailer trucks and passenger vehicles were observed traveling on both sides of the four-lane highway.

Review of Resident #6's FL2 dated 02/07/24 revealed:
-Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage.
-The recommended level of care was a skilled nursing facility (SNF).
-Resident #6 was intermittently disoriented.

Review of Resident #6's FL-2 dated 05/01/24 revealed:
-Diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage.
-The recommended level of care was SNF; documented beside other was memory care.
-Resident #6 was intermittently disoriented.
-Resident #6 had wandering behaviors.

Review of Resident #6's charting notes revealed:
-On 04/25/24 at 4:40pm, Resident #6 was observed by the Supervisor walking towards the road.
-The Supervisor attempted to redirect the resident back to the facility.
-The Resident Care Coordinator (RCC) witnessed Resident #6 push away from the Supervisor and continuing to walk away.
-The Supervisor and the RCC followed Resident #6 to a local store where he was trying to make a purchase.
-Resident #6 told the cashier he would be back the next day to make purchases.
-He was returned to the facility by the RCC and the Supervisor.

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-Resident #6's Power of Attorney (POA) and explained the action [leaving] was considered an elopement from the facility and a SNF with a memory care unit was the recommended level of care.
-Resident #6's primary care provider (PCP) and the Administrator were notified.
-The POA called the RCC back and told her Resident #6 said he was going back to the store the next day to be on the "lookout".
-The staff enforced one-hour checks for Resident #6 for twenty-four hours.
-On 04/26/24 at 5:59pm, Resident #6 eloped from the facility.
-He waked from the facility to the local store.
-The local 911 was called by the facility and the POA was contacted.

Review of the local Police Department (PD) reports revealed:
-On 04/25/24 at 4:00pm, the PD received a call from the receptionist from the facility about an older male walking towards the store.
-The resident was walking towards a store with a female staff.
-The resident refused to return to the facility.
-The resident was returned to the facility by the staff at 6:31pm.
-On 04/26/24 at 4:06pm, the PD received a 911 call from someone who drove past an elderly male wearing pajamas walking north on the side of the road.
-At 4:09pm, the PD attempted to contact the facility with no answer.
-At 4:16pm, Resident #6 was located; no location was noted.
-At 4:28pm, Resident #6 was returned to the facility.

Review of the facility's accident and incident

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reports for Resident #6 for April 2024 revealed the was not a report for 04/25/24 or 04/26/24.

Observation of Resident #6 on 05/01/24 at 5:30pm revealed:
-Resident #6 had a Wander Guard fob (an alarm system that activates when the wearer of the fob gets near a door that has a sensor) attached to a lanyard hanging around his neck.
-Resident #6 followed the survey team out of the main doors when they were leaving the facility for the day.
-The Wander Guard alarm sounded, and a MA came to the door.
-The MA redirected Resident #6 back into the facility; she told him he could not leave.
-Resident #6 said he wanted to go outside, and he did not understand why he could not go outside if other residents and people were allowed to go outside.

Observation of Resident #6 on 05/03/24 at 12:10pm revealed:
-He was seated in the dining room with other residents.
-He did not have a Wander Guard fob around his neck, wrist or ankles.

Telephone interview with Resident #6's PCP on 05/02/24 at 3:10pm revealed:
-Resident #6 had increased dementia and behaviors in the last few months and he needed a higher level of care.
-Resident #6 had eloped the week before.
-She was not told about the elopement when it happened.
-She was made aware of the elopement on 05/01/24 and she signed a new FL-2 with a recommendation for a skilled nursing facility with a [secured] memory care unit.

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ROXBORO ASSISTED LIVING OPCO LLC	5660 DURHAM ROAD ROXBORO, NC 27574

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-Elopement was a "red flag" and was an emergency situation.
-Resident #6 needed to be immediately discharged to a memory care unit for his safety.
-She was worried about him leaving and wandering onto the busy highway in front of the facility.
-Technically Resident #6 should not have been at the facility after the new FL-2 was signed with the recommendation for a memory care unit.

Interview with Resident #6 on 05/03/24 at 12:10pm revealed:
-He could leave the facility when he wanted to.
-He did not have to tell anyone when he left.
-He did not have an alarm he wore around his neck.
-He could walk anywhere he wanted.

Telephone interview with Resident #6's POA on 04/30/24 at 6:08pm revealed:
-Resident #6 had wandered away from the facility two times the week before and was at a local store both times.
-The PD was called both times and brought him back; the second time the sheriff told him not to wander away again or he would be arrested.
-Resident #6 had dementia and had good days and bad days.

Interview with a personal care aide (PCA) on 05/03/24 at 12:15pm revealed:
-She had seen the Wander Guard fob around Resident #6's neck on Wednesday, 05/01/24.
-No one had told her what it was, she had to ask.
-She had not seen the fob around his neck yesterday, 05/02/24, or today, 05/03/24.
-This morning, 05/03/24, she and another PCA had "torn his room up" looking for it but did not find the fob.

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-Resident #6 had not tried to leave the facility this week.
-She had heard about him leaving the week before but was not told to keep an eye on him.
-He seemed to be more confused lately but then he had good days and he seemed just fine.

Interview with a medication aide (MA) on 05/03/24 at 3:40pm revealed:
- Resident #6 started leaving the porch about three months ago; staff always tried to keep him on the porch.
-He could always be redirected back inside or to the porch when he would try to leave.
-Some residents were not allowed to go out to the front porch at all because they tried to leave.
-The busy highway in front of the facility made it unsafe for the residents to leave the facility and walk.
-The only new instructions she knew about Resident #6 was to do one-hour checks on him.
-She was not told to check him for a Wander Guard; she did not think he had one.

Interview with the facility's day shift receptionist on 04/30/24 at 10:40am revealed:
-The front door were not locked from the inside or the outside of the building.
-Visitors could come and go through the front entrance without sounding an alarm or ringing a bell for entrance.
-Residents could go outside without sounding an alarm.

Telephone interview with the facility's day shift receptionist on 05/03/24 at 2:31pm revealed:
-On Thursday 04/25/24, around 3:45pm she saw Resident #6 go out to the front porch.
-The residents could not go off the front porch.
-She saw Resident #6 go past the front porch, so

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she tried to call him back and he said he was going to the store.
-She ran back in to get the RCC and by the time they got back outside he was at the top of the driveway near the highway.
-She tried to redirect him back to the facility, but he grabbed her left arm and resisted.
-He was determined to go to the store and would not stop or come back to the building so the MA and the RCC walked with him.
-She called 911 to report the elopement.
-The 911 operator told her someone in the community had already called and reported the elopement, so she went back to the building.
-The RCC and the MA walked with him to the store and back.
-When they returned the sheriff was already at the facility.
-On Friday 04/26/24 she did not see Resident #6 leave the building because she was answering the telephone.
-She did not know Resident #6 left the facility until around 4:15pm when someone from the community called the facility and told her they were driving on the highway and passed him walking on the side of the road.
-The caller told her they had also called the local PD.
-She told the evening shift supervisor and she walked up to the store while the supervisor drove her personal car.
-Resident #6 was already at the store when she got there so she walked him back to the facility.
-She called his POA to tell her Resident #6 had eloped again and the sheriff came to the facility while she was on the telephone.
-The sheriff spoke to Resident #6 about not leaving the facility anymore.
-Before the first elopement on 04/25/24,there were incidents where he walked off the front

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porch towards the driveway and highway, but she could call him back and he would return.
-She did not recall how often or the number of times he had tried to walk off the porch.
-She was told to keep an eye on him when she told the RCC about him going past the porch.
-There was a Wander Guard system at the facility but Resident #6 did not have one.
-The facility did not have wrist straps for the Wander Guard fobs.
-She tried to keep an eye on the residents and the front porch, but she would leave the desk to answer call bells, go to the bathroom or to run to do something somewhere else in the building.
-The front door was not alarmed during the day time; she did not know about the evenings or overnight.
-She had not been told to alarm the front door.

Telephone interview with the facility's evening shift receptionist on 05/03/24 at 1:50pm revealed:
-She worked 4 to 5 days a week from 6:00pm to 9:00pm; she did not work weekends.
-She stayed at the front desk most of the time but did leave to assist residents.
-There was no one at the front desk once she left until the next morning when the day shift receptionist came to work.
-The front door was not alarmed; it was only locked from the outside in the evenings around 6:30pm.
-The alarm for the front door could be activated but she had never been told by anyone to activate it.
-There was an alarm panel at the front desk; the light for the front doors was always green which indicated the door was not alarmed.
-The front door was not alarmed even after Resident #6 eloped the week before.

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D 270	Continued From page 58 Interview with the day shift Supervisor on 05/03/24 at 5:20pm revealed: -At the shift change meeting on Saturday, 04/27/24 she was told to keep an eye on Resident #6 because he eloped the day before. -She took it upon herself and began to check on him every half an hour; she did not document it. -She did not know about a one-hour check until one day this week; she was not sure of the day. -The staff were supposed to initial on a log when they did the one-hour checks. -It was not part of the one-hour checks to check on his Wander Guard fob. -One day this week the RCC told her he had a Wander Guard fob around his neck, but he could pull it off. -Staff used to have to go out with Resident #6 when he went outside because he would try to leave the porch, but that had been a while ago. -Resident #6 could not be redirected anymore. -It was concerning to have a resident to elope because the resident could get hurt and because of the busy highway out front. Interview with the RCC on 05/01/24 at 4:10pm revealed: -Resident #6 eloped and walked to the store twice the week before. -On Thursday, 04/25/24, a MA was sitting in her car in the parking lot when saw him at the top of the driveway next to the highway. -The MA notified the receptionist about Resident #6 eloping and the receptionist told her. -The MA tried to get Resident #6 to come back to the facility, but he pushed and shoved on her so the RCC and the MA walked with him to the store. -The MA went back to the facility and the RCC stayed with him at the store and walked him back. -The facility considered it an elopement because Resident #6 did not sign out and when he was	D 270		

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asked to return, he could not be directed back to the facility.
-Resident #6 was unsteady and used a walker which he did not have when he walked to the store.
-She was concerned because he had cognitive issues and he could get somewhere and become confused; he would not recognize when he was in an unsafe environment and not be able to return to the facility on his own.
-Someone in the community had driven by and seen Resident #6 shoving the MA at the driveway next to the highway and called the local PD.
-The sheriff was at the facility when she returned from the store with Resident #6; the sheriff said that as long as Resident #6 was in the building and safe again, he was "done".
-The POA was notified about the elopement and she did not want Resident #6 to leave the facility alone.
-It was the first time he had wandered away from the facility so the RCC thought it would not happen again.
-Resident #6 eloped for a second time the next day, Friday, 04/26/24 and was found at the store.
-Someone from the community called the PD and reported him out of the facility.
-She was not sure how long Resident #6 had been gone from the facility.
-The PD called the facility and staff brought him back by personal vehicle.
-After he eloped on 04/26/24, the evening supervisor began conducting one-hour checks; they were only done for eight hours that evening and it was not documented.

Observation of the RCC on 05/01/24 at 4:55pm revealed:
-She opened a drawer to her desk and pulled out a fob for a Wander Guard.

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D 270	Continued From page 60 -She removed the lanyard from around her neck and fastened the Wander Guard fob to the lanyard. -She left the office with the lanyard and the fob. Observation of Resident #6 on 05/01/24 at 5:30pm revealed: -He had a Wander Guard fob on a lanyard around his neck. -He attempted to exit through the first set of double glass doors at the main entrance of the facility and the Wander Guard pendant made an alarming sound. -A medication aide (MA) redirected Resident #6 back into the facility as he said he was "following other people going outside." Telephone interview with the RCC on 05/03/24 at 2:23pm revealed: -Resident #6 was equipped with a Wander Guard fob on 05/01/24. -She did not have wristbands for the fob and there was no other way to attach the Wander Guard to Resident #6. -She removed the lanyard she had around her neck and she attached the Wander Guard fob to the ring on the lanyard and hung it around Resident #6's neck. -She was not sure who was responsible for ordering the wristbands for the fobs. -Resident #6 was placed on one-hour checks on 05/01/24; part of the checks included checking to see if he had the fob. -She had seen the fob on his neck yesterday, 05/02/24, in the morning and after lunch, because he showed it to her. -She had not been told by staff that he did not have it or staff could not find it. Interview with the Administrator on 05/01/24 at	D 270		

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D 270	Continued From page 61 5:05pm revealed: -She had not put a Wander Guard on Resident #6 after he eloped because she did not have wristbands for the fobs. -The facility had Wander Guard fobs but did not have the wristbands. -She tried to order wristbands but was unable to get them because they were out of stock. -She and the RCC put a fob on a lanyard and placed it around Resident #6's neck because that was the only way she could put a Wander Guard on hime without the wristband. -She was going to contact a sister facility and see if they had wristbands for the Wander Guard fobs. -Resident #6 was also placed on one-hour checks the Friday, 04/26/24, after his second elopement. Interview with the Administrator on 05/03/24 at 3:50pm revealed: -Resident #6 had a diagnosis of dementia but the facility had not seen signs of him trying to go out the door or leave the facility prior to 04/25/24. -She was told about both of Resident #6's elopements by the RCC last week when they happened. -Resident #6 was not given a Wander Guard fob because she did not have wristbands and the resident required an order from the PCP for the fob. -The staff and the receptionist were keeping eyes on him and they were continuing the one-hour checks for him as of 05/01/24. -The PCP recommended a memory care unit for his level of care on 05/01/24. -She had not begun placement for him, nor had she activated the alarm for the front door. Telephone interview with Resident #6's PCP on 05/02/24 at 3:10pm revealed:	D 270		

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D 270	Continued From page 62 -Resident #6 had increased dementia and behaviors in the last few months and he needed a higher level of care. -Resident #6 had eloped the week before. -She was not told about the elopement when it happened. -She was made aware of the elopement on 05/01/24 and she signed a new FL-2 with a recommendation for a SNF with a [secured] memory care unit. -Elopement was a "red flag" and was an emergency situation. -Resident #6 needed to be immediately discharged to a memory care unit for his safety. -She was worried about him leaving and wandering onto the busy highway in front of the facility. -Technically Resident #6 should not have been at the facility after the new FL-2 was signed with the recommendation for a memory care unit. Observation of Resident #6 on 05/03/24 at 12:10pm revealed: -He was seated in the dining room with other residents. -He did not have a Wander Guard fob on a lanyard around his neck, wrist or ankles. Attempted telephone interview with a second MA on 05/01/24 at 5:02pm was unsuccessful. _____ The facility failed to provide supervision for a resident (#6) who was diagnosed with Alzheimer's disease, was intermittently disoriented, had increased confusion and eloped from the facility. The facility was located on a four-lane highway with heavy traffic. This failure resulted in serious neglect of Resident #6 and constitutes a Type A1 violation. _____	D 270		

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D 270	Continued From page 63 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/01/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care needs of 3 of 8 sampled residents (#1, #2, and #4) related to fingerstick blood sugar (FSBS) not being obtained with parameters and blood pressures checks with parameters (#1); a dental appointment for extraction of four teeth that was not scheduled (#2); and failure to notify the primary care provider (PCP) of multiple refusals of wearing TED hose (#4). The findings are: 1. Review of Resident #1's admission FL-2 dated 2/27/24 signed by the admitting physician revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD).	D 273		

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D 273	Continued From page 64 Review of the Resident Register revealed Resident #1 was admitted to the facility on 03/21/24. a. Review of Resident #1's signed physician orders dated 02/27/24 revealed: -There was an order for fingerstick blood sugar (FSBS) checks three times daily and at bedtime with specified ranges to administer or hold insulin based on the FSBS reading. -There was an order to administer Insulin Aspart 2 units (a rapid acting insulin to manage blood sugar) as needed (PRN) for a FSBS reading greater than 500. -There was an order to notify the Primary Care Provider (PCP) for FSBS readings less than 80 or greater than 500; if less than 80 give 6 ounces of orange juice, recheck in 15 minutes, and if less than 90, notify the PCP; if greater than 500 give an additional 3 units of Insulin Aspart and notify the PCP. -There was an order to administer glucose 4mg tablets 4 tablets four times daily PRN for a FSBS reading less than 70, repeat in 15 minutes; anytime FSBS reading was less than 60, notify the PCP; if FSBS reading less than 50 call Emergency Medical Services (EMS) while administering glucose tablets and notify the PCP. Review of Resident #1's signed physician orders dated 04/17/24 revealed: -There was an order to check FSBS prior to insulin administration. -There was an order to administer Insulin Aspart 2 units as needed (PRN) for a FSBS reading greater than 500. -There was an order to inject Insulin Aspart 2 units before meals for FSBS readings greater than 150. -There was an order to administer glucose 4mg	D 273		

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tablets 4 tablets four times daily PRN for a FSBS reading less than 70, repeat in 15 minutes; anytime FSBS reading was less than 60, notify the PCP; if FSBS reading less than 50 EMS while administering glucose tablets and notify the PCP.

Review of Resident #1's FSBS log on 05/01/24 at 9:12am revealed:
-The Resident Care coordinator obtained the FSBS readings from Resident #1's glucometer.
-Resident #1's FSBS was checked 40 out of 108 opportunities from 03/21/24 to 04/16/24.
-The FSBS ranges from 03/21/24 to 04/16/24 were from 56 to 487.
-Resident #1's FSBS was checked 26 out of 42 opportunities from 04/17/24 to 04/30/24.
-The FSBS ranges from 04/17/24 to 04/30/24 were from 53 to 252.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed:
-There was no entry for FSBS checks three times daily and at bedtime.
-There was no documentation FSBS checks were done three times daily and at bedtime from 04/01/24 to 04/16/24.
-There was no entry for FSBS checks three times daily before insulin administration.
-There was no documentation FSBS checks were done three times daily before insulin administration from 04/17/24 to 04/30/24.

Review of the FSBS log on 05/01/24 at 9:12am revealed:
-Resident #1's FSBS was checked 40 out of 108 opportunities from 03/21/24 to 04/16/24.
-The FSBS ranges from 03/21/24 to 04/16/24 were from 56 to 487.

Based on interviews and record reviews the

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facility staff was unable to determine if additional insulin or glucose tablets were to be administered to Resident #1 and if the PCP needed to be notified based on ordered FSBS parameters because the FSBS readings were not obtained as ordered before meals and at bedtime.

Interview with a medication aide (MA) on 05/03/24 at 11:38am revealed:
-Resident #1 did not have an order for FSBS checks on the eMAR.
-The Supervisor instructed her to check her FSBS readings with each medication pass.
-She checked Resident #1's FSBS readings with each medication pass twice daily on the days that she worked.
-She did not document the FSBS readings anywhere because there was nowhere to document them since there was no entry on the eMAR.
-The Supervisor instructed her to let the Supervisor or RCC know if the FSBS was "out of range.
-She considered below 70 and greater than 180 out of range.
-She would let the Supervisor and RCC know if the FSBS readings were less than 70 or greater than 180 but she did not document it anywhere.
-The Supervisor and RCC was responsible for notifying the PCP.

Telephone interview with another MA on 05/03/24 at 5:01pm revealed:
-Resident #1 did not have an order on the eMAR to check her FSBS.
-She administered Resident #1's scheduled insulin as ordered but she did not administer the PRN insulin because she did not check the FSBS.

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D 273	Continued From page 67 Interview with the PCP on 05/02/24 at 2:31pm revealed: -Resident #1 was a diabetic. -She did not realize Resident #1's FSBS checks were not being done as ordered. -Resident #1 had several insulin orders where the insulin should be administered based on the FSBS reading. -The FSBS checks would assist in monitoring Resident #1's glucose and regulating her insulin. -She was concerned Resident's blood sugar would drop and have another hypoglycemic episode. -She was notified on 04/03/24 of Resident #1's having a low FSBS reading and she wrote an order to decrease Resident #1's Insulin Aspart. -She expected to be notified if Resident #1's FSBS reading was less than 70 or greater than 400. -She was informed of FSBS readings outside the set parameters when she visited the facility, not when the FSBS readings was obtained. Interview with a Supervisor on 05/03/24 at 12:35pm revealed: -She did not know Resident #1 had an order for FSBS checks when she was admitted to the facility. -The pharmacy should have entered the FSBS checks on the eMAR. -The MAs would check Resident #1's FSBS if she was confused or "out of it." Interview with the Resident Care Coordinator (RCC) on 04/30/24 at 4:42pm revealed: -She would notify the PCP of a FSBS outside of the ordered parameters if she was notified by the MA or Supervisor the FSBS was outside the orderd parameters. -The FSBS readings for Resident #1 should be	D 273		

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recorded on the eMAR.
-She did not know there was no entry on Resident #1's eMAR to check FSBS.
-She thought Resident #1 had an order for FSBS checks.
-The pharmacy should have entered the FSBS check on the eMAR.
-If the staff was not checking Resident #1's FSBS, they would not know whether to administer the insulin or to administer additional insulin.

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-The PCP should be notified of Resident #1's FSBS readings in order to manage Resident #1's medications for her FSBS.
-She was concerned Resident #1's FSBS were not checked as ordered by the PCP.
-The MAs would not be able to determine if an extra dose of insulin was needed if the FSBS was not checked.
-The MAs would not know to hold the insulin if the FSBS was too low.
-She expected the RCC to verify pharmacy order entries so the information would be on the eMAR for the MAs.

b. Review of Resident #1's signed physician orders dated 02/27/24 revealed:
-There was an order for weekly blood pressure checks.
-There was an order to notify the PCP if the systolic blood pressure (SBP) was greater than 190 or less than 90 and if the diastolic blood pressure (DBP) was greater than 110 or less than 50.

Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed:
-There was no entry for weekly blood pressure

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checks.
-There was no documentation of weekly blood pressure checks.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed:
-There was no entry for weekly blood pressure checks.
-There was no documentation of weekly blood pressure checks.

Review of Resident #1's record revealed:
-There was a blood pressure reading on the admission assessment of 164/84 dated 03/21/24.
-There was a blood pressure reading of 178/90 dated 04/10/24.

Observation of Resident #1's blood pressure being taken at the request of the surveyor on 05/02/24 at 9:12am revealed Resident #1's blood pressure reading was 183/97.

Based on interviews and record reviews the facility staff was unable to determine if the PCP needed to be notified based on ordered blood pressure ranges.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed:
-The pharmacy staff was not responsible for entering blood pressure readings onto the eMAR.
-Blood pressure checks were considered a medical entry and should be done by the facility staff.

Interview with the PCP on 05/02/24 at 2:31pm revealed:
-Resident #1 had a history of strokes.
-She did not realize Resident #1's blood pressure

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was not being checked weekly as ordered.
-She expected the facility staff to follow orders as written and if there were questions to notify her.
-Resident #1's was at a higher risk for having another stroke because of her history of strokes.
-The weekly blood pressure checks would assist in monitoring Resident #1's blood pressure and managing medications.
-She expected to be notified if Resident #1's blood pressure reading was elevated.

Interview with Resident #1 on 05/02/24 at 8:37am revealed:
-Her blood pressure was taken every week at the previous facility, and she took several medications for her blood pressure.
-Her blood pressure had only been checked a couple of times since she was admitted to this facility.

Interview with the MA on 05/02/24 at 11:24am revealed:
-Resident #1 did not have an order for weekly blood pressure readings.
-Resident #1's blood pressure was checked the first weekend of the month unless otherwise ordered.
-She did not tell her Supervisor or the RCC that Resident #1's blood pressure reading was 183/97 this morning.
-She did not notify the PCP of Resident #1's blood pressure reading this morning.
-She should have told the RCC Resident #1's blood pressure was elevated.

Interview with a Supervisor on 05/03/24 at 12:35pm revealed:
-Resident #1's blood pressure was checked monthly.
-If a resident did not have an order for a blood

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pressure check, the blood pressure was checked monthly.
-She did not know Resident #1 had an order for weekly blood pressure checks when she was admitted to the facility.
-The pharmacy should have entered the weekly blood pressure checks on the eMAR.

Interview with the RCC on 05/02/24 at 11:39am revealed:
-The facility routinely checked a resident's blood pressure on admission and monthly unless otherwise ordered.
-If a new admission had an order for weekly blood pressure checks, the pharmacy should enter the order on the eMAR.
-She did not know Resident #1 had an order for weekly blood pressures.
-All blood pressure orders should be placed on the eMAR so the staff would know when to obtain the blood pressure.
-Since Resident #1 did not have an entry on her eMAR for weekly blood pressure checks, her blood pressure would have been checked monthly on the first weekend of the month.
-She was not aware Resident #1's blood pressure was elevated this morning.
-She would have expected the MA to have told her Resident #1 had an elevated blood pressure.
-The MA did not report Resident #1's elevated blood pressure reading of 183/97 to her.
-The order for weekly blood pressure checks with parameters was not on the eMAR so the MA would not have known to notify the PCP that Resident #1's blood pressure was elevated.

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-She expected all orders to be entered on the eMAR and verified by the RCC for accuracy.

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D 273	Continued From page 72 -The PCP wanted to be notified of blood pressures outside of the ordered parameters. -She would have expected the staff to notify the PCP as ordered. 2. Review of Resident #2's current FL-2 dated 11/22/23 revealed diagnoses of dementia without behavioral disturbances, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), and oxygen dependency. Review of Resident #2's dental appointment dated 04/11/24 revealed: -Resident #1 had dental x-rays taken on 04/11/24. -He had an order for a referral to a surgical Dental clinic to schedule extractions. -After extractions, he was to return to the local Dentist office for fillings. Interview with Resident #2 on 05/02/24 at 8:15am revealed: -He saw the Dentist a few weeks ago because his teeth were hurting. -He was supposed to go to a clinic and have some teeth pulled, but he had not been yet. -He did not know when he was supposed to go to have his teeth pulled. -He did not have any mouth or tooth pain today. Telephone interview with a staff from the local Dentist office on 05/03/24 at 1:50pm revealed: -Resident #2 was seen on 04/11/24 for tooth pain. -He was referred to a surgical dental clinic to have 4 teeth extracted because of decay. -Resident #2 could possibly have a problem with infection if the decayed teeth were not removed. -The referral order was given to the transporter to take to the facility. -The facility was responsible for scheduling the tooth extraction.	D 273		

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D 273	Continued From page 73 Telephone interview with a staff from the surgical Dental clinic on 05/02/24 at 3:29pm revealed: -Resident #2 did not have an appointment with the clinic to have 4 teeth extracted. -Resident #2 had never been seen in the surgical Dental clinic. Telephone interview with the transportation staff on 05/03/23 at 2:58pm revealed: -She transported residents to and from appointments. -She transported Resident #2 to the local dentist office on 4/11/24. -She gave the receptionist a manila folder with Resident #2's information. -The Dentist would place any papers that needed to be returned to the facility in the manila folder. -She did not know if the Dentist placed anything in Resident #2's folder. -When she returned to the facility, she placed the manila folder inside Resident #2's record and left it on the desk at the nurse's station for the MA to review for any changes. -She did not look in the manila folder; she only transported the residents. -There was an appointment book on the desk of the nurse's station with scheduled appointments. -After the appointment was scheduled, the RCC or Administrator would write in the appointment book when the appointment was scheduled. -She would check the appointment book daily. Interview with a medication aide (MA) on 05/03/24 at 1:15pm revealed: -When a resident returned from an appointment the paperwork was laid across the resident's record. -The Supervisor or the Resident Care Coordinator (RCC) would review the paperwork	D 273		

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for changes.
-The RCC was responsible for making appointments for residents.

Interview with a Supervisor on 05/03/24 at 3:35pm revealed the RCC was responsible for reviewing resident's information when the resident returned from an appointment.
3. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension, chronic constipation, mild cognitive impairment, and anemia.

Review of Resident #4's physician's order dated 11/15/23 revealed an order for thrombo-embolic deterrent (TED) hose (stockings that help swelling and blood clots in the legs) apply every morning and remove at bedtime.

Review of Resident #4's electronic medication administration record (eMAR) for February 2024 revealed:
-There was an entry for TED hose apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 8:00pm.
-There was documentation Resident #4's TED hose were not applied for 4 of 29 opportunities on 02/04/24, on 02/17/24, on 02/18/24, and on 02/19/24.
-The reason documented for Resident #4's TED hose not being applied was resident refused.

Review of Resident #4's eMAR for March 2024 revealed:
-There was an entry for TED hose apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 8:00pm.
-There was documentation Resident #4's TED hose were not applied for 18 of 31 opportunities on 03/08/24, on 03/09/24, on 03/11/24, on

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D 273	Continued From page 75 03/12/24,on 03/13/24, on 03/15/24, on 03/16/24, on 03/17/24, on 03/18/24, on 03/19/24, on 03/21/24, on 03/22/24, on 03/23/24, on 03/24/24, on 03/26/24, on 03/27/24, on 03/30/24, and on 03/31/24. -The reason documented for Resident #4's TED hose not being applied was resident refused. Review of Resident #4's eMAR for April 2024 revealed: -There was an entry for TED hose apply every morning and remove at bedtime scheduled to be applied at 6:00am and removed at 8:00pm. -There was documentation Resident #4's TED hose were not applied for 13 of 30 opportunities on 04/01/24, from 04/03/24 to 04/05/24, on 04/09/24, on 04/10/24, from 04/19/24 to 04/22/24, and from 04/27/24 to 04/29/24. -The reason documented for Resident #4's TED hose not being applied was resident refused. Interview with a medication aide (MA) on 04/30/24 at 4:30pm revealed: -Resident #4 was supposed to wear ted hose daily but she did not wear them daily. -She encouraged Resident #4 to apply TED hose when she noticed the resident was not wearing TED hose and documented refusals on the eMAR. -She reported to the Supervisor when Resident #4 was seen not wearing TED hose. -The Supervisor was responsible for notifying the primary care provider (PCP) of refusals. Interview with another MA on 05/01/24 at 9:50am revealed: -The PCAs were responsible for applying TED hose in the morning and to make the MA aware if Resident #4 refused to wear TED hose. -She documented on the eMAR when Resident	D 273		

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#4 did not wear TED hose.
-The MAs were responsible for notifying the PCP of refusals.
-The MAs put charting notes in a folder for the PCP to review documentation for refusals.

Interview with Resident #4's PCP on 05/01/24 12:05pm revealed:
-The facility did not make her aware Resident #4 refused to wear TED hose as ordered.
-She used to receive notifications from the facility of refusals, but she had not received any lately.
-It was important for the facility to let her know that Resident #4 was refusing to wear TED hose because it could cause increased swelling in the resident's legs.
-She would have also evaluated the resident's legs and discontinued the TED hose if they were no longer needed.
-The PCP expected the facility to have Resident #4's TED hose available and applied and removed daily as ordered.
-She expected the facility to notify her every time Resident #4 refused to wear TED hose.

Interview with Resident #4 on 05/01/24 at 4:00pm revealed:
-She did not want to wear her TED hose, because they were too loose on her legs.
-Staff asked her to put them on, but she did not always apply them.

Interview with a Supervisor on 05/02/24 at 2:34pm revealed:
-The PCAs should ensure TED hose were worn and report refusals to the MA.
-The MAs documented refusals on the eMAR and reported refusals to the PCP.

Interview with Resident #4's family member on

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D 273	Continued From page 77 04/30/24 at 6:00pm revealed: -He was aware Resident #4 refused to wear her TED hose regularly. -The facility did not report when Resident #4 refused to wear TED hose. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm revealed: -She was aware Resident #4 did not wear TED hose regularly. -The Supervisors should have encouraged Resident #4 to wear TED hose. -The MAs and Supervisors should document refusals on the eMAR and document in the charting notes. -The MAs and Supervisors were responsible for putting a copy of the charting note in a folder to be reviewed by the PCP. Interview with the Administrator on 05/02/24 at 11:27am revealed: -She was unaware Resident #4 refused to wear TED hose. -The Supervisors, MAs, and the RCC were responsible for notifying the PCP that Resident #4 was refusing to wear TED hose. -Staff should document refusals on charting notes and put a copy in the PCP's folder for review. _____ The facility failed to ensure referral and follow-up with the PCP for a resident (#1) who was a diabetic, had FSBS readings outside the parameters resulting in the resident having a hypoglycemic episode with an Emergency Department visit, and had orders for weekly blood pressure checks with ordered parameters and a history of strokes. The facility failed to schedule an appointment with a dental surgeon for teeth extraction for a resident (#2) resulting in the resident having pain and risk for infection due to	D 273		

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D 273	Continued From page 78 tooth decay. This failure placed the residents at substantial risk for physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 2 of 3 sampled residents (#1, #3) related to daily application and removal of thrombo-embolic deterrent (TED) hose (#3) and weekly blood pressure checks and fingerstick blood sugar (FSBS) checks (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 01/03/24 revealed:	D 276		

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-Diagnoses included essential hypertension, diabetes mellitus two, chronic kidney disease, history of cerebral vascular accident (CVA), and spasticity.
-There was documentation Resident #3 was semi-ambulatory.

Review of Resident #3's physician's order dated 04/10/24 revealed:
-There was an order to start thrombo-embolic deterrent (TED) hose (used to prevent swelling and blood clots in the legs); apply to bilateral lower extremities daily at 8:00am and to remove daily at 8:00pm.
-There was a copy of the physician's order with highlighted handwriting in the margin; "please get TED hose measurement"and "right [calf and thigh] and left [calf and thigh]" measurements.

Review of Resident #3's physician's after visit report dated 04/18/24 revealed there was documentation Resident #3's bilateral venous ulcers had healed, and he was awaiting compression stockings [TED hose].

Review of Resident #3's April 2024 Home Health Nurse's notes revealed:
-On 04/09/24, his wounds had healed 99%.
-Resident #3 needed an order for daily TED hose.
-On 04/12/24, Resident #3's wounds had healed 100% and he was discharged from Home Health.
-Resident #3's primary care provider (PCP) had ordered TED hose to be applied daily.

Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for TED hose with the directions in the description box to apply to bilateral lower extremities at 8:00am and remove

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at 8:00pm.
-There was a line for documentation of application of TED hose scheduled at 6:00am.
-There was no line for documenting the removal of the TED hose and there were no other entries on the eMAR for TED hose removal.
-There was nothing documented from 04/10/24 to 04/19/24.
-Resident #3's TED hose were documented as not applied from 04/19/24 to 04/25/24 due to "left leg weeping".

Observations of Resident #3 on 04/30/24 at 11:30am and 1:04pm revealed:
-Resident #3 was sitting in his wheelchair.
-He had a TED hose on his right leg.
-He did not have a TED hose on his left leg.
-His left leg was swollen with open areas where skin was missing and were weeping including a large dried yellowish area on the outside of his calf from his ankle to his knee.

Observation of Resident #3 on 05/01/24 at 11:55am revealed he only had his TED hose on his right leg and not on his left leg.

Observation of Resident #3 on 05/02/24 at 11:45am revealed:
-Resident #3 was in a wheelchair in his room.
-He had one TED hose on his right leg.
-His left leg was swollen with open areas where skin was missing and were weeping including a large dried yellowish area on the outside of his calf from his ankle to his knee.

Interview with Resident #3 on 05/02/24 at 11:45am revealed:
-He had an order for TED hose because he had swelling in his lower legs.
-He had previous wounds on his legs that were

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taken care of by a wound nurse from a home health agency.
-Once the wounds were healed, he needed to begin wearing his TED hose again; he needed the compression to keep wounds from developing on his legs.
-If he did not wear TED hose his legs would begin to swell again and the slightest scratch would cause them to weep.
-Once his legs would begin to weep, he would develop "sores" [wounds] and would have to be treated with antibiotics and have a wound nurse wrap his legs again.
-He had muscle spasms and could not elevate his legs due to the spasms, so the TED hose were the "key" to preventing wounds.
-Sometimes the weeping would be caused when his legs thrashed around during a spasm.
-He currently had weeping and the start of a wound on his left leg because he had to wait for a pair of TED hose to be ordered and the weeping began before he got the pair of TED hose.
-About two or three weeks ago the wound nurse had told him to begin wearing his TED hose because his leg wounds had completely healed.
-He had an old pair of TED hose but could only find one, so the wound nurse told him to apply it to his right leg and she would request an order for a new pair.
-He knew from experience he could only go for seven to ten days without the TED hose before he was at risk of his legs weeping and wounds developing.
-He waited for someone to measure him for the new pair of TED hose, but no one did so no stockings [TED hose] were ordered.
-He got a new pair of TED hose about a week ago, but it was too late and now he had new wounds on his left leg.
- "I should have had my new TED hose right away

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D 276	Continued From page 82 and I would not have had any issues." Telephone interview with the pharmacist from the facility's contracted pharmacy on 05/01/24 at 8:56am revealed: -On 04/10/24, the pharmacy received an order for Resident #3 for TED hose. -There were no measurements for the TED hose on the order. -The pharmacy contacted the facility's receptionist and requested Resident #3 be measured for his TED hose. -The receptionist told the pharmacy she would send the measurement the next day, 04/11/24. -On 04/12/24, the pharmacy contacted the facility again to request measurements for Resident #3's TED hose and were told the measurements would be taken that day. -On 04/16/24, the pharmacy received the measurements for Resident #3's TED hose. -On 04/17/24, the pharmacy sent the TED hose to the facility. -The pharmacy could not provide the TED hose for Resident #3 until he was measured because TED hose were specific to each resident. -Separate measurements needed to be taken on Resident #3's right and left leg from the widest part of the calf and from the floor to the knee for each leg. -The facility entered the order on the eMAR to apply and remove the TED hose daily. Telephone interview with Resident #3's Home Health Wound Nurse on 05/04/24 at 8:59am revealed: -She treated and wrapped Resident #3's wounds on his legs; she did not have her computer so she could not recall any dates. -His wounds on his legs had healed so he was going to be discharged from Home Health.	D 276		

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-He only had one TED hose, so she requested Resident #3's PCP order TED hose for him.
-The compression was needed on his leg to prevent swelling and future wounds.
-He needed the TED hose for compression because he could not elevate his feet and legs due to muscle spasms.
-The compression from the TED hose on his legs would keep the swelling down and once the swelling would begin then he would get blisters and ulcers again.
-It was difficult to say how exactly how long he could go without TED hose before he would develop wounds again but 8 to 10 days without them would be long enough for wounds to develop.

Telephone interview with Resident #3's PCP on 05/02/24 at 3:10pm revealed:
-On 04/09/24 the wound nurse from the home health agency had left a request to order TED hose for Resident #3.
-The PCP ordered TED hose for Resident #3 twice; once on 04/10/24 and again on 04/17/24.
-When she visited Resident #3 on 04/17/24 he only had one TED hose and it was on his right leg; she did not recall the condition of his left leg.
-On 04/17/24 he had not been measured for TED hose, so she left a second order with the facility to measure and order the TED hose.
-The signing physician from the PCP's office visited Resident #3 on 04/18/24 and he also requested Resident #3 be measured and TED hose ordered.
-The PCP visited Resident #3 on 04/24/24 and he only had one TED hose on; he did not have a TED hose on his left leg.
-Resident #3 was admitted to the facility with severe leg wounds on both legs.
-He had been on several rounds of antibiotic

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treatments and was cared for by a Wound Nurse to treat his wounds.
-The compression from the TED hose would have helped to prevent weeping and future wounds.
-Resident #3 could not have a TED hose applied to his left leg possibly because of the weeping.

Telephone interview with the facility's receptionist on 05/03/24 at 2:31pm revealed:
-She did not remember a call from the pharmacy about measuring for Resident #3's TED hose.
-She walked around with the PCP when she did rounds about a week ago and she recalled Resident #3 asking the PCP about his TED hose.
-The PCP told Resident #3 she had written an order the week before.
-When the PCP wrote new orders for the residents the PCP would give her a copy.
-She was responsible for telling the medication aides (MA) about the orders; she set the orders out for the MAs to send to the pharmacy.
-There was a check list for the MAs to sign off on once the order was sent to the pharmacy.
-The MAs measured the residents for TED hose and the MAs entered the order into the eMAR.
-She did not recall the first order for TED hose for Resident #3.
-Once the PCP told her about the second order, she told a MA, but she did not recall who she told.
-She did not follow-up on the order for Resident #3's TED hose.

Interview with a MA on 05/03/24 at 1:30pm revealed:
-The night shift MAs applied the residents' TED hose before they left for the day and removed them in the evening.
-The Supervisor or the Resident Care Coordinator (RCC) were the only ones who measured the residents for TED hose.

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D 276	Continued From page 85 -Resident #3 had a TED hose on one of his legs but she could not recall which one. Interview with the Supervisor on 05/03/24 at 5:30pm revealed: -The MA measured residents for TED hose; she did not measure because she did not know how. -She did not know who measured Resident #3 for his TED hose. -The PCP would give the order for the TED hose to the RCC. -After the MA measured the resident for their TED hose, the MA sent the order and the measurements to the pharmacy. -The pharmacy entered the order to apply and remove the TED hose on the eMAR. -She did not monitor the order to see if it was filled; she thought the RCC was responsible for ensuring the order was completed. Interview with the RCC on 05/03/24 at 2:08pm revealed: -She did not measure residents for TED hose, the MAs or the Supervisor were responsible for measuring. -Then the MA or the Supervisor would give the order for the TED hose with the measurements to the pharmacy. -The MA or the Supervisor were responsible for ordering residents' TED hose and ensuring the TED hose were delivered by the pharmacy. -To her knowledge Resident #3 did not have any delays in getting his TED hose measured and ordered. -The Supervisor was responsible for monitoring the residents to make sure their TED hose were applied, not removed during the day and removed at bedtime. -She was not aware he had weeping and wounds again.	D 276		

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-The Wound Nurse told her Resident #3 would always have wounds because he could not keep his legs up [elevated].
-There was a morning and evening entry on the eMAR for the MAs to document application and removal of TED hose.
-The MAs applied and removed the residents TED hose and monitored them during the day to make sure they were still on the residents.
-She did not monitor the eMAR or spot check the residents to ensure they were wearing their TED hose.

Interview with the Administrator on 05/03/24 at 4:45pm revealed:
-She did not know who was responsible for measuring residents for TED hose.
-She was not familiar with the process to ensure residents TED hose were measured and ordered.
-She was not told about the delay in ordering Resident #3's TED hose so she did not know anything about them.
-The Supervisor and the RCC should have been communicating to ensure Resident #3's TED hose were ordered when the PCP wrote the order.
-The management team including the Administrator, the RCC and the Supervisor met three times a week at stand-up meeting to discuss items like issues with orders.
-The order for Resident #3's TED hose should have been followed by the RCC to make sure he was measured, and they were ordered.
-The delay in the order being filled explained why his legs were weeping again.
-She expected the process of measuring and sending the order to the pharmacy to have been followed.
2. Review of Resident #1's admission FL-2 dated 2/27/24 signed by the admitting physician

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revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD).

Review of the Resident Register revealed Resident #1 was admitted to the facility on 03/21/24.

a. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for FSBS checks three times daily and at bedtime, notify the PCP for FSBS less than 80 or greater than 500. If the FSBS reading was less than 80 give 6 ounces of orange juice and recheck in 1 hour. If the FSBS reading recheck was less than 90, notify the PCP.

Review of Resident #1's signed physician orders dated 04/17/24 revealed an order for FSBS checks three times daily prior to insulin injection.

Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/21/24 to 03/31/24 revealed:
-There was no entry for FSBS checks three times daily and at bedtime.
-There was no documentation FSBS checks were done three times daily and at bedtime from 03/21/24 to 03/31/24.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/30/24 revealed:
-There was no entry for FSBS checks three times daily and at bedtime.
-There was no documentation FSBS checks were done three times daily and at bedtime from 04/01/24 to 04/16/24.
-There was no entry for FSBS checks to be done three times daily prior to insulin administration

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-There was no documentation FSBS checks were done three times daily prior to insulin administration from 04/17/24 to 04/30/24.

Review of Resident #1's FSBS log on 05/01/24 at 9:12am revealed:
-The Resident Care coordinator obtained the FSBS readings from Resident #1's glucometer.
-Resident #1's FSBS was checked 40 out of 108 opportunities from 03/21/24 to 04/16/24.
-The FSBS ranges from 03/21/24 to 04/16/24 were from 56 to 487.
-Resident #1's FSBS was checked 26 out of 42 opportunities from 04/17/24 to 04/30/24.
-The FSBS ranges from 04/17/24 to 04/30/24 were from 53 to 252.

Interview with the Resident #1 on 04/30/24 at 8:57am revealed:
-The staff did not check her FSBS very often.
-Sometimes they checked her FSBS before meals, sometimes after meals, and sometimes not at all.
-Her FSBS was not checked with meals and at bedtime at this facility.
-Her FSBS was not checked this morning before breakfast.
-She was administered insulin this morning before breakfast, but she was not sure which insulin she received.
-At the previous facility the staff obtained FSBS checks with meals and at bedtime.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed:
-The order for Resident #1's FSBS checks was on the signed physicians orders dated 02/27/24.
-Since there was no order for test strips for Resident #1, the pharmacy did not enter the order

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for FSBS three times daily and at bedtime on the eMAR.
-The pharmacy received an order and dispensed 50 glucometer test strips on 03/24/24.
-If there had been an order to check FSBS with the order for glucometer test strips, the order to check the FSBS would have been placed on the eMAR.
-Both orders, the FSBS checks and the glucometer test strips had to be ordered at the same time for the FSBS checks to be placed on the eMAR.
-The facility staff should have the ability to enter FSBS checks on the eMAR.

Interview with a Supervisor on 05/03/24 at 12:35pm revealed:
-She did not know Resident #1 had an order for FSBS checks when she was admitted to the facility.
-The pharmacy should have entered the FSBS checks on the eMAR.
-The medication aide (MA) would check Resident #1's FSBS if she was confused or "out of it."
-If Resident #1's blood sugar was low, she would be sent to the local Emergency Department (ED).

Interview with the RCC on 04/30/24 at 4:42pm revealed:
-She did not know there was no entry on Resident #1's eMAR to check FSBS.
-She was unable to locate FSBS readings for Resident #1.
-She would speak to the MA to see where the FSBS readings were documented.

A second Interview with the Resident Care Coordinator (RCC) on 05/01/24 at 9:10am revealed:
-She spoke with the MAs about the recordings of

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the FSBS readings.
-They were not recorded on the eMAR, or anywhere else.
-The FSBS readings were on the glucometer.
-She went through the glucometer and documented the FSBS readings from the glucometer onto a form for review.
-She did not know Resident #1's FSBS readings were not being checked as ordered.

Interview with Resident #1 on 05/02/24 at 8:37am revealed:
-Her FSBS had not been checked this morning and she had not received any insulin.
-Her FSBS was checked twice yesterday, 05/01/24.
-Her FSBS was not checked three times on Tuesday, 04/30/24, after breakfast and lunch and before dinner.

Interview with the Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed:
-Resident #1 was a diabetic.
-She did not realize Resident #1's FSBS checks were not being checked as ordered.
-She had several insulin orders where the insulin should be administered based on the FSBS reading.
-The FSBS checks would assist in monitoring Resident #1's glucose and regulating her insulin.
-She expected the facility staff to follow orders as written and if there were questions to notify her.

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-The pharmacy should have entered the order for the FSBS checks.
-Once the orders were entered the RCC should have verified the orders entered matched the orders on the FL-2 and physician orders.

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D 276	Continued From page 91 -If they did not match, the RCC should call the pharmacy and find out why the order was not entered. -She expected medication cart audits to be done weekly by the RCC. b. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for weekly blood pressure checks. Notify the PCP if the systolic blood pressure (SBP) reading was greater than 190 and if the diastolic blood pressure (DBP) reading was greater than 110. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was no entry for weekly blood pressure checks. -There was no documentation of weekly blood pressure checks. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for weekly blood pressure checks. -There was no documentation of weekly blood pressure checks. Review of Resident #1's record revealed: -There was a blood pressure reading on the admission assessment of 164/84 dated 03/21/24. -There was monthly blood pressure reading of 178/90 dated 04/10/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed: -The pharmacy staff was not responsible for entering blood pressure readings onto the eMAR. -Blood pressure checks were considered a	D 276		

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medical entry and should be done by the facility staff.

Interview with Resident #1 on 05/02/24 at 8:37am revealed:
-Her blood pressure was taken every week at the previous facility, and she took several medications for her blood pressure.
-Her blood pressure had only been checked a couple of times since she was admitted to this facility.

Observation of Resident #1's blood pressure being taken at the request of the surveyor on 05/02/24 at 9:12am revealed Resident #1's blood pressure reading was 183/97.

Observation of Resident #1's blood pressure being taken at the request of the surveyor on 05/02/24 at 10:50am revealed Resident #1's blood pressure reading was 158/85.

Interview with a MA on 05/02/24 at 11:24am revealed:
-Resident #1 did not have an order for weekly blood pressure readings.
-Resident's blood pressure was checked the first weekend of the month unless otherwise ordered.
-She did not tell her Supervisor or the RCC that Resident #1's blood pressure reading was 183/97 this morning.
-She did not notify the PCP of Resident #1's blood pressure reading this morning.
-She told the RCC what Resident #1's blood pressure reading was when it was rechecked.
-Resident #1 took one medication for her blood pressure and that was amlodipine (used to treat elevated blood pressure).

Interview with a Supervisor on 05/03/24 at

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D 276	Continued From page 93 12:35pm revealed: -She did not know Resident #1 had an order for weekly blood pressure checks when she was admitted to the facility. -The pharmacy should have entered the weekly blood pressure checks on the eMAR. -The facility would check every resident's blood pressure monthly and record the findings. -Resident #1 had her blood pressure checked a few weeks ago. Interview with the RCC on 05/02/24 at 11:39am revealed: -The facility routinely checked a resident's blood pressure on admission and monthly unless otherwise ordered. -If a new admission had an order for weekly blood pressure checks, the pharmacy should enter the order on the eMAR. -She did not know Resident #1 had an order for weekly blood pressures. -The Supervisor who approved the orders entered by the pharmacy should have noticed the weekly blood pressure was not on the eMAR and notified the pharmacy. -All blood pressure orders were placed on the eMAR so the staff would know when to obtain a blood pressure. -Since Resident #1 did not have an entry on her eMAR for weekly blood pressure checks, her blood pressure would have been checked monthly on the first weekend of the month. -She could have entered the weekly blood pressure check on Resident #1's eMAR if the Supervisor who approved the orders had told her about the order for weekly blood pressure checks was not on the eMAR. -She was not aware Resident #1's blood pressure was elevated this morning. -She would have expected the MA to have told	D 276		

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her Resident #1 had an elevated blood pressure.
-The MA did not report Resident #1's elevated blood pressure reading of 183/97 to her.

Interview with the PCP on 05/02/24 at 2:31pm revealed:
-Resident #1 had a history of strokes.
-She did not realize Resident #1's blood pressure was not being checked weekly as ordered.
-She expected the facility staff to follow orders as written and if there were questions to notify her.
-Resident #1's was at a higher risk for having another stroke because of her history of strokes.
-The weekly blood pressure checks would assist in monitoring Resident #1's blood pressure.

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-The pharmacy should have entered the order for the blood pressure checks on the eMAR.
-Once the orders were entered the RCC should have verified the orders entered matched the orders on the FL-2 and physician orders.
-If they did not match, the RCC should call the pharmacy and find out why the order was not entered.
-She expected medication cart audits to be done weekly by the RCC.

_____

The facility failed to ensure physicians' order were implemented for a resident (#3) who had swelling, wounds and weeping areas on his legs as a result of the facility's failure to order thrombo-embolic deterrent (TED) hose; for a resident (#1) who was a diabetic, had orders for fingerstick blood sugar (FSBS) checks three times a day and at bedtime with FSBS parameters to administer additional insulin or glucose tablets depending on the FSBS results that were not obtained as ordered; and for

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D 276	Continued From page 95 resident (#1) with a history of strokes who had orders for blood pressure checks weekly which were not obtained.This failure resulted in serious neglect to Resident #3 and Resident #1 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/02/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 276		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing	D 278		

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D 278	Continued From page 96 wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative	D 278		

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D 278	Continued From page 97 treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, reviews and interviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by a LHPS nurse for 5 of 5 sampled residents (#1, #2, #3, #4, #6) who had tasks including fingerstick blood sugar checks (FSBS) and insulin injection (#1), oxygen administration and a nebulizer (#2), ambulation with a wheelchair, assistance with transfers to a wheelchair, application and removal of thrombo-embolic deterrent (TED) hose (#3), application and removal of thrombo-embolic deterrent (TED) hose (#4), and daily FSBS checks (#6). The findings are: A request was made for LHPS evaluations for Residents #1, #2, #3, #4 and #6 but was not provided prior to exit on 05/03/24.	D 278		

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D 278	Continued From page 98 1. Review of Resident #1's current FL-2 dated 2/27/24 revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD). Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/21/24. a. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for fingerstick blood sugars (FSBS) three times daily and at bedtime. Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/21/24 to 03/31/23 revealed: -There was no entry for FSBS checks. -There was no documentation FSBS checks were obtained from 03/21/24 to 03/31/24. Review of Resident #1's glucometer revealed Resident #1's FSBS was obtained once to three times daily from 03/21/24 to 03/23/24, 03/25/24 to 03/31/24. Review of Resident #1's April 2024 eMAR revealed: -There was no entry for FSBS checks. -There was no documentation FSBS checks were obtained in April 2024. Review of Resident #1's glucometer revealed Resident #1's FSBS was obtained once to three times daily from 04/01/24 to 04/05/24, 04/08/24 to 04/30/24. Review of Resident #1's record revealed there	D 278		

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were no LHPS evaluations available for review.

Observation of Resident #1 on 05/02/24 at 9:04am revealed the medication aide (MA) entered Resident #1's room and obtained a FSBS.

b. Review of Resident #1's signed physician orders dated 02/27/24 there was an order for Tresiba insulin (a long-acting insulin) 30 units every morning and 56 units every evening.

Review of Resident #1's signed physician's order dated 04/03/24 revealed:
-There was an order to discontinue Tresiba insulin 56 units in the evening.
-There was an order to start Tresiba insulin 45 units at bedtime and hold bedtime insulin if FSBS was less than 120.

Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/21/24 to 03/31/23 revealed:
-There was an entry for Tresiba insulin 30 units every morning with a scheduled administration time of 6:00am.
-There was documentation Tresiba insulin 30 units was administered at 6:00am from 03/24/24 to 03/31/24.
-There was an entry for Tresiba insulin 56 units every morning with a scheduled administration time of 7:00pm to 11:00pm.
-There was documentation Tresiba insulin 56 units was administered from 03/24/24 to 03/29/24.
-There were exceptions from 03/30/24 to 03/31/24; the exception was the insulin was held due to a low blood sugar reading.

Review of Resident #1's April 2024 eMAR

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revealed:
-There was an entry for Tresiba insulin 30 units every morning with a scheduled administration time of 7:00am to 9:00am.
-There was documentation Tresiba insulin 30 units was administered from 04/01/24 to 04/09/24, from 04/19/24 to 04/20/24, from 04/26/24 to 04/27/24 and on 04/30/24.
-There were exceptions documented from 04/24/24 to 04/25/24 and 04/28/24 to 04/29/24: the exception was held due to PCP's order.
-There was no documentation that Tresiba 30 units was administered from 04/10/24 to 04/18/24 and from 04/20/24 to 04/23/24; the eMAR was blank.
-There was an entry for Tresiba 45 units at bedtime with a scheduled administration time between 7:00pm and 11:00pm.
-There was documentation Tresiba insulin 45 units was administered from 04/03/24 to 04/09/24 and from 04/18/24 to 04/22/24.
-There was no documentation on the eMAR from 04/10/24 to 04/17/24; the eMAR was blank.
-There was an entry for Tresiba insulin 56 units every morning with a scheduled administration time of 7:00pm to 11:00pm.
-The was documentation Tresiba insulin 56 units was administered from 04/24/24 to 04/25/24 and 04/27/24 to 04/28/24.
-There were exceptions documented on 04/26/24 and 04/29/24; the exceptions were documented as withheld by PCP's orders.
-There was no documentation on 04/23/24 and 04/30/24; the eMAR was blank.

Review of Resident #1's record revealed there were no LHPS evaluations available for review.

Observation of Resident #1's room on 05/02/24 at 9:10am revealed the MA entered Resident #1's

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room and administered insulin.

Interview with the Resident #1 on 04/30/24 at 8:57am revealed:
-She was diabetic and required FSBS checks and insulin.
-The staff obtained her FSBS once to three times daily.
-The staff administered insulin to her three times a day.

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

2. Review of Resident #2's current FL-2 dated 11/22/23 revealed diagnoses included dementia without behavioral disturbances, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), and oxygen dependency.

Review of Resident #2's Resident Register revealed Resident #1 was admitted to the facility on 11/22/23.

a. Review of Resident #2's signed physician orders dated 12/06/23 revealed there was an order for oxygen 2L/M continuously.

Review of Resident #2's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for oxygen 2L/M continuously with scheduled times of 12:00am to 6:59am, 7:00am to 2:59pm, and 3:00pm to 10:59pm; there was no scheduled time from 11:00pm to 11:59pm.

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D 278	Continued From page 102 -There was documentation Resident #2's oxygen was applied from 02/01/24 at 12:00am to 02/20/24 at 2:29pm, from 2/21/24 at 12:00am to 2:59pm, and from 02/22/24 at 12:00am to 02/29/24 at 10:59pm. -There were exceptions documented on 02/20/24 and 02/21/24 at 3:00pm to 10:59pm; the exception was Resident #2 was not wearing his oxygen. Review of Resident #2's March 2024 eMAR revealed: -There was an entry for oxygen 2L/M continuously with scheduled times of 12:00am to 6:59am, 7:00am to 2:59pm, and 3:00pm to 10:59pm. -There was documentation Resident #2's oxygen was applied from 03/01/24 to 03/31/24. Review of Resident #2's April 2024 eMAR revealed: -There was an entry for oxygen 2L/M continuously with scheduled times of 12:00am to 6:59am, 7:00am to 2:59pm, and 3:00pm to 10:59pm. -There was documentation Resident #2's oxygen was applied from 04/01/24 at 12:00am to 04/10/24 at 2:59pm, on 04/12/24 at 12:00am, and from 04/18/24 at 7:00am to 04/30/24 at 10:59pm. -There was no documentation Resident #2's oxygen was applied on 04/10/24 at 3:00pm to 04/11/24 at 10:59pm and from 04/12/24 at 7:00am to 04/18/24 at 6:59am; the eMAR was blank. Review of Resident #2's record revealed there were no LHPS evaluations available for review. b. Review of Resident #2's signed physician orders dated 12/06/23 revealed there was an	D 278		

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D 278	Continued From page 103 order for albuterol 2.5mg/3ml by nebulizer every 4 hours as needed for shortness of breath. Review of Resident #2's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours as needed for shortness of breath. -There was documentation albuterol 2.5mg/3ml was administered on 02/13/24. Review of Resident #2's March 2024 eMAR revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours as needed for shortness of breath. -There was no documentation albuterol 2.5mg/3ml was administered from 03/01/24 to 03/31/24. Review of Resident #2's April 2024 eMAR revealed: -There was an entry for albuterol 2.5mg/3ml by nebulizer every 4 hours as needed for shortness of breath. -There was no documentation albuterol 2.5mg/3ml was administered from 04/01/24 to 04/30/24. Review of Resident #2's record revealed there were no LHPS evaluations available for review. Observation of Resident #2 on 04/30/24 at 8:54am revealed Resident #2 was lying in bed wearing oxygen at 2L/M. Interview with Resident #2 on 04/30/24 at 8:54am revealed: -He wore his oxygen most of the time.	D 278		

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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 278	Continued From page 104 -He took his oxygen off to walk outside and sit on the front porch and to go to the dining room for lunch and dinner. Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful. Refer to the interview with the Administrator on 05/02/24 at 4:28pm. 3. Review of Resident #3's current FL-2 dated 01/03/24 revealed: -Diagnoses included essential hypertension, diabetes mellitus two, chronic kidney disease, history of cerebral vascular accident (CVA), and spasticity. -Resident #3 was semi-ambulatory. a. Review of Resident #3's care plan dated 01/03/24 revealed: -He required limited assistance with grooming. -He required extensive assistance with toileting, and ambulation. -He required total assistance with bathing, dressing and transfers. -He was ambulatory with the aid of a wheelchair. Review of Resident #3's LHPS evaluations dated 12/28/23 revealed: -LHPS tasks included assistance with transfers to his wheelchair and ambulated with the aid of a wheelchair. -There were no other LHPS evaluation for review. Observations of Resident #3 on 04/30/24 at 11:30am and 1:04pm revealed Resident #3 was sitting in his wheelchair. Interview with Resident #3 on 05/02/24 at 11:45am revealed:	D 278		

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D 278	Continued From page 105 -He used a wheelchair to move around because he did not have full use of his left leg from a stroke. -He could transfer from his reclining chair but needed help from the staff when he transferred from his bed. b. Review of Resident #3's physician's order dated 04/10/24 revealed there was an order to start thrombo-embolic deterrent (TED) hose; apply to bilateral lower extremities daily at 8:00am and to remove daily at 8:00pm. Review of Resident #3's LHPS evaluations dated 12/28/23 revealed there were no other LHPS evaluations for review. Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose apply to bilateral lower extremities at 8:00am and remove at 8:00pm. -There was documentation of the application of TED hose scheduled at 6:00am. -There no documention of the removal of the TED hose because there was no place to document the removal. Observations of Resident #3 on 04/30/24 at 11:30am and 1:04pm revealed: -He had a thrombo-embolic deterrent (TED) hose on his right leg. -He did not have a TED hose on his left leg. Interview with Resident #3 on 05/02/24 at 11:45am revealed: -He had an order for TED hose because he had swelling in his lower legs. -He only had on one TED hose because he had a	D 278		

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wound on his left leg.
-Staff applied and removed his TED hose every day.

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

4. Review of Resident #6's FL-2 dated 05/01/24 revealed:
-Diagnoses included late onset Alzheimer's disease with behaviors, type two diabetes, cirrhosis of the liver and subarachnoid hemorrhage.
-There was an order for finger stick blood sugar (FSBS) checks once daily.

Review of Resident #6's LHPS evaluation dated 12/28/23 revealed:
-He had a LHPS task of collecting and testing of FSBS.
-There were no other LHPS evaluation for review.

Review of Resident #6's February, March and April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for a FSBS once daily scheduled at 7:00am.
-There was documentation FSBS were obtained 28 of 29 opportunities in February 2024.
-There was documentation FSBS were obtained 31 of 31 opportunities in March 2024
-There was documentation FSBS were obtained 19 of 30 opportunities in April 2024

Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was

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D 278	Continued From page 107 unsuccessful. Refer to the interview with the Administrator on 05/02/24 at 4:28pm. 5. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension, chronic constipation, mild cognitive impairment, and anemia. Review of Resident #4's physician's order dated 11/15/23 revealed an order for thrombo-embolic deterrent (TED) hose (stocking that help swelling in the legs) apply every morning and remove at bedtime. Review of Resident #4's physician's order dated 11/15/23 revealed an order for TED hose (stocking that help swelling in the legs) apply every morning and remove at bedtime. Review of Resident #4's current LHPS Evaluation dated 07/26/23 revealed: -The resident's LHPS personal care tasks included applying and removing ted hoses. -There were no additional LHPS Evaluations for review. Interview with Resident #4 on 05/01/24 at 4:00pm revealed: -She had an order for TED hose because she had swelling in her legs. -She applied and removed her TED hose. Attempted interview on 05/03/24 at 1:41pm with facility's previous Nurse Consultant was unsuccessful. Refer to the interview with the Administrator on 05/02/24 at 4:28pm.	D 278		

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D 278	Continued From page 108 Interview with the Administrator on 05/02/24 at 4:28pm revealed: -The nurse consultant from the pharmacy was responsible for completing the LHPS assessments. -The BOM was responsible for notifying the Registered Nurse when LHPS assessments were due. The facility failed to ensure that residents who had Licensed Health Professional Support (LHPS) tasks of fingerstick blood sugar checks, insulin administration and applicaton of thrombo-embolic deterrent (TED) hose were assessed within 30 days of admission and quarterly, thereafter, by a Registered Nurse. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2024.	D 278		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service guidance for 2 of 5 sampled residents (#1 & #7) with physicians' orders for a restricted concentrated sweets (RCS) diet.

The findings are:

Observation of the kitchen on 04/30/24 at 11:35am revealed:
-There was a binder which contained the regular menus and the therapeutic diet menus.
-There was a week at a glance menu for the week of 04/29/24 to 05/05/24.
-The therapeutic menus did not have a restricted concentrated sweets (RCS) diet for staff guidance.
-The regular menu for the lunch meal on 04/30/24 included Grilled cheese, Brunswick stew, a roll and fruit cocktail.
-The regular menu for the lunch meal on 05/01/24 included fried chicken, red potatoes, green beans a roll and pudding.
-There was a resident diet list but Resident #7 was not on the list.

Observation of the storage areas and refrigerator in the kitchen on 05/02/24 at 7:54am revealed:
-There were regular cake mixes, gelatin mixes and pudding mixes.
-There were canned apples packed in water and canned fruit packed in extra light syrup.
-There was sliced wheat loaf bread.
-There was individual packets of sugar substitute.

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-There were no sugar free cake mixes, gelatin mixes or pudding mixes.

1. Review of Resident #1's current FL-2 dated 04/17/24 revealed:
-Diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD), acute kidney failure and iron deficiency.
-There was an order for a no added salt (NAS and a no concentrated sweets (NCS) diet.

Review of Resident #1's physicians diet order dated 04/30/24 revealed:
-Resident #1 was ordered a restricted concentrated sweets (RCS) diet.
-The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods.

Observation of the lunch meal on 04/30/24 from 11:55am to 12:18pm revealed:
-Resident #1 was served approximately one cup of pasta salad, a cup of potato salad, and a cup of macaroni salad, a 12 ounce (oz) bowl of cut fresh fruit and a half cup of fruit cocktail, and water.
-Resident #1 ate 100% of her meal.

Observation of the lunch meal on 05/01/24 at 11:45am revealed:
-Resident #1 was served a piece of fried chicken, a bowl of tomato soup, roasted red skin potatoes, green beans, a dinner roll and water.
-Resident #1 ate 75% of her chicken and soup, and 100% of the potatoes, green beans and dinner roll.

Based on observation of the lunch meals serviced

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D 296	Continued From page 111 on 04/03/24 and 05/01/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to the kitchen not having a therapeutic diet menu that included an RCS diet for staff guidance. Interview with Resident #1 on 04/30/24 at 12:05 revealed: -She did not have a physician's order for a specific diet including any diabetic diets. -She was diabetic. -She ate meat once in a while. -She was served the plate of food and asked if she wanted anything else. -sometimes she asked for something other than what was on the menu and sometimes she ate items from the salad bar. Telephone interview with Resident #1's primary care provider on 05/02/24 at 3:1pm revealed: -She had ordered Resident #1 a RCS diet because she was diabetic and her finger stick blood sugar (FSBS) results were up and down. -She had asked the facility why they did not have a regular diabetic diet for the residents who were diabetic. -She told the facility they needed an extreme carb control diet to control the amount of sugars and carbohydrates the diabetic residents ate. -Resident #1 should not be eating breads, pasta, potatoes, fruits, sugary desserts and sugary drinks. -Resident #1 was experiencing hypoglycemia and hyperglycemia so it was important for her to follow the RCS diet. -She expected the facility to follow all her orders for Resident #1 including her [therapeutic] diet order. Refer to the interview with a cook on 05/02/24 at	D 296		

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D 296	Continued From page 112 8:50am. Refer to the interview with the Dietary Manager (DM) on 04/30/24 at 11:50am. Refer to the interview with the DM on 05/02/24 at 9:08am. Refer to the interview with the RCC on 05/02/24 at 9:30am. Refer to the interview with the Administrator on 05/02/24 at 10:50am. 2. Review of Resident #7's current FL-2 dated 12/05/23 revealed: -Diagnoses included hyperlipidemia, chronic kidney disease, and gastro-esophageal reflux disease (GERD). Review of Resident #7's physicians diet order dated 12/05/23 revealed: -Resident #7 was ordered a restricted concentrated sweets (RCS) diet. -The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods. Observation of the lunch meal on 04/30/24 from 11:55am to 12:18pm revealed: -Resident #7 was served a grilled cheese sandwich on white bread, Brunswick stew and a half cup of fruit cocktail, and water. -Resident #7 ate 75% of her stew, 50% of her grilled cheese and 100% of her fruit cocktail. Observation of the lunch meal on 05/01/24 at 11:45am revealed: -Resident #7 was served a piece of fried chicken,	D 296		

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D 296	Continued From page 113 a bowl of tomato soup, roasted red skin potatoes, green beans, a dinner roll, a bowl of fresh fruit and water. -Resident #1 ate none of her chicken, 50% of her soup, and none of the potatoes, 75% of her fresh fruit, 100% of her green beans and dinner roll. Based on observation of the lunch meals serviced on 04/03/24 and 05/01/24, it could not be determined if Resident #7 was served the correct therapeutic diet due to the kitchen not having a therapeutic diet menu that included an RCS diet for staff guidance. Interview with Resident #7 on 05/01/24 at 11:50am revealed: -She was a diabetic. -She did not have a physician's order for any diets related to her diabetes. -She could eat what ever she wanted to eat, and it did not bother her. Telephone interview with a nurse from Resident #7's primary care provider's (PCP) office on 05/03/24 at 8:59am revealed: -Resident #7 was ordered a RCS diet after her A1-c had increased from 6.1 to 6.8 on 02/12/24. -Resident #7 was considered a diabetic because her A1c was in the diabetic range. -The PCP expected the facility to follow the order for the RCS diet. -Resident #7 had received diabetic diet education from the physician's assistant (PA). -Resident #7's diet improvement was based on being in the facility and the facility providing her meals based on the RCS diet. Refer to the interview with a cook on 05/02/24 at 8:50am.	D 296		

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D 296	Continued From page 114 Refer to the interview with the Dietary Manager (DM) on 04/30/24 at 11:50am. Refer to the interview with the DM on 05/02/24 at 9:08am. Refer to the interview with the RCC on 05/02/24 at 9:30am. Refer to the interview with the Administrator on 05/02/24 at 10:50am. _____ Interview with a cook on 05/02/24 at 8:50am revealed: -The PCP ordered a diabetic diet for the residents who were diabetic. -The physician ordered [therapeutic] diet did not have a name; it was just called a diabetic diet. -The residents who were ordered the diabetic diet could eat everything that was on the regular menu; only the desserts and the bread were different. -The diabetic residents were served wheat bread and 2% milk. -The Dietary Manager (DM) told her what desserts to make for the diabetics. -She usually prepared a sugar free dessert and a regular dessert. -She prepared sugar free cakes, puddings, and gelatins. -She made an apple crisp from canned apples and did not add sugar to it. -Resident #1 was a new resident but she knew she was diabetic; she was served what she asked for. -Resident #7 was diabetic and would tell her what she did and did not want to eat. Interview with the DM on 04/30/24 at 11:50am revealed the only therapeutic diet the facility had	D 296		

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D 296	Continued From page 115 was a calorie/carbohydrate-controlled (CCHO) diet for the diabetics. Interview with the DM on 05/02/24 at 9:08am revealed: -The Resident Care Coordinator (RCC) gave him the names of residents who were ordered a CCHO diet and he made a diet list from the names. -The diabetic residents were served diabetic desserts, unsweetened tea, skim or 1% milk, and wheat bread. -He had been doing the job of a dietary manager for so long that he knew what to serve diabetic residents. -He had worked under a dietician about three years ago. -He did not have a therapeutic diet menu to follow for the residents who were ordered a diabetic diet. -The kitchen staff followed the spreadsheets for the CCHO diet for the desserts only. -The kitchen staff prepared fruit cobblers without sugar, and when they made a cake, they used low fat sugar free whipped cream on top for frosting. Interview with the RCC on 05/02/24 at 9:30am revealed: -She was responsible for providing the kitchen with any new diet orders. -He used the FL-2s and the physicians diet order sheet to get the residents diets. -The diet order sheet that the primary care provider (PCP) signed for the residents included a RCS diet. -The diet that the residents were placed on were the PCP's decision. -She expected the DM and the kitchen staff to follow the PCP's diet orders for the residents.	D 296		

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D 296	Continued From page 116 Interview with the Administrator on 05/02/24 at 10:50am revealed: -The RCC and the DM were responsible for the [therapeutic] diet menu. -She did not get involved in the diet orders. -She expected the RCC and the DM to be on "the same page" as the PCP when it came to the residents' diet orders. -The facility needed to follow the PCP's diet orders for the residents and to be consistent.	D 296		
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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#1) who was ordered three blood pressure medications, a mood stabilizer, a muscle relaxer, a medication for frequent urination, an allergy medication, and	D 344		

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D 344	Continued From page 117	D 344		

an insulin.

The findings are:

Review of Resident #1's admission FL-2 dated 2/27/24 revealed:
-Diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, and acute kidney failure.
-She was intermittently disoriented.
-She was ambulatory with the assistance of a walker.
-She was continent of bowels and bladder.
-See attached physician orders.

Review of Resident #1's current FL-2 dated 04/17/24 revealed:
-Diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, and acute kidney failure.
-She was intermittently disoriented.
-She was ambulatory.
-She was continent of bowels and bladder.
-See attached physician orders.

Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/21/24.

a. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for Tresiba insulin (a long-acting insulin) 56 units in the evening.

Review of Resident #1's signed physician's order dated 04/03/24 revealed:
-There was an order to discontinue Tresiba insulin 56 units in the evening.
-There was an order to start Tresiba insulin 45 units at bedtime and hold bedtime insulin if FSBS

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was less than 120.

Review of Resident #1's signed physician orders dated 04/17/24 revealed:
-There was an order for Tresiba insulin 56 units in the evening.
-There was no order for Tresiba insulin 45 units in the evening.

Review of Resident #1's electronic progress notes revealed:
-There was an entry on 04/03/24 to discontinue 56 units of Tresiba at bedtime and start Tresiba 45 units at bedtime; if FSBS was less the 120, do not give bedtime insulin.
-There was an entry on 04/26/24 Resident #1's FSBS was 58, was administered 4 glucose tablets and the FSBS reading was 86 after 30 minutes.

Review of Resident #1's incident report dated 03/29/24 revealed:
-The incident occurred at 8:00am on 03/29/24.
-A medication aide (MA) documented Resident #1 was in a "disoriented shape" from her sugar dropping.
-Resident #1 had an unwitnessed fall.
-Emergency Medical Services (EMS) was called.
-When EMS arrived, Resident #1's sugar dropped more.
-Resident #1's glucose was extremely low.
-She could, at times, comprehend and speak.
-EMS transported Resident #1 to the local Emergency Department (ED).

Review of Resident #1's electronic note dated 03/29/24 time stamped at 9:34am revealed:
-Entered Resident #1's room to administer medications.
-Resident #1 looked "out of it" and was slurring

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her words, so she checked her FSBS.
-Resident #1 had a FSBS reading of 65.
-The Resident Care Coordinator (RCC) instructed the MA to give Resident #1 sugar to raise her FSBS.
-The MA tried to give Resident #1 orange juice with sugar but Resident #1 could not suck on the straw.
-The MA placed packs of sugar in Resident #1's mouth to try to raise her glucose.
-The MA rechecked Resident #1's FSBS reading and it was 56 after the sugar was placed in Resident #1's mouth.

Review of Resident #1's electronic note dated 03/29/24 time stamped 11:07am revealed:
-Resident #1 had an unwitnessed fall from her bed to the floor.
-The MA stepped out of the room to the medication cart for a "split second."
-The MA found Resident #1 on the floor and called 911.

Review of an Emergency Medical Services (EMS) report dated 03/29/24 revealed:
-EMS was dispatched at 9:19am to the facility regarding a resident who had fallen.
-It was reported by the caller that the fall just happened, the reason for the fall was unknown, resident was still on the floor, it was not known if she was responding normally, and resident was a diabetic.
-Resident #1 was transported to the local ED at 9:46am.
-There were no FSBS checks noted on the EMS report.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed:

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D 344	Continued From page 120 -Resident #1 had admitting orders for Tresiba 30 units each morning and 56 units each evening which was started on 03/21/24. -Resident #1 had several low FSBS readings and she changed the order on 04/03/24 from 56 units in the evening to 45 units in the evening. -On 04/17/24, she signed the physician orders for Resident #1. -She did not know the physician orders printed and signed on 04/17/24 had Tresiba 56 units every evening instead of 45 units every evening. -She expected the facility to enter and review orders to ensure accuracy of the physician orders. -She did not increase Resident #1's Tresiba; Resident #1 should be receiving Tresiba 45 units in the evening and not 56 units. -Resident #1 had a history of low FSBS readings and the additional units of insulin could drop her blood sugar. Telephone interview with the RCC on 05/03/24 at 4:11pm revealed: -She printed the physician orders for the PCP to sign. -The PCP signed the most recent physician orders on 04/17/24. -She did not compare what was listed on the printed physician orders to the eMAR or to orders in Resident #1's medical record. -She thought the PCP would review the physician orders before she signed them to ensure they were accurate. -The PCPs signature verified she ordered Tresiba 56 units at bedtime. b. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for hydrochlorothiazide 12.5mg (used to treat elevated blood pressure) daily.	D 344		

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D 344	Continued From page 121 Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for hydrochlorothiazide 12.5mg daily. Review of Resident #1's record revealed there was no order to discontinue hydrochlorothiazide 12.5mg daily. Review of Resident #1's April 2024 electronic medication administration record (eMAR) from 04/17/24 to 04/30/24 revealed: -There was no entry for hydrochlorothiazide 12.5mg to be administered. -There was no documentation hydrochlorothiazide was administered. c. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for lisinopril 40mg (used to treat elevated blood pressure) daily. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for lisinopril 40mg daily. Review of Resident #1's record revealed there was no order to discontinue lisinopril 40mg. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for lisinopril 40mg to be administered. -There was no documentation lisinopril was administered. d. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for metoprolol tartrate 100mg (used to treat elevated blood pressure) twice daily.	D 344		

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D 344	Continued From page 122 Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for metoprolol tartrate 10mg twice daily. Review of Resident #1's record revealed there was no order to discontinue metoprolol tartrate 10mg twice daily. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for metoprolol tartrate 100mg to be administered. -There was no documentation metoprolol tartrate was administered. _____ Review of Resident #1's medical record revealed: -There was a blood pressure reading on the admission assessment of 164/84 dated 03/21/24. -There was a monthly blood pressure reading of 178/90 dated 04/10/24. Observation of Resident #1's blood pressure being taken at the request of the surveyor on 05/02/24 at 9:12am revealed Resident #1's blood pressure reading was 183/97. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -Her blood pressure was taken every week at the previous facility, and she took several medications for her blood pressure. -Her blood pressure had only been checked a couple of times since she was admitted to this facility. e. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for cyclobenzaprine 10mg (used to relax muscles and relieve pain) twice daily.	D 344		

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D 344	Continued From page 123 Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for cyclobenzaprine 10mg twice daily. Review of Resident #1's record revealed there was no order to discontinue cyclobenzaprine 10mg. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for cyclobenzaprine 10mg to be administered. -There was no documentation cyclobenzaprine 10mg was administered. Interview with Resident #1 on 04/30/24 at 8:57am revealed: -She complained of neck pain daily. -She complained about neck pain and muscle tightness in her neck and asked the MAs for medication. -The MAs were going to "check on it" and get back with me. -She never received any medications for the muscle tightness in her neck. f. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for divalproex 125mg (used as a mood stabilizer) three times daily. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for divalproex 125mg twice daily. Review of Resident #1's record revealed: -There was no order to discontinue divalproex 125mg twice daily. -There was no documentation of mood changes	D 344		

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D 344	Continued From page 124 or behaviors. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for divalproex 125mg to be administered. -There was no documentation divalproex 125mg was administered. g. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for loratadine 10mg (used to treat allergies) daily. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for loratadine 10mg twice daily. Review of Resident #1's record on revealed there was no order to discontinue loratadine 10mg twice daily. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for loratadine 10mg to be administered. -There was no documentation loratadine 10mg was administered. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -She took allergy medication at the previous facility. -She did not think she was taking an allergy medication now. -She complained to the staff about watery, itchy eyes, and a runny nose. -Her sinuses were "giving her a fit." -She had not asked anyone about her allergy medication.	D 344		

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D 344	Continued From page 125 h. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for myrbetriq 25mg (used to treat an overactive bladder) daily. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for myrbetriq 25mg twice daily. Review of Resident #1's record revealed there was no order to discontinue myrbetriq 25mg twice daily. Review of Resident #1's April 2024 eMAR from 04/17/24 to 04/30/24 revealed: -There was no entry for myrbetriq 25mg to be administered. -There was no documentation myrbetriq 25mg was administered. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -She got up at least twice each night to use the bathroom. -She used the bathroom a lot during the day. -She wore adult briefs all the time because she had to use the bathroom so much and she did not always make it to the bathroom in time. -She did not know if she took any medication or not for going to the bathroom so frequently. Refer to the telephone interview with Resident #1's Primary Care Provider (PCP) on 05/02/24 at 2:31pm. Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 11:39am. Refer to th interview with the Administrator on	D 344		

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D 344	Continued From page 126 05/03/24 at 5:22pm revealed: _____ Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed: -Resident #1 was admitted to the facility with orders from another physician. -She expected the facility to follow the admission orders from the admitting physician until she saw Resident #1. -She received printed physician orders from the facility on 04/17/24 to sign. -She expected the physician orders to be accurate when they were given to her to sign. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 11:39am revealed: -She would fax all orders to the pharmacy and the pharmacy would enter all orders onto the eMARs. -Once the orders were entered onto the eMAR, the Supervisor was responsible for approving the medications on the eMAR so the medications could be administered. -The Supervisor should compare the order entries on the eMAR with the admission orders. -If the order entry on the eMAR and the admission orders were the same, the Supervisor would approve the medication on the eMAR and the medication could be administered. -If there was a discrepancy between the entries on the eMAR and the admission orders, the Supervisor should call the pharmacy or let the RCC know. -She did not know the pharmacy only received 4 of 5 pages of Resident #1's admission orders. -A cover sheet was sent with the orders indicating how many pages were faxed; if the pharmacy did not receive the indicated number of pages, the pharmacy should have notified the facility. -The pharmacy did not contact the facility	D 344		

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D 344	Continued From page 127 regarding receiving 4 of 5 pages of orders for Resident #1. -The facility did not keep fax confirmations sheets; confirmation was when the pharmacy started building the new resident's profile. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -The RCC was responsible for faxing FL-2s and medication orders to the pharmacy. -The pharmacy was responsible for entering all information into the computer and onto the eMAR. -The RCC should look at the confirmation sheet to ensure all pages were received by the pharmacy. -Once the orders were entered, the RCC was responsible for checking and verifying the orders entered by the pharmacy were accurate. -If there were any discrepancies the RCC should call the pharmacy. _____ The facility failed to ensure clarification of physician's orders for Resident #1 who was a diabetic and had experienced several low blood sugars, had elevated blood pressure readings, neck pain, watery, itchy eyes and runny nose, and frequent urination related to the medications not being administered. This failure placed the resident at substantial risk for physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 344		

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D 358	Continued From page 128	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 sampled residents (#1, #9) observed during the medication pass including errors with the administration of an insulin (#1) and a cholesterol medication and a probiotic (#9); and for 5 of 7 sampled residents (#1, #2, #3, #4, #5) for record review including an anti-anxiety medication, a medication for a low blood sugar, three medications for blood pressure, a mood stabilizer, a muscle relaxer, a medications for frequent urination, and a seasonal allergy medication (#1); an anti-depressant medication and a bronchodilator (#2, #5); a blood thinner and a blood pressure medication (#3); a laxative and an antibiotic (#4). The findings are: 1. The medication error rate was 9% as evidenced by the observation of 3 errors out of 31 opportunities during the 8:00am/9:00am medication pass on 5/1/24 and 5/2/24.	D 358		

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D 358	Continued From page 129 Review of the facility's medication administration policy revealed: -The medication administration policy was not dated. -Medications must be administered in accordance with the orders. -The medication aide (MA) administering the medication must check the label three times to verify the right dosage. a. Review of Resident #1's current FL-2 dated 04/17/24 revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD), acute kidney failure and iron deficiency. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -Some days the MA checked her fingerstick blood sugar (FSBS) once or twice a day and administered insulin. -Some days the MAs would administer her insulin and not check her FSBS. -She used to have her FSBS checked four times a day at the previous facility, but at this facility her FSBS was not checked that often. Observation of Resident #1's room on 05/02/24 at 9:08am during Resident #1's interview revealed: -The MA entered Resident #1's room with a glucometer and a Tresiba insulin (a long-acting insulin) pen. -The MA checked Resident #1's FSBS and the reading was 255. -The MA dialed up 45 units of Tresiba and administered the insulin to Resident #1. -There was no prescription label on the Tresiba insulin pen.	D 358		

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D 358	Continued From page 130 Review of Resident #1's signed physician orders dated 04/17/24 revealed there was an order for Tresiba 30 units every morning. Review of Resident #1's May 2024 electronic medication administration record (eMAR) on 05/02/24 revealed: -There was an entry for Tresiba 30 units every morning with a scheduled administration time from 7:00am to 9:00am. -There was documentation Tresiba 30 units was administered between 7:00am and 9:00am on 05/02/24. Observation of Resident #1's medication on hand on 05/02/24 at 10:30am revealed: -There was a Tresiba insulin pen available for administration. -The Tresiba insulin pen was located in the top drawer of the medication cart. -The Tresiba insulin pen was in a zip-locked bag with a prescription label. -The prescription label read "inject 45 units every night at bedtime". Interview with the MA on 05/02/24 at 10:50am revealed: -She administered 45 units of Tresiba to Resident #1 this morning. -She was aware Resident #1 had an order for Tresiba 30 units every morning. -Resident #1's FSBS was 255 this morning. -She considered a FSBS reading of 255 high, and she thought Resident #1 needed more than 30 units of insulin. -She looked at the eMAR and the prescription label on the medications and if they were different, she would administer the medication as instructed on the prescription label because the	D 358		

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eMAR was incorrect most of the time.
-The prescription label was more accurate which was why she followed the prescription label instructions.

Review of Resident #1's incident report dated 03/29/24 revealed:
-The incident occurred at 8:00am on 03/29/24.
-A MA documented Resident #1 was in a "disoriented shape" from her sugar dropping. Resident had an unwitnessed fall. Emergency Medical Services (EMS) called. When EMS arrived, Resident #1's sugar dropped more. Resident #1's glucose was extremely low. She could, at times, comprehend and speak.
-EMS transported Resident #1 to the local Emergency Department (ED).

Review of Resident #1's electronic note dated 03/29/24 time stamped at 9:34am revealed:
-Entered Resident #1's room to administer medications.
-Resident #1 looked "out of it" and was slurring her words, so she checked her FSBS.
-Resident #1 had a FSBS reading of 65.
-The Resident Care Coordinator (RCC) instructed the medication aide (MA) to give Resident #1 sugar to raise her FSBS.
-The MA tried to give Resident #1 orange juice with sugar but Resident #1 could not suck on the straw.
-The MA placed packs of sugar in Resident #1's mouth to try to raise her glucose.
-The MA rechecked her FSBS reading and it was 56.

Review of Resident #1's electronic note dated 03/29/24 time stamped 11:07am revealed:
-Resident #1 had an unwitnessed fall from her bed to the floor.

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-The MA stepped out of the room to the medication cart for a split second.
-The MA found Resident #1 on the floor and called 911.

Review of an Emergency Medical Services (EMS) report dated 03/29/24 revealed:
-EMS was dispatched at 9:19am to the facility regarding a resident who had fallen.
-It was reported by the caller the fall just happened, the reason for the fall was unknown, resident was still on the floor, it was not known if she was responding normally, and resident was a diabetic.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/02/24 at 1:30pm revealed:
-The pharmacy received an FL-2 dated 02/27/24 and on 4/17/24 for Resident #1.
-There was an order for Tresiba 30 units in the morning to be administered to Resident #1.
-The pharmacy dispensed 4 pens of Tresiba 100 units on 04/03/24.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed:
-Resident #1 had an order for Tresiba 30 units each morning.
-Resident #1 should not have received 45 units in the morning, that was her evening dose of Tresiba.
-Resident #1 has a history of low FSBS readings and the additional units of insulin could drop her blood sugar.
-She expected the MAs to administer the insulin as ordered.

Observation of the MA re-checking Resident #1's

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D 358	Continued From page 133 FSBS on 05/02/24 at 10:50am revealed Resident #1's FSBS reading was 158. Second interview with the same MA on 05/02/24 at 11:54am revealed: -She realized after speaking with her supervisor she should have administered 30 units of Tresiba as ordered and to follow the orders on the eMAR and not on the prescription label. -If the eMAR order and the prescription label were different she should talk with her supervisor before administering the medication. Interview with the Supervisor on 05/02/24 at 12:23am revealed: -The MA should have looked at the eMAR to see what the order for Tresiba was before she administered the medication. -The MAs should always check the eMARS when administering medications. -If the eMAR and the prescription label were different, the MA should notify the supervisor, Resident Care Coordinator (RCC) or the pharmacy. Interview with the RCC on 05/02/24 at 11:39am revealed: -The MA should administer medications as ordered. -The MA should refer to the eMAR for the correct insulin dosage. -The MAs should check the medication against the eMAR three times before administering a medication. -Resident #1's blood sugar could have dropped with the additional insulin she was given. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -She expected the MAs to administer insulin as	D 358		

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ordered.
-Resident #1's blood sugar could have dropped, and she could have had an emergency situation.
-The MAs needed to pay attention and follow the orders as written.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

b. Review of #9's current FL-2 dated 11/15/23 revealed diagnoses included irritable bowel syndrome (IBS), gastro-esophageal reflux disease (GERD), and depression.

1. Review of Resident #9's signed physician orders dated 11/15/23 revealed there was an order for colestipol 1gm (used to lower cholesterol) daily.

Observation of the morning medication pass on 05/01/24 at 8:16am revealed:
-The MA removed 3 bubble packs and one bottle of medication for Resident #9 from the medication cart.
-The MA popped one pill from each bubble pack and removed two pills from the bottle, for a total of 5 pills.
-The MA administered the 5 medications to Resident #9.
-Colestipol 1mg was not 1 of the 5 pills administered.

Review of Resident #9's May 2024 electronic

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medication administration record (eMAR) on 05/01/24 revealed:
-There was an entry for colestipol 1mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation colestipol 1mg was administered on 05/01/24.

Observation of Resident #9's medication on hand revealed there was no colestipol 1mg on the medication cart available for administration.

Interview with the MA on 05/02/24 at 2:05pm revealed:
-She administered Resident #9's morning medications on 05/01/24.
-She administered 5 pills to Resident #9 between the 7:00am to 11:00am medication pass.
-She did not have colestipol 1mg available for administration.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 10:47am revealed:
-The pharmacy had an order for colestipol 1gm daily dated 03/05/24, as an onboarding order.
-They were a new pharmacy to this facility and all orders from 03/05/24 were profiled into the eMAR.
-The facility ordered medications on demand, meaning they re-ordered when they needed the medication.
-The pharmacy had not dispensed colestipol 1mg because the facility had not requested the medication.
-The facility ordered colestipol 1mg today, 05/01/24.

Interview with the Resident #9 on 05/02/24 at 9:45am revealed:

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D 358	Continued From page 136 -She was administered medications each morning; she was not sure how many pills she took. -She was not sure if she took a cholesterol pill or not. Telephone interview with Resident #9's Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed: -Resident #9 was ordered colestipol 1mg to help lower her cholesterol level. -Resident #9's cholesterol level could increase if the medication was not administered as ordered. -She expected the MAs to administer medications as ordered. 2. Review of Resident #9's signed physician orders dated 11/15/23 revealed there was an order for probiotic 250mg (used to treat gastro-intestinal issues) twice daily. Observation of the morning medication pass on 05/01/24 at 8:16am revealed: -The MA removed 3 bubble packs and one bottle of medication for Resident #9 from the medication cart. -The MA popped one pill from each bubble pack and removed two pills from the bottle, for a total of 5 pills. -The MA administered the 5 medications to Resident #9. -Probiotic was not 1 of the 5 pills administered. Review of Resident #9's May 2024 eMAR on 05/01/24 revealed: -There was an entry for probiotic 250mg twice daily with a schedule administration time between 7:00am and 11:00am. -There was documentation probiotic 250mg was administered on 05/01/24.	D 358		

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D 358	Continued From page 137 Observation of Resident #9's medication on hand revealed there was no probiotic on the medication cart available for administration. Interview with the MA on 05/02/24 at 2:05pm revealed: -She administered Resident #9 her morning medications on 05/01/24. -She administered 5 pills to Resident #9 between the 7:00am to 11:00am medication pass. -She did not have a probiotic available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 10:47am revealed: -The pharmacy had an order for probiotic 250mg twice daily dated 03/05/24, as an onboarding order. -The pharmacy dispensed probiotic on 03/08/24 for 54 tablets (27 day supply), on 03/29/24 for 28 tablets (14 day supply), on 04/11/24 for 28 tablets (14 day supply), and on 04/12/24 for 60 tablets (30 day supply). -The pharmacy received a new prescription on 04/12/24 for probiotic twice daily. -The pharmacy had dispensed enough probiotics from 03/08/24 to 04/12/24 to last 85 days or until 06/02/24. -Probiotic 250mg was used to balance out the gut, used along side antibiotic administration, or used for a resident who suffered from diarrhea. Interview with the Resident #9 on 05/02/24 at 9:45am revealed: -She was administered medications each morning; she was not sure how many pills she took. -She had problems with diarrhea and abdominal	D 358		

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D 358	Continued From page 138 cramping at times. -She had diarrhea a few days ago. Telephone interview with Resident #9's PCP on 05/02/24 at 2:31pm revealed: -Resident #9 was ordered Probiotic 250mg twice daily to help with gut health. -Resident #9 had a diagnosis of irritable bowel syndrome and would have discomfort from diarrhea and the probiotic would help with this. -Resident #9 could have increased discomfort if the medication was not administered as ordered. -She expected the MAs to administer medications as ordered. _____ Interview with the MA on 05/02/24 at 2:05pm revealed: -She documented her initials on the eMAR as if she had administered the medication. -She did not know how to document on the eMAR that the medication was not available for administration. -She did not ask anyone about how to document on the eMAR when a resident refused medications because she did not realize she had documented incorrectly. Interview with the Supervisor on 05/02/24 at 12:23pm revealed: -The MA did not ask her how to document a medication on the eMAR when it was not available. -The MA should have asked her how to document a medication on the eMAR when it was not available for administration. Interview with the RCC on 05/01/24 at 11:35am revealed: -The MAs should document correctly on the eMAR so when the PCP looked at the eMAR she	D 358		

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would see an accurate description of what the resident was or was not taking.
-The MA should have asked her or the Supervisor how to document a medication on the eMAR when it was not available for administration.
-The MA did not ask her how to document a medication on the eMAR when it was not available.

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-The MA should document the correct information on the eMAR so the PCP would have accurate information when the PCP reviewed the eMAR.
-She expected the MAs to document correctly on the eMAR and if the MAs did not know how, they should ask the Supervisor or the RCC.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

3. Review of Resident #1's current FL-2 dated 2/27/24 revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD).

Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/21/24.

Observation of Resident #1's blood pressure taken at the request of the surveyor on 05/02/24

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D 358	Continued From page 140 at 9:12am revealed Resident #1's blood pressure reading was 183/97. a. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for hydrochlorothiazide 12.5mg (used to treat elevated blood pressure) daily. Review of Resident #1's March 2024 electronic medications administration record (eMAR) from 03/21/24 to 03/31/24 revealed: -There was no entry for hydrochlorothiazide 12.5mg to be administered. -There was no documentation hydrochlorothiazide was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for hydrochlorothiazide 12.5mg to be administered. -There was no documentation hydrochlorothiazide was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for hydrochlorothiazide 12.5mg daily. Observation of Resident #1's medication on hand on 04/30/24 at 2:45pm revealed there was no hydrochlorothiazide 12.5mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for hydrochlorothiazide 12.5mg daily dated 02/27/24. Interview with the Primary Care Provider (PCP) on 05/02/24 at 2:31pm revealed:	D 358		

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D 358	Continued From page 141 -She saw Resident #1 on 04/17/24 and reviewed her physician orders and eMAR. -Hydrochlorothiazide 12.5mg was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on hydrochlorothiazide 12.5mg at the previous facility. -She did not know Resident #1 was not being administered hydrochlorothiazide 12.5mg as ordered since being admitted to the facility. -Hydrochlorothiazide 12.5mg was used to lower blood pressure. b. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for lisinopril 40mg (used to treat elevated blood pressure) daily. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was no entry for lisinopril 40mg to be administered. -There was no documentation lisinopril was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for lisinopril 40mg to be administered. -There was no documentation lisinopril was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for lisinopril 40mg daily. Observation of Resident #1's medication on hand on 04/30/24 at 2:45pm revealed there was no lisinopril 40mg available for administration.	D 358		

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D 358	Continued From page 142 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for lisinopril 40mg daily dated 02/27/24. Interview with the PCP on 05/02/24 at 2:31pm revealed: -She saw Resident #1 on 04/17/24 and reviewed her physician orders and eMAR. -Lisinopril 40mg was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on lisinopril 40mg at the previous facility. -She did not know Resident #1 was not being administered lisinopril 40mg as ordered since being admitted to the facility. -Lisinopril 40mg was used to lower blood pressure. c. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for metoprolol tartrate 100mg (used to treat elevated blood pressure) twice daily. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was no entry for metoprolol tartrate 100mg to be administered. -There was no documentation metoprolol tartrate was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for metoprolol tartrate 100mg to be administered. -There was no documentation metoprolol tartrate was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for	D 358		

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D 358	Continued From page 143 metoprolol tartrate 10mg twice daily Observation of Resident #1's medications on hand on 04/30/24 at 2:45pm revealed there was no metoprolol tartrate 100mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for metoprolol tartrate 100mg twice daily dated 02/27/24. Interview with the PCP on 05/02/24 at 2:31pm revealed: -She saw Resident #1 on 04/17/24 and reviewed her physician orders and eMAR. -Metoprolol tartrate 100mg was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on metoprolol tartrate at the previous facility. -She did not know Resident #1 was not being administered metoprolol tartrate as ordered since being admitted to the facility. -Metoprolol tartrate was used to lower blood pressure. _____ Interview with Resident #1 on 05/02/24 at 8:37am revealed: -Her blood pressure was taken every week at the previous facility, and she took several medications for her blood pressure. -Her blood pressure had only been checked a couple of times since she was admitted to this facility. Review of Resident #1's medical record revealed: -There was a blood pressure reading on the admission assessment of 164/84 dated 03/21/24. -There was a monthly blood pressure reading of	D 358		

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D 358	Continued From page 144 178/90 dated 04/10/24. Interview with the PCP on 05/02/24 at 2:31pm revealed: -Resident #1 had a history of strokes. -Resident #1 was at a higher risk for having another stroke because she had not been receiving her blood pressure medications and because she had a history of strokes. -She expected the MAs to administer Resident #1's medication as ordered upon admission until she evaluated the resident Interview with the Administrator on 05/03/24 at 5:22pm revealed: -Resident #1's medication should have been entered on the eMAR when Resident #1 was admitted to the facilty so Resident #1 could have been administered the medication. -She was concerned Resident #1's blood pressure would increase, and she could have complications from an increased blood pressure. -Resident #1 had a history of a stroke. d. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for cyclobenzaprine 10mg (used to relax muscles and relieve pain) twice daily. Review of Resident #1's March 2024 electronic medications administration record (eMAR) from 03/21/24 to 03/31/24 revealed: -There was no entry for cyclobenzaprine 10mg to be administered. -There was no documentation cyclobenzaprine 10mg was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed:	D 358		

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D 358	Continued From page 145 -There was no entry for cyclobenzaprine 10mg to be administered. -There was no documentation cyclobenzaprine 10mg was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for cyclobenzaprine 10mg twice daily. Observation of Resident #1's medications on hand on 04/30/24 at 2:45pm revealed there was no cyclobenzaprine 10mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for cyclobenzaprine 10mg twice daily dated 02/27/24. Interview with Resident #1 on 04/30/24 at 8:57am revealed: -She complained of neck pain daily. -She complained about neck pain and muscle tightness in her neck and asked the MAs for medication. -The MAs were going to "check on it" and get back with me. -She never received any medications for the muscle tightness in her neck. Interview with the PCP on 05/02/24 at 2:31pm revealed: -She saw Resident #1 on 04/17/24 and reviewed her physician orders and eMAR. -Cyclobenzaprine was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on cyclobenzaprine at the previous facility. -She did not know Resident #1 was not being	D 358		

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administered cyclobenzaprine as ordered since being admitted to the facility.
-Cyclobenzaprine was used to relax muscles.
-Resident #1 could have increase in pain and/or muscle spasms if the medication was not administered as ordered.
-She expected the MAs to administer Resident #1's medication as ordered upon admission until she evaluated the resident

Interview with the Administrator on 05/03/24 at 5:22pm revealed:
-Resident #1's medication should have been entered on the eMAR when Resident #1 was admitted to the facilty
so Resident #1 could have been administered the medication.
-She was concerned Resident #1 would have increased pain if she did not get her muscle relaxant.

e. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for divalproex 125mg (used as a mood stabilizer) three times daily.

Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed:
-There was no entry for divalproex 125mg to be administered.
-There was no documentation divalproex 125mg was administered.

Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed:
-There was no entry for divalproex 125mg to be administered.
-There was no documentation divalproex 125mg was administered.

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D 358	Continued From page 147 Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for 04/30/24 at 2:45pm twice daily. Observation of Resident #1's medications on hand on 04/30/24 at 2:45pm revealed there was no divalproex 125mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for divalproex 125mg three times daily on 02/27/24. Interview with Resident #1's Mental Health Provider (MHP) on 05/02/24 at 3:45pm revealed: -Resident #1 was admitted to the facility on 03/21/24. -She saw Resident #1 on 04/05/24 for the first time. -She reviewed Resident #1's current eMAR with expectations that the eMAR was correct. -She did not see divalproex on the eMAR when she reviewed it. -She did not know Resident #1 was on divalproex at the previous facility. -She would expect the MAs to administer Resident #1's medication as ordered upon admission until she evaluated the resident. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -Resident #1's medication should have been entered on the eMAR when Resident #1 was admitted to the facilty so Resident #1 could have been administered the medication. -Resident #1 could have a change in her mood or behavior if she did not receive this medication.	D 358		

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D 358	Continued From page 148 f. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for loratadine 10mg (used to treat allergies) daily. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was no entry for loratadine 10mg to be administered. -There was no documentation loratadine 10mg was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for loratadine 10mg to be administered. -There was no documentation loratadine 10mg was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for loratadine 10mg twice daily. Observation of Resident #1's medications on hand on 04/30/24 at 2:45pm revealed there was no loratadine 10mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for loratadine 10mg daily dated 02/27/24. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -She took allergy medication at the previous facility. -She did not think she was taking an allergy medication now. -She complained to the staff about watery, itchy eyes, and a runny nose.	D 358		

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D 358	Continued From page 149 -Her sinuses were "giving her a fit." -She had not asked anyone about her allergy medication. Interview with the PCP on 05/02/24 at 2:31pm revealed: -She saw Resident #1 on 04/17/24 and reviewed her physician orders and eMAR. -Loratadine was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on loratadine at the previous facility. -She did not know Resident #1 was not being administered loratadine as ordered since being admitted to the facility. -Myrbetriq was used to help control an overactive bladder. -Resident #1 could have an increase in allergy symptoms, such as watery and itchy eyes and a runny nose. -She expected the MAs to administer Resident #1's medication as ordered upon admission until she evaluated the resident. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -Resident #1's medication for allergies should have been entered on the eMAR when Resident #1 was admitted to the facilty so Resident #1 could have been administered the medication. -Resident #1 could have an increase in allergy symptoms. g. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for myrbetriq 25mg (used to treat an overactive bladder) daily. Review of Resident #1's March 2024 eMAR from	D 358		

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D 358	Continued From page 150 03/21/24 to 03/31/24 revealed: -There was no entry for myrbetriq 25mg to be administered. -There was no documentation myrbetriq 25mg was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for myrbetriq 25mg to be administered. -There was no documentation myrbetriq 25mg was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for myrbetriq 25mg twice daily. Observation of Resident #1's medications on hand on 04/30/24 at 2:45pm revealed there was no myrbetriq 25mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed the pharmacy did not have an order for myrbetriq 25mg daily dated 02/27/24. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -She got up at least twice each night to use the bathroom. -She used the bathroom a lot during the day. -She wore adult briefs all the time because she had to use the bathroom so much and she did not always make it to the bathroom in time. -She did not know if she took any medication or not for going to the bathroom so frequently. Interview with the PCP on 05/02/24 at 2:31pm revealed: -She saw Resident #1 on 04/17/24 and reviewed	D 358		

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D 358	Continued From page 151 her physician orders and eMAR. -Myrbetriq was not on the physician orders or eMAR she reviewed -She did not know Resident #1 was on Myrbetriq at the previous facility. -She did not know Resident #1 was not being administered myrbetriq as ordered since being admitted to the facility. -Myrbetriq was used to help control an overactive bladder. -Resident #1 could have an increase in urinary incontinence and having to use the bathroom more frequently. She expected the MAs to administer Resident #1's medication as ordered upon admission until she evaluated the resident Interview with the Administrator on 05/03/24 at 5:22pm revealed: -Resident #1's medication for an overactive bladder should have been entered on the eMAR when Resident #1 was admitted to the facilty so Resident #1 could have been administered the medication. -Resident #1 may have to go to the bathroom more frequently since she was not getting her medication. _____ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed: -The pharmacy received a faxed FL-2 and signed physician orders dated 02/27/24 for Resident #1 on 03/21/24. -The pharmacy staff entered the medication orders onto the eMAR. -The pharmacy only received 4 of 5 pages of the signed physician orders dated 02/27/24. -The pharmacy had not noticed page 4 was missing until today, 05/01/24.	D 358		

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D 358	Continued From page 152 Interview with Resident #1 on 04/30/24 at 8:57am revealed: -The administration of medications was sporadic. -They were not administered at the same time each day. Interview with Resident #1 on 05/02/24 at 8:37am revealed: -She used to get 12 pills every morning at the previous facility. -She only got 6 pills every morning since moving into this facility. -She had told the MAs who administered her medications that she used to take more medications in the morning, but nothing changed; she still received 6 medications. -She did not know what medications she was being administered but she knew she was not getting all of her blood pressure medications. -When she was admitted to the facility, she did not receive any medications for several days. Telephone interview with Resident #1's PCP on 05/02/24 at 2:31pm revealed: -She did not know Resident #1 was not administered her medications as ordered when she was admitted to the facility. -She expected the facility to administer Resident #1 her medications as ordered upon admission until she was seen by the facility PCP. Interview with the Supervisor on 05/02/24 at 12:20pm revealed: -She faxed daily orders to the pharmacy -She or the RCC would approve the daily orders entered onto the eMAR. -She did not fax admission orders to the pharmacy, and she did not approve admission orders on the eMAR.	D 358		

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D 358	Continued From page 153 -The RCC was responsible for faxing and approving admission orders for new residents. -She did not fax or approve Resident #1's admission orders. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 11:39am revealed: -The Administrator received the FL-2 and orders for new admissions. -Once the Administrator completed her part, the Administrator gave the FL-2 and orders to her. -She would fax all orders to the pharmacy and the pharmacy would enter all orders onto the eMARs. -Once the orders have been entered onto the eMAR by the pharmacy, a Supervisor was responsible for approving the medications on the eMAR so the medications could be administered. -The Supervisor would compare the order entries on the eMAR with the admission orders. -If the order entry on the eMAR and the admission orders were the same, the Supervisor would approve the medication on the eMAR and the medication could be administered. -If there was a discrepancy between the eMAR and the admission orders, or if a medication was not on the eMAR, the Supervisor should call the pharmacy or let the RCC know. -She did not know the pharmacy only received 4 of 5 pages of Resident #1's admission orders. -A cover sheet was sent with the orders indicating how many pages were faxed; if the pharmacy did not receive the indicated number of pages, the pharmacy should have notified the facility. -The pharmacy did not contact the facility regarding receiving 4 of 5 pages of orders for Resident #1. -The facility did not keep fax confirmations sheets; confirmation was when the pharmacy started building the new resident's profile.	D 358		

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D 358	Continued From page 154 Interview with the Administrator on 05/03/24 at 5:22pm revealed: -The RCC was responsible for faxing FL-2s and medication orders to the pharmacy. -The pharmacy was responsible for entering all information into the computer and onto the eMAR. -The RCC should look at the confirmation sheet to ensure all pages were received by the pharmacy. -Once the orders were entered, the RCC was responsible for checking and verifying the orders entered by the pharmacy were accurate. -If there were any discrepancies the RCC should call the pharmacy. h. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for alprazolam 0.25mg (used to treat anxiety) twice daily. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was no entry for alprazolam 0.25mg to be administered. -There was no documentation alprazolam was administered. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/16/24 revealed: -There was no entry for alprazolam 0.25mg to be administered. -There was no documentation alprazolam was administered. Review of Resident #1's signed physician orders dated 04/17/24 revealed there was no order for alprazolam 0.25mg. Observation of Resident #1's medications on	D 358		

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hand on 04/30/24 at 2:45pm revealed there was alprazolam 0.25mg available for administration.

Interview with Resident #1 on 05/02/24 at 8:37am revealed:
-She felt nervous all the time.
-Sometimes her hands shook.
-She was receiving medication at the previous facility for anxiety.
-She did not think she was getting the medication for anxiety now.
-She asked the MAs about the anxiety medication several times, but she never got an answer to whether she was taking it or not.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 11:05am revealed:
-The pharmacy received an order for alprazolam 0.25mg on 03/21/24.
-The order was obtained from a signed physician's order dated 02/27/24.
-The medication was not filled because alprazolam was a controlled substance and required a prescription from the PCP.
-They had not received a prescription from the PCP.
-They did not notify the PCP; it was the facility's responsibility to notify the PCP.

Interview with the RCC on 05/02/24 at 11:39am revealed:
-She did not know Resident #1 had an order for alprazolam 0.25mg upon admission.
-The pharmacy did not notify her that a prescription was needed to fill the prescription and for the pharmacy to place the medication on the eMAR.
-She would have expected the pharmacy to notify the PCP when a prescription was needed for a

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D 358	Continued From page 156 controlled substance. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -The RCC should have known alprazolam 0.25mg was a controlled substance and needed a prescription. -The RCC should have notified the PCP and requested a prescription for alprazolam. -Resident #1 could have increased anxiety without taking her medication. i. Review of Resident #1's signed physician orders dated 02/27/24 revealed there was an order for glucose chewable 4mg tablets administer 4 tablets when fingerstick blood sugar (FSBS) readings were less than 70 and repeat FSBS reading in 15 minutes. Review of Resident #1's March 2024 eMAR from 03/21/24 to 03/31/24 revealed: -There was an entry for glucose chewable 4mg tablets administer 4 tablets for FSBS reading less than 70 and repeat FSBS in 15 minutes. -There was no documentation glucose chewable 4gm tablets were administered from 03/21/24 to 03/31/24. Review of Resident #1's electronic note dated 03/29/24 time stamped at 9:34am revealed: -Entered Resident #1's room to administer medications. -Resident #1 looked "out of it" and was slurring her words, so she checked her FSBS. -Resident #1 had a FSBS reading of 65. -The RCC instructed the MA to give Resident #1 sugar to raise her FSBS. -The MA tried to give Resident #1 orange juice with sugar but Resident #1 could not suck on the straw.	D 358		

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-The MA placed packs of sugar in Resident #1's mouth to try to raise her glucose.
-The MA rechecked her FSBS reading and it was 56.

Review of Resident #1's electronic note dated 03/29/24 time stamped 11:07am revealed:
-Resident #1 had an unwitnessed fall from her bed to the floor.
-The MA stepped out of the room to the medication cart for a split second.
-The MA found Resident #1 on the floor and called 911.

Observation of the treatment cart on 05/01/24 at 3:31pm revealed:
-There were three bottles of glucose tablets 4mg in a zip lock bag for Resident #1.
-The zip lock bag had a prescription label with a dispensed date of 03/01/24.
-There were 30 glucose tablets dispensed.
-The instructions on the prescription label read "take four tablets 4 times a day as needed for FSBS less than 70 and recheck in 15 minutes.
-There were 26 of 30 glucose tablets remaining for administration.

Telephone interview with a MA on 05/03/24 at 5:01pm revealed:
-She worked with Resident #1 on 03/29/24.
-She had prepared Resident #1's morning medication for administration.
-When she entered the room, Resident #1 looked "out of it" and when she spoke to Resident #1, her speech was slurred.
-She checked her FSBS because of the way Resident #1 was behaving.
-Her FSBS readings was 65.
-She attempted to administer orange juice with sugar through a straw, but Resident #1 could not

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suck on the straw.
-She took several packages of sugar and placed them in Resident #1's mouth to help raise her FSBS.
-She re-checked Resident #1's FSBS after 15 to 20 minutes and the FSBS reading was 56.
-She called 911.
-Resident #1 rolled off her bed to the floor at some point during the low blood sugars, but she was not sure when it happened.
-She did not routinely check Resident #1's FSBS because there was no entry on the MAR.
-She checked Resident #1's FSBS the morning of 03/29/24 because Resident #1 was "not acting right."
-She could not locate glucose chewable tablets on the medication cart.
-She did not know the glucose tablets were on the treatment cart; they should be on the medication cart.
-There was no order to check Resident #1's FSBS to know if she needed the glucose tablets.

Interview with Resident #1 on 04/30/24 at 8:57am revealed:
-She had experienced several low blood sugars since moving in the facility.
-She had been to the ED for a low FSBS reading.
-She went to the local ED sometime in March 2024, but could not recall the exact date.

Interview with the PCP on 05/02/24 at 2:31pm revealed:
-The MAs should have followed physician orders and administered the glucose tablets.
-She expected the MAs to follow physician orders as written.

Interview with a Supervisor on 05/03/24 at 12:35pm revealed:

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-Resident #1 was taken to the local ED on 03/29/24 because her FSBS was low and she had a fall.
-A staff member from the local ED telephoned and stated Resident #1 was getting too much insulin and it was causing her blood sugar to drop.
-She was instructed by the local ED staff to hold the nighttime insulin on 03/29/24.
-She told the RCC about the phone call from the local ED and what she was told.
-She did not call the PCP.
-She told the RCC and thought the RCC would call the PCP.

Interview with the RCC on 05/03/24 at 4:11am revealed:
-She recalled a Supervisor informing her of the telephone call from the local ED.
-She did not call the PCP regarding the order.
-She expected the Supervisor to call the PCP.

Interview with the Administrator on 05/03/24 at 5:22pm revealed the RCC was responsible to notify the PCP or ensuring the Supervisor notified the PCP.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

4. Review of Resident #2's current FL-2 dated 11/22/23 revealed diagnoses of dementia without behavioral disturbances, anxiety disorder,

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depression, chronic obstructive pulmonary disease (COPD), and oxygen dependency.

a. Review of Resident #2's signed physician orders dated 12/06/23 revealed there was an order for sertraline 50mg (used to treat depression) daily.

Review of Resident #2's signed physician order dated 04/05/24 revealed there was an order to increase sertraline to 75mg daily.

Review of Resident #2's signed physician's order dated 04/19/24 revealed there was an order to increase sertraline to 100mg daily.

Review of Resident #2's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for sertraline 50mg daily with a scheduled administration time between 7:00am and 11:00am.
-There was documentation sertraline 50mg was administered daily from 04/01/24 to 04/05/24.
-There was a second entry dated 04/05/24 for sertraline 50mg 1.5 tablets (75mg) daily with a scheduled administration time between 7:00am and 11:00am
-There was documentation sertraline 50mg 1.5 tablets (75mg) was administered from 04/08/24 to 04/10/24 and from 04/19/24 to 04/20/24.
-There was no documentation of administration from 04/06/24 to 04/07/24 and 04/11/24 to 04/18/24.
-There was a third entry dated 04/19/24 for sertraline 100mg daily with a scheduled administration time between 7:00am and 11:00am.
-There was documentation sertraline 100mg was administered daily from 04/21/24 to 04/30/24.

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D 358	Continued From page 161 Observation of Resident #2's medications on hand on 05/01/24 at 3:35pm revealed: -There was a bubble pack of sertraline 50mg tablets available for administration on the medication cart. -There were 3 of 23 tablets of sertraline 50mg dispensed on 04/03/24 remaining for administration. -There was a bubble pack, labeled card 1 of 2, containing 30 - ½ tablets of sertraline 50mg dispensed on 04/11/24. -There were 30 - ½ tablets of sertraline remaining in card 1 of 2. -There was a bubble pack, labeled card 2 of 2, containing 30 sertraline 50mg tablets dispensed on 04/11/24. -There were 17 of 30 tablets of sertraline 50mg remaining in card 2 of 2. -There was no sertraline 100mg tablets on the medication cart available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/02/24 at 9:16am revealed: -Resident #2 had an order for sertraline 50mg daily from 03/05/24. -The pharmacy dispensed 23 tablets of sertraline 50mg on 03/12/24 and 04/03/24. -The pharmacy received an order to increase sertraline from 50mg daily to 75mg daily on 04/05/24. -The pharmacy dispensed 30 tablets of sertraline 50mg in a bubble pack and 30 sertraline 50mg ½ tablets in a second bubble pack for a total of 75mg. -The facility staff should pop a 50mg and a ½ tablet (25mg) from each bubble pack, each time sertraline 75mg was administered. -The pharmacy received an order for sertraline	D 358		

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D 358	Continued From page 162 100mg on 04/19/24. -The pharmacy dispensed 30 sertraline 100mg on 04/19/24. Interview with Resident #2 on 04/30/23 at 8:40am revealed: -He took several medications each day. -He did not know what the medications were for. -He took whatever medications the medication aide (MA) brought him. Interview with a MA on 05/03/24 at 11:38am revealed: -She administered Resident #2's sertraline 75mg as ordered. -The sertraline was in a bubble pack, and she popped the medication from the bubble pack. -She knew there were two bubble packs she needed to pop from. -She thought she popped from both bubble packs when she administered sertraline 75mg. -She did not know the sertraline 50mg ½ tablets had not been used since it was dispensed. -She thought sertraline 100mg was on the medication cart and that she had administered it to Resident #2. Telephone interview with Resident #2's Mental Health Provider (MHP) on 05/03/24 at 3:45pm revealed: -She increased Resident #2's sertraline because Resident #2 showed signs of increased sexual impulsetivity. -She was titrating (slowly increasing the dose of a medication) his medication every two weeks. -She did not know Resident #2 had not received sertraline 75mg or 100mg as ordered. -She expected the facility staff to administer the medications as ordered.	D 358		

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b. Review of Resident #2's signed physician orders dated 12/06/23 revealed there was an order for albuterol 2.5mg/3ml every 4 hours as needed (PRN) for shortness of breath.

Review of Resident #2's February 2024 eMAR revealed:
-There was an entry for albuterol 2.5/3ml every 4 hours PRN for shortness of breath.
-There was documentation albuterol 2.5/3ml was administered on 02/02/24.

Review of Resident #2's March 2024 eMAR revealed:
-There was an entry for albuterol 2.5/3ml every 4 hours PRN for shortness of breath.
-There was no documentation albuterol 2.5/3ml had been administered.

Review of Resident #2's April 2024 eMAR revealed:
-There was an entry for albuterol 2.5/3ml every 4 hours PRN for shortness of breath.
-There was no documentation albuterol 2.5/3ml had been administered.

Observation of Resident #2's medication on hand on 05/01/24 at 3:35pm revealed there was no albuterol 2.5/3ml available to administer by nebulizer.

Interview with Resident #2 on 04/30/23 at 8:40am revealed:
-He had COPD and became short of breath at times.
-He used to use his nebulizer machine when he was admitted to the facility.
-He had not used his nebulizer machine in several months.
-He had asked for nebulizer treatments when he

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was short of breath.
-He did not receive a nebulizer treatment when he asked for it; the staff told him they would check on it.
-He asked multiple times for a nebulizer treatment,.
-He was ignored so many times, he stopped asking for the nebulizer treatments.
-When he became short of breath and could not get his nebulizer treatment, he would turn his oxygen from 2L/M to 3L/M or 3.5L/M.
-When he felt better, he would turn the oxygen back down to 3L/M.
-When he walked to the dining room or to the front porch without his oxygen, he would get short of breath.

Interview with the Resident Care Coordinator (RCC) on 05/03/24 at 4:11pm revealed:
-The MA could have re-ordered albuterol 2.5/3ml vials on the eMAR by clicking on the re-order tab for Resident #2's nebulizer
-Nobody had told her Resident #2 needed his medication for his nebulizer.
-She expected the MAs to administer medications as ordered.
-If a medication was not available for administration, the MA should call the pharmacy or let her know.

Interview with the Administrator on 05/02/24 at 5:22pm revealed:
-The MAs should administer medications as ordered.
-If the medication was not available, the MA should re-order it or call the pharmacy.
-She expected the MA to administer medications as ordered.

Refer to the interview with the Pharmacist from

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D 358	Continued From page 165 the facility's contracted pharmacy on 05/01/24 at 9:10am. Refer to the interview with the RCC on 05/02/24 at 11:39am. Refer to the interview with the Administrator on 05/03/24 at 5:22pm. 5. Review of Resident #3's current FL-2 dated 01/03/24 revealed diagnoses included essential hypertension, diabetes mellitus type 2, chronic kidney disease, history of cerebral vascular accident (CVA), and spasticity. a. Review of Resident #3's current FL-2 dated 01/03/24 revealed there was an order for clopidogrel (a blood thinner) 75mg one tablet once daily. Review of Resident #3's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for clopidogrel 75mg one tablet once daily scheduled from 7:00am to 11:00am. -Clopidogrel was documented as administered from 02/01/24 to 02/29/24. Review of Resident #3's March 2024 eMAR revealed: -There was an entry for clopidogrel 75mg one tablet once daily scheduled from 7:00am to 11:00am. -Clopidogrel was documented as administered from 03/01/24 to 03/31/24. Review of Resident #3's April 2024 eMAR from 04/01/24 to 04/30/24 revealed:	D 358		

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D 358	Continued From page 166 -There was an entry for clopidogrel 75mg one tablet once daily scheduled from 7:00am to 11:00am. -Clopidogrel was documented as administered 21 of 30 opportunities from 04/01/24 to 04/30/24. -Clopidogrel was not documented as admistered from 04/10/24 to 04/18/24; the entries were blank and there were no exceptions documented. Observation of Resident #3's medication on hand on 05/01/24 at 11:30am revealed: -There were 30 tablets of clopidogrel 75mg dispensed on 04/21/24. -There were 29 tablets of clopidogrel available for administration. Telephone interview with a pharmacist from the facility's previously contracted pharmacy on 05/02/24 at 2:50pm revealed: -Resident #3 had an order for clopidogrel 75mg once daily. -Thirty tablets of clopidogrel were dispensed on 01/25/24 and 02/21/24 Telephone interview with the pharmacist from the facility's current contracted facility on 05/01/24 at 8:56am revealed: -The pharmacy had started providing services for the facility on 03/05/24. -Resident #3 had an order for clopidogrel 75mg once daily. -Thirty tablets of clopidogrel were dispensed on 04/21/24. -The medications were not on a cycle fill and needed to be reordered by the MAs through the eMAR. -Clopidogrel was not dispensed for Resident #3 in March 2024. -Clopidogrel was a blood thinner used to prevent thrombotic events.	D 358		

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D 358	Continued From page 167 -Possible outcomes might not be noticed by the resident but if he had a history of stroke, he could have a stroke, or if he wore thrombo-embolic deterrent (TED) hose for blood clots he could have a blood clot if clopidogrel was not administered as ordered. Telephone interview with Resident #3's primary care provider (PCP) on 05/02/24 at 3:10pm revealed: -Resident #3 was ordered clopidogrel because he had a history of a stroke that caused him to be in a wheelchair. -He could not go without the clopidogrel because it was a blood thinner and if he went without it, he was at risk for another stroke. -She expected the facility to follow her orders for Resident #3's medications and to notify her if the medications were not available for administration. Interview with Resident #3 on 05/02/24 at 12:10pm revealed: -He knew he was administered clopidogrel and that it was a blood thinner. -He had two blood thinners and did not know why he needed two. -He knew what medications he took, and he looked in his medication cup and counted them in the mornings. -He had to monitor his medications because the staff did not always tell him when there was a change in his medications. -He thought the clopidogrel was discontinued a couple of months ago because he did not have it in his medication cup; clopidogrel was a small pink tablet. -He thought the clopidogrel was discontinued because he took a second blood thinner and did not need both. -He had been told by a medication aide (MA) he	D 358		

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did not have medications because a shipment had not come in yet.
-He thought it had been a couple of months ago.

Interview with a MA on 05/01/24 at 11:30am revealed:
-Resident #3 did not have any other medication cards anywhere else in the facility.
-Resident #3 was good about taking his medications and did not refuse.
-There was a blue area on the medication cards with eight tablets in the blue that indicated when it was time to reorder the medication in the card.
-The MAs reordered medications from the pharmacy through the eMAR system by clicking on a reorder tab at the bottom of the medication order.
-The medication would be delivered either that same evening or the next depending on the time of day the order was placed.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

b. Review of Resident #3's current FL-2 dated 01/03/24 revealed there was an order for amlodipine (used to treat high blood pressure) 10mg one tablet once daily.

Review of Resident #3's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 10mg one

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tablet once daily scheduled at 7:00am.
-Amlodipine was documented as administered from 02/01/24 to 02/29/24.

Review of Resident #3's March 2024 eMAR revealed:
-There was an entry for amlodipine 10mg one tablet once daily scheduled at 7:00am.
-Amlodipine was documented as administered 27 of 31 opportunities from 03/01/24 to 03/31/24.
-There was documentation of an exception on 03/21/24, as "not here".
-There was documentation of an exceptions on 03/22/24, 03/23/24 and 03/30/24 as "waiting on pharmacy".

Review of Resident #3's April 2024 eMAR from 04/01/24 to 04/30/24 revealed:
-There was an entry for amlodipine 10mg one tablet once daily scheduled at 7:00am.
-Amlodipine was documented as administered 21 of 30 opportunities from 04/01/24 to 04/30/24.
-Amlodipine was not documented as admistered from 04/10/24 to 04/18/24; the entries were blank and there were no exceptions documented.

Observation of Resident #3 on 05/02/24 at 6:35pm revealed his blood pressure taken by a medication aide (MA) was 147/77.

Observation of Resident #3's medication on hand on 05/01/24 at 11:30am revealed:
-There were 30 tablets of amlodipine dispensed on 04/22/24.
-There were 27 of 30 tablets of amlodipine available for administration.

Telephone interview a pharmacist from the facility's previously contracted pharmacy on 05/02/24 at 2:50pm revealed:

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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 358	Continued From page 170 -Resident #3 had an order for amlodipine 10mg once daily. -Thirty tablets of amlodipine were dispensed on 01/16/24 and 02/18/24 -Amlodipine was used to treat high blood pressure and could cause increased blood pressures when not administered as ordered. Telephone interview with the pharmacist from the facility's current contracted facility on 05/01/24 at 8:56am revealed: -The pharmacy started providing services with the facility on 03/05/24. -Resident #3 had an order for amlodipine 10mg once daily. -Thirty tablets of amlodipine had been dispensed on 03/30/24 and 04/22/24. -The medications were not on a cycle fill and needed to be reordered by the MAs through the eMAR. Telephone interview with Resident #3's PCP on 05/02/24 at 3:10pm revealed: -Resident #3 was ordered amlodipine because he had high blood pressure and a history of stroke. -She did not want Resident #3 to go without his blood pressure medications because he would be at risk for another stroke. -She expected the facility to follow her orders for Resident #3's medications. Interview with Resident #3 on 05/02/24 at 12:10pm revealed: -He knew he was ordered a medication for high blood pressure, but he did not know what the medication was. -He knew how many medications he took, and he looked in his medication cup and counted them in the mornings. -He had to monitor his medications because the	D 358		

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D 358	Continued From page 171 staff did not always tell him when there was a change in his medications. -He had been told by a MA he did not have medications because a shipment had not come in yet. -He thought it had been a couple of months ago. -Once he was given a blood pressure medication in the afternoon because the shipment was not in and it came in later in the day. -His blood pressure was only checked when he saw his PCP. _____ Interview with the MA on 05/01/24 at 11:30am revealed: -Resident #3 did not have any other medication cards anywhere else in the facility. -Resident #3 was good about taking his medications and did not refuse. -There was a blue area on the medication cards with eight tablets in the blue that indicated when it was time to reorder the medication in the card. -The MAs reordered medications from the pharmacy through the eMAR system by clicking on a reorder tab at the bottom of the medication order. -The medication would be delivered either that same evening or the next depending on the time of day the order was placed. Interview with the Supervisor on 05/03/24 at 5:30pm revealed: -The MAs were supposed to report to her when a medication was not on the medication cart to administer to a resident. -There were so many medications that were not in the facility and not reordered. -Medications should have been ordered before they ran out. -If there was a problem with getting a medication in from the pharmacy the MAs would tell her, and	D 358		

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D 358	Continued From page 172	D 358		

she would let the Resident Care Coordinator (RCC) know so she could take care of it.
-She was not told Resident #3 did not have his clopidogrel on the medication cart.
-She expected the MAs to tell her when medications were not on the medication cart, especially a blood thinner and a heart medication.

Interview with the RCC on 05/03/24 at 2:08pm revealed:
-The MAs were instructed to tell the Supervisor when a resident did not have a medication to administer.
-The Supervisor then contacted the PCP and the MAs contacted the pharmacy to reorder the medication.
-She was not aware Resident #3 did not have clopidogrel to administer; no one told her.

Interview with the Administrator on 05/03/24 at 3:50pm revealed:
-The MAs were responsible for notifying the RCC when medication was not available to administer to a resident.
-She was not aware Resident #3 was not administered his clopidogrel because it was not available to administer.
-She was concerned Resident #3 was not administered his clopidogrel because she knew it was a blood pressure medication and he could have had a [blood]clot and died.
-None of the residents should go without any medication.
-The PCP's orders should have been followed and the resident's medication should have been given the way the PCP expected it to be given.
-Something should have been done about Resident #3's medications not being in the facility.
-The staff should have realized the medication was not in the facility and reordered it.

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D 358	Continued From page 173 Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am. Refer to the interview with the RCC on 05/02/24 at 11:39am. Refer to the interview with the Administrator on 05/03/24 at 5:22pm. 6. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension and chronic constipation. a. Review of Resident #4's physician order dated 11/15/23 revealed there was an order for senna plus 8.6-50mg one tablet in the morning and two tablets at bedtime (used to treat constipation). Review of Resident #4's electronic medication administration record (eMAR) for February 2024 revealed: -There was an entry for senna plus one tablet scheduled from 7:00am to 11:00am daily and two tablets scheduled from 7:00pm to 11:00pm. -Senna plus was documented as administered once daily in the morning from 02/01/24 to 02/29/24. -Senna plus was documented as administered two tablets at bedtime from 02/01/24 to 02/29/24. Review of Resident #4's eMAR for March 2024 revealed: -There was an entry for senna plus one tablet scheduled from 7:00am to 11:00am daily and two tablets scheduled from 7:00pm to 11:00pm. -Senna plus was documented as administered once daily in the morning from 03/01/24 to 03/15/24, on 03/20/24, from 03/23/24 to 03/25/24, on 03/28/24, and on 03/29/24.	D 358		

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D 358	Continued From page 174 -There were exceptions documented on 03/16/24 to 03/19/24, and 03/21/24, 03/22/24 03/26/24, 03/26/24, 03/30/24, and 03/31/24; the exceptions documented were out of stock, waiting on pharmacy. -Senna plus was documented as administered two tablets at bedtime from 03/01/24 to 03/14/24, on 03/24/24, and on 03/28/24. -There was no documentation Senna plus was administered from 03/15/24 to 03/23/24, from 03/25/24 to 03/27/24, and from 03/29/24 to 03/31/24; the exceptions documented were out of stock, waiting on pharmacy. Review of Resident #4's eMAR for April 2024 revealed: -There was an entry for senna plus one tablet scheduled from 7:00am to 11:00am daily and two tablets scheduled from 7:00pm to 11:00pm. -Senna plus was documented as administered once daily in the morning on 04/02/24, on 04/03/24, from 04/06/24 to 04/06/24, and from 04/11/24 to 04/30/24. -There was no documentation Senna plus was on 04/01/24, on 04/04/24, on 04/05/24, on 04/09/24, and on 04/10/24; the exceptions documented were out of stock, waiting on pharmacy. -Senna plus was documented as administered two tablets at bedtime on 04/02/24, from 04/05/24 to 04/07/24, and from 04/10/24 to 04/30/24. -There was no documentation Senna plus was administered on 04/01/24, on 04/03/24, on 04/04/24, on 04/08/24, and on 04/09/24; the exceptions documented were out of stock, waiting on pharmacy. Observation of Resident #4's medications on hand on 04/30/24 at 4:30pm revealed there was one medication card of senna plus 8.6-50mg with a dispensed date of 02/08/24; 30 tablets were	D 358		

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D 358	Continued From page 175 dispensed, and 21 tablets were available for administration. Interview with a pharmacist with the facility's previous contracted pharmacy on 05/01/24 at 11:24am revealed: -Resident #4 had an order for senna plus 8.6-50mg once daily in the morning and two tablets at bedtime. -Resident #4 had a 30-day supply (90 each) of senna plus dispensed on 12/05/23, 01/11/24, and 02/08/24. -Senna plus was used for constipation. -Not getting the medication as ordered could increase constipation. Interview with a pharmacist with the facility's contracted pharmacy on 05/02/24 at 8:59am revealed: -The pharmacy began contracting with the facility on 03/05/24. -There was not an active order for Resident #4 for senna plus 8.6-50mg. -Senna plus had not been dispensed by the pharmacy. Interview with Resident #4 on 05/01/24 at 4:00pm revealed: -She did not receive all of her medications on time but could not recall the exact times she received her medications. -She was constipated last week and asked the medication aide (MA) for medication to help her use the bathroom. -The MA gave Resident #4 medication and it helped to soften her stools. Interview with a MA on 05/01/24 at 9:50am revealed: -Senna Plus was always available to administer	D 358		

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to Resident #4.
-She did not recall, not having senna plus for administration to Resident #4.
-She could not explain why there were not enough tablets to administer senna plus daily.

Interview with Resident #4's primary care provider (PCP) on 05/01/24 12:05pm revealed:
- Senna Plus was ordered for constipation.
-The effects of discontinuing senna plus could increase constipation resulting in hemorrhoids.
-She expected the facility staff to follow her orders as written.

b. Review of Resident #4's physician order dated 03/23/24 revealed there was an order for cephalexin (an antibiotic used to treat urinary tract infections) 500mg one tablet twice daily.

Review of Resident #4's eMAR for March 2024 from 03/23/24 to 03/31/24 revealed:
-There was an entry for cephalexin one tablet scheduled from 7:00am to 11:00am and a second tablet from 7:00pm to 11:00pm.
-Cephalexin was documented as administered from 7:00am to 11:00am from 03/25/24 to 03/29/24.
-There was no documentation cephalexin was administered on 03/30/24 and on 03/31/24; the exceptions documented were out of stock, waiting on pharmacy.
-Cephalexin was documented as administered from 7:00pm to 11:00pm from 03/25/24 to 03/28/24.
-There was no documentation cephalexin was administered from 03/29/24 to 03/31/24; the exceptions documented were out of stock, waiting on pharmacy.

Review of Resident #4's eMAR for April 2024

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D 358	Continued From page 177 revealed: -There was an entry for cephalexin one tablet scheduled from 7:00am to 11:00am and a second tablet from 7:00pm to 11:00pm. -Cephalexin was documented as administered from 7:00am to 11:00am on 04/02/24, on 04/03/24, on 04/05/24, and on 04/07/24. -There was no documentation cephalexin was administered on 04/01/24, on 04/04/24, on 04/05/24, and from 04/08/24 to 04/30/24; the exceptions documented were out of stock, waiting on pharmacy. -Cephalexin was documented as administered from 7:00pm to 11:00pm on 04/02/24, on 04/03/24, on 04/06/24, and on 04/07/24. -There was no documentation cephalexin was administered on 04/01/24, on 04/03/24, on 04/04/24, and from 04/08/24 to 04/30/24; the exceptions documented were out of stock, waiting on pharmacy. Observation of Resident #4's medications on hand on 04/30/24 at 4:30pm revealed there was no cephalexin available for administration. Interview with a pharmacist with the facility's contracted pharmacy on 05/02/24 at 8:59am revealed: -Resident #4 had an order for cephalexin 500mg 1 tablet twice daily. -Resident #4 had a 30-day supply (60 tablets) of cephalexin dispensed once on 03/23/24. -Cephalexin was used for urinary tract infections. -The effects of discontinuing cephalexin could cause an increase of urinary tract infections. -There had been no request for more cephalexin by the facility in April for Resident #4. - Cephalexin was not on a monthly cycle fill; the facility had to request refills of the medication.	D 358		

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D 358	Continued From page 178 Interview with Resident #4 on 05/01/24 at 4:00pm revealed: -She did not receive all of her medications on time but could not recall the exact times she received her medications. -She had a lot of urinary tract infections. -She had symptoms of frequent urination. Interview with a MA on 05/01/24 at 9:50am revealed: -Cephalexin was always available to administer to Resident #4. -She did not recall, not having cephalexin for administration to Resident #4. -She could not explain why there were not enough tablets to administer cephalexin daily. Interview with Resident #4's PCP on 05/01/24 12:05pm revealed: -Cephalexin was used to treat urinary tract infections. -Not getting the medication as ordered could cause reoccurring urinary tract infections. -She expected the facility staff to follow her orders as written. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm revealed: -She was not aware Resident #4 did not have medication to be administered. -The MAs and the Supervisor should have contacted the pharmacy to have medications ordered. -The medication would have to be reordered by the MA when it was low. -The MA should have looked at eMAR and then ordered medication. -Resident #4's medications were not part of the pharmacy's cycle fill.	D 358		

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Interview with the Administrator on 05/02/24 at 11:27am revealed:
-She was not aware Resident #4 did not have medication to be administered.
-It was her expectation medications be administered as ordered by the physician.
-The RCC should have done cart audits to ensure that Resident #4 had all of her medications in the facility.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

Refer to the interview with the Administrator on 05/03/24 at 5:22pm.

7. Review of Resident #5's current FL2 dated 01/19/24 revealed diagnoses included unspecified anxiety disorder.

Review of Resident #5's physician's orders dated 01/19/24 revealed there was an order for Duloxetine HCL DR 20mg (used to treat depression and anxiety) 2 capsules once daily.

Review of Resident #5's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Duloxetine 20mg 2 capsules once daily.
-There was documentation duloxetine was administered from 04/01/24 to 04/07/24, from 04/09/24 to 04/23/24, on 04/25/24, on 04/26/24, and on 04/30/24.
-There was no documentation duloxetine was administered from 04/07/24 to 04/09/24 and from

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D 358	Continued From page 180 04/27/24 to 04/29/24; the exceptions documented were Resident #5 was out of the facility. -There was no documentation duloxetine was administered on 04/24/24; the exception was Resident #5 refused. Observations of Resident #5's medications on hand on 05/01/24 at 2:45pm revealed there was no Duloxetine available for administration on the medication cart. Interview with a pharmacist from the facility's previously contracted pharmacy on 05/01/24 at 11:24am revealed there was a 30-day supply (60 tablets) were dispensed by the pharmacy on 01/03/24, on 01/30/24, and on 02/29/24 for Resident #5. Interview with a pharmacist from the facility's contracted pharmacy on 05/02/24 at 8:59am revealed: -There was not an active order for Resident #5 for Duloxetine 20mg. -Duloxetine had not been dispensed by the pharmacy. -There had been no requests for more duloxetine by the facility in April for Resident #5. -Duloxetine was not on a monthly cycle fill; the facility had to request refills of the medication. Interview with a medication aide (MA) on 05/01/24 at 9:50am revealed: -Duloxetine was always available to administer to Resident #5. -She did not recall, not having duloxetine for administration to Resident #5. -She could not explain why there were not enough tablets to administer duloxetine daily for Resident #5.	D 358		

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D 358	Continued From page 181 Interview with Resident #5's primary care provider (PCP) on 05/01/24 12:05pm revealed: -Resident #5 was ordered Duloxetine 20mg for depression. -The effects of discontinuing duloxetine would cause increased depression and anxiety. -The facility did not make her aware Resident #5 d was not receiving medications as ordered. -She expected the facility to notify her when medications were not available to be administered at the facility. -It was important for Resident #5 to have the physician ordered medication daily. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. _____ Interview with Resident #5's responsible person on 05/01/24 at 10:51am revealed: -She was concerned about Resident #5 not receiving medications as ordered by the physician. -Resident #5 was admitted to the facility after discharge from a psychiatric hospital in March 2022 for depression. -Resident #5's family member passed away two months ago and she had become more depressed and isolated. -Resident #5 was picked up on 04/26/24 for a home visit and all of her medications were not available at the facility. -Six of twelve medications were available when Resident #5 left the facility for a home visit with the family. -She was told by a MA to come back the next day (04/27/24) to pick up additional medications because the pharmacy had not delivered the medications. -On 04/27/24 there were only two additional	D 358		

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medications available for pickup and another MA told her she would need to come back on 04/28/24 to pick up all of the medications.
-One of the medications was not available for pickup and the MA was unable to explain why the medication was not available.

Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm revealed:
-She was not aware Resident #5 did not have medication to be administered.
-The MAs and the Supervisor should have contacted the pharmacy to have medications ordered.
-The medication would have to be reordered by the MA when it was low.
-The MA should have looked at the eMAR before she ordered medication.
-Resident #5's medications were not part of the pharmacy's cycle fill.
-Resident #5 could experience increased symptoms of depression without the medication.

Interview with the Administrator on 05/02/24 at 11:27am revealed:
-She was not aware Resident #5 did not have medication to be administered.
-It was her expectation medications be administered as ordered by the physician.
-The RCC should have done cart audits to ensure Resident #5 had all of her medications in the facility.

Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am.

Refer to the interview with the RCC on 05/02/24 at 11:39am.

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ROXBORO ASSISTED LIVING OPCO LLC	5660 DURHAM ROAD ROXBORO, NC 27574

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D 358	Continued From page 183 Refer to the interview with the Administrator on 05/03/24 at 5:22pm. _____ Interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:10am revealed: -The medication carts were not audited by the pharmacy. -The Pharmacist audited the eMAR electronically. -The last pharmacy review was completed on 04/30/24, off-site. Interview with the RCC on 05/02/24 at 11:39am revealed: -Medication cart audits were completed by the two night shift Supervisors. -The medication cart audits should be done weekly on all medication carts. -If medications were missing from the medication cart, the missing medications should be documented on the 24 hour summary report and placed in her box for review. -The pharmacy completed the chart audits every 3 months to ensure all orders were on the eMAR. -The previous pharmacy completed an electronic, off-site review on 04/30/24. Interview with the Administrator on 05/03/24 at 5:22pm revealed: -The Pharmacy reviewed the eMARs every 3 months to ensure all ordered medications were on the eMAR. -The RCC should audit each medication cart weekly to ensure all medication were on the medication cart and available for administration. _____ The facility failed to ensure medications were administered as ordered for 2 of 7 residents observed during the medication pass and for 5 of 7 residents sampled for record review. Resident	D 358		

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D 358	Continued From page 184 #1 was a Type 2 diabetic who was administered the wrong amount of insulin, and experienced a low FSBS of 56, and fell on 03/29/24, was taken to the local Emergency Department, had a history of a stroke and was not administered 3 blood pressure medications since admission on 03/21/24 and whose blood pressure was 187/90 on 05/02/24; Resident #2 who had COPD, complained of shortness of breath and was not administered his albuterol as needed, causing him to increase his oxygen from 2L/M to 3L/M or 3.5L/M; and Resident #3 who had a history of a stoke and missed doses of a blood pressure medication and was not administered a blood thinner for thirty days. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/03/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2024.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	D 366		

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D 366	Continued From page 185 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication aide (MA) who administered the medication documented on the electronic medication administration record (eMAR) immediately after administering medications for 4 of 6 sampled residents (#1, #3, #4, and #9). The findings are: Review of the facility's medication administration policy revealed the medication aide (MA) administering the medication would document on the resident's medication administration record the administration of the medication. 1. Review of Resident #1's current FL-2 dated 2/27/24 revealed diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, gastro-esophageal reflux disease (GERD). Review of Resident #1's Resident Register revealed Resident #1 was admitted on 03/21/24. Review of Resident #1's signed physician orders dated 02/27/24 revealed an order for acetaminophen 325mg (used to treat mild pain) two every 4 hours as needed (PRN). Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/21/24 to 03/31/24 revealed: -There was an entry for acetaminophen 325mg two every 4 hours PRN pain. -There was no documentation acetaminophen 325mg was administered from 03/21/24 to 03/31/24.	D 366		

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D 366	Continued From page 186 Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/23/24 revealed: -There was an entry for acetaminophen 325mg two every 4 hours PRN pain. -There was no documentation acetaminophen 325mg was administered from 04/01/24 to 04/23/24. -There was documentation acetaminophen 325mg was discontinued on 04/23/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 05/01/24 at 10:47am revealed: -The pharmacy had an order for Resident #1 for acetaminophen 325mg tablets two every 4 hours PRN pain. -The pharmacy dispensed 30 acetaminophen 325mg tablets on 03/21/24. Observation of Resident #1's medications on hand on 04/03/24 at 2:46pm revealed -There was a bubble pack of acetaminophen 325mg tablets dispensed on 03/21/24 available for administration. -There were 17 of 30 acetaminophen tablets remaining for administration. Based on record reviews, interviews, and observation of medication on hand it was determined 30 acetaminophen tablets were dispensed on 03/21/24 with 17 tablets remaining and no documentation of administration leaving 13 tablets unaccounted for. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 4:00pm revealed: -The MAs should document on the eMAR each time a PRN medication was administered. -The MA was also expected to document in the	D 366		

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D 366	Continued From page 187	D 366		

resident's progress notes.
-The resident could be administered the medication to close together if the MA did not know the last time the PRN medication was administered.
-The primary care provider (PCP) would have the correct information when the eMARs were reviewed.

Interview with the Administrator on 05/02/24 at 4:28pm revealed:
-The MAs should document on the eMAR each time a PRN medication was administered.
-The PCP needed the correct information related to medication administration when she reviewed the eMARs.

Refer to the interview with a MA on 04/30/24 at 4:30pm.

Refer to the interview with another MA on 05/01/24 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm.

Refer to the interview with the Administrator on 05/02/24 at 11:27am.

2. Review of Resident #9's current FL-2 dated 11/15/23 revealed diagnoses included irritable bowel syndrome, constipation, depression, glaucoma, osteoporosis, vitamin D deficiency, degenerative disc disease (DDD), and gastro-esophageal reflux disease (GERD).

Observation of the morning medication pass on 05/01/24 at 8:16am revealed:
-The medication aide (MA) administered Resident #9 her morning medications.

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D 366	Continued From page 188 -The MA returned to the computer and documented on the electronic medication administration record (eMAR) she administered Resident #9 her medications. Review of Resident #9's May 2024 electronic medication administration record (eMAR) on 05/01/24 revealed the MA who administered the medications to Resident #9 electronically documented the Supervisors initials as administering the medications to Resident #9. Interview with the MA on 05/02/24 at 2:05pm revealed: -She returned to work on Monday, 04/29/24, after being out of work for 3 months. -She could not remember her code to sign into the computer. -She asked the Resident Care Coordinator (RCC) for a new code, but she did not receive a new code. -The Supervisor gave the MA the Supervisor's code, and the MA worked under the Supervisor's name. -Each time the MA signed the eMAR she administered a medication from 04/29/24 to 05/01/24, she signed the Supervisor's initials. Interview with the Supervisor on 05/02/24 at 2:24pm revealed: -She gave her code to sign into the eMAR to a MA so the MA could administer medications to the residents. -The MA had been out of work for 3 months and the MA could not remember her code when she returned to work on Monday, 04/29/24. -The MA needed to administer medications, and this was the only way she could get into the eMAR system to administer medications to the residents.	D 366		

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D 366	Continued From page 189 -She had given her code to the eMAR system to several different MAs because they were not assigned a code when they were hired. Interview with the RCC on 05/02/24 at 4:05pm revealed: -Each MA had a code to enter on the eMAR system to access residents' information. -Each code was specific to a MA. -If a MA was having problems signing in, the MA should come to her and get a new code. -The wrong MA could be held responsible for an error because their initials where on the eMAR system, when another MA actually administered the medications and signed the incorrect initials. -The MAs should not be sharing their codes to enter into eMAR. Interview with the Administrator on 05/02/24 at 4:38pm revealed: -The MAs should never sign in the eMAR under someone else's name. -The eMAR should be accurate in case there was a problem with a medication, management would know who to speak too about the problem. Refer to the interview with a MA on 04/30/24 at 4:30pm. Refer to the interview with another MA on 05/01/24 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm. Refer to the interview with the Administrator on 05/02/24 at 11:27am. 3. Review of Resident #3's current FL-2 dated 01/03/24 revealed:	D 366		

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D 366	Continued From page 190 -Diagnoses included essential hypertension, diabetes mellitus two, chronic kidney disease, history of cerebral vascular accident (CVA), and spasticity. -There was an order for amlodipine (used to treat high blood pressure) 10mg once daily. -There was an order for aspirin (used to treat inflammation and reduce the risk of heart attacks) 81mg once daily. -There was an order for atorvastatin (used to treat high cholesterol) 80mg once daily. -There was an order for clopidogrel (used to prevent blood clots) 75mg one tablet once daily. -There was an order for cyclobenzaprine (used to treat muscle pain) 5mg three times daily. -There was an order for ferrous sulfate (used to treat iron-deficiency anemia) 325mg once daily. -There was an order for lisinopril (used to treat high blood pressure) 20mg once daily. Review of Resident #3's April 2024 electronic medication administration record (eMAR) from 04/01/24 to 04/30/24 revealed: -There was an entry for amlodipine 10mg take once daily schedule from 7:00am to 11:00am. -There was an entry for aspirin 81mg once daily scheduled from 7:00am to 11:00am. -There was an entry for atorvastatin 80mg once daily scheduled from 7:00am to 11:00am. -There was an entry for clopidogrel 75mg one tablet once daily scheduled from 7:00am to 11:00am. -There was an entry for cyclobenzaprine 5mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an entry for ferrous sulfate 325mg take once daily scheduled from 7:00am to 11:00am. -There was an entry for lisinopril 20mg once daily scheduled from 7:00am to 11:00am.	D 366		

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D 366	Continued From page 191 -There was no documention from 04/10/24 to 04/18/24 for any medications; the entries were blank and there was no documentation in the exceptions. Observation of Resident #3's medications on hand on 05/01/24 at 11:30am revealed: -There was a bubble pack containing 27 amlodipine 10mg tablets dispensed on 04/22/24. -There was a bubble pack containing 27 aspirin 81mg tablets dispensed non 04/21/24. -There was a bubble pack containing 2 atorvastatin 80mg tablets dispensed on 04/01/24. -There was a bubble package of clopidogrel 75mg dispensed on 04/21/24. -There were three bubble packages of cyclobenzaprine 5mg tablets dispensed on 04/21/24; card one had 15 tablets, card two had 16 tablets and card three had 30 tablets. -There was a bubble pack containing 29 ferrous sulfate 325mg tablets dispensed on 04/30/24. - There was a bubble pack containing 29 lisinopril 20mg tablets dispensed on 04/30/24. Interview with the medication aide (MA) on 05/01/24 at 11:30am revealed: -She did not know why there were blank spaces for administration on Resident #3's eMAR from 04/10/24 to 04/18/24. -She did not know if she worked on any of those dates or if she administered Resident #3 on any of those dates. -She could not explain why there was nothing documented; not even initials on those dates. Interview with Resident #3 on 05/02/24 at 12:10pm revealed he knew what medications he took, and he looked in his medication cup and counted them in the mornings.	D 366		

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D 366	Continued From page 192 Refer to the interview with a MA on 04/30/24 at 4:30pm. Refer to the interview with another MA on 05/01/24 at 9:50am. Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm. Refer to the interview with the Administrator on 05/02/24 at 11:27am. 4. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension, chronic constipation, mild cognitive impairment, and anemia. Review of Resident #4's physician's order dated 11/15/23 revealed: -There was an order for acetaminophen (used to treat pain) 500mg take one tablet 3 times a daily. -There was an order for amlodipine (used to treat high blood pressure) 10mg take one tablet once daily. -There was an order for torsemide (used to treat edema) 20mg take one tablet once a daily. Review of Resident #4's electronic medication administration record (eMAR) for April 2024 revealed: -There was an entry for acetaminophen 500mg take one tablet 3 times a daily at 8:00am, 2:00pm, and 8:00pm with no documentation of administration from 04/11/24 to 04/18/24; the entries were blank and there were no documented exceptions. -There was an entry for amlodipine 10mg take one tablet once daily from 7:00am to 11:00am with no documentation of administration from 04/11/24 to 04/18/24; the entries were blank and	D 366		

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D 366	Continued From page 193	D 366		

there were no documented exceptions.
-There was an entry for torsemide 20mg take one tablet once daily from 7:00am to 11:00am with no documentation of administration from 04/11/24 to 04/18/24; the entries were blank and there were no documented exceptions.

Interview with a pharmacist from the facility's contracted pharmacy on 05/02/24 at 8:59am revealed:
-The medications (acetaminophen, amlodipine, and torsemide) were not on a monthly cycle fill; the facility had to request refills of the medications.
-There had been no medication returned to the pharmacy for Resident #4.
-There had been no request for more medications by the facility since April 2024 for Resident #4.
-The pharmacy had not been notified of any issues with the medications for Resident #4.
-Resident #4 would have had enough medication available for administration for April 2024.

Interview with Resident #4 on 05/01/24 at 4:00pm revealed she did receive all of her medications, but not always on time.

Refer to the interview with a MA on 04/30/24 at 4:30pm.

Refer to the interview with another MA on 05/01/24 at 9:50am.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm.

Refer to the interview with the Administrator on 05/02/24 at 11:27am.

_____
Interview with a MA on 04/30/24 at 4:30pm

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D 366	Continued From page 194 revealed: -She had been trained to document on the eMAR immediately after administering the medications to a resident prior to going on to the next resident. -She and the other MAs should document after the administration of medications on the eMAR. -She worked on 04/10/24, and from 04/15/24 to 04/17/24 but, could not recall if she administered Resident #4's medications. -She documented on the eMAR after administering each medication to residents. -She was not aware of holes or blank spaces on the eMAR and would have reported it to a Supervisor. Interview with another MA on 05/01/24 at 9:50am revealed: -She had been trained to document on the eMAR immediately after administering the medications to a resident prior to going on to the next resident. -She and the other MAs should document after the administration of medications on the eMAR. -She was unsure if she administered Resident #4's medications from 04/10/24 to 04/18/24. -There were issues with internet service in the facility and could have been the reason for the holes or blank spaces on the eMAR. -The MAs should have notified the Supervisor when they had trouble documenting on the eMAR. Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm revealed: -She was not aware of the holes or blank spaces on the eMAR. -She was responsible for checking the eMAR for accuracy of documentation and medication entries each month. -She did not complete audits to ensure the eMAR was correct.	D 366		

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D 366	Continued From page 195 -She should have completed audits but could not recall why they had not been done. -The pharmacy was responsible for adding new medication order entries to the eMARs. -She was responsible for checking the eMARs for accuracy monthly by comparing the eMAR to the most current physician's orders when the eMARs were delivered by the pharmacy. -She had not checked the eMARs for accuracy or compared the eMAR to the most current physician's orders. Interview with the Administrator on 05/02/24 at 11:27am revealed: -She was not aware there were holes or blank spaces on the eMAR. -Staff should document on the eMAR immediately after they have administered medications to each resident. -The RCC was responsible for checking the eMAR for accuracy monthly by comparing the eMAR to the most current physician's orders when the eMAR was delivered by the pharmacy. -The MAs and RCC were responsible for auditing the eMARs for accuracy of documentation monthly. -She expected the MAs and RCC to complete eMAR audits monthly with the medication cart audit and check the eMARs for accuracy when they were delivered by the pharmacy. -She was not aware of the dates of the last audits or how the RCC selected which residents to audit. -She expected MAs to document medications administered on the residents' eMARs.	D 366		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage	D 378		

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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 378	Continued From page 196 (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure treatment carts were locked when not under the direct supervision of a medication aide. The findings are: Observation of a treatment cart on 04/30/24 between 3:53pm and 5:12pm revealed: -The treatment cart was located on the 200-hall with residents' rooms, and which lead to a living room, the activity room, the dining room and the front exit. -At 3:53pm, the treatment cart was unlocked and no medication aide (MA) was present. -The treatment cart contained medicated creams, ointments, and glucose tablets prescribed by a physician. -Multiple residents walked past the treatment cart multiple times daily. -At 5:12pm, the treatment cart remained unlocked. Observations a treatment cart on 05/01/24 at various times between 8:00am and 3:30pm revealed: -The treatment cart was located on the 200-hall with residents' rooms, and which lead to a living room, the activity room, the dining room and the front exit.	D 378		

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D 378	Continued From page 197 -The treatment cart contained medicated creams, ointments, and glucose tablets prescribed by a physician. -Multiple residents walked past the treatment cart multiple times daily. -At 8;00am, the treatment cart was unlocked. -At 8:28am the MA was not at the cart and the cart was unlocked. -At 8:30am, the treatment cart remained unlocked. -At 9:43am, the treatment cart was unlocked. -At 10:35am, the treatment cart was unlocked. -At 11:29am, the treatment cart remained unlocked. -At 12:57am, the treatment cart remained unlocked. -At 3:30pm, the treatment cart remained unlocked. Interview with a medication aide (MA) on 05/02/24 at 2:05pm revealed: -Treatment carts should be locked when not in use. -She did not know the treatment cart was unlocked. Interview with a Supervisor on 05/02/24 at 2:24pm revealed: -The treatment carts should be locked at times when not being used by a MA. -There were medicated creams and ointments on the treatment carts there were prescribed by physicians. -She did not know the treatment cart on the 200-hall was unlocked. -A resident could have gotten a medicated cream they were allergic too, the bandage scissors and harmed themselves or another resident, or taken the glucose tablets and their blood sugar could have dropped.	D 378		

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D 378	Continued From page 198 Interview with the Resident Care Coordinator (RCC) on 05/02/24 at 2:02pm revealed: -The treatment carts should be locked when the MA was not at the treatment cart. -Anything could happen if the treatment cart was left unlocked and unattended; anyone could take medications. Interview with the Administrator on 05/02/24 at 11:27am revealed: -Before the MA walked away from the treatment cart, MA should make sure the cart was locked and everything was secured. -She was concerned the treatment cart had been left unlocked because someone could take medication from the cart.	D 378		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including	D 400		

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D 400	Continued From page 199 current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure on-site medication reviews were completed quarterly for 6 of 7 residents sampled (#2, #3, #4, #5, #7, and #8). The findings are: A request was made for quarterly pharmacy reviews for Residents #2, #3, #4, #5, #7, and #8 but were not provided prior to exit on 05/03/24. 1. Review of Resident #2's current FL-2 dated 11/22/23 revealed diagnoses of dementia without behavioral disturbances, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), and oxygen dependency.	D 400		

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D 400	Continued From page 200 Review of Resident #2's Resident Register revealed an admission date of 10/31/23. Review of Resident #2's record revealed there was no documentation of a quarterly pharmacy review. Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. 2. Review of Resident #4's current FL2 dated 11/15/23 revealed diagnoses included hypertension, chronic constipation, mild cognitive impairment, and anemia. Review of Resident #4's Resident Register revealed an admission date of 07/27/21. Review of Resident #4's record on 05/01/24 revealed there was no documentation of a quarterly pharmacy review. Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. 3. Review of Resident #5's current FL2 dated 01/19/24 revealed diagnoses included unspecified anxiety disorder and major neurocognitive disorder to multiple etiologies with	D 400		

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D 400	Continued From page 201 behavior disturbance. Review of Resident #5's Resident Register revealed an admission date of 03/16/22. Review of Resident #5's record on 05/01/24 revealed there was no documentation of a quarterly pharmacy review. Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. 4. Review of Resident #3's current FL-2 dated 01/03/24 revealed diagnoses included essential hypertension, diabetes mellitus two, chronic kidney disease, history of cerebral vascular accident (CVA), and spasticity. Review of Resident #3's Resident Register revealed an admission date of 12/15/23. Review of Resident #3's record revealed there was no documentation of a quarterly pharmacy review. Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. 5. Review of Resident #7's current FL-2 dated	D 400		

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D 400	Continued From page 202 12/05/23 revealed diagnoses included pneumonitis, hyperlipidemia, sepsis, overactive bladder, hypertensive heart & chronic kidney disease w/heart failure, chronic kidney disease, unspecified artificial fibrillation, rheumatoid arthritis, atherosclerotic heart disease of native coronary artery and gastroesophageal reflux disease (GERD). Review of Resident #7's Resident Register revealed she was admitted to the facility on 09/29/23. Review of Resident #7's record revealed there was no documentation of quarterly pharmacy reviews available for review. Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. 6. Review of Resident #8's current FL2 dated 8/23/2023 revealed diagnoses included non-ischemic cardiomyopathy, history of occipital stroke, gastroesophageal reflux disease (GERD), dyslipidemia, Type 2 diabetes, and vascular dementia. Review of Resident #8's Resident Register revealed she was admitted to the facility on 08/09/23. Review of Resident #8's record revealed there was no documentation of quarterly pharmacy reviews available for review.	D 400		

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D 400	Continued From page 203 Refer to the interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24. Refer to the interview with the Area Regional Manager on 05/01/24 at 12:32pm. Refer to the interview with the Administrator on 05/01/24 at 12:36pm. _____ Interview with the Pharmacist from the facility's contracted pharmacy on 05/01/24 at 9:35am revealed: -She was told by the Assisted Living Coordinator from the facility's contracted pharmacy the pharmacy started servicing this facility on 03/05/24. -She was assigned to this facility last week for pharmacy reviews. -She was scheduled for pharmacy reviews today, 05/01/24. -She had not completed any pharmacy reviews for this facility. -The pharmacy would complete new admission medication reviews in the facility. -The quarterly medication reviews would be completed using the facility census at the home office. -The medication carts were not audited by the pharmacy staff. Interview with the Area Regional Director (ARD) on 05/01/24 at 12:32pm revealed: -The pharmacy reviews should be completed quarterly by the pharmacist. -She would prefer the pharmacy reviews to be completed on-site. -She was not aware the state regulation required the pharmacy reviews to be completed in the facility.	D 400		

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D 400	Continued From page 204 Interview with the Administrator on 05/01/24 at 12:36pm revealed: -She thought the pharmacist should be in the facility monthly to review medications. -She was not aware of the state regulations that pharmacy reviews completed by the pharmacist should be done on-site. -The new pharmacy that started on 03/05/24, had not been to the facility for a medication review until today, 05/01/24. -She expected the pharmacy to be compliant with the state rules and regulations.	D 400		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local Department of Social Services (DSS) of incidents/accidents for 2 of 5 sampled residents that required emergency medical evaluation (#1 and #6) for a resident who had a low blood sugar and a fall (#1); and a resident who had a swollen hand after a fall (#6). Review of the facility's Resident Fall policy and	D 451		

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procedure revealed:
-The Supervisor or the Resident Care Coordinator (RCC) will be called to assess the resident and would decide for any physician notification, and/or treatment indicated.
-A resident Incident/Accident report would be filled out, family, guardians, and responsible parties would be notified.
-The staff would follow instructions to ensure complete reporting.

The findings are:

1. Review of Resident #1's current FL-2 dated 2/27/24 revealed:
-Diagnoses included cerebral infarction, diabetes mellitus type 2, dementia, major depression, anxiety, and gastro-esophageal reflux disease (GERD).
-She was intermittently disoriented.
-She was ambulatory with the assistance of a walker.
-She was continent of bowels and bladder.

Review of Resident #1's care plan dated 04/17/24 revealed:
-Resident #1 used a walker for ambulation with no problems.
-Resident #1 was sometimes disoriented.
-Resident #1 needed extensive assistance when bathing and dressing.
-Resident #1 needed limited assistance when toileting.

a. Review of Resident #1's incident/accident report dated 03/27/24 revealed:
-The time of the incident was 10:00am.
-Resident #1 fell while in the shower and hit her head.
-Resident #1 was transported to the hospital by

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Emergency Medical Services (EMS) on 03/27/24 at 10:10am.

Interview with the Adult Home Specialist (AHS) with the local county DSS on 05/02/24 at 3:22pm revealed she did not receive an incident/accident report for Resident #1 dated 03/27/24.

b. Review of Resident #1's incident/accident report dated 03/29/24 revealed:
-The time of the incident was 8:00am.
-Resident #1 was disoriented from her blood sugar dropping.
-Resident #1 had an unwitnessed fall.
-Resident #1 was transported to the hospital by Emergency Medical Services (EMS) on 03/29/24; there was no time documented for transfer.

Interview with the Adult Home Specialist (AHS) with the local county DSS on 05/02/24 at 3:22pm revealed she did not receive an incident/accident report for Resident #1 dated 03/29/24.

Interview with Resident #1 on 04/30/24 at 8:57am revealed:
-Her blood sugar had dropped and she was transported to the hospital.
-She was "out of it" and did not remember much about the incident.
-She knew she fell two times.
-She busted her head one time she fell and had to have stitches in her head.

Refer to the interview with a medication aide on 05/02/24 at 10:30am.

Refer to the interview with the Supervisor on 05/02/24 at 12:30pm.

Refer to the interview with the RCC on 05/02/24

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D 451	Continued From page 207 at 4:05pm. Refer to the interview with the Administrator on 05/02/24 at 4:28pm. 2. Review of Resident #6's FL2 dated 02/07/24 revealed diagnoses included late onset Alzheimer's disease with behaviors, cirrhosis of the liver and subarachnoid hemorrhage. Review of Resident #6's incident/accident report dated 02/13/24 revealed: -The time of the incident was not documented. -Resident #6 had and unwitnessed fall and was observed sitting on the floor against the wall; there was no location documented. -Resident #6 had a small abrasion on his right arm and complained of pain in his buttocks. -His left hand was swollen. -His Power of Attorney (POA) was notified at 3:55pm. -The primary care provider (PCP) was not notified. -He was not transported to the hospital and first aid was not needed. Review of Resident #6's progress notes revealed: -On 02/13/24, Resident #6 fell in his room and was found sitting against the wall; he had a small abrasion to his right elbow and his POA was called. -On 02/13/24 at 5:10pm, his left hand was swollen from the fall; he could move his hand. -His POA was called to see if she wanted him to go out but she said to let the PCP look at it the next day. -On 02/14/24, his hand was still being monitored due to swelling; resident had no complaints of pain and could move it. -On 02/15/24, his hand was still swollen; resident	D 451		

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refused to get an x-ray.
-On 02/17/24, Resident #6 hand was still swollen, and his PCP ordered an x-ray.
-On 02/18/24, Resident #6 hand was still swollen; x-ray was done at the facility by portable x-ray.
-At 7:10pm the facility contacted the POA and requested to call emergency transportation for Resident #6; the POA transported him to the hospital.
-On 02/19/24, Resident back in the facility and seemed to be doing well; no broken bones in his hand.

Interview with the Adult Home Specialist (AHS) with the local county Department of Social Services (DSS) on 05/02/24 at 3:22pm revealed she did not receive an incident/accident report for Resident #3 dated 02/13/24 or 02/18/24.

Refer to the interview with a medication aide (MA) on 05/02/24 at 10:30am.

Refer to the interview with the Supervisor on 05/02/24 at 12:30pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 05/02/24 at 4:05pm.

Refer to the interview with the Administrator on 05/02/24 at 4:28pm.

_____
Interview with a MA on 05/02/24 at 10:30am revealed when incident reports were completed, they were given to the Supervisor or the RCC.

Interview with the Supervisor on 05/02/24 at 12:30pm revealed once the incident/accident report was completed, it was placed in the RCC's box or given to the RCC.

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D 451	Continued From page 209 Interview with the RCC on 05/02/24 at 4:05pm revealed: -The incident/accident reports were to be sent to the AHS if the resident was sent to the Emergency Department (ED) for treatment. -She was responsible for sending the incident/accident reports to the AHS. -She reviewed the incident/accident reports and scanned them into the system. -The incident/accident reports were scanned to the Business Office Managers (BOM) email address. -The BOM would email incident/accident reports to her and she would email the incident/accident reports to the AHS. -The facility did not have a BOM at this time. -She was not receiving emails of the incident/accident reports to send to the AHS. -She did not know who was responsible for emailing the incident/accident reports to her since the facility did not have a BOM. Interview with the Administrator on 05/02/24 at 4:28pm revealed: -The RCC was responsible for sending the incident/accident reports to the AHS. -She did not know the incident accident reports were not being sent to the AHS. -She expected the RCC to send incident/accident reports to the AHS if needed.	D 451		