STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL073019	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 05/28/2024

NAME OF PROVIDER OR SUPPLIER: **ROXBORO ASSISTED LIVING OPCO LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **5660 DURHAM ROAD ROXBORO, NC 27574**

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D 000	Initial Comments The Adult Care Licensure Section and the Person County Department of Social Services conducted a complaint investigation from 05/22/24 to 05/24/24 and on 05/28/24.	D 000		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on record reviews and interviews, the facility failed to ensure the required aide hours were met during 30 of 35 shifts from 05/10/24 through 05/21/24.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was a licensed Assisted Living with a capacity of 120 residents.

Review of the facility's census record for 05/10/24 to 5/14/24 revealed there was a census of 81 to 84 residents which required 36 aide hours on first and second shifts and 24 aide hours on third shift.

Review of the facility's census record for 05/15/24 to 05/21/24 revealed there was a census of 78 to 80 residents which required 32 aide hours on first and second shifts and 24 aide hours on third shift.

Review of staff timecard punches from 05/10/24 through 05/21/24 revealed:
-On 05/10/24, 14.00 aide hours were provided on first shift leaving a shortage of 22.00 aide hours.
-On 05/10/24, 21.00 aide hours were provided on second shift leaving a shortage of 15 aide hours.

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D 201	Continued From page 2 -On 05/11/24, 21.00 aide hours were provided on first shift leaving a shortage of 15 aide hours. -On 05/11/24, 15.28 aide hours were provided on second shift leaving a shortage of aide 20.72 hours. -On 05/11/24, 8.00 aide hours were provided on third shift leaving a shortage of 16.00 aide hours. -On 05/12/24, 21.00 aide hours were provided on first shift leaving a shortage of 15 aide hours. -On 05/12/24, 20.00 aide hours were provided on second shift leaving a shortage of 16.00 aide hours. -On 05/12/24, 15.75 aide hours were provided on third shift leaving a shortage of 8.25 aide hours. -On 05/13/24, 21.00 aide hours were provided on first shift leaving a shortage of 15 aide hours. -On 05/13/24, 20.00 aide hours were provided on second shift leaving a shortage of 16.00 aide hours. -On 05/13/24, 15.50 aide hours were provided on third shift leaving a shortage of 8.50 aide hours. -On 05/14/24, 28.00 aide hours were provided on first shift leaving a shortage of 8.00 aide hours. -On 05/14/24, 27.50 aide hours were provided on second shift leaving a shortage of 8.50 aide hours. -On 05/15/24, 21.75 aide hours were provided on first shift leaving a shortage of 10.25 aide hours. -On 05/15/24, 23.50 aide hours were provided on second shift leaving a shortage of 8.50 aide hours. -On 05/15/24, 16.00 aide hours were provided on third shift leaving a shortage of 8.00 aide hours. -On 05/16/24, 23.50 aide hours were provided on second shift leaving a shortage of 8.50 aide hours. -On 05/16/24, 15.00 aide hours were provided on third shift leaving a shortage of 9.00 aide hours. -On 05/17/24, 21.00 aide hours were provided on first shift leaving a shortage of 11.00 aide hours.	D 201		

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-On 05/18/24, 18.50 aide hours were provided on first shift leaving a shortage of 13.50 aide hours.
-On 05/18/24, 21.50 aide hours were provided on second shift leaving a shortage of 10.50 aide hours.
-On 05/18/24, 14.50 aide hours were provided on third shift leaving a shortage of 9.50 aide hours.
-On 05/19/24, 20.00 aide hours were provided on first shift leaving a shortage of 12.00 hours.
-On 05/19/24, 24.75 aide hours were provided on second shift leaving a shortage of 7.25 aide hours.
-On 05/20/24, 14.00 aide hours were provided on first shift leaving a shortage of 18.00 aide hours.
-On 05/20/24, 16.00 aide hours were provided on second shift leaving a shortage of 16.00 hours.
-On 05/20/24, 15.25 aide hours were provided on third shift leaving a shortage of 8.75 aide hours.
-On 05/21/24, 14.00 aide hours were provided on first shift leaving a shortage of 18.00 aide hours.
-On 05/21/24, 12.00 aide hours were provided on second shift leaving a shortage of 20.00 aide hours.
-On 05/21/24, 7.25 aide hours were provided on third shift leaving a shortage of 16.75 aide hours.

Interview with a resident on 05/24/24 at 9:24am revealed:
-There were not enough staff working on any shift.
-He could ring his call bell and it would take 30 minutes for someone to come, if they came at all.
-He was scheduled to receive a shower three times a week, but he only received a shower once or twice a week.
-Snacks were supposed to be passed out three times a day.
-He would get a snack once or twice a day, but rarely three times a day.
-He received his medications if the medication

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was in the facility.
-There was no certain time his medication was administered.

Interview with a second resident on 05/24/24 at 9:40am revealed:
-She was supposed to get a shower three days a week.
-Most weeks she only received one shower.
-She did not receive a shower three times a week because "the staff did not have time" to assist her with a shower.
-The facility did not have enough staff.
-Someday's snacks were not offered to the residents.

Interview with a resident's family member on 05/24/24 at 10:05am revealed:
-The resident should receive a shower three times a week in the morning.
-The resident would wash off in the sink and dress herself because no staff was available to assist with the shower.
-The resident had a brace to wear on her leg and the staff did not help the resident apply the brace.

Interview with a second resident's family member on 05/24/24 at 10:20 am revealed:
-Fresh water and ice were never passed out to the residents.
-The family member constantly had to refill the residents' cup with ice and water.
-Clean towels were not placed in the bathroom; the family member would have to go to the laundry to get them.
-The staff did not assist with donning and removing hearing aids for her family member.

Interview with a third resident's family member on 05/24/24 at 10:30am revealed:

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-The resident fell on 05/19/24 and was transferred to the Emergency Department (ED).
-After the resident returned to the facility later the same day, she stayed with the resident until 6:00pm.
-The resident was not checked on by any staff after the resident was returned to the facility from the ED.
-She was with the resident on Saturday and Sunday, 05/25/24 and 05/26/24, and no staff checked on the resident.
-She thought the staff would check on the resident even if she was visiting.
-She had provided incontinent care to the resident when she was soiled.
-The resident fell again this morning, 05/28/24.
-The resident's table mate at meals saw the resident was not in the dining room for breakfast and went to the resident's room to check on her after breakfast and found her lying on the floor.
-No staff had checked on the resident to see why she did not come to breakfast.
-The resident did not receive breakfast the morning of 05/28/24.

Interview with a personal care aide (PCA) on 05/24/24 at 7:15am revealed:
-She worked the 12-hour night shift which was 6:30pm to 6:30am.
-She had worked the 12-hour night shift with one other PCA and one medication aide (MA) but could not remember when.
-The MA helped with personal care for about 1 hour a night.
-The MAs were responsible for MA duties.

Interview with a second PCA on 05/24/24 at 8:52am revealed:
-The facility had two groups that alternated working 12-hour day shifts.

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-She was moved from one group to the other group a few weeks ago, because there were only two PCAs on the rotation she moved to.
-After she changed rotation groups, one of the PCAs quit, leaving only 2 PCAs again.
-The person working in the laundromat, who was a PCA, was pulled to the floor to work as a PCA.
-Sometimes there was a fourth PCA assigned to work, but not very often.
-The MAs did not have a lot of time to help the PCAs; the MAs helped mostly during mealtimes when they were not passing medications.
-She was late passing snacks somedays because she was busy providing personal care.

Interview with a third PCA on 05/24/24 at 9:40am revealed:
-She was a PCA and used to work full-time as a PCA.
-She transferred to the laundromat when an opening occurred.
-She was pulled to the floor to work as a PCA when the facility was short staffed.
-When she worked the floor there was nobody working laundry, so she would do laundry when she had time while working as a PCA.
-The laundry had to be done also for residents to have clean clothes.
-She worked yesterday 05/23/24 and today 05/24/24 as a PCA.
-She worked 3 days the week of 05/13/24 as a PCA.
-She worked as a PCA when a third PCA was needed on the floor.

Interview with a MA on 05/24/24 at 8:47am revealed:
-Today, 05/24/24, there were two MAs working first shift.
-There should be 3 MAs working first shift

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because the facility had 3 medication carts.
-The 100-hall and 200-hall medications were administered first and both MAs worked the 300-hall medication carts to administer the medications.
-There were 3 PCAs working first shift today, 05/24/24.
-Sometimes there was a fourth PCA who worked first shift.
-When there were two MAs on first shift, she did not have time to assist with personal care.

Interview with the Resident Care Coordinator (RCC) on 05/24/24 at 9:04am revealed:
-She started working as the RCC on Monday 05/20/24.
-She worked as a staff coordinator in another facility and was used to doing the schedule.
-She was learning the scheduling process for this facility.
-She did not know how many hours were required per shift for 78 to 84 residents.
-The previous RCC scheduled 3 PCAs for the 12-hour day shift and 3 PCAs for the 12-hour night shift.
-She had been working with the schedule this week with the assistance of the Administrator.

Interview with the Administrator on 05/24/24 at 1:10pm revealed:
-She did not realize the previous RCC was not scheduling enough staff to meet the state requirements.
-She took over the scheduling on 05/04/24.
-She was so busy she did not pay attention to how many PCA hours were scheduled per shift.
-She continued scheduling as the previous RCC had scheduled.
-She realized the facility was short staffed when it was brought to her attention today, 05/24/24.

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-She did not use the census when she scheduled the staff.
-She was not scheduling staff based on the staff regulations.
-If the staff worked an 8-hour shift they received a 30-minute break.
-If the staff worked a 12-hour shift they received an hour break.

Interview with the Regional Director on 05/24/24 at 1:22pm revealed.
-There should be 4 to 5 PCAs on the schedule for the 12-hour day shift and the 12-hour night shift.
-The Administrator should request staff to work extra hours.
-The Administrator should have the RCC work as a MA or PCA to ensure enough staff.
-The Administrator could offer bonuses of $50.00 to $75.00 to employees for picking up extra hours.
-The Administrator would work to cover hours to ensure there was enough staff available to provide personal care.

____

The facility failed to provide the required number of staffing hours for 30 of 35 shifts between 05/10/24 through 05/21/24 which resulted in a resident who fell and staff did not check on the resident to determine why the resident did not go to breakfast and was found on the floor in the resident's room by another resident; and residents not getting showers, hydration and snacks, or personal hygiene in a timely manner. This failure placed the residents at substantial risk for serious physical harm, which constitutes a Type A2 Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/22 for this violation.

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D 201	Continued From page 9 THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 27, 2024.	D 201		
D 223	10A NCAC 13F .0702 (a) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (h) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure the requirements for a written notice of discharge were met prior to discharging residents for 3 of 3 sampled residents (#5, #7 and #8). The findings are: 1. Review of Resident #7's previous FL2 dated 04/10/24 revealed: -Diagnoses included dementia without behavioral	D 223		

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disturbance, bipolar disorder, major depressive disorder, edema, chronic obstructive pulmonary disease (COPD), and hypokalemia.
-Resident #7's current level of care was documented as "other, assisted living."
-Resident #7's recommended level of care was "other."

Review of Resident #7's current FL2 dated 04/17/24 revealed:
-Diagnoses included dementia without behavioral disturbance, bipolar disorder, major depressive disorder, edema, COPD, and hypokalemia.
-Resident #7's current level of care was documented as "other, assisted living."
-Resident #7's recommended level of care was "other, mental health facility."

Review of Resident #7's primary care provider's (PCP) progress note dated 04/17/24 revealed:
-The reason for the visit was to sign a new FL2 for Resident #7's transfer to a mental health facility.
-The PCP was seeing Resident #7 that day, 04/17/24, at the request of the facility to sign a new FL2 as Resident #7 was no longer appropriate for the facility due to her behaviors and uncontrolled anxiety levels.
-Resident #7 was more suited for a mental health facility.
-Upon assessment of Resident #7 she was calm and cooperative.
-Resident #7 had moderate dementia with anxiety and per staff reports, her anxiety levels were out of control.
-Resident #7 was constantly crying and worrying and making other residents anxious.
-Resident #7 was prescribed and taking medications to help with anxiety.

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D 223	Continued From page 11 Review of Resident #7's Resident Register dated 05/30/23 revealed: -Resident #7 was admitted to the facility on 05/31/23. -Resident #7 had a Power of Attorney (POA). -Section G for Discharge/Transfer Information was left blank and had no date of notice of discharge, reason for discharge, date of discharge/transfer, new address, or information on whether or not a copy of the discharge notice had been given to the POA. -Resident #7's POA had not signed the discharge portion of the Resident Register. Review of Resident #7's Notice of Transfer/Discharge form dated 05/13/24 revealed: -The date of notice was 05/13/24. -The date of transfer/discharge was 05/13/24. -The reason for the notice was it was necessary for the resident's welfare and her needs could not be met at the facility as documented by the resident's physician or nurse practitioner. -There was documentation Resident #7's POA had been called on the phone for verbal notification, date of call was not specified. -Resident #7 was being transferred to an assisted living facility in another town. Review of Resident #7's care plan dated 04/10/24 revealed she was oriented and her memory was adequate. Review of Resident #7's psychiatry progress note dated 04/19/24 revealed: -Resident #7 had moderate dementia but was alert and oriented to person, place, and situation, but not to time. -Resident #7 reported to her that day on 04/17/24, her anxiety had improved since starting	D 223		

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a new medication.
-Resident #7 had a diagnosis of generalized anxiety disorder and was prescribed medications to treat and manage her anxiety.
-Resident #7 reported lower levels of anxiety since her previous visit and that she had been using various techniques suggested in the binder which was given to her including implementing distraction, deep breathing, and walking for stress management.
-Staff needed to cue Resident #7 to use the binder when she had anxiety.
-Resident #7 would continue to benefit from supportive care and redirection.

A request was made on 05/23/24 for Resident #7's progress notes for the previous 6 months but were not provided by survey exit.

Telephone interview with Resident #7's POA on 05/23/24 at 11:20am revealed:
-The Administrator called him at 9:00am on 05/13/24, the morning they transferred Resident #7 to the other facility, and that was the first time he had heard anything about Resident #7 needing to move out of the facility.
-He felt the Administrator was rude while on the phone with him and told him that Resident #7 needed to move to their sister facility an hour and a half away because the sister facility had a Special Care Unit (SCU), unless he knew of another place to move her into.
-He told the Administrator that he would have arranged a transfer to another local facility if he had been given enough notice to do so.
-He had not agreed with Resident #7 being transferred to a different facility.
-All of Resident #7's family lived in the same town as her current facility, so he did not want her moving an hour and a half away because it would

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

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D 223	Continued From page 13 make it hard for them to visit her. -He was never given any paperwork to sign from the facility. -He had not received a Notice of Transfer/Discharge or a form to appeal the discharge. -Resident #7 had resided at the facility for many years, except for a brief discharge and re-admission the previous year. -She was "out of her element" at the new facility they had transferred her to in that she was not familiar with the staff or the routines of the new facility. -The facility never made him aware of any behaviors or concerns that Resident #7 was having that would require them to transfer her to another facility. -No behaviors had ever been reported to him other than the day she was transferred to the new facility when he was told she had a panic attack. -He was told by an unnamed staff that staff went into Resident #7's room after breakfast on 05/13/24 and told her they were taking a little trip, packed up some clothes from her room and got her on the bus to go to the new facility. -He went to the facility that Friday on 05/17/24, and packed up the rest of Resident #7's belongings because the facility only sent one week's worth of clothing with her. -He visited Resident #7 at the new facility on Saturday, 05/18/24, and took her belongings to her and to see how she was doing. -Resident #7 did not like the new facility because she did not know anyone at the facility or in that town, and she still did not understand why she had to leave her previous facility. -He was trying to get Resident #7 moved to a facility closer to where he and all the rest of her family lived. -The facility had reported to the new facility that	D 223		

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Resident #7 wandered and was an elopement risk, so he was having a hard time getting a local facility to admit her.

Interview with a medication aide (MA) on 05/23/24 at 12:16pm revealed:
-She had worked at the facility for a couple of weeks but was familiar with Resident #7.
-Resident #7 went up to the medication cart a lot to request her anxiety medication.
-Resident #7 did not have any behaviors other than telling staff she was nervous.
-Resident #7 was oriented to person, place, time and situation.
-She did not know why Resident #7 was transferred to another facility.
-She did not find out about Resident #7 being transferred until the morning Resident #7 was discharged.

Interview with a second MA on 05/23/24 at 3:00pm revealed:
-Resident #7 had anxiety and even with her medications she still had anxiety attacks often where she would want the staff to sit with her and hold her hand.
-Resident #7's mental health provider (MHP) gave her a binder to go through whenever she had anxiety, but she did not know if Resident #7 found it helpful.
-Resident #7 did not have any behaviors, and she was alert and oriented to person, place, time and situation.
-She did not know why Resident #7 was transferred to another facility.

Telephone interview with Resident #7's PCP on 05/23/24 at 3:25pm revealed:
-She saw Resident #7 in April 2024 to sign a new FL2 for her transfer to another facility because

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the current facility could not control her anxiety.
-Resident #7's behaviors were that she was constantly crying, yelling, and would sit in the front room talking and crying and it made other residents uncomfortable.
-She agreed that Resident #7 needed to transfer to a different facility, but she thought Resident #7 would go to a mental health facility, not that she would be transferred to a SCU at another Assisted Living facility.
-She was not aware of where Resident #7 had been transferred to until Resident #7's POA contacted her asking why Resident #7 went to a dementia unit.
-Resident #7 did not have a history of wandering or elopement.

Interview with the Administrator on 05/23/24 at 4:20pm revealed:
-On 05/12/24 she arranged Resident #7's transfer with the sister facility in another town.
-She called the facility on the evening of 05/12/24, the night before Resident #7 was discharged, to notify staff that Resident #7 should be up and eating breakfast the following morning to prepare for her transfer to the new facility.
-She texted the transportation staff on the evening of 05/12/24 and told her to transfer Resident #7 along with 7 days' worth of clothing and her television to the new facility the following morning.
-She did not know who told Resident #7 that she was being transferred to another facility the morning of 05/13/24 because she did not see Resident #7 before she left that day.
-Resident #7 found out she was being transferred to another facility the morning she was discharged.
-She never spoke to Resident #7 about being transferred or why she was being transferred.

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-Resident #7's POA called her the day of the discharge to ask why Resident #7 was being discharged because he thought she was doing fine at the facility.
-Resident #7 was transferred to the other facility prior to 11:00am because she remembered the facility sent a packed lunch with her.
-Resident #7's POA never signed a Notice of Transfer/Discharge because she had a phone conversation with him about the discharge instead.
-She did not send Resident #7's POA the paperwork to appeal the discharge decision because after the POA spoke with the PCP about Resident #7's discharge, she thought the POA was agreeable to the discharge.

Interview with a personal care aide (PCA) on 05/24/24 at 8:10am revealed:
-Resident #7 was transferred to a locked SCU a couple of hours away.
-Resident #7 was very sweet but she had really bad anxiety attacks.
-Resident #7 was easy to calm down during her anxiety attacks if you took the time to be with her for a few minutes because she did not like to be alone.
-Resident #7 did not disturb other residents or have any other behaviors other than her anxiety.
-Resident #7 was alert and oriented and independent with her activities of daily living.
-Neither the staff nor Resident #7 had been aware of the transfer to the other facility on 05/13/24 until the transportation staff started packing her belongings and putting them on the bus.

Interview with the transportation staff person on 05/24/24 at 8:50am revealed:
-The Administrator texted her to let her know that

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D 223	Continued From page 17 Resident #7 would be discharged the following day on 05/13/24, and that she would call and let the facility know to have her ready. -She was told by the Administrator not to tell Resident #7 what was going on. -She packed up Resident #7's clothes and necessities with a couple of PCAs while Resident #7 was out of her room. -When she was getting Resident #7 on the bus, Resident #7 asked where she was going and so she told her they were going to another facility. -Resident #7 asked several times during the bus ride to the sister facility where she was going; she did not know how Resident #7 was reacting because it was raining that day, and the bus was loud. -Resident #7 did not seem upset and she did not know if Resident #7 was aware she was being moved to the sister facility rather than just visiting the facility for another reason. -She did not tell Resident #7 she was being moved to the sister facility because she was afraid Resident #7 would have a panic attack on the bus if she told her the truth. Interview with a second PCA on 05/24/24 at 9:00am revealed: -She went with the transportation staff person to transfer Resident #7 to the sister facility. -She had not been aware until that day (05/13/24) that Resident #7 was being transferred to a sister facility when she got to work and saw a note saying to pack up Resident #7's belongings. -Resident #7 was not aware she was being moved to a sister facility. -Resident #7's clothes were packed up while she was in the dining room having breakfast. -Resident #7 got on the bus to go to the sister facility and she seemed fine. -Resident #7 seemed "okay" when she was	D 223		

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shown her new room at the sister facility, but when she hugged her goodbye Resident #7 told her she hoped she would see her again and said she was sad that after 12 years at the facility she had to move.
-Resident #7 did not have any behaviors or wandering while at the facility and she was a respectful resident.
-Resident #7 had not been disruptive to the other residents.
-Resident #7 had panic attacks where she would need physical touch like a hand on her arm or someone holding her hands to calm her down.

Telephone interview with Resident #7's MHP on 04/24/24 at 10:25am revealed:
-Resident #7 had anxiety her whole life and was taking medications to manage it.
-Resident #7 also had a diagnosis of bipolar disorder, but the diagnosis was controlled well with medication.
-Resident #7 enjoyed group activities but she had no coping mechanisms, so the MHP developed a binder for Resident #7 to review during anxiety attacks to help her identify what was triggering the anxiety along with some coping skills to try.
-She last saw Resident #7 on 05/09/24 and she was the best that she had ever seen her; Resident #7 reported she had not had any anxiety for the previous few days.
-Her goal in treating Resident #7 was to stabilize her anxiety and decrease her medication use.
-Resident #7 liked to hold people's hands and she did well with redirection during her anxiety attacks.
-Resident #7 used the binder she was given and reported that it was helpful to her.
-Resident #7 did not have any behaviors towards other residents; she was just "needy" with the staff at times wanting them to hold her hands.

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-She did not know why Resident #7 had been discharged; a PCA told her that it was because Resident #7's anxiety was getting to be too much for the facility.
-Resident #7 had some cognitive impairment when it came to remembering time but socially, she did really well and was appropriate.
-Resident #7 did not have any wandering behaviors.
-She had not initiated or suggested that Resident #7 be discharged or transferred to a different level of care.

Interview with the Administrator on 05/24/24 at 2:11pm revealed:
-She was aware that residents or their responsible party were supposed to receive a 30-day discharge notice and appeal form.
-She did not give Resident #7's POA notice because Resident #7's new FL2 documented she needed a different level of care, so she thought she had to move her out right away.
-She should have given Resident #7's POA the Notice of Discharge/Transfer form and appeal form on 04/17/24 when the PCP signed the new FL2.
-Resident #7 was discharged because she felt the facility was not able to meet her needs because she was constantly wanting someone to sit with her and hold her hand.
-Resident #7 had anxiety attacks daily.
-The facility did not have enough staff to comfort Resident #7 as often as she needed.
-She spoke with staff at the sister facility the day before Resident #7 was transferred there and staff at the sister facility approved the transfer.
-The staff at the sister facility who approved the transfer for the following day was her boss.

2. Review of Resident #8's current FL2 dated

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12/06/23 revealed:
-Diagnoses included diabetes, depression, and bipolar disorder.
-Current level of care was documented as domiciliary.
-Recommended level of care was documented as skilled nursing facility.

Review of Resident #8's undated Resident Register revealed:
-Resident #8 was admitted to the facility on 06/24/21.
-Resident #8 was her own responsible person; she did not have a power of attorney (POA) or guardian.
-Section G for Discharge/Transfer Information was left blank and had no date of notice of discharge, reason for discharge, date of discharge/transfer, new address, or information on whether or not a copy of the discharge notice had been given to Resident #8.
-Resident #8 had not signed the discharge portion of the Resident Register.

Review of Resident #8's care plan dated 05/10/23 revealed she was oriented and her memory was adequate.

Review of Resident #8's psychiatry progress note dated 04/19/24 revealed:
-Resident #8 had a diagnosis of bipolar disorder that was chronic and stable.
-Resident #8 was calm with the mental health provider (MHP) during her assessment but became irritable and labile whenever mention of getting a new roommate was brought up.
-Resident #8 reported feeling depressed but denied suicidal ideation.
-Resident #8 was less withdrawn since her previous visit on 04/05/24.

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D 223	Continued From page 21 A request was made on 05/23/24 for Resident #8's progress notes for the previous 6 months but were not provided by survey exit. Interview with a medication aide (MA) on 05/23/24 at 3:00pm revealed: -Resident #8 had some behaviors which included cursing at staff and other residents. -Resident #8 would get upset if she asked staff for something and it was not completed right away. -She had verbal outbursts such as cursing or name calling with staff and other residents around once per week. -She was never physical towards staff or other residents. -She was alert and oriented to person, place, time, and situation. -She did not know why Resident #8 had been discharged to a Special Care Unit (SCU) at another facility. Telephone interview with Resident #8's primary care provider (PCP) on 05/23/24 at 3:25pm revealed: -Resident #8 had some behaviors including not wanting a roommate, being medically noncompliant, and would curse at staff and other residents weekly. -She was not aware of Resident #8 having any physical altercations with staff or residents. -She could not remember the date, but the Administrator told her that Resident #8 needed to transfer to another facility due to her behaviors, so she signed a new FL2 for her. -Resident #8 was appropriate to be transferred to another assisted living facility or skilled nursing facility due to her history of fracture with immobility and noncompliance.	D 223		

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-She did not know why Resident #8 was discharged from the facility to a SCU.
-She felt Resident #8 would benefit from more care at a skilled facility, but she did not initiate or recommend the discharge.

Interview with the Administrator on 05/23/24 at 4:20pm revealed:
-Resident #8 was her own responsible person.
-Resident #8 was discharged because she had a lot of confrontations with other residents which she felt made her a danger to herself or others, and she sometimes would fall when she became angry.
-Resident #8 was noncompliant with fingerstick blood sugar (FSBS) checks and incontinence.
-Resident #8 disrupted activities and cursed out staff and other residents when she became upset.
-Resident #8's PCP was aware of her behaviors.
-There was no family contact information available for Resident #8 other than one friend who was her contact person.
-Resident #8 was not given a notice of discharge, but she talked to her about discharging the morning she transferred her to the sister facility on 05/13/24 with two other residents to let her know that she was leaving.
-Resident #8 seemed happy to be transferring to a different facility so she did not provide her with an appeal form.
-Resident #8 had not signed her Resident Register or a Notice of Transfer/Discharge prior to being transferred to the sister facility.
-Resident #8's family member came to the facility to pick up the rest of her belongings, but she did not have a phone number to contact him.

Interview with a personal care aide (PCA) on 05/24/24 at 8:10am revealed:

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-Resident #8 was in her right mind and did not have memory impairment.
-Resident #8 treated others however they treated her.
-If staff did not do what Resident #8 wanted them to do, she would get mad and curse at the staff person.
-Resident #8 sometimes cursed out other residents too, but she never got physically aggressive with staff or residents.
-The PCAs did not document behaviors; they reported behaviors to the MAs and the MAs were responsible for documentation.

Interview with the transportation staff on 05/24/24 at 8:50am revealed:
-The Administrator texted her to let her know that Resident #8 would be discharged the following day along with two other residents on 05/13/24, and she would call and let the facility know to have her ready.
-She was told by the Administrator not to tell Resident #8 what was going on.
-She packed up Resident #8's clothes and necessities with a couple of other PCAs and Resident #8 was in her room as they packed her items.
-Resident #8 was told she was transferring to another facility and she said she was happy to be leaving.

Interview with a second PCA on 05/24/24 at 9:00am revealed:
-Resident #8 had some verbal behaviors where she cursed at residents and staff but no physical behaviors.
-Resident #8 was able to be redirected during her behaviors.
-She went with the transportation staff to transfer Resident #8 to the new facility.

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-She had not been aware until that day that Resident #8 was being transferred to a sister facility when she got to work and saw a note saying to pack up Resident #8's belongings.
-Resident #8 was not aware she was being moved to another facility because when she saw Resident #8 that morning and made a comment to her about Resident #8 leaving her, Resident #8 asked what she was talking about.
-Resident #8 seemed happy about transferring to another facility until she found out the sister facility was over an hour and a half away.
-Resident #8 did not want to move so far away because she said she did not have any friends or family near that town.
-When Resident #8 was getting on the bus to leave for the sister facility, her family member showed up and asked what was going on.
-When she told Resident #8's family member that Resident #8 was moving to a new facility, he told her he did not know when he would get to see her because the other facility was so far away.
-Resident #8 received visitors while she resided at the facility and she told her that if she could stay in the same town she would at least still be able to see her family.
-She did not know why Resident #8 would be discharged to a SCU.

Telephone interview with Resident #8's mental health provider (MHP) on 05/24/24 at 10:25am revealed:
-Resident #8 had no physical behaviors but was withdrawn at times.
-During her last visit with Resident #8 on 05/09/24, she was told by staff that Resident #8 had caused a scene by yelling at the nurse's station.
-Resident #8 was calm during her assessment on 05/09/24 and told her she wanted to leave the

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facility and return to her home.
-Resident #8 was alert and oriented to person, place, time, and situation.
-Resident #8 was frustrated over getting a new roommate, but she was able to be redirected when she became upset.
-She had not initiated Resident #8's discharge nor recommended a different level of care.
-Her goal with Resident #8 was to stabilize her on her medications and walk her through any distress she had.
-Resident #8 had a labile mood but she did not have a diagnosis of dementia, so she was not sure why she was transferred to a SCU.

Attempted telephone interview with Resident #8's contact person on 05/23/24 at 2:45pm was unsuccessful.

Attempted telephone interview with Resident #8 on 05/24/24/ at 11:00am was unsuccessful.

3. Review of Resident #5's current FL2 dated 05/01/24 revealed:
-Diagnoses included late onset Alzheimer's dementia with behaviors, hypertension, and diabetes.
-Resident #5's current level of care was documented as "other, assisted living."
-Resident #5's recommended level of care was "other, memory care and skilled nursing facility."

Review of Resident #5's Resident Register that was not dated revealed:
-There was no date of admission listed.
-Resident #5 had a Power of Attorney (POA).
-Section G for Discharge/Transfer Information had a date of notice of discharge of 05/13/24.
-The discharge was initiated by the Administrator with the reason documented as "need memory

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care."
-The date of discharge/transfer was 05/13/24.
-The new address section was left blank.
-The "yes (required)" checkbox on whether a copy of the discharge notice had been given to the POA was not checked and was left blank.
-Resident #5's POA had not signed the discharge portion of the Resident Register.

A copy of Resident #5's Notice of Transfer/Discharge form was requested on 05/23/24 but was not provided.

Telephone interview with Resident #5's family member on 05/23/24 at 2:24pm revealed:
-The Administrator called the POA around 7:00pm on 05/13/24 and said that she was going to get the Administrator for another facility on the phone because they needed to move Resident #5 to another facility by 05/15/24.
-The facility issued a discharge notice previously on 03/19/24 for failure to pay for services but the discharge notice had "run out".
-The discharge notice sent on 03/19/24 had a planned discharge location of "not applicable."
-Resident #5 was paying all that he could towards his expenses of living at the facility.
-Resident #5 was moved 90 miles away from his family on 05/14/24.
-He had never seen the new facility where Resident #5 was moved.
-He and another family member went to the facility on 05/18/24 and moved the rest of Resident #5's belongings to the new facility.
-There was never a new discharge notice issued after the discharge notice in March 2024.
-There was no prior notice given until the day before Resident #5 was moved.
-Two other residents were moved the same day Resident #5 was moved.

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-He was "extremely angry and frustrated" at this whole process.

Telephone interview with Resident #5's PCP on 05/23/24 at 3:44pm revealed:
-She was not notified of where Resident #5 was going until 05/14/24 when Resident #5 was on the bus being transferred to another facility.
-She was told by the Administrator that Resident #5 needed to be moved because of the previous survey in early May 2024 and Resident #5 had to leave for the facility to be in compliance.
-She signed a new FL2 for Resident #5 on 05/01/24.
-She had previously told the facility Resident #5 could have used a higher level of care but there was a delay.
-Resident #5 would have benefited from a memory care unit but the family was "not on board."
-She agreed that Resident #5 needed to transfer to a different facility because he had a previous elopement and it was best for Resident #5's safety.

Interview with the Administrator on 05/23/24 at 4:25pm revealed:
-She had previously issued a discharge notice to Resident #5 on 03/19/24 for financial reasons because Resident #5 owed the facility $17,000.
-Resident #5's POA told her it was the facility's responsibility to find somewhere for Resident #5 to move.
-On 05/13/24 she arranged Resident #5's transfer with the sister facility in another town.
-Resident #5 was transferred because he had previously eloped from the facility twice and had tried several other times to elope from the facility.
-She called the facility the night before Resident #5 was discharged, to notify staff that Resident

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#5 should be up and eating breakfast the following morning to prepare for his transfer to the sister facility.
-She texted the transportation staff on the evening of 05/13/24 and told her to transfer Resident #5 along with 7 days' worth of clothing to the sister facility the following morning.
-She never spoke to Resident #5 about being transferred or why he was being transferred.
-Resident #5 was transferred to the sister facility prior to 11:00am on 05/14/24.
-There was no second written notice about the discharge given to Resident #5's family other than the initial discharge notice issued in March 2024.

Interview with a personal care aide (PCA) on 05/24/24 at 8:25am revealed:
-Resident #5 was transferred to a locked SCU a couple of hours away.
-Neither the staff nor Resident #5 had been aware of the transfer to the other facility until the transportation staff started packing his belongings and putting them on the bus.

Interview with the transportation staff person on 05/24/24 at 8:50am revealed:
-The Administrator texted her to let her know that Resident #5 would be discharged the following day on 05/13/24, and that she would call and let the facility know to have him ready.
-She packed up Resident #5's clothes and necessities with a couple of PCAs while Resident #5 was out of his room.

Interview with a second PCA on 05/24/24 at 9:00am revealed:
-She went with the transportation staff person to transfer Resident #5 to the sister facility.
-She had not been aware until that day (05/14/24) that Resident #5 was being transferred to a sister

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facility when she got to work and saw a note saying to pack up Resident #5's belongings.
-Resident #5 was not aware he was being moved to a sister facility.
-Resident #5 got on the bus to go to the sister facility and he did not seem upset.
-Resident #5 wandered while he was at the facility.

Telephone interview with Resident #5's family member on 05/28/24 at 3:20pm revealed that Resident #5's family had only been able to go see him once since he was moved on 05/18/24 when they moved Resident #5's belongings to the new facility.

Interview with the Administrator on 05/24/24 at 2:20pm revealed:
-She was aware that residents or their responsible party were supposed to receive a 30-day discharge notice and appeal form.
-She should have given Resident #5's POA the Notice of Discharge/Transfer form and appeal form on 05/01/24 when the PCP signed the new FL2.
-She did not send Resident #5's POA the paperwork to appeal the discharge decision.
-Resident #5 was discharged because she felt the facility was not able to meet his needs because he had eloped the facility twice and had tried to elope several other times and she was concerned for Resident #5's safety.
-She spoke with staff at the new facility the day before Resident #5 was transferred there and the new facility approved the transfer.
-The staff at the other facility who approved the transfer of Resident #5 was her boss.

____

The facility failed to provide a discharge notice or opportunity to choose where to live when the

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residents were abruptly moved out of the facility; the residents' family members and POAs expressed feelings of frustration and being upset about the residents being moved out of the facility to a sister facility over an hour away with no prior notice and the residents being unable to take all their personal belongings with them. This failure resulted in serious neglect which constitutes a Type A1 Violation.

____

The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 05/24/24.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED, JUNE 27, 2024.

D 338 10A NCAC 13F .0909 Resident Rights D 338

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on record reviews and interviews, the facility failed to ensure that all residents were treated with respect and dignity including a resident (#4) who was yelled at by the Administrator while she was lying on the ground and other residents being yelled at by staff and who felt embarrassed after being yelled at by staff.

The findings are:

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1. Review of Resident #4's FL2 dated 04/10/24 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and unspecified traumatic brain injury (TBI).

Review of Resident #4's incident/accident report dated 05/15/24 at 5:12pm revealed:
-Resident #4 was observed on the ground in the outside commons area.
-Resident #4 stated another resident kicked and knocked her down.
-Resident #4 stated she hit her head.
-Resident #4 was sent to the Emergency Department (ED).

Review of Resident #4's progress notes dated 05/16/24 revealed:
-Resident #4 was sent out to the hospital due to a fight with another resident over a pack of cigarettes.
-Resident #4's family member was out of the country and an email was sent about the incident.
-Resident #4 was sent to the hospital due to the incident.
-Another resident's family member felt like the Administrator was being abusive to Resident #4.
-The Administrator told the resident "your [family member] does not want you to smoke".
-Resident #4 yelled at the Administrator.

Review of Resident #4's incident/accident report dated 05/16/24 at 11:00am revealed:
-The incident occurred in the outside courtyard.
-Resident #4 ran into the walker of another resident and the other resident kicked Resident #4 back.
-The cause was listed as Resident #4's family member did not want her smoking.
-Resident #4 was seen by a physician.

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-Resident #4 was taken to the hospital and was transported by Emergency Medical Services (EMS) at 11:30am.
-The additional comments and/or steps taken to prevent recurrence was listed as reeducated residents not to interact with one another.
-The space for the person who prepared the incident/accident report was left blank.
-The report was signed by the Administrator.

Interview with Resident #4 on 05/22/24 at 11:39am revealed:
-She reported a recent incident where she was kicked and pushed by another resident.
-She fell to the ground after being pushed backwards by the other resident.
-While she was lying on the ground, the Administrator stood over her and yelled at her, "look at you on the ground, that's where you belong on the ground, you should not be out here anyway, you know your [family member] does not want you smoking, and I am going to leave you down there.'
-The Administrator left her lying on the ground.
-She was embarrassed by the Administrator yelling at her so she yelled back at the Administrator.
-The Administrator did not address the other resident for assaulting her.
-She remembered someone recommended she not be moved until EMS could get there but she could not remember who that person was.

Interview with a resident on 05/22/24 at 11:29am revealed:
-The resident witnessed an incident where two residents had an altercation regarding cigarettes and money.
-The incident took place outside in the courtyard where smoking was permitted.

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-One resident pushed Resident #4 down to the ground.
-The resident observed the Administrator come outside and stand over Resident #4 who was on the ground.
-The Administrator yelled at Resident #4 who was on the ground stating something about her "deserving to be on the ground", for her to "just lay there in the dirt" and she was going to leave her on the ground.
-The resident called for a staff member when they saw the resident was on the ground.

Interview with Resident #4 on 05/23/24 at 3:20pm revealed:
-During the incident where she was assaulted, the Administrator did not listen to her account of what happened.
-She did not think the other resident was addressed about her actions.
-The other resident called her a "[expletive] liar" and the Administrator did not do anything about it nor did she intervene.
-While she was at the hospital, her glasses, teeth and earrings were misplaced.
-The resident reported her teeth were returned but none of the staff attempted to retrieve her belongings despite being asked to do so.
-She felt unimportant.

Interview with a second resident on 05/23/24 at 3:46pm revealed:
-The resident witnessed the altercation between two residents regarding cigarettes.
-One of the residents was waiting for the other resident to walk towards the door when she pushed her to the ground.
-The Administrator walked up to the resident laying on the ground, looked down at her and yelled at her that she was "on the ground where

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D 338	Continued From page 34 she deserves". -The Administrator also yelled to the resident on the ground that she "deserves to be in the mud" in front of everybody. Interview with one of the resident's family members on 05/24/24 at 10:05am revealed: -She observed Resident #4 lying on the ground outside. -She observed the Administrator standing over Resident #4 pointing and shaking her finger at the resident. -She overheard the Administrator say, "you are laying exactly where you need to lay". -The Administrator went inside the facility and left Resident #4 lying on the ground. -The Administrator did not return to the resident lying on the ground until EMS arrived. Interview with a personal care aide (PCA) on 05/23/24 at 4:30 pm revealed: -She observed one resident pushing Resident #4 down on the ground. -Resident #4 fell and landed on the ground on her back. -The transportation staff saw the resident on the ground and notified the Administrator. -The Administrator started "fussing and cursing" loudly as she walked towards the resident on the ground. -The Administrator yelled at the resident on the ground "if you would have had your [expletive] in the building and not out here smoking, then you would not have [fallen]". -There were some family members who witnessed the incident with the residents who were arguing over cigarettes, and the family members were very upset. -This was not the only incident where the Administrator yelled at a resident.	D 338		

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Interview with Administrator on 05/24/24 at 3:10 pm revealed:
-There was a recent altercation between two residents over a pack of cigarettes.
-She yelled at one of the residents to remind her that her family member did not want her to smoke.
-Resident #4 was on the ground because the other resident pushed her.
-The resident got "riled up" so the Administrator raised her voice and reminded her again "your [family member] does not want you smoking".

2. Interview with a third resident on 05/22/24 at 11:33am revealed:
-She was visiting with another resident in their room and was reading to the other resident.
-The Administrator came into the room and yelled at her for being in someone else's room.
-She explained she was reading to the other resident.
-The Administrator yelled at her to "stop" and forbade her from going into other residents' rooms.
-She was embarrassed and upset by the Administrator's actions.

Interview with a fourth resident on 05/22/24 at 11:35am revealed:
-She was assisting another resident in the dining room.
-She put a fork in the other resident's hand because she was having difficulty.
-The Administrator saw her assisting the other resident and yelled at her in the dining room.
-The Administrator yelled out "[you] know you [are] not supposed to do this" and "she needs to do it herself" in front of everybody.
-She was embarrassed and upset and walked

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away.

Interview with a fifth resident on 05/22/24 at 11:40am revealed:
-She helped another resident in the dining room and was yelled at by the Administrator.
-She assisted another resident with opening her condiments.
-The Administrator yelled at her that "this is Assisted Living" and for her to stop helping the other resident.
-This incident took place in the dining room in front of everybody.
-The Administrator hurt her feelings and she returned to her room to cry.
-She recalled whenever she cleaned up after herself or other residents in the dining room, no one ever yelled at her about that.
-She was disappointed with the Administrator.
-She chose this facility after visiting and observing positive interactions, but she had not witnessed those types of exchanges recently.

Interview with a sixth resident on 05/23/24 at 3:39pm revealed since the "state" had been in the building, the Administrator had been yelling at the residents, "you all know the state is here" and "I do not have time for you all" in response to any requests.

Interview with a seventh resident on 05/23/24 at 3:44pm revealed:
-Staff had "attitudes" and did not smile.
-One of the other staff members was often observed yelling at residents.

Interview with an eighth resident on 05/23/24 at 3:49pm revealed:
-Most of the staff were hateful and mean.
-She and her roommate both felt like they were

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being "targeted" by staff if they ordered anything online and had it delivered to the facility.
-If they received a delivery, staff went through their bags or packages.
-Sometimes staff took their items and did not return them.

Interview with a ninth resident on 05/23/24 at 3:55pm revealed the resident did not like how they were treated by staff and did not feel they were treated like regular human beings.

Interview with a personal care aide (PCA) on 05/23/24 at 4:30 pm revealed:
-The Administrator talked to residents "like they were dogs".
-Some other staff members also treated residents like "dogs."
-Staff took residents' food from them before they finished eating.

Interview with Resident Care Coordinator (RCC) on 05/24/24 at 1:25pm:
-She had not heard any staff yell at the residents since she started working on 05/20/24.
-The normal process when a resident was assaulted was to complete an incident/accident report and notify family members.

Interview with Administrator on 05/24/24 at 3:10 pm revealed:
-She addressed any staff found to interact inappropriately with residents.
-Employees were suspended or terminated because of not treating residents with respect and dignity.
-There was previously an allegation a staff member was cursing at a resident.
-Staff denied cursing at the resident but used profanity when she refused to complete a task

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she was asked to do.
-The staff member was terminated immediately.
-She yelled at two residents on two different occasions.
-Someone confronted the Administrator alleging that the Administrator was "too harsh".
-She reported having to yell at a male resident who invaded her personal space often to "back up".
-She described the resident as "big" and was always demanding medications that were not ordered by his PCP.
-The Administrator did not not mean to be "disrespectful" to the residents, but she had been overwhelmed.
-There was a grievance box outside her office for anyone to utilize should they have a complaint about her.
-She provided her supervisor's phone number to a family member when asked.

____

The facility failed to ensure residents were treated with dignity and respect when the Administrator yelled at a resident (#4) who was lying on the ground following an incident with another resident, resulting in mental anguish of Resident #4; and residents being yelled at by staff, including the Administrator and made to feel embarrassed for helping other residents. This failure resulted in abuse, which constitutes a Type A1 Violation.

____

The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 05/28/24 for this violation.

THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2024.

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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 3 of 4 sampled residents (#1, #2, and #9) including two residents with orders for a blood thinner (#1 and #2) and a resident with orders for two medications to lower blood sugar, an antidepressant, a medication to control the heart rate, a blood thinner, a diuretic, an antihypertensive medication, an antibiotic, a laxative, and an eye drop (#9). The findings are: 1. Review of Resident #1's FL-2 dated 04/14/23 revealed: -Diagnoses included atrial fibrillation and Alzheimer's. -There was an order for warfarin (a blood thinner used to control atrial fibrillation) 2mg take one tablet daily on Tuesday, Thursday, Saturday and Sunday. -There was an order for warfarin 3mg take one tablet daily on Monday, Wednesday, and Friday.	D 358		

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D 358	Continued From page 40 Review of Resident #1's signed physician's order dated 02/21/24 revealed: -There was an order for warfarin 3mg take one tablet daily on Monday, Tuesday, Wednesday, Friday and Saturday. -There was an order for warfarin 2mg take one tablet daily on Thursday and Sunday. Review of Resident #1's signed physician's order dated 03/23/24 revealed: -There was an order for warfarin 3mg take one tablet daily on Monday through Saturday. -There was an order for warfarin 2mg take one tablet daily on Sunday. Review of Resident #1's signed physician's order dated 03/24/24 revealed there was an order to discontinue both orders of warfarin. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for warfarin 2mg take one tablet twice a week on Thursday and Sunday scheduled at 5:00pm that was discontinued on 03/07/24. -There was an entry for warfarin 3mg take one tablet on Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday that was discontinued on 03/24/24. -There was no documentation warfarin 3mg was administered and there were blank spaces on the eMAR from 03/08/24 to 03/22/24. Review of Resident #1's signed physician's order dated 04/18/24 revealed: -There was an order for warfarin 3mg take one tablet daily on Monday through Saturday. -There was an order for warfarin 2mg take one	D 358		

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tablet daily on Sunday.

Review of Resident #1's signed physician's order dated 04/24/24 revealed there was an order for warfarin 3mg take one tablet daily.

Review of Resident #1's April 2024 eMAR revealed:
-There was an entry for warfarin 3mg take one tablet daily each morning on Monday, Tuesday, Wednesday, Thursday, Friday and Saturday scheduled from 7:00am to 11:00am with a discontinued date of 04/24/24.
-There was an entry for warfarin 3mg take one tablet daily with a start date of 04/24/24.
-There was documentation warfarin 3mg was administered from 04/19/24 to 04/30/24.
-There was an entry for warfarin 2mg take one tablet daily in the morning on Sunday scheduled from 7:00am to 11:00am with a discontinued date of 04/24/24.
-There was documentation warfarin 2mg was administered from 04/19/24 to 04/22/24.

Review of a signed physician's order dated 05/15/24 revealed:
-There was an order for warfarin 3mg take one tablet daily on Monday, Tuesday, Wednesday, Friday, and Saturday.
-There was an order for warfarin 4mg take one tablet daily on Thursday and Sunday.

Review of a physician's order from a hospital after visit summary dated 05/16/24 revealed there was an order for warfarin 2mg take one tablet daily.

Review of Resident #1's May 2024 eMAR from 05/01/24 to 05/22/24 revealed:
-There was an entry for warfarin 3mg take one

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tablet daily scheduled at 4:00pm with a discontinued date of 05/08/24.
-There was documentation warfarin 3mg was administered from 05/01/24 to 05/08/24, 05/10/24, 05/12/24 to 05/14/24, 05/17/24 and 05/19/24 to 05/21/24.
-There was an entry for warfarin 3mg take one tablet five times weekly on Sunday, Monday, Tuesday, Wednesday, and Friday scheduled at 4:00pm with an order start date of 05/08/24.
-There was an entry for warfarin 4mg take one tablet every Thursday and Saturday scheduled at 4:00pm with an order start date of 05/08/24.
-There was documentation warfarin 4mg was administered on 05/11/24, 05/16/24 and 05/18/24.
-There was an entry for warfarin 2mg take one tablet daily scheduled at 4:00pm with an order start date of 05/16/24 and an order stop date of 05/20/24.
-There was documentation warfarin 2mg was administered from 05/17/24 to 05/20/24.
-There was documentation Resident #1 was out of the facility on 05/15/24.

Review of Resident #1's laboratory results for International Normalized Ratio (INR) (used to determine coagulation status and necessity for warfarin dose adjustments; the therapeutic range for atrial fibrillation should be between 2.0-3.0) revealed the following:
-On 02/23/24, Resident #1's laboratory results revealed an INR value of 1.65.
-On 03/23/24, Resident #1's laboratory results revealed an INR value of 0.99.
-On 03/30/24, Resident #1's laboratory results revealed an INR value of 1.02.
-On 04/20/24, Resident #1's laboratory results revealed an INR value of 1.07.
-On 05/15/24, Resident #1's laboratory results revealed an INR value of 9.4 at 12:27pm.

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-On 05/15/24, Resident #1's laboratory results revealed an INR value of 8.6 at 1:21pm.
-On 05/16/24, Resident #1's laboratory results revealed an INR value of 2.9.

Review of Resident #1's Incident/Accident report dated 05/14/24 at 11:00am revealed:
-Resident #1 was in her restroom at the facility and was disoriented.
-Resident #1's blood pressure was 93/37.
-Resident #1 was sent out to the hospital per the recommendation of the PCP.

Review of Resident #1's PCP visit note dated 05/15/24 revealed:
-She saw Resident #1 at the facility on 05/15/24 for an acute concern of dizziness and syncope.
-Resident #1 did not lose consciousness.
-Resident #1 was in atrial fibrillation on auscultation by the PCP.
-911 was called and Resident #1 was sent to the hospital.

Interview with Resident #1's primary care provider (PCP) on 05/22/24 at 11:50am revealed Resident #1's laboratory results dated 05/22/24 revealed an INR value of 7.7.

Observation of Resident #1's medications on hand on 05/23/24 at 3:00pm revealed:
-There was a medication card for warfarin 3mg take one tablet daily on Monday through Saturday with a dispensed date of 03/07/24 with 4 of 12 tablets remaining.
-There was a medication card for warfarin 3mg take one tablet daily on Monday, Tuesday, Wednesday, Friday, and Sunday with a dispensed date of 05/08/24 with 9 of 10 tablets remaining.
-There was a medication card for warfarin 2mg

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take one tablet daily with a dispensed date of 05/16/24 with 25 of 30 tablets remaining.
-There was no medication card for warfarin 4mg.

Telephone interview with a representative from the facility's contracted pharmacy on 05/23/24 at 1:45pm revealed:
-The facility's medications were not on a cycle fill.
-The turnaround time from when a medication was requested to be dispensed and when it was dispensed was normally within 72 hours and medications may be dispensed the same day they were requested depending on the time of day they were requested.
-The pharmacy entered medication orders on the eMAR but the facility had to approve the orders for the orders to be active on the eMAR.
-Resident #1's current active orders for warfarin on file with the pharmacy were warfarin 3mg take one tablet five times weekly on Sunday, Monday, Tuesday, Wednesday, and Friday, and warfarin 4mg take one tablet on Thursday and Saturday.
-There was a separate order for Resident #1 for warfarin 2mg daily written on 05/16/24 that was discontinued on 05/20/24.
-A quantity of 30 warfarin 2mg tablets were dispensed on 05/16/24.
-A quantity of four warfarin 4mg tablets were dispensed on 05/08/24 corresponding with the order for warfarin 4mg take 1 tablet every Thursday and Saturday.
-A quantity of 10 warfarin 3mg tablets were dispensed on 05/08/24 corresponding with the order for warfarin 3mg take one tablet five times weekly on Sunday, Monday, Tuesday, Wednesday, and Friday.
-A quantity of 14 warfarin 3mg tablets were dispensed on 04/24/24 corresponding with the previous order of warfarin 3mg take one tablet daily which was a two-week supply.

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-A quantity of 12 warfarin 3mg tablets were dispensed on 04/12/24 and on 03/07/24 corresponding with the previous order of warfarin 3mg take one tablet Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday.
-A quantity of 24 warfarin 3mg tablets were dispensed on 03/23/24 corresponding with the previous order of warfarin 3mg take one tablet Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday.
-A quantity of two warfarin 2mg tablets were dispensed on 04/12/24 and on 03/07/24 corresponding with the previous order of warfarin 2mg take one tablet on Sunday.

Attempted telephone interview with a medication aide (MA) on 05/24/24 at 9:44am unsuccessful.

Telephone interview with a second MA on 05/24/24 at 9:46am revealed:
-There were sometimes multiple entries of the same medication on the eMAR and if she was not sure if they were correct, she asked a Supervisor or another MA to verify.
-The pharmacy put order entries on the eMAR but she thought a Supervisor had to approve the orders.
-The MAs conducted cart audits and cart audits involved making sure medication was available to be administered to the residents and was not expired.
-She did not know how often cart audits were done.
-She did not know what a blank space on the eMAR in a medication administration entry meant and she also did not know what circled initials meant.
-It was documented on the eMAR, she administered both 2mg warfarin and 3mg warfarin to Resident #1 on 05/17/24 and if it was

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documented on the eMAR, she must have administered the medication.

Interview with a third MA on 05/24/24 at 12:54pm revealed:
-She administered medications to Resident #1 on 05/18/24 to 05/20/24.
-If there was no documentation or MA initials on the eMAR for medication administration, that indicated no medications were administered.
-There was documentation on the eMAR she administered both 2mg warfarin and 3mg warfarin to Resident #1 on 05/19/24 and 05/20/24.
-There was documentation on the eMAR she administered both 2mg warfarin and 4mg warfarin to Resident #1 on 05/18/24.
-She could not recall if she administered two separate doses of warfarin to Resident #1 from 05/18/24 to 05/20/24.
-If a medication was on the eMAR, she administered the medication.
-There was no Resident Care Coordinator (RCC) working at the facility at the time (05/15/24-05/18/24) to approve new medication order entries on the eMAR.

Telephone interview with Resident #1's PCP on 05/23/24 at 3:30pm revealed:
-Resident #1 had a diagnosis of atrial fibrillation which was the reason she was prescribed warfarin.
-The normal INR value therapeutic range for atrial fibrillation and Resident #1 was 2.0 to 3.0.
-She had monitored Resident #1's INR values for a long time and was never able to get a therapeutic INR level.
-Resident #1's warfarin had to be administered every day and on time as scheduled.
-Resident #1's INR value was low in March 2024, but the PCP did not know Resident #1 was not

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being administered warfarin at that time.
-The facility changed contracted pharmacies sometime in March 2024 and the PCP thought one of Resident #1's medication pages was missed in the transition to the new pharmacy.
-Resident #1's INR value was 1.44 on 05/08/24 so she titrated Resident #1's warfarin dose up.
-On 05/15/24, Resident #1 was "out of it" and complaining of heart palpitations when the PCP was at the facility.
-The PCP told the facility to call 911 on 05/15/24 and Resident #1 was sent out to the hospital and her INR value was above 9.0.
-Multiple warfarin order entries were put on the eMAR after Resident #1 returned from the hospital on 05/17/24.
-There was a 2mg warfarin ordered daily on the eMAR by the hospital and the orders for 3mg warfarin and 4mg warfarin the PCP had written previously.
-The pharmacy entered both orders on the eMAR and the facility administered all the ordered warfarin.
-An INR laboratory value was drawn for Resident #1 on 05/20/24 and the result was received on 05/22/24 which was an INR value of 7.7.
-Resident #1 was sent back to the hospital on 05/22/24.
-A high INR value indicated Resident #1 was not administered the correct dose of warfarin.
-She did not know Resident #1 was not administered warfarin from 03/24/24 to 04/18/24 until 04/24/24.
-She expected Resident #1 to have been administered warfarin as ordered.
-Potential side effects of missing doses of warfarin administration and a low INR value included risk for blood clots.
-Potential side effects of too much warfarin administration and high INR values included risk

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of death, uncontrolled atrial fibrillation, and bleeding.

Interview with Resident #1 on 05/23/24 at 5:05pm revealed:
-She thought she was not administered her warfarin at times.
-She had just returned to the facility from the hospital.
-She was in the restroom and "felt faint" on 05/15/24.
-The PCP was at the facility on 05/15/24 and the PCP insisted Resident #1 be sent to the hospital.
-There were times when her heartbeat felt irregular while she was at the facility.
-She felt strange on the night of 05/21/24 and the morning of 05/22/24.
-The MAs advised Resident #1 she should be sent out to the hospital, but Resident #1 did not want to go to the hospital sometime during the night of 05/21/24 or morning of 05/22/24.

Interview with Resident #1's family member on 05/23/24 at 5:15pm revealed:
-Resident #1 was in the hospital on 05/15/24 and 05/16/24.
-Resident #1 went three weeks without being administered her warfarin in March and April 2024 per the facility and Resident #1's INR value was low.
-Sometimes the MAs said they administered Resident #1's warfarin when she said she was not administered warfarin.
-Resident #1 was "incoherent and dizzy" on 05/15/24 and the PCP insisted Resident #1 be sent out to the hospital.
-She told the PCP that she could meet the PCP at the facility on 05/22/24 to discuss Resident #1's most recent INR value.
-Resident #1 told the PCP that she felt like she

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was in atrial fibrillation on 05/22/24.
-Resident #1's INR value was above 9.0 when she got to the hospital on 05/22/24.
-No one called her or the PCP the morning of 05/22/24 to let them know Resident #1 was not feeling right.
-There were times when Resident #1 was administered too much warfarin and times when she was administered no warfarin which was reflected by Resident #1's INR values.

Interview with the RCC on 05/24/24 at 12:25pm revealed:
-She started auditing medications on 05/20/24.
-She did not know when the last eMAR audit was completed.
-She did not know Resident #1 was not administered warfarin for a 15-day period in March 2024.
-She did not know Resident #1 was administered two separate doses of warfarin on 05/17/24 to 05/20/24.

Interview with the Administrator on 05/24/24 at 2:12pm revealed:
-There were no eMAR audits being done prior to the week of 05/20/24 when the new RCC was hired.
-If there was no documentation on the eMAR and there were blanks spaces, that would indicate a medication was not administered.
-The pharmacy entered orders on the eMAR and the RCC was responsible for checking the order to ensure it was accurate.
-The facility was without an RCC from 05/03/24 to 05/17/24.
-The Administrator would have reviewed medication orders placed on the eMAR by the pharmacy between 05/03/24 and 05/17/24.
-She did not know Resident #1 was not

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administered warfarin for a three-week period in March and April 2024.
-Either a Supervisor or the Administrator approved the order for Resident #1's warfarin when she came back from the hospital on 05/17/24.
-She expected MAs to administer medications as ordered.

2. Review of Resident #2's current FL2 dated 04/10/24 revealed:
-Diagnoses included hemiplegia, epilepsy, muscle weakness, aphasia, and deep vein thrombosis (DVT) on long-term anticoagulation.
-There was an order for warfarin (a blood thinning medication used to treat or prevent blood clots) 5mg daily.

Review of Resident #2's physician's order dated 10/13/23 revealed there was an order for warfarin 5mg daily.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for warfarin 5mg take one tablet daily scheduled at 5:00pm.
-There was documentation warfarin was not administered on 03/26/24 due to the medication not available, or on 03/27/24 due to waiting on the pharmacy.

Review of Resident #2's primary care provider's (PCP) progress note dated 04/18/24 revealed:
-Resident #2 was receiving warfarin therapy due to her history of DVT and receiving chronic anticoagulation.
-Resident #2's international normalized ratio (INR, a laboratory blood test used to assess coagulation speed of the blood) in November

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2023 was 2.82 which was within Resident #2's therapeutic goal range of having an INR between 2.0 and 3.0.
-The PCP had ordered a repeat INR and the result was pending.
-She recommended Resident #2 have monthly INR checks.

Review of Resident #2's INR result dated 04/20/24 revealed her INR level was elevated at 3.47.

Interview with the Resident Care Coordinator (RCC) on 05/23/24 at 10:22am revealed the facility did not have any other INR results for Resident #2 for review.

Review of Resident #2's April 2024 eMAR revealed:
-There was an entry for warfarin 5mg take one tablet daily scheduled at 5:00pm.
-There was no documentation warfarin was administered from 04/10/24 through 04/18/24 or 04/25/24 with no documented reason.
-There was documentation warfarin was not administered from 04/26/24 through 04/30/24 with a documented reason of waiting on the pharmacy.

Review of Resident #2's physician's order dated 05/01/24 revealed:
-There was an order to discontinue the previous warfarin order.
-There was an order for warfarin 4mg once daily on Fridays, and 5mg once daily on Monday, Tuesday, Wednesday, Thursday, Saturday, and Sunday.

Review of Resident #2's physician's order dated 05/08/24 revealed:

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D 358	Continued From page 52 -There was an order to discontinue the previous warfarin order. -There was an order for warfarin 5mg once daily on Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday. Review of Resident #2's physician's order dated 05/10/24 revealed there was an order clarification to take warfarin 5mg daily. Review of Resident #2's May 2024 eMAR revealed: -There was an entry for warfarin 4mg take one tablet once weekly on Friday scheduled at 4:00pm, with an order discontinue date of 05/08/24. -There was documentation warfarin 4mg was administered on Thursday 05/02/24, Friday 05/03/24, Saturday 05/04/24, Sunday 05/05/24, and Wednesday 05/08/24. -There was an entry for warfarin 5mg daily on Sunday, Monday, Tuesday, Wednesday, Thursday, and Saturday scheduled at 4:00pm, with an order discontinue date of 05/08/24. -There was no documentation warfarin 5mg was administered on 05/01/24 with no documented reason. -There was documentation warfarin 5mg was not administered on 05/02/24 due to "not here." -There was documentation warfarin 5mg was administered on 05/04/24, 05/05/24, and 05/08/24 along with the 4mg dose for a dose total of 9 mg. -There was an entry for warfarin 5mg daily scheduled at 4:00pm, with an order start date of 05/08/24. -There was no documentation warfarin 5mg was administered daily from 05/09/24 through 05/13/24, with documentation on 05/09/24 of withheld per doctor's orders, and documentation	D 358		

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on 05/10/24 of medication ordered, and documentation on 05/13/24 of awaiting pharmacy.

Review of Resident #2's progress note dated 03/27/24 revealed at 5:03pm, the medication aide (MA) documented that she spoke to the pharmacy staff, and they were going to send over a refill of warfarin 5mg right away.

Observation of medications on hand for Resident #2 on 05/23/24 at 10:20am revealed:
-There were two medication cards containing warfarin 5mg tablets.
-One medication card for warfarin 5mg daily had a dispensed date of 05/14/24 and there were 5 of 12 dispensed tablets remaining.
-The second medication card for warfarin 5mg daily had a dispensed date of 05/20/24 and there were 29 of 30 dispensed tablets remaining.

Interview with Resident #2 on 05/23/24 at 9:10am revealed:
-She was ordered warfarin to take every day.
-She did not always receive warfarin daily and missed doses.
-When she missed doses of warfarin the MAs told her it was because they were waiting on it to come from the pharmacy.
-She did not know if her INR was in range or if it was high or low due to the missed doses of warfarin.
-She did not know which days she had missed doses of warfarin.

Interview with a MA on 05/23/24 at 12:02pm revealed:
-The blank spaces on the eMAR where there was no documentation meant the medication had not been administered.

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-The MAs were supposed to reorder medications when the quantity remaining was down to the last row on the medication card which was usually 7 or 8 tablets.
-She had not worked any shifts where Resident #2 did not have warfarin available on the medication cart.

Telephone interview with a representative from the facility's contracted pharmacy on 05/23/24 at 1:45pm revealed:
-Their pharmacy contracted with the facility on 03/01/24 and Resident #2's warfarin order had been 5mg daily for the entire time except for 05/01/24 through 05/08/24 when the order changed to 5mg daily except for 4mg on Fridays.
-On 03/12/24, 03/27/24, and 04/10/24 the pharmacy dispensed 14 tablets of warfarin 5mg to take one tablet daily.
-On 04/29/24, the pharmacy dispensed 30 tablets of warfarin 5mg to take one tablet daily.
-On 05/01/24, the pharmacy dispensed 4 tablets of warfarin 4mg to take once weekly on Fridays.
-On 05/14/24, the pharmacy dispensed 12 tablets of warfarin 5mg to take one tablet daily.
-On 05/20/24, the pharmacy dispensed 30 tablets of warfarin 5mg to take one tablet daily.
-Warfarin was not on cycle-fill, so each time Resident #2 ran low on warfarin the facility was responsible for sending a refill request to the pharmacy.
-The pharmacy's contract with the facility included information that refills could take up to 72 hours to be delivered to the facility from the time the refill request was received, but typically the pharmacy could get a medication to the facility either later that same day or the following day, depending on what time the refill request was made.
-The pharmacy had received refill requests for

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Resident #2's warfarin 5mg tablets on 03/27/24, 04/29/24 and 05/14/24.

Interview with a second MA on 05/23/24 at 3:00pm revealed:
-She had worked several days where Resident #2 did not have warfarin available on the medication cart for administration.
-One of the other MAs had called the pharmacy to request a refill of Resident #2's warfarin but the pharmacy had told the other MA that they had already dispensed a 30-day supply of warfarin 5mg for Resident #2.
-The MAs were supposed to request medication refills when the quantity was down to 8 tablets remaining in the medication card.
-The MAs requested refills from the pharmacy by either calling the pharmacy or clicking the reorder button on the eMAR.
-On 05/10/24, she did not have any warfarin 5mg on the medication cart to administer to Resident #2 so she clicked the reorder button.
-Usually when the reorder button was clicked in the eMAR, the medication arrived at the facility within 24 hours.
-She had not worked the days following her shift on 05/10/24 so she did not know when the warfarin arrived for Resident #2.

Telephone interview with a third MA on 05/24/24 at 9:46am revealed:
-She had worked when Resident #2 was out of warfarin.
-She called the pharmacy to request a refill for Resident #2's warfarin but the pharmacy had told her that since they dispensed a 30-day supply, they were not able to refill the warfarin yet.
-She thought the pharmacy had sent a 14-day supply rather than a 30-day supply and that was why Resident #2 had run out of warfarin.

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-She did not know how many days Resident #2 went without warfarin.
-She had documented administering both warfarin 4mg and 5mg on 05/08/24, but she could not remember if she had actually administered both doses or not.
-The eMAR had both doses of warfarin pop up as due from 05/01/24 through 05/08/24.
-Usually if two different doses of the same medication popped up as being due on the eMAR, she would ask the supervisor what the correct dose to administer was.
-She could not remember if she clarified Resident #2's warfarin dose on 05/08/24.
-The pharmacy entered medication orders on the eMAR, and a supervisor was responsible for reviewing the order entry and approving it if it was entered correctly.

Telephone interview with Resident #2's PCP on 05/23/24 at 3:25pm revealed:
-Resident #2's INR on 11/17/23 was 2.82 which was in her therapeutic range, so Resident #2 had been taking warfarin 5mg daily until she rechecked her INR on 04/19/24 and it was up to 3.47.
-She reviewed Resident #2's INR result from 04/19/24 on 05/01/24, and because the INR was elevated at 3.47, she decreased Resident #2's warfarin dose from 5mg daily, to 5mg daily except for 4mg on Fridays.
-On 05/08/24, Resident #2's INR was checked again and was down to 1.02 which was below her therapeutic range and indicated that Resident #2 had not been receiving her warfarin.
-Based on Resident #2's INR of 1.02, she increased the dose of warfarin back up to 5mg daily.
-An INR below Resident #2's goal range of 2.0 to 3.0 placed her at risk for blood clots which could

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result in DVT's or a stroke.
-An INR above Resident #2's goal range of 2.0 to 3.0 placed her at risk for bleeding.
-She was not aware of Resident #2's missed doses of warfarin in March 2024, April 2024, or May 2024, or that the MAs had documented giving Resident #2 both the 4mg and 5mg dose of warfarin three days in May 2024.
-She expected the MAs to administer warfarin to Resident #2 exactly as she ordered it because missing any doses or receiving the incorrect dose of warfarin even one time could change her INR level.

Interview with the RCC on 05/24/24 at 12:25pm revealed:
-She was newly hired at the facility a couple of days prior.
-She was not aware of Resident #2 missing doses of warfarin in March, April, and May 2024.
-The MAs were expected to document either that a medication was administered or not administered each day; there should not be any holes or blank spaces in the eMAR.
-If a medication was not available on the medication cart, the MA was expected to call the pharmacy to request a refill right away, or to ask if the prescription needed to be renewed by the PCP.
-Medications should be reordered by the MAs when the quantity remaining reached the last row on the medication card.
-She was not aware of Resident #2 experiencing any symptoms of bleeding or blood clots.

Interview with the Administrator on 05/24/24/ at 2:11pm revealed:
-Prior to the new RCC starting earlier that week, no staff had been responsible for auditing the eMARs for accuracy of medication administration.

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D 358	Continued From page 58 -She expected the previous RCC to audit the eMARs but the former RCC had not completed the audits. -She was not aware that Resident #2 had not received warfarin as ordered for 2 days in March 2024, for 15 days in April 2024, and 6 days in May 2024. -She was not aware that Resident #2 had received the wrong dose of warfarin 4 days in May 2024. -The MAs were expected to request medication refills by clicking the reorder button in the eMAR or faxing the pharmacy when the quantity of medication remaining was down to the last row on the medication card or around 8 doses remaining. -If a medication had already run out, the MA was responsible for notifying the RCC. -If there was no documentation on the eMAR that a medication had been administered, like on Resident #2's April 2024 eMAR from 04/10/24 through 04/18/24 and 04/25/24 where the entries were blank, it meant the medication had not been administered. -The pharmacy entered new or changed medication orders into the eMAR system and the RCC was responsible for checking the entry for accuracy before approving the order. -She had been working in the role of the RCC from 05/03/24 through 05/17/24 and was responsible for approving medication orders during that time. -She had worked on the medication cart between 05/01/24 and 05/08/24 and had noticed that Resident #2's warfarin 4mg and warfarin 5mg doses both showed as being due on the same days, but she had not checked the order or contacted the pharmacy to have one of the entries removed to prevent medication errors.	D 358		

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3. Review of Resident #9's admission FL-2 dated 10/11/23 revealed diagnoses included diabetes mellitus type 2 with neuropathy, Alzheimer's disease, atrial fibrillation, glaucoma, hypertension, insomnia, and depression.

a. Review of Resident #9's signed physician orders dated 03/25/24 revealed there was an order for Ozempic 4mg/3ml (used to lower blood sugar) inject 1mg subcutaneously (SQ) every week.

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for Ozempic 4mg/3ml inject 1mg SQ weekly with a scheduled administration time of 8:00am.
-There was documentation Ozempic was administered on 05/03/24 and 05/24/24.
-There were exceptions documented on 05/10/24 and 05/17/24; the exceptions were "ordered" and "awaiting pharmacy."
-There was an entry for fingerstick blood sugar (FSBS) checks daily before breakfast scheduled at 7:30am.
-The FSBS readings ranged from 124 to 307.

Observation of Resident #9's medication on hand on 05/28/24 at 9:27am revealed there was an Ozempic 4mg/3ml pen with 3mg of medication available for administration with a dispensed date of 05/16/24.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed:
-Resident #9 missed two doses of Ozempic injections on 05/10/24 and 05/17/24.
-She asked the MAs why it was not administered, and she was told the pharmacy had not sent the medication.

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D 358	Continued From page 60 -She called the pharmacy and questioned why Ozempic had not been sent to the facility, and she was told the facility had to fax a request for all refills. -The pharmacy was going to contact the facility regarding refill status. Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed: -Resident #9 had an order for Ozempic 4mg/3ml administer 1mg SQ weekly. -The pharmacy dispensed one Ozempic 4mg/3ml pen on 03/25/24 and on 05/16/24. -One Ozempic 4mg/3ml pen would last 28 days or 4 doses of medication. Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed: -Resident #9 had an order dated 03/25/24 for Ozempic 4mg/3ml administer 1mg SQ weekly. -Resident #9 was a diabetic and Ozempic was used to treat elevated blood sugar readings. -If Resident #9 did not receive the medication as ordered, Resident #9's blood sugar could become elevated. b. Review of Resident #9's signed physician orders dated 05/20/24 revealed there was an order for Septra DS 800-160 (used to treat a urinary tract infection) twice daily for 5 days. Review of Resident #9's May 2024 eMAR from 05/20/24 to 05/25/24 revealed: -There was an entry for Septra DS 800-160 twice daily for 5 days with a scheduled administration time of 7:00am to 11:00am and 7:00pm to 11:00pm. -There was documentation Septra DS was	D 358		

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administered on 05/20/24 and 05/22/24 between 7:00pm to 11:00pm; twice daily on 05/21/24, 05/23/24, and 05/24/24 between 7:00am to 11:00am and 7:00pm to 11:00pm; and on 05/25/24 between 7:00am to 11:00am.
-There was an exception documented on 05/22/24 between 7:00am to 11:00am; the exception was "ordered."

Observation of Resident #9's medication on hand on 05/28/24 at 9:14am revealed there were 3 Septra DS 800-160mg tablets available for administration.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed:
-Resident #9 was treated for a UTI last week, week of 05/20/24.
-She had been treated for two or three UTIs in the past 2 months.
-She had not heard Resident #9 complain of any pain or discomfort with urination.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:40am revealed:
-The pharmacy had an order for Septra DS 800-160mg twice daily for 5 days.
-The pharmacy filled the new order and delivered the medication to the facility on 05/20/24.
-The medication was an antibiotic for an infection.
-Resident #9 should take all of the medication to treat the infection.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 05/20/24 for Septra DS 800-160 twice daily for 5 days.
-Resident #9 was treated for a UTI.

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

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-Resident #9 should take all of the antibiotic as ordered.
-If Resident #9 did not receive the medication as ordered, the UTI may linger.

c. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Farxiga 10mg (used to lower blood sugar) daily.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Farxiga 10mg daily.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for Farxiga 10mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation Farxiga was administered daily from 03/01/24 to 03/17/24, on 03/19/24, and from 03/21/24 to 03/31/24.
-There was an exception documented on 03/18/24; the exception was "out of facility."
-The eMAR was blank for 03/20/24.
-There was an entry for FSBS checks daily before breakfast scheduled at 7:30am.
-The FSBS readings ranged from 157 to 325.

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for Farxiga 10mg daily with a scheduled administration time between 7:00am and 11:00am.
-There was documentation Farxiga was administered on 04/01/24, from 04/03/24 to 04/26/24, and on 04/30/24.
-There was an exception documented on 04/02/24; the exception was the "resident refused."
-There was an exception documented from

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04/27/24 to 04/29/24; the exception was "ordered."
-There was an entry for FSBS checks daily before breakfast scheduled at 7:30am.
-The FSBS readings ranged from 96 to 292.

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for Farxiga 10mg daily with a scheduled administration time between 7:00am and 11:00am.
-There was documentation Farxiga was administered from 05/01/24 to 05/09/24, on 05/13/24, and from 05/17/24 to 05/27/24.
-There were exceptions documented from 05/10/24 to 05/12/24 and from 05/14/24 to 05/16/24; the exception was "ordered."
-There was an entry for FSBS checks daily before breakfast scheduled at 7:30am.
-The FSBS readings ranged from 122 to 307.

Observation of Resident #9's medication on hand on 05/28/24 at 9:13am revealed there were 23 of 30 Farxiga 10mg tablets dispensed on 05/16/24 available for administration.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for Farxiga 10mg daily.
-The pharmacy dispensed 30 Farxiga 10mg on 01/27/23 and 05/16/24.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for Farxiga 10mg daily
-Resident #9 was a diabetic and Farxiga was

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used to control blood sugar readings and to prevent heart and kidney damage.
-If Resident #9 was not administered Farxiga as ordered she could experience elevated blood sugar readings, damage to her heart and kidneys leading to a heart attack and kidney damage.

d. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Escitalopram 10mg (used to treat depression) daily.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Escitalopram 10mg daily.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for escitalopram 10mg daily with an administration time between 7:00am and 11:00am.
-There was documentation escitalopram was administered daily from 03/01/24 to 03/17/24 and from 03/19/24 to 03/31/24.
-There was an exception documented on 03/18/24; the exception was "out of the facility."

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for escitalopram 10mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation escitalopram was administered on 04/01/24, from 04/03/24 to 04/28/24, and on 04/30/24.
-There was an exception documented on 04/02/24; the exception was "refusal."
-There was an exception documented on 04/29/24; the exception was "ordered."

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Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for escitalopram 10mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation escitalopram was administered from 05/01/24 to 05/09/24, from 05/13/24 to 05/14/24, and from 05/18/24 to 05/27/24.
-There were exceptions documented from 05/10/24 to 05/12/24 and from 05/15/24 to 05/17/24; the exceptions were "ordered" and "awaiting pharmacy."

Observation of Resident #9's medication on hand on 05/28/24 at 9:13am revealed there were 22 of 30 escitalopram tablets dispensed on 05/16/24 remaining for administration.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed:
-She had noticed Resident #9 becoming anxious in the late afternoon and evenings.
-She had not noticed if Resident #9 was depressed.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for escitalopram 10mg daily.
-The pharmacy dispensed 30 tablets of escitalopram 10mg on 12/15/23 and 05/16/24.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for escitalopram 10mg daily.
-Escitalopram 10mg was used for depression and

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anxiety.
-If Resident #9 was not administered escitalopram as ordered she could experience an increase in anxiety and depression.

e. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Linzess 290mcg (used to treat constipation) 30 minutes before breakfast.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Linzess 290mcg 30 minutes before breakfast.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for Linzess 290mcg 30 minutes before breakfast with a scheduled administration time at 7:30am.
-There was documentation Linzess was administered each morning between 02/01/24 to 02/29/24.

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for Linzess 290mcg 30 minutes before breakfast with a scheduled administration time between 7:00am and 11:00am.
-There was documentation Linzess was administered on 04/01/24, from 04/03/24 to 04/17/24, from 04/19/24 to 04/22/24, from 04/25/24 to 04/26/24, and on 04/30/24.
-There was an exception documented on 04/02/24; the exception was "refusal."
-There were exceptions documented on 04/18/24, from 04/23/24 to 04/25/24 and from 04/27/24 to 04/29/24; the exceptions were "ordered" and "awaiting pharmacy."

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Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for Linzess 290mcg 30 minutes before breakfast with a scheduled administration time between 7:00am and 11:00am.
-There was documentation Linzess was administered from 05/01/24 to 05/03/24, from 05/05/24 to 05/09/24, and from 05/18/24 to 05/27/24.
-The eMAR was blank on 05/04/24 and 05/13/24.
-There were exceptions documented from 05/10/24 to 05/12/24 and from 05/14/24 to 05/17/24; the exceptions were "ordered" and "awaiting pharmacy."

Observation of Resident #9's medication on hand on 05/28/24 at 9:13am revealed there were 24 of 30 Linzess tablets dispensed on 05/16/24 available for administration.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed:
-Resident #9 had not had a bowel movement in several days.
-Resident #9 took Linzess so she would not get constipated.
-Resident #9 had constipation several times that caused her stomach to hurt.
-Resident #9 was so constipated a few weeks ago, she had to "pull the stool out of her".
-She gave Resident #9 an enema to relieve constipation.
-When Resident #9 took Linzess as ordered she would not get constipated.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for Linzess 290mcg

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daily.
-The pharmacy dispensed 30 tablets of Linzess 290mcg on 12/15/23 and 05/16/24.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for Linzess 290mcg daily.
-Linzess was ordered for constipation.
-If Resident #9 was not administered Linzess as ordered she would have constipation.

f. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Xarelto 20mg (used to prevent blood clots) daily.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Xarelto 20mg daily.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for Xarelto 20mg daily with an administration time between 7:00am and 11:00am.
-There was documentation Xarelto was administered daily from 03/01/24 to 03/17/24 and from 03/19/24 to 03/31/24.
-There was an exception documented on 03/18/24; the exception was "out of the facility."

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for Xarelto 20mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation Xarelto was administered on 04/01/24, from 04/03/24 to 04/28/24, and on 04/30/24.

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-There was an exception documented on 04/02/24; the exception was "refusal."
-There was an exception documented on 04/29/24; the exception was "ordered."

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for Xarelto 20mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation Xarelto was administered from 05/01/24 to 05/09/24, from 05/12/24 to 05/12/24, and from 05/17/24 to 05/27/24.
-There were exceptions documented from 05/10/24 to 05/11/24 and from 05/14/24 to 05/16/24; the exception was "ordered."

Observation of Resident #9's medication on hand on 05/28/24 at 9:12am revealed there were 20 of 30 Xarelto 20mg tablets dispensed on 05/16/24 available for administration.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed:
-Resident #9 had a history of blood clots in her legs.
-Resident #9 did not have any swelling in her legs that she was aware of.
-Resident #9 had an order for TED hose and Resident #9 wore them most day.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for Xarelto 20mg daily.
-The pharmacy dispensed 30 Xarelto 20mg tablets on 12/15/23 and 05/16/24.

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Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for Xarelto 20mg because of history of deep vein thrombosis (DVT) (blood clots that develop in the veins).
-If Resident #9 was not administered Xarelto as ordered she would have an increased risk of having a DVT.

g. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for furosemide 20mg (used to treat fluid overload) daily.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for furosemide 20mg daily.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for furosemide 20mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation furosemide was administered daily from 03/01/24 to 03/17/24 and from 03/19/24 to 03/31/24.
-There was an exception documented on 03/18/24; the exception was "out of the facility."

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for furosemide 20mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation furosemide was administered on 04/01/24, from 04/03/24 to 04/28/24, and on 04/30/24.
-There was an exception documented on

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04/02/24; the exception was "refusal."
-There was an exception documented on 04/29/24; the exception was "ordered."

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for furosemide 20mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation furosemide was administered from 05/01/24 to 05/11/24 and from 05/13/24 to 05/27/24.
-There was an exception documented on 05/12/24; the exception was "ordered."

Observation of Resident #9's medication on hand on 05/28/24 at 9:12am revealed there were 18 of 30 furosemide tablets dispensed on 04/05/24 available for administration.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for furosemide 20mg daily.
-The pharmacy dispensed 30 furosemide 20mg on 02/16/24 and 04/05/24.

Observation of Resident #9 on 05/28/24 at 11:30am revealed Resident #9 did not have swelling in her feet or ankles.

Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed she had not noticed Resident #9 with shortness of breath or swelling in her feet or ankles.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:

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D 358	Continued From page 72 -Resident #9 had an order dated 10/11/23 for furosemide 20mg daily used for fluid overload. -If Resident #9 was not administered furosemide as ordered she could have an increased risk of fluid overload or swelling in her feet and ankles. h. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for losartan 50mg (used to treat elevated blood pressure) daily. Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for losartan 50mg (used to treat elevated blood pressure) daily. Observation of Resident #9's blood pressure taken at the request of the surveyor on 05/28/24 at 4:23pm revealed Resident #9's blood pressure reading was 137/75. Review of Resident #9's March 2024 eMAR revealed: -There was an entry for losartan 50mg daily with a scheduled administration time between 7:00am to 11:00am. -There was documentation losartan was administered daily from 03/01/24 to 03/17/24 and from 03/19/24 to 03/31/24. -There was an exception documented on 03/18/24; the exception was "out of the facility." Review of Resident #9's April 2024 eMAR revealed: -There was an entry for losartan 50mg daily with a scheduled administration time between 7:00am to 11:00am. -There was documentation losartan was administered on 04/01/24, and from 04/03/24 to 04/30/24.	D 358		

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-There was an exception documented on 04/02/24; the exception was "refusal."

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for losartan 50mg daily with a scheduled administration time between 7:00am to 11:00am.
-There was documentation losartan was administered from 05/01/24 to 05/03/24 and from 05/05/24 to 05/27/24.
-The eMAR was blank for 05/04/24.

Observation of Resident #9's medication on hand on 05/28/24 at 9:14am revealed there were 18 of 30 losartan 50mg tablets dispensed on 04/05/24 available for administration.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for losartan 50mg daily.
-The pharmacy dispensed 30 losartan 50mg on 12/16/24 and 04/05/24.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for losartan 50mg daily for elevated blood pressure.
-If Resident #9 was not administered losartan as ordered she could have elevated blood pressure which could increase the risk of stroke.

i. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Verapamil 120mg (used to control heart rate) daily.

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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 74 Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Verapamil 120mg daily. Review of Resident #9's March 2024 eMAR revealed: -There was an entry for Verapamil 120mg daily with a scheduled administration time between 7:00am and 11:00am. -There was documentation Verapamil was administered from 03/01/24 to 03/17/24 and from 03/19/24 to 03/31/24. -There was an exception documented on 03/18/24; the exception was "out of facility." Review of Resident #9's April 2024 eMAR revealed: -There was an entry for Verapamil 120mg daily with a scheduled administration time between 7:00am and 11:00am. -There was documentation Verapamil was administered on 04/01/24, from 04/03/24 to 04/26/24, and on 04/30/24. -There was an exception documented on 04/02/24; the exception was "refusal." -There were exceptions documented from 04/27/24 to 04/29/24; the exceptions were "ordered" and "refill." Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed: -There was an entry for Verapamil 120mg daily with a scheduled administration time between 7:00am and 11:00am. -There was documentation Verapamil was administered from 05/01/24 to 05/09/24, on 05/13/24 and from 05/17/24 to 05/27/24. -There were exceptions documented from 05/10/24 to 05/12/24 and from 05/14/24 to 05/16/24; the exception was "ordered."	D 358		

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	HAL073019	A. BUILDING: ___ B. WING ___	C 05/28/2024

NAME OF PROVIDER OR SUPPLIER: **ROXBORO ASSISTED LIVING OPCO LLC**

STREET ADDRESS, CITY, STATE, ZIP CODE: **5660 DURHAM ROAD ROXBORO, NC 27574**

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Observation of Resident #9's medication on hand on 05/28/24 at 9:12am revealed there were 23 of 30 Verapamil 120mg tablets dispensed on 05/16/24 available for administration.

Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed:
-The pharmacy had an order for Verapamil 120mg daily.
-The pharmacy dispensed 30 Verapamil 120mg on 11/27/23 and 05/16/24.

Telephone interview with a representative from Resident #9's Primary Care Provider (PCP) on 05/28/24 at 11:22am revealed:
-Resident #9 had an order dated 10/11/23 for Verapamil 120mg daily.
-Verapamil was used to control the heart rate in residents with atrial fibrillation.
-If Resident #9 was not administered Verapamil as ordered she could experience an increase heart rate potentially causing a stroke.

j. Review of Resident #9's admission FL-2 dated 10/11/23 revealed there was an order for Simbrinza 1-0.2% (used to treat high pressure in the eyes) instill one drop in both eyes three times daily.

Review of Resident #9's signed physician orders dated 04/09/24 revealed there was an order for Simbrinza 1-0.2% instill one drop in both eyes three times daily.

Review of Resident #9's March 2024 eMAR revealed:
-There was an entry for Simbrinza 1-0.2% instill one drop in both eyes three times daily with a

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scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Simbrinza was administered three times daily from 03/01/24 to 03/17/24 and from 03/20/24 to 03/31/24, on 03/18/24 and 03/19/24 at 2:00pm and 8:00pm.
-There was an exception documented on 03/18/24; the exception was "out of facility."
-The eMAR was blank on 03/19/24 at 8:00am.

Review of Resident #9's April 2024 eMAR revealed:
-There was an entry for Simbrinza 1-0.2% instill one drop in both eyes three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Simbrinza was administered three times daily on 04/01/24, from 04/03/24 to 04/30/24, and on 04/02/24 at 2:00pm and 8:00pm.
-There was an exception documented on 04/02/24 at 8:00am; the exception was "refusal."

Review of Resident #9's May 2024 eMAR from 05/01/24 to 05/27/24 revealed:
-There was an entry for Simbrinza 1-0.2% instill one drop in both eyes three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Simbrinza was administered three times daily from 05/01/24 to 05/02/24, from 05/04/24 to 05/09/24, from 05/15/24 to 05/27/24, on 05/03/24 at 8:00am and 2:00pm, on 05/10/24 at 8:00am and 8:00pm, on 05/12/24 at 8:00pm, and on 05/13/24 at 2:00pm.
-There were exceptions on 05/03/24 at 8:00pm, on 05/10/24 at 2:00pm, on 05/12/24 at 8:00am and 2:00pm, on 05/13/24 at 8:00pm, and on 05/11/24 and 05/14/24 at 8:00am, 2:00pm, and 8:00pm; the exceptions were "not on cart", "out of

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D 358	Continued From page 77 the facility" and "ordered." -The eMAR was blank on 05/13/24 at 8:00am. Observation of Resident #9's medication on hand on 05/28/24 at 9:29am revealed: -There was a bottle of Simbrinza eye drops with a dispensed date of 05/16/24. -The bottle of eye drops was opened and appeared full. Interview with Resident #9's Power of Attorney (POA) on 05/28/24 at 11:30am revealed: -Resident #9 had complained of the rooms being dark when the lights were on and when it was daylight. -She was with Resident #9 all day on 05/27/24 and the medication aide (MA) did not administer any eye drops to Resident #9. Telephone interview with the Pharmacist from Resident #9's local pharmacy on 05/28/24 at 10:20am revealed: -The pharmacy had an order for Simbrinza one drop three times daily. -The pharmacy dispensed Simbrinza on 12/15/23 and 05/16/24. -Each bottle of Simbrinza contained 160 drops, administering 1 drop to each eye three times daily, the medication would last 26 to 27 days. Second telephone interview with the Pharmacist from the local pharmacy on 05/28/24 at 10:20am revealed: -The pharmacy serviced Resident #9 with her prescription medications. -The facility would fax the refill request for Resident #9's medications to the pharmacy. -If the facility faxed the refill request before 12:00pm the medication would be delivered the same day.	D 358		

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-If the facility faxed the refill request after 12:00pm the medication would be delivered the next day.

Attempted telephone interview with Resident #9's eye doctor on 05/28/24 at 11:10am was unsuccessful.

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Interview with Resident #9's POA on 05/28/24 at 11:30am revealed:
-The local pharmacy was the only pharmacy Resident #9 got her medications from.
-She visited Resident #9 daily from mid-morning until after dinner.
-There were many days Resident #9 did not get her medications when she visited.

Interview with a medication aide (MA) on 05/28/24 at 2:30pm revealed:
-Resident #9 received her medications from a local pharmacy.
-The MA would fax the medication refill information to the pharmacy when it was time to re-order.
-Medications should be re-ordered when there was only one row of pills left in the bubble pack, which was 8 pills.
-The pharmacy would deliver the refilled medication in a few days after ordering.
-Any MAs could fax the request for a refill to the pharmacy.
-If the medication was not in the facility, she would document "ordered" on the eMAR.
-She never documented the medication was administered when it was not in the facility to administer.

Interview with a second MA on 05/28/24 at 2:57pm revealed:
-She faxed refill requests to the local pharmacy

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for Resident #9.
-The pharmacy delivered the medications in a day or two.
-Resident #9's medication could not be re-ordered on the computer because Resident #9 did not get her medications from the facility's contracted pharmacy.
-She worked second shift and she re-ordered Resident #9's evening medications.
-She did not re-order Resident #9's morning medications because she did not administer them and she would not know when the medications needed to be re-ordered.
-The MAs started doing medication cart audits on 05/23/24 or 05/24/24.
-She looked on the medication cart to ensure all medications listed on the eMAR were on the medication cart.
-She did not know how often the MAs would be doing the medication cart audits; the MAs had not been told.

Interview with the Administrator on 05/28/24 at 3:10pm revealed:
-The MAs should order refills in a timely manner, so the medications did not give out.
-The MAs should document accurately on the eMAR when the medication was not in the facility to administer.
-The MA should call the pharmacy to see why the medication was not in the facility in a timely manner.

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The facility failed to ensure medications were administered as ordered for a resident who was administered too much blood thinner for treatment of atrial fibrillation, resulting in an irregular heart rhythm and multiple hospitalizations due to episodes of atrial fibrillation (#1); a resident who was not

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D 358	Continued From page 80 administered a blood thinner for treatment/prevention of blood clots placing her at risk for DVT's or a stroke, and was administered too much blood thinner for 3 days, placing her at increased risk for bleeding (#2); and a resident with a diagnosis of type 2 diabetes who was not administered 2 medications to control elevated blood sugars, resulting in FSBS readings above 300 (#9). This failure resulted in serious physical harm and neglect of the residents and constitutes a Type A1 Violation. _______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/22/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 27, 2024.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of an allegation against the Administrator not treating a resident with respect and dignity (Resident #4).	D 438		

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The findings are:

Interview with Resident #4 on 05/22/24 at 11:39am revealed:
-She reported a recent incident where she was kicked and pushed by another resident.
-She fell to the ground after being pushed backwards by the other resident.
-While she was lying on the ground, the Administrator stood over her and yelled at her, "look at you on the ground, that's where you belong on the ground, you should not be out here anyway, you know your [family member] does not want you smoking, and I am going to leave you down there.'
-The Administrator left her lying on the ground.
-She was embarrassed by the Administrator yelling at her so she yelled back at the Administrator.
-The Administrator did not address the other resident for assaulting her.
-She remembered someone recommended she not be moved until EMS could get there but she could not remember who that person was.

Interview with the Regional Director of Operations (RDO) on 05/24/24 at 11:50am revealed:
-She had not heard any of the residents or family members complain about the Administrator's treatment of residents, but some family members wanted to talk with the RDO and she had not talked with the family members yet.
-She did not know of any incidents of the Administrator being rude to residents or yelling at them.
-None of the staff had mentioned anything about the Administrator being rude to residents or yelling at them.
-She was not aware of the incident that occurred between the Administrator and a resident on

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05/15/24.

Second interview with the RDO on 05/28/24 at 1:15pm revealed:
-She had not reported the Administrator to the HCPR.
-She knew the normal process for HCPR reporting must be done within 24 hours.

Interview with the Administrator on 05/24/24 at 2:50pm revealed:
-She had been an Administrator since 2015.
-She and the primary care provider (PCP) for the facility were in the Administrator's office when staff came to her office on 05/15/24.
-Staff said there was a disagreement in the courtyard between two residents.
-The Administrator went outside and told Resident #4, "your [family member] does not want you smoking" while Resident #4 was lying on the ground.
-She said her tone of voice "went up" when she made the statement to the resident but she was more upset with staff because staff did not defuse the situation.
-If anyone had a concern or complaint about her, there was a grievance box outside her office, and she had also provided her supervisor's phone number when she was asked by residents' family members.

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The facility failed to report to the HCPR within 24 hours regarding an allegation of the Administrator treating a resident without respect and dignity and continuing to work full time as the person in charge at the facility. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a Plan of Protection in

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D 438	Continued From page 83 accordance with G.S. 131D-34 on May 31, 2024 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 12, 2024.	D 438		