| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL017056 | A. BUILDING: _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABUNDANT LIVING # 2 | 3816 CHERRY GROVE ROAD ELON, NC 27244 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Caswell County Department of Social Services conducted an annual survey on 06/05/24. | C 000 | Addendum per email with the Administrator<br>Tag #069 Addendum 07/08/24: correction date 06/08/24 | |
| C 069 | 10A NCAC 13G .0312(g) Outside Entrance And Exits<br><br>10A NCAC 13G .0312 Outside Entrance and Exits<br>(g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors that were accessible to two residents (#1, #2) , who were intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents, resulting in one of the residents wandering away from the facility (#1).<br><br>The findings are:<br><br>Observation of the area on 06/05/24 at 7:45am:<br>-There was a mental health facility on the main | C 069 | The facility's policy ensures that all exit doors for resident use are fitted with a sounding device that activates upon opening. The device's volume is sufficient for staff to hear, complying with 10A NCAC 13G .0312(g).<br><br>Corrective Action for Affected Residents: On June 5, 2024, the Administrator confirmed that all three exit doors had functioning, audible alarms installed. Care plans for Residents #1 and #2 were revised to note their occasional disorientation and risk of wandering. Staff received immediate training on the importance of monitoring these residents and responding to door alarms.<br><br>Identifying Other Residents Potentially Affected: On June 7, 2024, the Director of Nursing conducted an assessment across the facility to identify any other residents who might be occasionally disoriented or at risk of wandering. The care plans for all residents were reviewed and amended as needed to address any identified risks.<br><br>Systemic Changes or Measures Implemented:<br><br>By June 5, 2024, the Maintenance Director will have installed and tested audible alarms on all exit doors to ensure they can be heard throughout the facility.<br>By June 7, 2024, the NPC will update the facility's wandering risk assessment policy to include regular evaluations of all residents for wandering risk.<br>By June 7, 2024, the Administrator will hold mandatory training for all staff covering: a. The significance of operational door alarms b. Appropriate responses to activated alarms c. Oversight and care of residents prone to wandering d. Immediate reporting of any alarm malfunctions | 6//2024 |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| David A. Humphrey Sr. | Administrator | 7/6/2024 |



Reviewed and acknowledged 07/08/24 with addendum added on page #1 on 07/08/24. KJ

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| C 069 | Continued From page 1 | C 069 | | |

highway.
-Immediately beside the entrance driveway to the mental health facility, was the entrance driveway for the facility and another facility.
-There was a long-graveled road to the two sister facilities that were situated side by side at the end of the driveway.

Observation of three entrance/exit doors of the facility on 06/05/24 at various times between 7:45am-6:00pm revealed no alarm sounded when the door was opened and closed.

Interview with a resident on 06/05/24 at 4:15pm revealed:
-He was allowed to go and come as he pleased, and he could move about on the premises freely.
-Since he had been there, there had not been any alarms on the doors.

1. Review of Resident #1's current FL-2 dated 07/14/23 revealed:
-Diagnoses included schizophrenia and hypertension.
-The resident was intermittently disoriented.

Review of Resident #1's assessment and care plan dated 01/19/24 revealed:
-The resident needed supervision with eating and toileting.
-The resident needed limited assistance with ambulation, bathing, dressing, grooming, and personal hygiene.

Review of Resident #1's after-visit summary dated 06/04/24 revealed Resident #1's medications were being changed due to behavior changes and the resident had wandered away from the facility.

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| C 069 | Continued From page 2<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/34 at 3:32pm revealed:<br>-About 3-4 weeks ago, at about 11:30pm, Resident #1 was not in his room.<br>-She looked everywhere inside the facility and did not see Resident #1.<br>-She looked around the porch area and did not see Resident #1.<br>-She called the [named] facility (the mental health facility) and asked the staff to look outside their facility for the resident.<br>-The mental health facility staff saw Resident #1 in the yard.<br>-She met the resident halfway and they walked back to the facility together.<br>-The resident told her he went to get a "soda."<br>-The resident then started talking about himself as if he were someone else; he did not do this often.<br>-Resident #1 had never walked away from the facility before.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-She talked with the facility's contracted primary care provider (PCP), yesterday, 06/04/24, about the change in Resident #1's behavior, and the PCP was making medication changes.<br>-When Resident #1 walked off about three weeks ago, it was the only time the resident had walked off.<br>-She thought Resident #1 was attention-seeking.<br><br>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:<br>-She was notified Resident #1 had walked away from the facility and was located at another facility.<br>-The staff at the other facility called about the resident and the staff went and got Resident #1. | C 069 | | |

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| C 069 | Continued From page 3<br>-Resident #1 would need to be supervised when exiting the facility.<br><br>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable.<br><br>Refer to the interview with the SIC on 06/05/24 at 3:32pm and 5:36pm.<br><br>Refer to the interview with the Administrator on 06/05/24 at 4:42pm.<br><br>Refer to the telephone interview with the facility's PCP on 06/05/24 at 3:16pm.<br><br>2. Review of Resident #2's current FL-2 dated 03/28/24 revealed:<br>-Diagnoses included schizophrenia.<br>-The resident was intermittently disoriented.<br><br>Review of Resident #2's assessment and care plan dated 01/09/24 revealed:<br>-The resident needed supervision with eating and toileting.<br>-The resident needed limited assistance with ambulation, bathing, dressing, grooming, and personal hygiene.<br><br>Interview with the SIC on 06/05/34 at 3:32pm revealed:<br>-Resident #2 had very short-term memory.<br>-Resident #2 did not remember, for example, the resident would eat and then forget he had just eaten.<br>-Resident #2 walked around the grounds at the facility and went to the sister facility next door.<br>-Resident #2 had never wandered away from the facility. | C 069 | | |

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| C 069 | Continued From page 4<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-Resident #2 was new so she did not know much about him.<br>-She thought Resident #2 had short-term memory loss because he could not remember names.<br><br>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:<br>-She documented Resident #2 was intermittently disoriented based on reviewing his record as the resident was new to the facility.<br>-Resident #2 needed to be monitored because if he walked away, he would not know how to find his way back since he was new to the area.<br><br>Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable.<br><br>Refer to the interview with the SIC on 06/05/24 at 3:32pm and 5:36pm.<br><br>Refer to the interview with the Administrator on 06/05/24 at 4:42pm.<br><br>Refer to the telephone interview with the facility's PCP on 06/05/24 at 3:16pm.<br><br>_____<br>Interview with the SIC on 06/05/34 at 3:32pm and 5:36pm revealed:<br>-The residents were supposed to be inside at 10:00pm; the last smoke break was at 8:00pm.<br>-If she had not seen a resident in ten minutes, she would look for the resident.<br>-She did not sleep a lot, she tried to stay awake, but if she did doze off, she would know if a resident opened the door.<br>-There had not been any sounding devices on the exit doors as long as she could remember. | C 069 | | |

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| C 069 | Continued From page 5<br>-There had once been a sounding device on the kitchen door because of residents trying to go into the kitchen.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-The doors observed were new, and the installation was not complete.<br>-A resident broke two of the three exit doors on Saturday, 06/01/24, and the replacement started on 06/04/24.<br>-The exit doors always had chimes on them before being replaced.<br>-She did not think the exit door in the living room had a chime.<br>-She did not know why a chime was not installed on the exit door in the living room.<br><br>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:<br>-She was concerned any resident could walk away from the facility.<br>-Even if a resident did not have memory loss, she thought the facility needed door alarms so the staff would know when a resident had left.<br>-Installing alarms would be an intervention to prevent a resident from wandering away from the facility.<br><br>_____<br>The failure of the facility to ensure the alarms on the exit doors to the facility had an audible sounding device when activated which resulted in 2 residents (#1,#2) who were intermittently disoriented, having access to the doors allowing Resident #1 to leave the facility without staff knowing he was gone. This failure was detrimental to the safety and welfare of the residents and constitutes a a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in | C 069 | | |

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| C 069 | Continued From page 6<br>accordance with G.S. 131D-34 on 06/05//24 for this violation<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED JULY 20, 2024. | C 069 | | |
| C 257 | 10A NCAC 13G .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Family Care Homes:<br>(1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to expired food, improper storage of food items in the cabinets, freezer, and refrigerator, and lack of cleanliness in the kitchen including appliances, the pantry, utensil drawers, and the interior of the refrigerator.<br><br>The findings are: | C 257 | It is the facility's policy to comply with 10A NCAC 13G .0904 Nutrition and Food Service, ensuring that food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600, assuring storage, preparation, and serving of food under sanitary conditions.<br><br>**Corrective Action for Affected Residents:** On 06/05/24, the following actions were taken:<br><br>1. All expired and undated food items were immediately discarded, including the expired cranberry sauce, milk, undated hot dogs, bacon, moldy barbecue pork, undated slaw, ham slices, cheese slices, and moldy hot dog buns.<br><br>2. The refrigerator, freezer, food closet, utensil drawers, and oven were thoroughly cleaned and sanitized.<br><br>3. All remaining food items were properly sealed, labeled, and dated.<br><br>4. The build-up of ice in the upright freezer was removed.<br><br>Identifying other Residents having the Potential to be Affected: All residents have the potential | 6/5/2024 |

to be affected by improper food storage and kitchen sanitation. A full inventory and inspection of all food storage areas, including the pantry, refrigerator, and freezer, was conducted on 06/06/24 to ensure all food items are properly stored, labeled, and within their expiration dates.

**Measures put into place or Systemic Changes:**

1. On 06/07/24, the Administrator conducted mandatory in-service training for all staff members on proper food storage, labeling, and kitchen sanitation procedures.2. A new daily kitchen cleaning checklist was implemented on 06/08/24, which includes cleaning and sanitizing all surfaces, appliances, and storage areas.

3. A weekly food inventory and expiration date check procedure was implemented on 06/09/24, to be conducted by the Supervisor-in-Charge (SIC).

4. The facility's policy on food storage and kitchen sanitation was updated on 06/09/24 to reflect these new procedures and responsibilities.

5. Clear labels and markers were placed in the kitchen on 06/09/24 to facilitate proper food labeling and dating.

**Plan to Monitor Performance:**

1. The SIC will conduct daily inspections of the kitchen, including food storage areas, using the new cleaning checklist. Any issues identified will be addressed immediately.

2. The Administrator will conduct weekly unannounced kitchen inspections, focusing on food storage, labeling, and overall cleanliness.

3. The results of these inspections

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| | | | will be documented and reviewed monthly by the Administrator to identify any trends or recurring issues.<br><br>4. The Administrator will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.<br><br>The facility expects to be in full compliance with this regulation by 06/10/24. | |

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| C 257 | Continued From page 7<br><br>Observation of the kitchen on 06/05/24 between 8:23am-8:40am revealed:<br>-There was a build-up of ice in the upright freezer.<br>-There was a large plastic container of cranberry sauce that was dated as opened on 07/01/23 and expired 09/21/22.; the container was ½ full.<br>-There was a gallon of milk with a best-used date of May 22 (there was no year indicated).<br>-There was a second gallon of milk with a best-used-by date of 04/23/24.<br>-There was an opened bag of hot dogs that were not dated, and the bag was not sealed or dated.<br>-There was a large, open package of bacon, it was not sealed or dated.<br>-There was a plastic container labeled by the manufacturer as barbecue pork and vinegar sauce, the contents were not barbecue pork and were covered in a thick dark grey mold.<br>-There was a resealable plastic bag of slaw that was not labeled or dated.<br>-There was a resealable plastic bag of an unidentified food that was not labeled or dated.<br>-There was an opened bag of ham slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents.<br>-There was an opened bag of cheese slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents.<br>-The inside of the refrigerator had food crumbs and sticky brown substances.<br>-There was a bag of molded hot dog buns on a shelf.<br>-There was a plastic container labeled from the manufacturer as barbecue pork and vinegar sauce, the contents were labeled as sugar.<br>-Inside the food closet, there were crumbs and powders on all the shelves.<br>-Inside the utensil drawers, there were crumbs and debris.<br>-The handles to multiple utensil drawers and | C 257 | | |

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| C 257 | Continued From page 8<br>cabinets had a build-up of grime.<br>-On the inside of the oven door and the sides and bottom of the oven, there was a build-up of a sticky black substance.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:<br>-Food was supposed to be sealed and dated; anything opened.<br>-Cleaning the kitchen was the responsibility of a [named] staff member.<br>-She had noticed today, 06/05/24, that the kitchen needed to be cleaned.<br>-She did not know there was food in the refrigerator that had not been labeled.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-Staff were responsible for cleaning the kitchen; whoever was working.<br>-She had not been in the kitchen in the past 2-3 weeks, until today, 06/05/24.<br>-Food should be labeled when opened and in an appropriate container.<br><br>Attempted telephone interview with the [named] staff member on 06/05/24 at 6:01pm was unsuccessful. | C 257 | | |
| C 259 | 10A NCAC 13G .0904(a)(3) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Family Care Homes:<br>(3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule, | C 259 | | |

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| C 259 | Continued From page 9<br>for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews the facility failed to ensure there was a five-day supply of non-perishable food maintained in the facility based on the menus for the six residents residing at the facility.<br><br>The findings are:<br><br>Review of the menu posted in the kitchen on 06/05/24 at 8:25am revealed no menu was posted.<br><br>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed:<br>-An example of a daily menu included breakfast, lunch, and dinner.<br>-Breakfast was 6 ounces of orange juice, 1 scrambled egg, 2 strips of bacon, ½ cup of cream wheat, 1 slice of toast with jelly, milk, coffee, and water.<br>-Lunch was 3 ounces of fish, 1 cup of French fries, ½ cup of slaw, 1 serving of hush puppies, ½ cup of lemon pudding, 1 teaspoon of tartar sauce, coffee, tea, and water. | C 259 | It is the facility's policy to maintain a three-day supply of perishable food and a five-day supply of non-perishable food based on the established menus for both regular and therapeutic diets, in accordance with 10A NCAC 13G .0904(a)(3).<br><br>**Corrective Action for Affected Residents:** On 06/06/24, the Administrator conducted a full inventory of all food supplies in the facility and the off-site storage. A five-day supply of non-perishable food based on the established menu was immediately ordered and delivered to the facility. The molded bread was discarded and replaced with fresh bread. All residents have access to adequate food supplies as of 06/07/24.<br><br>**Identifying other Residents having the Potential to be Affected:** All six residents in the facility have the potential to be affected by this deficiency. The Administrator reviewed the dietary needs of all residents on 06/07/24 to ensure that the new food supply meets their individual requirements.<br><br>**Measures put into place or Systemic Changes:**<br>1. The Administrator has developed a new food inventory tracking system as of 06/08/24. This system includes a weekly inventory check and a bi-weekly order schedule to maintain the required food supply.<br>2. A new menu planning and posting process has been implemented as of 06/09/24. The Supervisor-in-Charge (SIC) is now responsible for posting the daily menu in the kitchen each morning. | 6/15/2024 |

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| | | | 3. The Administrator has scheduled food safety and inventory management training for all staff members, to be completed by 06/09/24. This training will cover proper food storage, inventory management, and the importance of maintaining adequate food supplies.<br>4. A new policy has been implemented as of 06/10/24 requiring the SIC to conduct daily checks of the food storage areas, including checking for expired or spoiled items.<br>5. The Administrator has designated a backup staff member responsible for food ordering and delivery in case the primary staff member is unavailable. This change was implemented on 06/11/24.<br><br>**Plan to Monitor Performance:** The Administrator will conduct weekly audits of the food inventory and menu posting for the next three months (until 09/05/24). These audits will ensure compliance with the five-day non-perishable food supply requirement and proper menu posting.<br><br>The SIC will report any food supply issues or concerns to the Administrator immediately. The Administrator will review these reports daily and take corrective action as needed.<br><br>The Administrator will report monitoring | |

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| ABUNDANT LIVING # 2 | 3816 CHERRY GROVE ROAD ELON, NC 27244 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| C 259 | Continued From page 10<br>-Dinner was ½ cup of tossed salad, 3 ounces of creamed turkey, ½ cup of buttered noodles, ½ cup of stewed tomatoes, 1 slice of wheat bread, ½ cup of ice cream, milk, and a second beverage.<br>-Bedtime snack was milk and ½ sandwich.<br><br>Observation of the food closet on 06/05/24 at 8:32am revealed:<br>-There were 4 bags of grits: each bag contained 57, 1 cup servings.<br>-There were 3 containers of oatmeal: each container was 30, ½ cup servings.<br>-There were 2 bags of dried split peas; each bag contained 26, 1/4 cup servings.<br>-There was a plastic container that was not labeled, the contents were rice and there were less than 2 cups.<br>-There were two resealable plastic bags of spaghetti noodles.<br>-There was a can of yams; there were 3, 2/3 cups servings.<br>-There was a can of unsweetened applesauce: there were 3.5, ½ cup servings.<br>-There were two boxes of macaroni and cheese; each box contained 3, 1/3 cup servings.<br>-There were two individual serving containers of mixed fruit.<br>-There were multiple bags of marshmallows.<br><br>Observation of a shelf in the kitchen on 06/05/24 at 8:36am revealed:<br>-There was an opened package of grits and oatmeal.<br>-There were multiple bags of bread; one bag of bread was molded.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:<br>-The Administrator usually came to the facility to | C 259 | | |

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| C 259 | Continued From page 11<br>see what food was needed and then ordered the food.<br>-The food was restocked every two weeks.<br>-She thought the food had been restocked "a week ago."<br>-There used to be additional food stored in a building outside of the facility, but now that food was stored in a building off-site.<br><br>Interview with the Administrator on 06/05/24 at 5:36pm revealed:<br>-Food was delivered to the facility every two weeks.<br>-If staff called and stated they were out of something, it would be delivered immediately.<br>-A [named] staff member was responsible for ordering and delivering food to the facility.<br><br>Attempted telephone interview with the [named] staff member on 06/05/24 at 6:02pm was unsuccessful. | C 259 | | |
| C 272 | 10A NCAC 13G .0904(d)(2) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(d) Food Requirements in Family Care Homes:<br>(2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.<br><br>This Rule is not met as evidenced by: | C 272 | | |

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| C 272 | Continued From page 12<br>Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day.<br><br>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed:<br>-Bedtime snack was milk and ½ sandwich<br>-There was no other snack listed.<br><br>Observation of the kitchen on 06/05/24 between 8:23am-8:40am revealed:<br>-There were two individual serving containers of mixed fruit.<br>-There were multiple bags of marshmallows.<br>-There were no other snack foods identified.<br><br>Interview with a resident on 06/05/24 at 7:59am revealed:<br>-The residents needed snacks.<br>-The residents were served snacks, "sometimes."<br>-They were served a fruit cup every once in a while, as a snack; he could not remember the last time he was served a fruit cup.<br><br>Interview with a second resident on 06/05/24 at 8:03am revealed snacks were served, "every now and then."<br><br>Interview with a third resident on 06/05/24 at 8:07am revealed:<br>-Snacks were served "sometimes."<br>-There were times he got hungry between meals.<br><br>Interview with a fourth resident on 06/05/24 at 8:10am revealed:<br>-Snacks were not served "often."<br>-He wished snacks were served more often.<br><br>Interview with the Supervisor-in-Charge (SIC) on | C 272 | It is the facility's policy to offer foods and beverages in accordance with each resident's prescribed diet or make available to all residents as snacks between each meal for a total of three snacks per day and show on the menu as snacks, as per 10A NCAC 13G .0904(d)(2).<br><br>**Corrective Action for Affected Residents:** On 06/06/24, the Administrator reviewed the snack menu and implemented a new snack schedule to ensure all residents are offered three snacks daily. The new schedule includes snacks at 10:00 AM, 2:00 PM, and 7:00 PM, seven days a week. All residents were informed of the new snack schedule on 06/06/24.<br><br>**Identifying other Residents having the Potential to be Affected:** On 06/06/24, the Administrator conducted a facility-wide assessment and determined that all residents have the potential to be affected by this deficiency. The new snack schedule applies to all residents.<br><br>**Measures put into place or Systemic Changes:**<br>1. On 06/06/24, the Administrator revised the facility's nutrition policy to clearly state that three snacks must be offered daily to all residents, regardless of whether they attend day programs.<br>2. On 06/08/24, the Administrator created a new snack menu that includes a variety of options (e.g., fruit cups, chips, popcorn, granola bars, juices) for each snack time. This menu is posted in the kitchen and dining area.<br>3. On 06/09/24, the Administrator conducted an in-service training | 6/15/2024 |

course for all staff members on the importance of offering three daily snacks and the new snack schedule. Staff members were trained in how to document snack offerings and resident acceptance/refusal.

4. By 06/09/24, the Administrator will implement a snack log to be completed by staff members daily, indicating the snacks offered and any residents who decline.
5. By 06/09/24, the Administrator will ensure that an adequate supply of snack items is always available in the facility by implementing a weekly inventory check and ordering system.

**Plan to Monitor Performance:**

1. The Supervisor-in-Charge (SIC) will conduct daily audits of the snack log for the first 30 days to ensure compliance with the new snack schedule and policy.
2. After the initial 30-day period, the Administrator will conduct weekly audits of the snack log and perform random observations of snack times for 60 days.
3. The Administrator will interview at least 5 randomly selected residents weekly for 90 days to ensure they are being offered snacks as scheduled and to gather feedback on snack preferences.
4. The Administrator will review the results of these audits and interviews monthly and report findings to the Quality Assurance and Performance Improvement (QAPI) committee.

The Administrator will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved
and maintained for at least three consecutive months.

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| C 272 | Continued From page 13<br><br>06/05/24 at 3:32pm revealed:<br>-Snacks were served at 10:00am, 2:00pm, and 7:00pm.<br>-The residents were served fruit cups, chips, popcorn, granola bars, and juices.<br>-When she was working, she brought in things she knew the residents liked such as popcorn.<br>-When she was not working, the Administrator usually made sure there were snacks in the facility.<br><br>Interview with the Administrator on 06/05/24 at 5:36pm revealed:<br>-Snacks were supposed to be served three times per day on the weekends.<br>-Snacks were served once a day Monday-Friday because the residents went to a day program.<br>-Snacks provided were fruit cups, chips, and rice krispy snacks. | C 272 | | |
| C 273 | 10A NCAC 13G .0904(d)(3) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(d) Food Requirements in Family Care Homes:<br>(3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost. | C 273 | | |

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| C 273 | Continued From page 14<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to ensure the residents were served one and a half cups of fruit daily and 3 cups of dairy as recommended based on the U.S. Department of Agriculture Dietary Guidelines for Americans.<br><br>The findings are:<br><br>Review of the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025 revealed:<br>-Adults aged 19-59 and 60+ should consume a minimum of 1 1/2 cups of fruit daily for a 1600-calorie diet and up to 2 cups for higher caloric diets.<br>-The fruit food group included whole fruits and 100% fruit juice.<br>-Whole fruits included fresh, canned, frozen, and dried forms.<br>-Whole fruits could be eaten in various forms, such as cut, sliced, diced, or cubed.<br>-At least half of the recommended amount of fruit should come from whole fruit, rather than 100% juice.<br>-When juices were consumed, they should be 100% juice and always pasteurized or 100% juice diluted with water (without added sugars).<br>-Adults age 60+ should consume dairy to equal 3 cups per day.<br><br>Observation of the refrigerator and the freezer on 06/05/24 at 8:23am revealed:<br>-There was a gallon of milk with a best-used date of May 22 (there was no year indicated).<br>-There was a second gallon of milk with a best-used-by date of 04/23/24. | C 273 | It is the facility's policy to ensure that residents are served meals and snacks in accordance with 10A NCAC 13G .0904 Nutrition and Food Service, which requires daily menus for regular diets to be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025.<br><br>**Corrective Action for Affected Residents:** On June 6, 2024, the Dietary Manager conducted a comprehensive review of all residents' dietary needs and preferences. Based on this review:<br>1. The menu was immediately revised to include 1.5 cups of fruit and 3 cups of dairy daily for each resident.<br>2. Fresh fruits, canned fruits, and 100% fruit juices were added to the inventory to ensure adequate supply.<br>3. Expired milk was discarded, and fresh milk was obtained to meet the daily dairy requirements.<br>4. All residents were provided with education on the importance of fruit and dairy consumption in their diet.<br><br>Identifying other Residents having the Potential to be Affected: All residents have the potential to be affected by this deficiency. Therefore, on June 7, 2024, the Dietary Manager and Administrator reviewed the dietary needs of all residents to ensure compliance with the USDA Dietary Guidelines.<br><br>**Measures put into place or Systemic Changes:**<br>1. On June 8, 2024, the Administrator revised the facility's | 6/15/2024 |

Nutrition and Food Service policy to explicitly include the requirement for 1.5 cups of fruit and 3 cups of dairy daily for each resident.
2. On June 10, 2024, the Dietary Manager developed a new menu cycle that incorporates the required fruit and dairy servings, which was reviewed and approved by a registered dietitian.
3. On June 12, 2024, the Administrator implemented a new inventory management system to ensure adequate stock of fresh fruits, canned fruits, 100% fruit juices, and dairy products.
4. On June 12, 2024, all staff received comprehensive training on the new menu, proper food storage, and the importance of following expiration dates.
5. The Administrator established a bi-weekly food delivery schedule to ensure a consistent supply of fresh produce and dairy products.
6. The Supervisor-in-Charge implemented a daily checklist to verify that fruit and dairy offerings meet the required amounts for each meal and snack.

**Plan to Monitor Performance:**
1. The Dietary Manager will conduct daily audits of meals and snacks for the first 30 days, then weekly for 60 days, and monthly thereafter to ensure compliance with fruit and dairy requirements.
2. The Administrator will perform weekly checks of the refrigerator and freezer to ensure proper food storage and that no expired items are present.
3. The Supervisor-in-Charge will maintain a log of fruit and dairy servings offered at each meal and snack, which will be reviewed weekly by the Administrator.
4. The Administrator will conduct monthly resident satisfaction surveys regarding meal quality and variety, including specific questions about fruit and dairy

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| | | | offerings.<br><br>The Administrator will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. | |

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| C 273 | Continued From page 15<br>-There was an opened bag of cheese slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents.<br>-There were 16 individual cartons of milk; the best-used date was May 2 (there was no year indicated).<br>-There was a can of unsweetened applesauce: there were 3.5, ½ cup servings.<br>-There were two individual serving containers of mixed fruit.<br>-There were no frozen fruits or fruit juices.<br>-There were multiple individual containers of 100% apple juice from concentrate; the juice boxes were not dated with a best-used-by date.<br><br>Review of the manufacturers guidelines for the individual containers of apple juice revealed juices were delivered frozen. The juice should be thawed under refrigeration and used within 10-days of thawing.<br><br>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed:<br>-An example of a daily menu included breakfast, lunch, and dinner.<br>-Breakfast was 6 ounces of orange juice, 1 scrambled egg, 2 strips of bacon, ½ cup of cream wheat, 1 slice of toast with jelly, milk, coffee, and water.<br>-Lunch was 3 ounces of fish, 1 cup of French fries, ½ cup of slaw, 1 serving of hush puppies, ½ cup of lemon pudding, 1 teaspoon of tartar sauce, coffee, tea, and water.<br>-Dinner was ½ cup of tossed salad, 3 ounces of creamed turkey, ½ cup of buttered noodles, ½ cup of stewed tomatoes, 1 slice of wheat bread, ½ cup of ice cream, milk, and a second beverage.<br>-Bedtime snack was milk and ½ sandwich. | C 273 | | |

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| C 273 | Continued From page 16<br><br>Observation of the dinner meal service on 06/05/24 at 4:10pm revealed:<br>-The residents were served a large piece of fish.<br>-One cup of rice.<br>-One-half cup of broccoli.<br>-One-half cup of zucchini.<br>-Beverages included water and tea.<br>-There was no fruit juice or fruit served.<br>-The milk available to be served was expired.<br><br>Interview with four residents on 06/05/24 between 7:48am-8:28am revealed:<br>-The residents were not served milk daily.<br>-One resident stated milk was served "sometimes."<br>-A second resident stated milk was served "every so often."<br>-He liked milk and would drink milk if it was served.<br>-A third resident stated milk was served "every once in a while:<br>-He thought milk was served last week; he liked milk and would drink more often.<br>-A fourth resident stated he was served milk with cereal.<br>-He would like to have milk to drink at meals.<br>-The residents were not served fruit or fruit juice daily.<br>-One resident stated fruit or fruit juice was served "every once in a while."<br>-A second resident stated he was served juice, sometimes.<br>-He was last served juice last week and had apples "several weeks ago."<br>-A third resident liked juice and did not recall when juice was last served.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed: | C 273 | | |

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| C 273 | Continued From page 17<br>-Milk was served with cereal.<br>-She offered milk to the residents 2-3 times per week during lunch or dinner.<br>-The residents usually wanted Kool-Aid or tea.<br>-The residents were served fruit cups.<br>-The residents had watermelon two days ago.<br>-Fruit delivered to the facility included fruit cocktail, apples, and oranges.<br>-There were apples and oranges served last week.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-Fruit juices were delivered frozen because they had a longer shelf life.<br>-She did not know the process of delivery to the facility, as a [named] staff member handled that.<br>-Individual cups of apples, mandarin oranges, pears, and peaches, were delivered to the facility.<br>-She thought there had been fresh apples and oranges at the facility, "maybe last month."<br>-Food was delivered every two weeks.<br>-Staff should be offering milk three times per day.<br>-She did not know the milk in the refrigerator was expired.<br><br>Attempted telephone interview with the [named] staff person who handled the facility's food on 06/05/24 at 6:02pm was unsuccessful. | C 273 | | |
| C 315 | 10A NCAC 13G .1002(a) Medication Orders<br><br>10A NCAC 13G .1002 Medication Orders<br>(a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours | C 315 | | |

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| C 315 | Continued From page 18<br>of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews the facility failed to clarify an order for 1 of 3 sampled residents (#2) related to an antipsychotic medication.<br><br>The findings are:<br><br>Review of Resident #2's FL-2 dated 03/13/24 revealed:<br>-Diagnosis was schizophrenia.<br>-There was an order for Prolixin (used to treat allergies) 5mg daily.<br><br>Review of Resident #2's FL-2 dated 03/2824 revealed no order for Prolixin 5mg to be administered daily.<br><br>Review of Resident #2's April 2024 medication administration record (MAR) revealed:<br>-There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am.<br>-There was documentation that Prolixin 5mg was administered daily from 04/01/24-04/30/24.<br><br>Review of Resident #2's May 2024 MAR revealed:<br>-There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am. | C 315 | It is the facility's policy to ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments if orders are not clear or complete, as per 10A NCAC 13G .1002(a)(2).<br><br>**Corrective Action for Affected Residents**:<br>On 06/06/24, the Administrator contacted Resident #2's Primary Care Provider (PCP) to clarify the order for Prolixin 5mg daily. The PCP confirmed the order, and a new FL-2 was obtained with the correct medication order included. The Medication Administration Record (MAR) was updated to reflect the clarified order, ensuring continuity of care for Resident #2.<br><br>**Identifying other Residents having the Potential to be Affected**: By 06/10/24, the Nursing Practitioner (NP) will conduct a comprehensive review of all current residents' FL-2s, comparing them with their respective MARs and medications on hand. Any discrepancies identified will be immediately addressed with the respective PCPs for clarification and correction.<br><br>**Measures put into place or Systemic Changes:**<br><br>1. By 06/15/24, the Administrator will revise the facility's medication management policy to include a double-check system for reviewing new FL-2s against current MARs and medications on hand.<br>2. By 06/20/24, the DON will conduct mandatory in-service training for all nursing staff and medication aides on a. The importance of thorough FL-2 reviews upon receipt b. The process for identifying and addressing medication discrepancies c. Proper communication protocols with PCPs and the pharmacy | 6/15/2024 |

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| | | | for order clarification<br>3. Effective 06/21/24, a new FL-2 Review Checklist will be implemented. This checklist will be completed by the receiving staff member and double-checked by a supervisor within 24 hours of receiving a new FL-2.<br>4. By 06/25/24, the Administrator will establish a formal communication process with the contracted pharmacy to ensure timely notification of any medication discrepancies identified by either party.<br><br>**Plan to Monitor Performance:**<br><br>1. Starting 07/01/24, the NP or designee will conduct weekly audits of 25% of all new FL-2s received, ensuring they are properly reviewed, and any discrepancies are addressed promptly. These audits will continue for 3 months.<br>2. The NP will review the results of these audits monthly and report findings to the Quality Assurance and Performance Improvement (QAPI) committee.<br>3. After 3 months of consistent compliance (90% or higher), the audit frequency will be reduced to monthly for an additional 3 months.<br>4. The Administrator will conduct random spot checks of the FL-2 Review Checklist completion bi-weekly for 3 months to ensure the new process is being followed consistently.<br><br>The Administrator will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved and sustained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | FCL017056 | A. BUILDING: _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ABUNDANT LIVING # 2 | 3816 CHERRY GROVE ROAD ELON, NC 27244 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| C 315 | Continued From page 19 | C 315 | | |

-There was documentation that Prolixin 5mg was administered daily from 05/01/24-05/31/24.

Review of Resident #2's June 2024 MAR from 06/01/24-06/05/24 revealed:
-There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am.
-There was documentation that Prolixin 5mg was administered daily from 06/01/24-06/05/24.

Observation of Resident 1's medications on hand on 06/05/24 at 11:53am revealed Prolixin 5mg was available to be administered.

Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed:
-Resident #2's FL-2 dated 03/13/24 was received at the pharmacy and a 7-day supply was dispensed on 03/27/24.
-On 04/01/24, an additional 21 tablets of Prolixin were dispensed, to get the resident's medication on cycle with the facility's other medications.
-On 04/30/24 Resident #2's primary care provider (PCP) sent in a prescription for Resident #2's Prolixin 5mg daily.
-The pharmacy did not receive Resident #2's FL-2 dated 03/28/24.
-When the Prolixin was not on Resident #2's FL-2 dated 03/28/24, the facility staff should have called the PCP to clarify the order for the medication.
-The staff at the facility could have also notified the pharmacy and they would have clarified the order.

Telephone interview with Resident #2's PCP on 06/05/24 at 3:16pm revealed if Resident #2's Prolixin was missed on the FL-2, she would have

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| C 315 | Continued From page 20<br>expected the facility staff to have made her aware and she could have gotten the order corrected.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:<br>-When a new FL-2 was received she or a [named] Administrator reviewed the FL-2 and matched it with the resident's MAR and medications on hand and if it did not match she would notify the Administrator or call the PCP.<br>-She had not noticed Resident #2's Prolixin was not on the current FL-2.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed when a new FL-2 was completed and signed on a resident, the staff member working should compare the new FL-2 to the MAR and the medications on hand and if there were any discrepancies, the staff member should reach out to the PCP for clarification. | C 315 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled | C 330 | | |

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| C 330 | Continued From page 21<br>residents (#1) related to an inhaler.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 07/14/23 revealed:<br>-Diagnoses included schizophrenia and hypertension.<br>-The resident was intermittently disoriented.<br>-There was no order for a Breo Ellipta inhaler (used to treat and prevent wheezing and shortness of breath).<br><br>Review of Resident #1's April 2024 medication administration record (MAR) revealed:<br>-There was an entry for Breo Ellipta 200-25mcg, inhale one puff by mouth daily with a scheduled administration time of 8:00am.<br>-There was documentation that the Breo Ellipta was administered at 8:00am daily from 04/01/24-04/30/24.<br><br>Review of Resident #1's May 2024 MAR revealed:<br>-There was an entry for a Breo Ellipta inhaler to be administered once daily with a scheduled administration time of 8:00am.<br>-There was documentation that the Breo Ellipta inhaler was administered daily from 05/01/24-05/31/24.<br><br>Review of Resident #1's June 2024 MAR from 06/01/24-06/05/24 revealed:<br>-There was an entry for a Breo Ellipta inhaler to be administered once daily with a scheduled administration time of 8:00am.<br>-There was documentation that the Breo Ellipta inhaler was administered daily from 06/01/24-06/05/24. | C 330 | It is the facility's policy to ensure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner which are maintained in the resident's record, and rules in this Section and the facility's policies and procedures, as per 10A NCAC 13G .1004(a).<br><br>**Corrective Action for Affected Residents:** On 06/05/24, the Nursing Practitioner (NP) immediately contacted Resident #1's Primary Care Physician (PCP) to clarify the order for the Breo Ellipta inhaler. The PCP confirmed the order, and a new prescription was obtained. The NP then contacted the pharmacy to obtain a new inhaler, which was delivered on 06/06/24. The Medication Administration Record (MAR) was updated to reflect the correct order and administration instructions. The DON provided education to Resident #1 on the importance of using the inhaler as prescribed.<br><br>**Identifying other Residents having the Potential to be Affected:** On 06/06/24, the NP conducted a comprehensive review of all residents' medication orders, MARs, and on-hand medications to identify any other discrepancies or potential issues with medication administration, particularly focusing on inhalers and other as-needed medications.<br><br>**Measures put into place or Systemic Changes:**<br><br>1. On 06/07/24, the NP revised the facility's medication administration policy to include a specific protocol for managing inhaler medications, including proper documentation of administration and refill procedures.<br>2. On 06/08/24, the NP conducted an in-service training for all medication aides | 6/15/2024 |

and nurses on proper medication administration, documentation, and the importance of timely medication refills. This training specifically addressed inhaler administration and documentation.

3. By 06/10/24, the Administrator will implement a new system for tracking medication refills, including a weekly review of all medications to identify those needing refills within the next 7 days.
4. By 06/15/24, the NP will create and implement a "Medication Discrepancy Report" form to be used by staff to immediately report any issues with medication orders, administration, or supply.

**Plan to Monitor Performance:**

1. The NP or designee will conduct daily audits of medication administration records and on-hand medications for all residents for 2 weeks, then weekly for 1 month, and then monthly for 3 months to ensure compliance with medication orders and proper documentation.
2. The NP will review all "Medication Discrepancy Report" forms weekly and address any issues immediately.
3. The Administrator will conduct random observations of medication passes twice weekly for 1 month, then weekly for 2 months to ensure proper administration techniques and documentation.
4. The NP will review the weekly medication refill tracking system every Friday to ensure timely ordering of medications.

The NP will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.

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| **ABUNDANT LIVING # 2** | **3816 CHERRY GROVE ROAD ELON, NC 27244** |

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| C 330 | Continued From page 22<br><br>Observation of Resident 1's medications on hand on 06/05/24 at 11:53am revealed a Breo Ellipta inhaler with the directions to inhale one puff daily was dispensed on 03/11/24; 13 puffs were remaining.<br><br>Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed:<br>-Resident #1's had an order dated 10/06/23, for the Breo Ellipta with the directions to inhale one puff once daily.<br>-Resident #1's Breo Ellipta was dispensed on 02/14/24, 03/11/24, and 04/01/24 for a 30 day supply each dispensing.<br>-Resident #1's Breo Ellipta had not been cycle-filled and the facility staff would have needed to request a refill.<br><br>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 06/05/24 at 1:47pm revealed:<br>-Resident #1's Breo Ellipta inhaler was used to prevent worsening of chronic lung disease symptoms.<br>-If the inhaler was not administered correctly, the resident may experience a worsening of any symptoms he was experiencing such as shortness of breath or coughing.<br><br>Telephone interview with Resident #2's PCP on 06/05/24 at 3:16pm revealed:<br>-Resident #1 was ordered the Ellipta inhaler because the resident had asthma.<br>-If Resident #1's Ellipta was not administered as ordered he could experience an asthma attack or worsening of symptoms.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed: | C 330 | | |

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| C 330 | Continued From page 23<br>-There were no other inhalers available for Resident #1, just the one provided (dated 03/11/24).<br>-Resident #1's inhaler used to be automatically refilled.<br>-Resident #1 had not refused the inhaler, he might refuse at that time, but would return later to get the medication.<br>-She did not know why puffs were remaining in the inhaler.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-When a resident's inhaler was low, the SIC was responsible for calling the pharmacy to reorder.<br>-Resident #1's inhaler should be reordered monthly.<br>-If Resident #1 was refusing the inhaler it should be documented.<br>-She expected the medication to be administered as ordered. | C 330 | | |
| C 342 | 10A NCAC 13G .1004(j) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration; | C 342 | | |

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| C 342 | Continued From page 24<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents including an antipsychotic medication used to treat schizophrenia (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 07/14/23 revealed:<br>-Diagnoses included schizophrenia and hypertension.<br>-The resident was intermittently disoriented.<br>-There was an order for Clozapine (an antipsychotic medication used to treat schizophrenia) 100mg take one and a half tablets at bedtime.<br><br>Review of Resident #1's primary care provider's (PCP) order dated 03/12/24 revealed:<br>-Resident #1 was going to be weaned off his Clozapine by decreasing the dose by 50mg weekly until discontinued with a start date of 03/15/24.<br>-Week one 250mg night for 7 days.<br>-Week two 200mg each night for 7 days.<br>-Week three 150mg each night for 7 days.<br>-Week four 100mg each night for 7 days.<br>-Week five 50mg each night for 7 days; then | C 342 | It is the facility's policy to ensure that medication administration records (MARs) are accurate and include all required information as per 10A NCAC 13G .1004(j), including the resident's name, medication or treatment order, strength and dosage, administration instructions, reason for PRN medications, date and time of administration, documentation of omissions, and name or initials of the person administering the medication.<br><br>**Corrective Action for Affected Residents:** On 06/06/24, the Nursing Practitioner (NP) reviewed and corrected Resident #1's MAR to accurately reflect the Clozapine taper order dated 03/12/24. The NP also conducted a medication reconciliation for Resident #1 to ensure all current medications are accurately listed on the MAR.<br><br>Identifying other Residents having the Potential to be Affected: By 06/12/24, the NP will review all residents' MARs to identify any other instances of inaccurate documentation, particularly for medications with changing doses or tapering schedules.<br><br>**Measures put into place or Systemic Changes:**<br><br>1. By 06/15/24, the Administrator will revise the facility's medication administration policy to include specific procedures for documenting medication tapers and changing doses on MARs.<br>2. By 06/20/24, the NP will conduct mandatory in-service training for all medication aides and nurses on a. Proper documentation on MARs, including tapering medications b. The importance of accurately transcribing medication orders c. Procedures for handling MARs when new medication orders are received<br>3. By 06/25/24, the Administrator will | 6/28/2024 |

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| | | | implement a new process requiring the Supervisor-in-Charge (SIC) to immediately update MARs when new medication orders are received, including writing in tapered doses as needed.<br>4. By 07/01/24, the facility will establish a formal communication process with the contracted pharmacy to ensure timely receipt of updated MARs for medication changes, particularly for tapered medications.<br><br>**Plan to Monitor Performance:**<br><br>1. Starting 07/01/24, the NP or designee will conduct weekly audits of 25% of resident MARs, with a focus on medications with changing doses or tapering schedules, for a period of 3 months.<br>2. The Administrator or designee will conduct monthly audits of all MARs to ensure accuracy and compliance with medication orders.<br>3. The NP will report audit findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly for the next 3 months, then quarterly thereafter.<br>4. The QAPI committee will review the audit results, identify any trends or ongoing issues, and implement additional corrective actions as needed.<br><br>The Administrator will be responsible for overseeing the implementation of this plan of correction and ensuring ongoing compliance. The QAPI committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. | |

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| C 342 | Continued From page 25<br>discontinue the medication.<br><br>Review of Resident #1's April 2024 medication administration record (MAR) revealed:<br>-There was an entry for Clozapine 100mg take one tablet at bedtime for 7 days.<br>-There was documentation that Clozapine 100mg was administered from 04/01/24 to 04/30/24 at 8:00pm.<br>-There was no other entry for Clozapine.<br><br>Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed:<br>-Resident #'1 Clozapine was dispensed once a week for a 7-day supply with the following taper.<br>-On 03/12/24, Clozapine 100mg take 2 ½ tablets for 7 days.<br>-On 03/17/24, Clozapine 100mg take 2 tablets for 7 days.<br>-On 03/22/24, Clozapine 100mg take 1 ½ tablets for 7 days.<br>-On 03/28/24, Clozapine 100mg take 1 tablet for 7 days.<br>-On 04/03/24, Clozapine 25mg take 2 tablets for 7 days.<br>-MARs were sent monthly.<br>-The staff at the facility should have used a blank MAR to write the Clozapine taper in, so it was clear what the resident would receive each week.<br><br>Based on a review of records and interviews, there would not have been any Clozapine on hand to administer between 04/19/24-04/30/24 and the amount to be administered between 04/12/24-04/18/24, would have been 50mg, not 100mg as documented.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed: | C 342 | | |

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| C 342 | Continued From page 26<br><br>-When new medication was sent from the pharmacy, the pharmacy may or may not send a new MAR.<br>-For medication that was tapered, when the medication was sent each week a new MAR should have been sent with the medication, "the current pharmacy did not do that."<br>-She did not know why she did not write the taper each week.<br><br>Interview with the Administrator on 06/05/24 at 4:42pm revealed:<br>-She expected the SIC to write in the tapered order for Resident #1's Clozapine and document it on the MAR according to the taper.<br>-She expected staff to document the administration of every medication on the MARs.<br>-If a medication was not listed on the MAR, the SIC could write the medication in on the MAR and notify the pharmacy to have a MAR delivered with the medication listed.<br>-A second Administrator was responsible for auditing the MARs.<br><br>Interview with the second Administrator on 06/05/24 at 6:02pm revealed:<br>-He audited the MARs at the facility once a month.<br>-He audited the MARs in May 2024.<br>-He had not seen the error in the documentation for Resident #1's Clozapine taper. | C 342 | | |
| C 352 | 10A NCAC 13G .1006 (a) Medication Storage<br><br>10a NCAC 13G .1006 Medication Storage<br><br>(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the | C 352 | | |

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| C 352 | Continued From page 27<br>facility's medication storage policy and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure medications remained under the direct supervision of staff in charge of medication administration at all times including a bottle of Miralax (a stool softener) and multiple tablets of medication found on the floor in a resident's room.<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated 07/14/23 revealed:<br>-Diagnoses included schizophrenia and hypertension.<br>-The resident was intermittently disoriented.<br>-Medication orders included Metoprolol (used to treat high blood pressure) 100mg, Omeprazole (used to treat reflux) 20mg, Lisinopril (used to treat high blood pressure) 30mg, Haloperidol (an antipsychotic used to treat mental disorders) 5mg, Clozapine (an antipsychotic medication used to treat schizophrenia) 100mg, Trazadone (an antidepressant) 100mg, Simvastatin (used to treat high cholesterol) 10mg, Desmopressin (an antidiuretic used to treat the body losing fluid) 0.1mg and Acetaminophen (used to treat mild pain) 325mg | C 352 | It is the facility's policy to ensure that medications are stored in a safe and secure manner as specified in the facility's medication storage policy and procedures, in accordance with 10A NCAC 13G .1006(a).<br><br>**Corrective Action for Affected Residents:** On 06/05/24, the Supervisor-in-Charge (SIC) immediately removed the bottle of MiraLAX and all loose tablets from Resident #1's room. The Nurse Practitioner (NP) conducted a thorough assessment of Resident #1 to ensure no adverse effects from potential medication errors. The Administrator also reviewed Resident #1's medication administration records to verify all prescribed medications were administered as ordered.<br><br>**Identifying other Residents having the Potential to be Affected:** On 06/06/24, the NP and SIC conducted a facility-wide audit of all residents' rooms to ensure no medications were present. Any medications found were immediately removed and securely stored in the medication room. The DON reviewed all residents' medication administration records to verify proper administration.<br><br>**Measures put into place or Systemic Changes:**<br>1. On 06/07/24, the Administrator revised the facility's medication storage and administration policy to reinforce that no medications are to be stored in residents' rooms and that staff must directly observe residents swallowing medications.<br>2. On 06/08/24, the NP conducted mandatory in-service training for all staff involved in medication administration. The training | 6/15/2024 |

covered: a. Proper medication storage procedures b. Importance of direct observation during medication administration c. Techniques to ensure residents swallow medications (e.g., "tongue roll") d. Proper documentation of medication administration e. Reporting and addressing medication errors

3. By 06/10/24, the Administrator will install locks on all medication carts and ensure they are securely stored in the medication room when not in use.
4. By 06/10/24, the NP will implement a "double-check" system where two staff members verify medication administration for residents with a history of medication refusal or "cheating meds."

**Plan to Monitor Performance:**

1. The NP or designee will conduct daily room checks for all residents for the first week, then three times a week for two weeks, and weekly thereafter to ensure no medications are present in residents' rooms.

2. The NP or designee will observe medication administration practices for each staff member involved in medication administration weekly for one month, then monthly thereafter.

3. The NP will review medication administration records weekly for one month, then monthly thereafter to ensure proper documentation and administration.

4. The Administrator will conduct random audits of medication storage areas and carts twice a week for one month, then weekly thereafter.
5. Any issues identified during

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| | | | monitoring will be addressed immediately, including additional staff training if necessary.<br><br>The NP will report monitoring plan results to the quarterly Quality Assurance and Performance Improvement (QAPI) committee. The QAPI committee will review the data, identify any trends or ongoing issues, and make recommendations for further improvements as needed. The committee will continue to monitor this issue until substantial compliance is achieved and maintained for at least three consecutive months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | FCL017056 | A. BUILDING: _____ B. WING _____ | 06/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ABUNDANT LIVING # 2 | 3816 CHERRY GROVE ROAD ELON, NC 27244 |

| (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 |
|---|---|---|---|---|
| C 352 | Continued From page 28<br><br>Observation of Resident #1's room on 06/05/24 at 2:27pm revealed:<br>-There was a bottle of Miralax on top of the resident's dresser.<br>-The bottle of Miralax was not labeled for the resident in the room.<br>-There were 4 whole tablets and multiple broken tablets of medication on the floor in the resident's room.<br><br>Observation of Resident #1's medication on hand 06/05/24 at 11:36am revealed none of the tablets could be confirmed to resemble the medications found in the resident's room.<br><br>Interview with the Supervisor-in-Charge (SIC) on 06/05/34 at 3:32pm revealed:<br>-She did not know where the tablets found on Resident #1's floor would have come from.<br>-All residents' medications were administered individually in the medication room.<br>-She made sure the residents swallowed the medications before walking away but maybe the resident "cheeked" the medication and then spit it out later.<br>-One of the tablets resembled a controlled substance, Lacosamide (used to treat seizures) that was ordered for another resident.<br>-The other resident had been Resident #1's roommate.<br>-She had not seen a bottle of Miralax in Resident #1's room.<br>-The resident's name on the bottle of Miralax had not been a resident at the facility.<br>-She did not know who the Miralax belonged to or where Resident #1 would have gotten the bottle of Miralax.<br><br>Interview with the Administrator on 06/05/24 at | C 352 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| C 352 | Continued From page 29<br><br>4:42pm revealed:<br>-There should be no medications in a resident's room.<br>-Medications were to be administered at the medication room.<br>-The SIC should make sure the medication had been swallowed by encouraging the resident to do a "tongue roll" before walking off.<br>-No residents had an order to self-administer medication.<br>-She did not know the resident whose name was on the Miralax bottle or how the medication got to the facility.<br>-The resident may have brought the medication from the day program where they were with other residents.<br><br>Telephone interview with the facility's contracted Primary Care Provider (PCP) on 06/05/24 at 3:16pm revealed:<br>-Residents should not have medication in their rooms.<br>-If a resident were to take the Miralax it could cause the resident to have diarrhea.<br>-None of the residents had an order to self-administer medications.<br>-If tablets were found in a resident's room, it was concerning the resident was not receiving the medication as ordered.<br>-She expected the SIC to watch the residents take their medications before the resident walked away.<br><br>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable. | C 352 | | 6/15/2024 |