Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073019	A. BUILDING: ______ B. WING ______	R-C 07/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation from 07/08/24-07/10/24.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: FOLLOW UP TO THE TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (A and B) had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -Staff A was hired on 06/01/24. -There was no signed consent for a criminal background check. -There was no documentation of a criminal background check being completed. Interview with Staff A on 07/10/24 at 3:54pm revealed: -She signed a consent to have a criminal background check done when she was hired and	D 139		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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two other times since.
-She thought the facility completed the criminal background check.
-She went to the courthouse and paid to have a criminal background check done because the facility could not locate one for her.
-She did not have a copy of her criminal background check.

Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed:
-She called the company the facility used to conduct criminal background checks to obtain copies but there was no evidence Staff A had a criminal background check completed with that company.
-She did not have Staff A sign a consent to have criminal background checks completed.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed:
-There was not a criminal background check for Staff A.
-Staff A started after the previous Administrator left and her criminal background check did not get completed.
-The previous Administrator left the facility in May 2024.

Refer to the interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:58pm.

Refer to the interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm.

2. Review of Staff B's, personal care aide (PCA), personnel record revealed:
-Staff B was hired on 03/14/24.

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-There was a signed consent for a criminal background check.
-There was no documentation of a criminal background check being completed.

Interview with a Staff B on 07/09/24 at 4:11am revealed:
-She had worked at the facility for about three months.
-She had been asked by the Assistant to the Administrator to fill out a consent for a criminal background check three times.
-She had been asked to fill out the third one today, 07/09/24.

Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed:
-She called the company the facility used to conduct criminal background checks to obtain copies but there was no evidence Staff B had a criminal background check completed with that company.
-She did not have Staff B sign a consent to have criminal background checks completed.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed:
-There was not a criminal background check for Staff B.
-There may have been a billing issue when Staff B's criminal background check was completed.

Refer to the interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:58pm.

Refer to the interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm.

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D 139	Continued From page 3 Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed: -She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024. -She had not had any training for the position; the Resident Care Coordinator (RCC) was helping her learn what needed to be done. Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed: -The previous Administrator conducted criminal background checks but she no longer worked at the facility. -She was now responsible for completing criminal background checks on new employees. -She did not audit personnel records. Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed criminal background checks should be completed prior to a new employee beginning work. _________________ The facility failed to ensure criminal background checks were completed for Staff A and Staff B, prior to working in the facility, resulting in the facility being unaware if the staff had a criminal record. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an unabated Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/24 for this violation.	D 139		
D 182	10A NCAC 13F .0602 (b) Management Of Facilities with a Capacity of	D 182		

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D 182	Continued From page 4 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (b) When the administrator is not on duty in the facility, there shall be a person designated as administrator-in-charge on duty in the facility who has the responsibility for the overall operation of the facility and meets the qualifications for administrator-in-charge required in Rule .0602 of this Section. The personal care aide supervisor, as required in Rule .0605 of this Subchapter, may serve simultaneously as the administrator-in-charge. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the Administrator-in-Charge was qualified and trained to be in charge of the overall operations of the facility. The findings are: Observations of the facility on 07/08/24 from 9:30am to 5:00pm revealed only the Assistant to the Administrator was in the building; the Administrator/Regional Director of Operations and the Resident Care Coordinator (RCC) were not in the facility.	D 182		

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Observations of the facility on 07/09/24 from 7:30am to 5:15pm revealed:
-The Assistant to the Administrator left the facility to transport residents to their physicians' appointments around 9:30am and returned around 2:00pm.
-The Administrator/Regional Director of Operations was on a cell phone in an office at approximately 11:00am.
-At 12:30pm, the RCC requested the Administrator/Regional Director of Operations to come to the front desk on the intercom system.
-The survey team waited for five minutes before a facility staff told the RCC the Administrator/Regional Director of Operations had left the facility.
-The survey team did not meet or interact with the Administrator/Regional Director of Operations on 07/09/24.

Observations of the facility on 07/10/24 from 8:00am to 6:00pm revealed the Administrator/Regional Director of Operations arrived at the facility at around 2:00pm and was there until the survey team exited at 6:00pm.

Review of the Assistant to the Administrator's personnel record revealed:
-She was hired on 11/24/20 as the front desk receptionist.
-There was no training for personal care aide (PCA) or a medication aide (MA).
-She did not have a certificate for an Assisted Living Administrator.
-She did not have any Administrator training.

Interview with a resident on 07/09/24 at 4:25pm revealed:
-The facility did not have an Administrator now.
-The Assistant to the Administrator was who she

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went to if she needed anything.

Interview with a second resident on 07/09/24 at 4:50 pm revealed:
-The facility did not have an Administrator now.
-She did not know who the Administrator/Regional Director of Operations was.
-The Assistant to the Administrator was in charge.

Interview with a third resident on 07/09/24 at 3:53pm revealed the resident thought the Assistant to the Administrator was the new Administrator.

Interview with a fourth resident on 07/09/24 at 3:57pm revealed:
-When the resident needed help she went to a PCA or a MA for help.
-She was not sure who was in charge.

Telephone interview with a resident's family member on 07/09/24 at 6:41pm revealed:
-She came to the facility every day to feed her family member; sometimes she was at the facility three times a day.
-She had only seen the Administrator/Regional Director of Operations once.
-She reached out to the Assistant to the Administrator when she had concerns.
-The Assistant to the Administrator could not always handle issues and only did paperwork.
-The Assistant to the Administrator had previously been the transportation and front desk receptionist and seemed overwhelmed with her new position.

Interview with a dietary staff on 07/09/24 at 4:03pm revealed:
-There was no communication with the

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D 182	Continued From page 7 Administrator/Regional Director of Operations and staff in the facility. -She saw the Administrator/Regional Director of Operations in the facility and did not know who she was until a week later. -She had only seen her twice since May 2024. -Staff did not know the chain of command. -She went to the Assistant to the Administrator with concerns in the facility. Interview with a PCA on 07/09/24 at 4:11am revealed: -She had only seen the Administrator/Regional Director of Operations at the facility twice, and she was only at the facility for thirty minutes to an hour and a half each time. -The first time she saw her was about two weeks ago. -The Administrator/Regional Director of Operations told her and a few other staff she was only concerned about the other facility where she was also the Administrator. -When she needed something resolved or had a question, she would go to the Assistant to the Administrator Interview with the RCC on 07/09/24 at 2:00pm revealed: -The Administrator/Regional Director of Operations was at the facility two days a week for about two hours each time. -She was here today, 07/09/24, for about two hours. -The Administrator/Regional Director of Operations did not let her know when she left for the day. -She discovered the Administrator/Regional Director of Operations had left the facility because she requested the Administrator/Regional Director of Operations	D 182		

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come to the front desk by announcing it on the intercom system and one of the staff informed her she had already left the facility.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not taken the Administrator's certification exam.
-She did not plan on taking the certification exam because she had too much to do right now with being the Assistant to the Administrator.
-She had not had any training for the position; the RCC was helping her learn what needed to be done.
-She was at the facility alone most of the time because the RCC had recently missed work due to a family illness.
-She was in charge when the Administrator/Regional Director of Operations was not in the building.
-She reported to the Administrator/Regional Director of Operations.
-The Administrator/Regional Director of Operations would not be at the facility on 07/08/24, because she was at a sister facility.

Interview with the Assistant to the Administrator on 07/10/24 at 2:58pm revealed:
-When she was promoted from the transportation/receptionist, she was told by the Administrator/Regional Director of Operations her new title was the "Assistant Administrator".

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-She went to a meeting at another facility and she was introduced at the meeting as the "Assistant Administrator" so that was the title she was using.
-The RCC helped her with some of the paperwork.
-She was not familiar with the rules and regulations for the facility; she had a book she was going to read and learn them.
-She was out of the facility in the morning on 07/09/24, because she was taking residents to their appointments.
-The Administrator/Regional Director of Operations did the staff time sheets and handled new admissions.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:27pm revealed:
-She was the Regional Director of Operations and the Administrator.
-She was at the facility on Wednesdays and Thursdays; her hours at the facility fluctuated but she usually was at the facility from 9:00am to 4:00pm.
-She was also the Administrator at a sister facility in another city.
-The Assistant to the Administrator was the "Administrator in Charge" when she was not at the facility.
-The Assistant to the Administrator's responsibilities were combined with the Business Office Manager's responsibilities which included paperwork like preparing the FL-2s for physicians' appointments.

1. Based on record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (A and B) had a criminal background check completed upon hire. [Refer to tag 139 G.S. 10A NCAC 13F .0407(a)(7) Other staff Qualifications (Unabated TYPE B VIOLATION)]

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D 182	Continued From page 10 2. Based on observations, record review, and interviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#3) related to an order for leg dressings. [Refer to tag 0276, 10A NCAC 13F .0902 (c)(3-4) Health Care (TYPE B VIOLATION)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3, #4) including a nasal spray, and a laxative (#3); and a vitamin and a medication for sleep (#4). [Refer to tag 0358, 10A NCAC 13F .1004 (a) Medication Administration]. 4. Based on record reviews and interviews, the facility failed to ensure an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 1 of 5 residents (#3). [Refer to tag 235 10A NCAC 13F .0703(b) Tuberculosis Test, Medical Examination and Immunization.] 5. Based on record reviews and interviews, the facility failed to ensure medical assessments were completed annually for each resident and results entered onto the FL-2 for 1 of 5 residents (#4).[Refer to tag 0253, 10A NCAC 13F .0801(a) Resident Assessment]. 6. Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1, #3) with physicians' orders for a restricted concentrated sweets (RCS) diet. [Refer to tag 286 10A NCAC 13F .0904(c)(7) Nutrition and Food Service.]	D 182		

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7. Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets including nutritional supplements were served as ordered for 3 of 3 sampled residents (#1, #3, #4) for residents with physicians' orders for a restricted concentrated sweets (RCS) diet (#1, #3) and a resident ordered a nutritional supplement with meals (#4). [Refer to tag 0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service].

8. Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of medication orders that were not included on an FL-2 for 1 of 5 residents (#4). [Refer to tag 344 10A NCAC 13F .1002(a) Medication Orders.]

____

The Administrator failed to ensure there was a qualified Administrator-In-Charge, who was trained and responsible for the overall management, operations and implementation of the facility's policies and procedures. There was no Administrator-In-Charge immediately available to address resident or staff concerns and to ensure compliance with rules for adult care homes when the Administrator was not available. 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 accordance with G.S. 131D-34 on 07/24/24 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 24, 2024.

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D 235	Continued From page 12	D 235		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medical examinations were completed annually for 1 of 5 residents sampled (#3) and results of the examination were entered onto the FL-2. The findings are: Review of Resident #3's FL-2 dated 04/14/23 revealed diagnoses included atrial fibrillation and	D 235		

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D 235	Continued From page 13 chronic kidney failure. Review of Resident #3's record revealed there was not an FL-2 dated after 04/14/23 available for review. Interview with a medication aide (MA) on 07/09/24 at 4:00pm revealed: -She did not fill out FL-2s for the residents. -She did not know why Resident #3's FL-2 was outdated. -The Resident Care Coordinator (RCC) or the Assistant to the Administrator handled the FL-2s. Telephone interview with a Registered Nurse from Resident #3's primary care provider's (PCP) office on 07/10/24 a 9:30am revealed: -The facility was supposed to send over the FL-2 when it was due to be updated and the PCP would complete the FL-2 and send it back to the facility. -She did not see where an updated FL-2 for Resident #3 was received from the facility. Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed: -Resident #3 had an outside provider that did not come to the facility. -The RCC was responsible for filling out the FL-2s and getting them to the outside providers. -The RCC was out of work a lot and the FL-2 for Resident #3 did not get updated. -The FL-2s were supposed to be updated annually. Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:43pm revealed: -The RCC filled out the FL-2 based on the most recent care plan, physicians orders, previous FL-2 and any order changes. -The RCC then faxed the FL-2 to the physician to	D 235		

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D 235	Continued From page 14 sign and the family brought the FL-2 back to the facility after the appointment with the physician. -The RCC was supposed to review the FL-2 for accuracy and contact the PCP if there was information that needed correcting or was missing.	D 235		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure an initial assessment of each resident was completed within 72 hours of admission using the Resident Register for 1 of 5 residents (#4). The findings are: Review of Resident #4's current FL-2 dated 06/20/24 revealed diagnoses included altered mental status, memory disorder, dementia with behavioral disturbances, and malignant neoplasm of the right lung stage four. Review of Resident #4's record revealed Resident #4 did not have a Resident Register.	D 253		

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Telephone interview with Resident #4's Power of Attorney (POA) on 07/09/24 at 6:41pm revealed she was admitted to the facility on 11/06/23.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not had any training for the position; the Resident Care Coordinator (RCC) was helping her learn what needed to be done.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed:
-The previous Administrator was responsible for completing the Resident Registers as part of the admissions packet.
-She did not know who audited the residents' records.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:27pm revealed:
-The Resident Register was to be completed during the admission process.
-The RCC was working on completing resident record audits including the Resident Registers.
-She was looking at the Resident Registers for completion of all information including dates and signitures.
-The Resident Register was important because it was the initial assessment for the resident when they were admitted to the facility.
-She or the Assistant to the Administrator and the

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D 253	Continued From page 16 RCC were responsible for completing the Resident Registers. -There were Resident Registers that had fallen through the "crack" and were not completed or were missing.	D 253		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW UP TO THE TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, record review, and interviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#3) related to an order for dressing changes. The findings are: Review of Resident #3's current FL-2 dated 04/14/23 revealed diagnoses of chronic kidney disease and atrial fibrillation. Review of Resident #3's physician's order dated 06/17/24 revealed an order for "dressing change	D 276		

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legs daily and as needed" dated 06/17/24.

Observation of Resident #3 on 07/08/24 at 4:00pm revealed:
-There was a clean gauze dressing in place to Resident #3's left lower leg.
-The gauze dressing had a handwritten date of 06/17/24.
-There was no odor.
-A medicaion aide (MA) was in the room and removed the gauze dressing to Resident #3's left leg at the surveyor's request.
-Resident #3's left lower leg had non-pitting edema.
-Resident #3's left lower leg had areas of dried, cracked skin and her left foot had a powder like substance that covered the top of her foot.
-There was a sock on Resident #3's right lower leg.

Observation of Resident #3 on 07/09/24 at 9:45am revealed:
-Resident #3 was in her wheelchair in her room.
-She had socks on both feet.
-She did not have a dressing on either leg.
-Her left leg was swollen from her knee down to her foot.
-There was no swelling to the right lower leg or foot.

Interview with Resident #3 on 07/08/24 at 4:05pm revealed:
-She went to see her doctor about a month ago and he put the bandage on her left lower leg.
-Her left leg had swelling off and on.
-Sometimes her legs would weep fluid from them.
-She was not in any pain now.
-No one had changed the dressing since she had been back from the doctor's appointment.

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Review of Resident #3's June 2024 and July 2024 from 07/01/24 to 07/08/24 electronic medication administration record (eMAR) revealed:
-There was not an entry for dressing changes to Resident #3's legs daily and prn.
-There was no documentation of dressing changes having been completed as ordered on any date.

Telephone interview with a representative from the facility's contracted pharmacy on 07/09/24 at 10:30am revealed the pharmacy did not receive an order for Resident #3 to have dressing changes to her legs daily and prn.

Interview with a (MA) on 07/08/24 at 4:10pm revealed:
-Resident #3 had swelling to her lower legs and took medication for it.
-Resident #3 went out of the facility to see her primary care provider (PCP).
-When Resident #3 returned from an appointment with her PCP, the paperwork went to the Resident Care Coordinator (RCC) or the Supervisor and they faxed any new orders to the pharmacy and the RCC or the Supervisor put them on the eMAR.
-She was not aware Resident #3 had an order to change dressings to her legs daily and prn.
-There was not an order to change dressing to Resident #3's legs on the eMAR.

Interview with the RCC on 07/09/24 at 2:10pm revealed:
-She could not recall if she was at work when Resident #3 returned from her appointment with her PCP on 06/17/24.
-The Supervisor should have taken the paperwork from the PCP's office and faxed any

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new orders to the pharmacy.
-Orders for dressing changes should go onto the eMAR.
-If orders needed to be clarified, the pharmacy would contact the facility and let them know.
-She had not seen the order for Resident #3 to have dressing changes to her legs daily and prn.
-She had not seen Resident #3's legs.

Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed:
-Resident #3 had chronic edema to her lower legs.
-When she went to see the PCP, they sent a folder with a new order form so the PCP could fill it out if there were new orders.
-On return to the facility from the appointment, the MAs should fax any new orders to the pharmacy so the orders were added to the eMAR.
-She did not know why the order for Resident #3's dressing changes to her legs daily and prn did not get implemented.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed:
-When a resident went out to an appointment with their PCP, they were sent with a folder that included the residents' orders and a blank form for the PCP to fill out if there were any new orders.
-When the resident returned from the appointment, the MA should receive the folder back and implement any new orders.
-When Resident #3 returned from the PCP's office on 06/17/24, the MA should have followed up to check if there were new orders and if so, put them into place.
-The order to change dressings on Resident #3's legs should have been implemented.
-She was concerned orders were getting missed.

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Interview with Resident #3's PCP's on 07/09/24 at 2:15pm revealed:
-He saw Resident #3 in his office on 06/17/24.
-Resident #3 had chronic edema (swelling) to her lower legs.
-Resident #3 did not like to wear compression stockings because they hurt her legs.
-He wrote the order to wrap her legs daily and as needed to decrease some of the swelling and ease some of the pain associated with the edema.
-He knew he could not fix Resident #3's swelling to her legs but wanted to try to reduce it.
-His intent was for the staff to apply a snug dressing of gauze or ace wraps daily.
-He was not aware Resident #3 was not having her legs wrapped daily and the dressing was still in place from the appointment with him on 06/17/24.
-He expected orders to be followed as written or facility staff to notify him if clarification was needed.
-Increased swelling could cause Resident #3's legs to leak fluid which could cause wounds or infection.

____

The facility failed to ensure a physician's order was implemented for a resident (#3) who had chronic swelling in her legs and an order for her legs to be wrapped daily to decresae swelling in her legs which placed her at risk for swelling, leaking of fluid from her legs, and development of wounds and infection. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/24 for this violation.

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D 276	Continued From page 21 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 24, 2024.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1, #3) with physicians' orders for a restricted concentrated sweets (RCS) diet. The findings are: Observation of the kitchen on 07/09/24 at 8:20am revealed: -There was a binder which contained the regular menus and the therapeutic diet menus. -There was a week at a glance menu for the week of 07/07/24 to 07/13/24. -The therapeutic menus did not have a restricted concentrated sweets (RCS) diet for staff guidance.	D 296		

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-There was a resident diet list for a controlled carbohydrate diet (CCHO); Resident #1 and Resident #3 were on the list for a CCHO diet.

1. Review of Resident #1's current FL-2 dated 04/17/24 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #1's physician's diet order dated 11/18/23 revealed:
-Resident #1 was ordered a restricted concentrated sweets (RCS) diet.
-The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods.

Interview with Resident #1 on 07/10/24 at 1:05pm revealed:
-He did not know if he had a physician's order for a specific diet.
-He was served sugar-free foods and drinks during all meals.

Attempted telephone interview with the dietitian from the facility's contracted food supply company on 07/09/24 at 10:51am was unsuccessful.

Refer to the interview with the Kitchen Manager on 07/09/24 at 8:15am.

Refer to the interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:56pm.

Refer to the interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm.

2. Review of Resident #3's current FL-2 dated

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04/14/23 revealed diagnoses included atrial fibrillation and chronic kidney disease.

Review of Resident #3's physician's diet order dated 11/15/23 revealed:
-Resident #3 was ordered a restricted concentrated sweets (RCS) diet.
-The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods.

Interview with Resident #3 on 07/10/24 at 1:15pm revealed:
-She was a diabetic.
-She did not think she was on a special diet.
-She received the same food the other residents received.

Attempted telephone interview with the dietitian from the facility's contracted food supply company on 07/09/24 at 10:51am was unsuccessful.

Refer to the interview with the Kitchen Manager on 07/09/24 at 8:15am.

Refer to the interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:56pm.

Refer to the interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm.

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Interview with the Kitchen Manager on 07/09/24 at 8:15am revealed:
-The only therapeutic diets the facility offered were for diabetics and was a CCHO diet.
-Basically, the residents were all served the same menu.

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-The facility had a new contracted food supply company; the new food supply company provided the therapeutic diet menus.
-The new contracted food supply company provided the facility with the new therapeutic diet menus today, 07/09/24.
-The therapeutic diet menus would not be used until the following week and they did not include the RCS diet.
-The kitchen staff served sugar free beverages and desserts to the residents who where diabetic.
-He would have to let the Assistant to the Administrator or the Administrator/Regional Director of Operations know there was no RCS diet on the menu.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not had any training for the position; the RCC was helping her learn what needed to be done.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not have any responsibilities regarding the kitchen and the resident diets.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm revealed:
-The facility was using a new contract food service company.
-The therapeutic diet menus had been delivered

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D 296	Continued From page 25 the day before, 07/09/24. -The new therapeutic diet menus should match the physician ordered diets; including the RCS diet. -She had not reviewed the therapeutic diet menus to see if the RCS diet was included on the menu. -The Kitchen Manager was responsible for obtaining the therapeutic diet menu with the correct diets. -She and the Assistant to the Administrator were responsible for monitoring the therapeutic diet menus.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets including nutritional supplements were served as ordered for 3 of 3 sampled residents (#1, #3, #4) for residents with physicians' orders for a restricted concentrated sweets (RCS) diet (#1, #3) and a resident ordered a nutritional supplement with meals (#4). The findings are: 1. Review of Resident #1's current FL-2 dated 04/17/24 revealed diagnoses included diabetes mellitus type 2. Review of Resident #1's physician's diet order	D 310		

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dated 11/18/23 revealed:
-Resident #1 was ordered a restricted concentrated sweets (RCS) diet.
-The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods.

Observation of the kitchen on 07/09/24 at 8:20am revealed:
-There was a binder which contained the regular menus and the therapeutic diet menus.
-There was a week at a glance menu for the week of 07/07/24 to 07/13/24.
-The therapeutic menus did not have a restricted concentrated sweets (RCS) diet for staff guidance.
-The regular breakfast menu for the breakfast meal on 07/09/24 consisted of oatmeal, confetti eggs, bacon, toast, milk and juice.
-The regular menu for the lunch meal on 07/09/24 consisted of a pork chop, macaroni and cheese, cooked cabbage, beans, a roll and fruit cocktail.
-There was a resident diet list for a controlled carbohydrate diet (CCHO); Resident #1 and Resident #3 were on the list for a CCHO diet.

Observation of the breakfast meal on 07/09/24 from 8:06am to 8:24am revealed:
-Resident #1 was served approximately one cup of oatmeal, a half a cup of scrambled eggs, a slice of bacon and a slice of toast with butter and regular jelly, a 6-ounce glass of orange juice and water.
-Resident #1 ate 100% of his meal.

Observation of the lunch meal on 07/09/24 from 11:42am to 12:18pm revealed:
-Resident #1 was served approximately one cup of macaroni and cheese, a half cup of sautéed

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cabbage, half a cup of pinto beans, piece of cornbread, a half cup of fruit cocktail, iced tea and water.
-Resident #1 ate 100% of his meal.

Based on observations of the breakfast and lunch meals served on 07/09/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to the kitchen not having a therapeutic diet menu that included an RCS diet for staff guidance.

Interview with Resident #1 on 07/10/24 at 1:05pm revealed:
-He did not know if he had a physician's order for a specific diet.
-He was served sugar-free foods and drinks during all meals.

Interview with Resident #1's primary care provider on 07/10/24 at 10:17am revealed:
-The previous physician had ordered Resident #1 a RCS diet and she continued the order for the diet because he was diabetic.
-She expected the facility to follow all her orders for Resident #1 including his [therapeutic] diet order.

Attempted telephone interview with the dietitian from the facility's contracted food supply company on 07/09/24 at 10:51am was unsuccessful.

Interview with the Kitchen Manager on 07/09/24 at 8:15am revealed:
-The only therapeutic diets the facility offered were for diabetics and was a CCHO diet.
-Basically, the residents were all served the same menu.

Interview with the Assistant to the Administrator

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on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not taken the Administrator's certification exam.
-She did not plan on taking the certification exam because she had too much to do right now with being the Assistant to the Administrator.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not have any responsibilities regarding the kitchen and resident diets.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm revealed:
-The facility was using a new contract food service company.
-The therapeutic diet menus had been delivered the day before, 07/09/24.
-The new therapeutic diet menus should match the physician ordered diets; including the RCS diet.
-She had not reviewed the therapeutic diet menus to see if the RCS diet was included on the menu.
-The Kitchen Manager was responsible for obtaining the therapeutic diet menu with the correct diets.
-The Assistant to the Administrator and the Administrator/Regional Director of Operations were responsible for monitoring the therapeutic diet to ensure they were served as ordered to the residents.

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2. Review of Resident #3's current FL-2 dated 04/14/23 revealed diagnoses included atrial fibrillation and chronic kidney disease.

Review of Resident #3's physician's diet order dated 11/15/23 revealed:
-Resident #3 was ordered a restricted concentrated sweets (RCS) diet.
-The RCS diet was defined on the order as restricted foods high in sugar or other concentrated sweets and fat; the diet allowed extra servings of appropriate foods.

Review of Resident #3's June 2024 and July 1-8, 2024 electronic medication adminisration record (eMAR) revealed finger stick blood sugar results ranged from 89-130.

Interview with Resident #3 on 07/10/24 at 1:15pm revealed:
-She was a diabetic.
-She did not think she was on a special diet.
-She received the same food the other residents received.

Interview with a Registered Nurse (RN) from Resident #3's primary care provider on 07/10/24 at 9:30am revealed:
-Resident #3 was a diabetic and was ordered a RCS diet.
-The RCS diet was ordered to help keep Resident #3's blood sugar levels controlled.

Observation of the kitchen on 07/09/24 at 8:20am revealed:
-There was a binder which contained the regular menus and the therapeutic diet menus.
-There was a week at a glance menu for the week of 07/07/24 to 07/13/24.
-The therapeutic menus did not have a restricted

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concentrated sweets (RCS) diet for staff guidance.
-The regular breakfast menu for the breakfast meal on 07/09/24 consisted of oatmeal, confetti eggs, bacon, toast, milk and juice.
-The regular menu for the lunch meal on 07/09/24 consisted of a pork chop, macaroni and cheese, cooked cabbage, beans, a roll and fruit cocktail.
-There was a resident diet list for a controlled carbohydrate diet (CCHO); Resident #1 and Resident #3 were on the list for a CCHO diet.

Observation of the breakfast meal on 07/09/24 from 8:06am to 8:24am revealed:
-Resident #3 was served approximately a half a cup of scrambled eggs, a slice of bacon and a slice of toast with butter and regular jelly, a 6-ounce glass of orange juice, coffee and water.
-Resident #3 ate 90% of her meal.

Observation of the lunch meal on 07/09/24 from 11:42am to 12:18pm revealed:
-Resident #3 was served approximately one cup of macaroni and cheese, a half cup of sautéed cabbage, half a cup of pinto beans, piece of cornbread, a half cup of fruit cocktail, iced tea and water.
-Resident #3 ate 75% of her meal.

Based on observations of the breakfast and lunch meals served on 07/09/24, it could not be determined if Resident #3 was served the correct therapeutic diet due to the kitchen not having a therapeutic diet menu that included an RCS diet for staff guidance.

Attempted telephone interview with the dietitian from the facility's contracted food supply company on 07/09/24 at 10:51am was unsuccessful.

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Interview with the Kitchen Manager on 07/09/24 at 8:15am revealed:
-The only therapeutic diets the facility offered were for diabetics and was a CCHO diet.
-Basically, the residents were all served the same menu.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not taken the Administrator's certification exam.
-She did not plan on taking the certification exam because she had too much to do right now with being the Assistant to the Administrator.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not have any responsibilities regarding the kitchen and resident diets.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:42pm revealed:
-The facility was using a new contract food service company.
-The therapeutic diet menus had been delivered the day before, 07/09/24.
-The new therapeutic diet menus should match the physician ordered diets; including the RCS diet.
-She had not reviewed the therapeutic diet menus to see if the RCS diet was included on the menu.
-The Kitchen Manager was responsible for

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obtaining the therapeutic diet menu with the correct diets.
-The Assistant to the Administrator and the Administrator/Regional Director of Operations were responsible for monitoring the therapeutic diet to ensure they were served as ordered to the residents.

3. Review of Resident #4's current FL-2 dated 06/20/24 revealed diagnoses included altered mental status, memory disorder, dementia with behavioral disturbances, and malignant neoplasm of the right lung stage four.

Review of Resident #4's physician's order dated 06/18/24 revealed:
-There was an order for one can of [named] nutritional supplement vanilla with ice and a straw as needed (PRN) at breakfast and dinner if she did not eat more than 25% of her meal.
-There was an order for one can of vanilla nutritional supplement with ice and a straw served once daily at lunch time.

Review of Resident #4's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for a nutritional supplement 1 can with ice and a straw once daily at lunch time with the scheduled time indicated PRN.
-There was no documentation the nutritional supplement was served as ordered on any dates.
-There was an entry for nutritional supplement 1 can with ice and a straw PRN at breakfast and dinner if the resident did not eat more that 25% of her meal.
-There was no documentation on the entry for nutritional supplement PRN at breakfast and lunch.

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Review of Resident #4's July 2024 eMAR from 07/01/24 to 07/08/24 revealed:
-There was an entry for a nutritional supplement 1 can with ice and a straw once daily at lunch time with the scheduled time indicated PRN.
-There was no documentation the nutritional supplement was served as ordered on any dates.
-There was an entry for nutritional supplement 1 can with ice and a straw PRN at breakfast and dinner if the resident did not eat more that 25% of her meal.
-There was no documentation on the entry for nutritional supplement PRN at breakfast and lunch.

Observation of Resident #4 at the lunch meal on 07/09/24 from 11:42am to12:38pm revealed:
-She ate 100% of her dessert and then walked out of the dining room.
-She returned to the dining room at 11:46am and sat down again; she took a few bites of her macaroni and cheese and left the dining room.
-She returned at 11:47am and took a bite of her corn bread after the personal care aide (PCA) cued her to take a bite; she left the dining room again.
-Resident #4 continued to walk around and then return to the dining room; she would take a bite of her food each time she sat down.
-She ate 100% of her pinto beans, less than ¼ of her cornbread, none of her cabbage and 1/3 of her macaroni and cheese.
-The PCA served her a cup of nutritional supplement poured over ice with a straw at 12:38pm.
-Resident #4 drank 100% of her nutritional supplement.

Observation of Resident #4's room on 07/10/24 at 9:45am revealed:

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-There was a case of nutritional supplements, 8-ounce bottles on the floor next to Resident #4's refrigerator.
-The case of nutritional supplement was opened and 10 bottles of 24 bottles were remaining.
-There were 6 bottles of nutritional supplement in Resident #4's refrigerator.
-There was a total of 16 bottles of nutritional supplement available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/09/24 at 4:45pm revealed:
-Resident #4's nutritional supplement was provided by the facility.
-Resident #4 had a current order dated 06/18/24, for one can of nutritional supplement with lunch daily.
-There was a separate order also dated 6/18/24, for one can of nutritional supplement PRN for breakfast and lunch if not more than 25% of the meal was eaten.
-The facility faxed the orders to the pharmacy and the pharmacy entered the profile onto the eMAR.

Telephone interview with a Registered Nurse (RN) form Resident #4's primary care provider (PCP) on 07/09/24 at 3:29pm revealed:
-Resident #4's Power of Attorney (POA) requested she have an order for nutritional supplements because Resident #4 had loss some weight.
-Resident #4's POA reported she would get up during the meal and was not eating all of her meals.
-Resident #4 had an order dated 06/18/24, for one bottle of nutritional supplement poured over ice with a straw as needed when she did not eat more than 25% of her meal at breakfast and lunch.

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-Resident #4 had an order dated 06/18/24, for one bottle of nutritional supplement poured over ice with a straw once daily at lunch time.
-Resident #4 had lost some weight; she weighed 131.6 pounds on 04/15/24, and 122.22 on 06/20/24.
-Resident #4 was walking more and had a terminal illness.

Interview with Resident #4 on 07/10/24 at 9:45am revealed:
-She did not like the shakes [nutritional supplements] the staff gave her.
-She did not know how many times a day staff gave them to her.
-She did not know what she ate for breakfast today, 07/09/24 or lunch yesterday, 07/08/24.

Telephone interview with Resident #4's POA on 07/09/24 at 6:41pm revealed:
-Resident #4 paced and did not want to sit to eat her entire meal so she wanted the resident to have the nutritional supplement.
-The PCP had ordered the nutritional supplement for Resident #4 because she had weight loss.
-Resident #4 had been losing weight since she was admitted to the facility in November 2023.
-She had left a full case of 24 bottles of nutritional supplement at the facility for the resident on 06/18/24 when the PCP wrote the new order.
-On 06/27/24, she asked the Assistant to the Administrator for an nutritional supplement to give Resident #4 at a meal and she gave the POA the case of nutritional supplement to put in Resident #4's room.

Interview with a PCA on 07/09/24 at 12:09am revealed:
-Resident #4 did not have any physician's orders for a nutritional supplement.

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-Resident #4's POA just wanted her to have it.
-The nutritional supplement was stored in Resident #4's refrigerator in her room.
-Resident #4 would not sit and eat her entire meal; she would sit down and take a few bites of something and then get up and walk around and then return to sit and take a few more bites of her food.

Second interview with the PCA on 07/09/24 at 4:11am revealed:
-She had served Resident #4 a nutritional supplement after lunch today, 07/09/24, because the resident did not eat well.
-She sat with her while she drank the nutritional supplement and, she drank 100%.
-She was not told by anyone to give Resident #4 the nutritional supplement; she tried to give one to her at least one meal a day.
-Resident #4 usually ate 100% of her breakfast so she never gave her one after breakfast.
-She never told the MA when she gave Resident #4 a nutritional supplement because she did not have an order.

Interview with a MA on 07/09/24 at 4:25pm revealed:
-Resident #4's POA wanted her to have the nutritional supplement if she did not eat her meal.
-Resident #4 refused the nutritional supplement when she was served it; she had to follow Resident #4 down the hall to try to get her to drink it.
-She would give the PCA the nutritional supplement to serve to Resident #4 with meals because she did not stay in the dining room with the resident but the PCA did.
-She gave the POA the case of the nutritional supplement to put in the resident's refrigerator a few weeks ago because the POA said she would

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give it to Resident #4.
-She had not served the nutritional supplement to Resident #4 since the POA took it to her room because the POA wanted to give it to Resident #4.
-The nutritional supplement was not a medication so she did not enter it on the eMAR or contact the PCP when the resident refused it.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed:
-Resident #4 could not ask for a nutritional supplement; the MAs were responsible for giving her a nutritional supplement when she needed one.
-If there was an order on the eMAR for Resident #4's nutritional supplement to be scheduled then the MAs should have been administering it as ordered and documenting the administration.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not have any responsibilities regarding the kitchen and resident diets.

Interview with theAdministrator/ Regional Director of Operations on 07/10/24 at 4:27pm revealed:
-She was told by the Assistant to the Administrator that morning, 07/10/24, that there

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were two different orders for the nutritional supplement; PRN and scheduled.
-Resident #4 should have been getting the nutritional supplement as ordered; the MAs should have followed Resident #4's orders.

D 344

10A NCAC 13F .1002(a) Medication Orders

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
THIS IS A FOLLOW-UP TO THE TYPE A2 VIOLATION

The Type A2 Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of medication orders that were not included on an FL-2 for 1 of 5 residents (#4).

The findings are:

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Review of Resident #4's current FL-2 dated 06/20/24 revealed:
-Diagnoses included altered mental status, memory disorder, dementia with behavioral disturbances, and malignant neoplasm of the right lung stage four.
-There was a note to "see attached physician's orders" in the space where the medications were to be documented.
-There were no medication orders listed on the FL-2 and there were no medication orders attached to the FL-2.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/09/24 at 4:45pm revealed she did not have a medication order list dated 06/20/24 for Resident #4.

Telephone interview with Resident #4's Power of Attorney (POA) on 07/09/24 at 6:41pm revealed:
-She did not want the facility to fax Resident #4's FL-2 to the primary care provider's (PCP's) office; she wanted to take the hard copies there herself.
-She took Resident #4 to a PCP appointment on 06/20/24; she took the FL-2 with her.
-The facility staff gave her the FL-2 to take with her.
-Resident #4's FL-2 was already filled out when she took it to the PCP appointment; she did not receive a list of medications.
-When she returned the FL-2 to the facility, the medication aide (MA) asked her where the medication list was.
-She told them the list was not given to her to take to the appointment.
-The Resident Care Coordinator (RCC) said she would print another list for her to take to the PCP but the POA was never given the medication list.

Telephone interview with a Registered Nurse

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(RN) from Resident #4's PCP on 07/09/24 at 3:29pm revealed:
-The PCP did not have a medication order list from the facility for Resident #4; only the FL-2 at the appointment on 06/20/24.
-Resident #4's POA brought her to her appointments and brought documents with her.
-The PCP's office maintained a list of medications for Resident #4 in her record at the office.

Interview with the RCC on 07/09/24 at 9:51am revealed:
-FL-2s were scanned to the PCP along with the list of medications.
-The medication list was generated from the resident's current electronic medication administration record (eMAR), including the medication name, dosage, and scheduled time.
-The FL-2s were scanned to the pharmacy after they were signed by the resident's PCP.
-The FL-2s had "See attached physician's orders" where the medication list were usually written; it was the system that was in place when she started.
-After the FL-2 and the medication list were signed by the PCP they were attached to each other.
-The system for attaching the signed physicians' orders to the FL-2 was in place when she started working at the facility.
-Sometimes outside providers did not return the signed medication list with the FL-2.
-The MAs were responsible for contacting the resident's PCP to get a signed copy of the list.
-Resident #4's POA took her to an outside PCP.
-She did not realize Resident #4' did not have a medication list attached to her FL-2.
-It was her responsibility to ensure the FL-2s were complete, including the medication orders; she did not know about the missed medication orders

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so it fell through the cracks.

Interview with the Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not had any training for the position; the RCC was helping her learn what needed to be done.
-She reported to the Administrator/Regional Director of Operations.

Second interview with the Assistant to the Administrator on 07/08/24 at 12:29pm revealed:
-There should have been a medication list attached to Resident #4's FL-2; the list was printed from the medications on the eMAR.
-Resident #4's POA took her to an outside physician and took the FL-2 with her to the appointment.
-She did not know if the medication list was returned by the POA when she brought the FL-2 back to the facility.
-The RCC was responsible for the FL-2's and making sure the medication list was signed by the PCP.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:43pm revealed:
-The RCC filled out the FL-2 based on the most recent care plan, physicians' orders, previous FL-2 and any order changes.
-The RCC then faxed the FL-2 to the physician to sign and the family brought the FL-2 back to the

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D 344	Continued From page 42 facility. -The RCC was supposed to review the FL-2 for accuracy and contact the PCP if there information needed correcting or was missing. -She did not know why the missing medication order list was never clarified.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (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: THIS IS A FOLLOW-UP TO THE TYPE A1 VIOLATION The Type A1 Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3, #4) including a nasal spray, and a laxative (#3); and a vitamin and a medication for sleep (#4). Review of the facility's medication adminitration policy dated April 2010 revealed: -Medication shall be administered in a safe and timely manner and as prescribed. -The individual administering the medication must	D 358		

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initial the resident's MAR on th appropriate line after each medicaiton given.
-If a medication is withheld, refused, or given at a time other than the schduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.

The findings are:

1. Review of Resident #4's current FL-2 dated 06/20/24 revealed:
-Diagnoses included altered mental status, memory disorder, dementia with behavioral disturbances, and malignant neoplasm of the right lung stage four.
-There was a note to "see attached physician's orders" in the space where the medications were to be documented.
-There were no medication orders listed on the FL-2 and there were no medication orders attached to the FL-2.

a. Review of Resident #4's physician orders dated 04/08/24 revealed there was an order for trazadone (used as a sedative for sleep) 50mg at bedtime.

Review of Resident #4's after visit report from the physician dated 06/20/24 revealed there was an order to discontinue the trazadone.

Review of Resident #4's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for trazadone 50mg at bedtime scheduled from 7:00pm to 11:00pm.
-Trazadone was documented as administered for 19 of 22 opportunities from 04/08/24 to 04/30/24.
-There was a note on 04/12/24, resident asleep.

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-There was a note on 04/13/24, awaiting on pharmacy.
-There was a note on 04/14/24, on order.
-There was a note on 04/15/24, waiting on order.

Review of Resident #4's May 2024 eMAR revealed:
-There was an entry for trazadone 50mg at bedtime scheduled from 7:00pm to 11:00pm.
-There was documentation trazadone was administered for 15 of 18 opportunities from 05/01/24 to 05/22/24.
-There was documentation Resident #4 was out of the facility from 05/14/24 to 05/17/24.
-There was a note on 05/09/24, awaiting pharmacy.
-There was a note on 05/22/24, trazadone ordered.
-There was nothing documented after 05/23/24.
-There was documentation on the entry trazadone was discontinued but there was no date.

Review of Resident #4's June 2024 eMAR revealed there was no entry for trazadone 50mg at bedtime and no documentation of administration on any date.

Interview with Resident #4 on 07/10/24 at 9:45am revealed:
-She did not know what medications she took or why she took them.
-She did not have trouble sleeping at night; she never had trouble sleeping at night.
-She never took anything to help her sleep.

Interview with Resident #4's roommate on 07/10/24 at 1:07pm revealed:
-Resident #4 walked all the time.
-About four months ago, Resident #4 used to

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walk all night long.
-She would get up and walk and then return to the room for a while and then get up and leave again.
-Resident #4 would wake her up and she would see her either coming or going.
-About three weeks or a month ago, Resident #4 stopped walking at night.

Telephone interview with Resident #4's Power of Attorney (POA) on 07/09/24 at 6:41pm revealed:
-One 05/13/24, she went to the facility to take Resident #4 out for a few days and the staff could not find the trazadone.
-The medication aide (MA) did not know where the trazadone was, she looked in the overstock supplies and in the medication cart.
-The staff looked for about 30 minutes and told her they did not have it to give her to take with Resident #4.
-She was concerned Resident #4 had not been administered her trazadone because the staff could not find the medication.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/09/24 at 4:45pm revealed:
-They had entered the profile for the order for Resident #4's trazadone 50mg once daily on 04/09/24 but they had never filled the order.
-They had a verbal order from Resident #4's mental health provider to discontinue the trazadone on 05/23/24.
-She did not know why they never filled the trazadone order.

Telephone interview with a Registered Nurse (RN) from Resident #4's primary care provider (PCP) on 07/09/24 at 3:29pm revealed:
-Resident #4's PCP had not ordered the trazadone; he discontinued it on her appointment

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on 06/20/24 because the POA reported the facility was not administering it to Resident #4.
-Resident #4's mental health (MH) provider must have written the order for the trazadone.
-Trazadone was a sedative taken in the evening to help sleep.
-If the trazadone was not administered as ordered Resident #4 would have difficulty sleeping at night.

Telephone interview with Resident #4's mental health provider on 07/10/24 at 3:02pm revealed:
-She saw the order for trazadone had not been filled from 04/04/24.
-She discontinued Resident #4's trazadone on 05/23/24 after she saw the resident had not been administered it and the staff reported she was sleeping better.
-Resident #4 was ordered the trazadone for insomnia and it was a safer alternative for mild agitation.
-A possible outcome of not being administered the trazodone as ordered would be the resident would not be able to get to sleep and would be awake all night.

Interview with a MA on 07/09/24 at 4:25pm revealed she did not recall anything about Resident #4's trazadone order.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed:
-She made copies of any orders and handed them to the MA after the PCP or POA gave them to her.
-The MAs were responsible for faxing any orders to the pharmacy.
-The facility's pharmacy entered the orders on the eMAR once they were faxed; the MAs approved he orders before administration.

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D 358	Continued From page 47 -She did not know why Resident #4's medications were not ordered; staff had not reported anything to her about the medications being out of stock or needing new orders. Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:27pm revealed: -If Resident #4 had an order for trazadone and it was on the eMAR then it should have been in the facility or on the medication cart. -The RCC and the MAs were responsible for ensuring Resident #4's trazadone was in the facility. -She did not understand why Resident #4's medications were not at the facility if they were on the eMAR. -There were times the insurance would not cover certain medications. -The RCC or a MA were responsible for auditing the medication carts to ensure medications were on the medication cart. -When medication was delivered from the pharmacy the RCC or the MA checked the delivered medication against the eMAR. -If a medication was not delivered from the pharmacy then the RCC was responsible for contacting the pharmacy and the PCP. -It was the facility's responsibility to ensure Resident #4's medications were available for administration. -If there was an issue with getting a medication for a resident the facility would need to order it from the pharmacy and authorize payment so the resident would have the medication without delay. Attempted telephone interview with an evening shift PCA on 07/10/24 at 3:33pm was unsuccessful. Attempted telephone interview with a second MA	D 358		

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on 07/10/24 at 3:35am was unsuccessful.

b. Review of Resident #4's signed physicians orders dated 12/04/23 revealed there was an order for Vitamin D3 with K2 (used to help absorb calcium and prevented blood clotting) 50mcg/100mcg once daily.

Review of Resident #4's physician's order dated 06/18/24 revealed an order for Vitamin D3 plus Vitamin K2 50mcg/100mcg once daily.

Review of Resident #4's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin K2 plus D3 one tablet once daily scheduled at 7:00am to 11:00am.
-There was documentation Vitamin K2 plus D3 was administered 23 of 26 opportunities.
-There was documentation Resident #4 was out of the facility from 05/13/24 to 05/17/24.
-There was a note on 05/30/24 and 05/31/24, which read "ordered".

Review of Resident #4's June 2024 eMAR revealed:
-There was an entry for Vitamin K2 plus D3 one tablet once daily scheduled at 7:00am to 11:00am.
-There was documentation Vitamin K2 plus D3 was administered 13 of 30 opportunities.
-There was documentation on 06/01/24, 06/05/24, 06/07/24 to 06/10/24, and 06/14/24, "awaiting pharmacy".
-There was documentation on 06/03/24, 06/07/24, 06/11/24, 06/12/24, 06/13/24, 06/15/24, 06/16/24, 06/17/24 that the resident refused and stated she already took her medication.
-There was documentation on 06/18/24, that the

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medication was "reordered".
-There was documentation on 06/19/24, which read "new script ordered".
-There was documentation on 06/20/24, which read "ordered".

Observation of Resident #4's medication on hand on 07/08/24 at 4:39pm revealed:
-There was one medication card with Vitamin K2 plus D3 50mcg/100mcg.
-Twenty-eight tablets were dispensed on 06/20/24; 10 tablets of 28 were available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/09/24 at 4:45pm revealed:
-Resident #4 had an order for Vitamin K2 plus Vitamin D3 50mcg/100mcg once daily.
-She had a second order for Vitamin K2 plus Vitamin D3 50mcg/100mcg written by Resident #4's primary care provider (PCP) on 06/20/24.
-On 04/23/24, 30 tablets of Vitamin K2 plus Vitamin D3 were dispensed.
-On 06/20/24, 28 tablets of Vitamin K2 plus Vitamin D3 50mcg/100mcg were dispensed.
-There were no other dispense dates for Vitamin K2 plus Vitamin D3; Vitamin K2 plus Vitamin D3 was not dispensed in May 2024.
-Vitamin D3 aided in the absorption of calcium and Vitamin K2 worked like an aspirin and prevented blood clotting.

Telephone interview with a Registered Nurse (RN) form Resident #4's PCP on 07/09/24 at 3:29pm revealed:
-Resident #4 was ordered the Vitamin D3 because her labs were low; her lab work done on 06/05/23 showed her Vitamin D3 level was 20.3 nanomeoles per liter (nmol/L), (Vitamin D3 levels

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of 50nmol/L are considered adequate, levels below 30nmol/L are too low and may weaken bones).
-Resident #4 was due to have her lab work done again so she was not sure what her levels were now.
-If the Vitamin D3 was not administered as ordered her Vitamin D levels would remain low.
-The Vitamin K2 was ordered because Resident #4 was having some bruising.
-If the Vitamin K2 was not administered as ordered then she would have increased bruising.
-The was no bruising noted at Resident #4's appointment on 06/20/24.

Interview with Resident #4 on 07/10/24 at 9:45am revealed she did not know what medications she took or why she took them.

Telephone interview with Resident #4's Power of Attorney (POA) on 07/09/24 at 6:41pm revealed:
-She was told by an medication aide (MA) that Resident #4 needed a new order from the PCP for Vitamin K2 plus Vitamin D3.
-She got a new order when Resident #4 had an appointment and she gave the order to a MA.
-The facility staff could reach out to the PCP when they needed to; they did not have to go through her first.
-She did not know if Resident #4 ran out of the Vitamin while she waited for an order from the PCP.
-She had never had the order for the Vitamin K2 plus Vitamin D3 filled at another pharmacy; the facility used their pharmacy when ordering medication for Resident #4.

Interview with a MA on 07/09/24 at 4:25pm revealed:
-Resident #4 ran out of her Vitamin K2 plus

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Vitamin D3 about a month ago.
-Resident #4 was out of the Vitamin K2 plus Vitamin D3 for a couple of weeks because when she tried to reorder it from the pharmacy, she was told the resident needed a new order.
-She contacted the pharmacy after about three days because the medication was not in the facility.
-She contacted Resident #4's POA because the POA wanted to get the new order from the PCP herself.
-The resident's POA took about two weeks to get the new order for the Vitamin K2 plus Vitamin D3.
-Once she got the new order, she faxed it to the pharmacy.
-She documented on the eMAR the facility was waiting on the pharmacy.
-She did not call Resident #4's PCP because the POA wanted to be the only one in contact with the PCP.
-She did not tell the Resident Care Coordinator (RCC) because the POA was handling it.

Interview with the Assistant to the Administrator on 07/10/24 at 3:56pm revealed she did not know why Resident #4's medications were not ordered; staff had not reported anything to her about the medications being out of stock or needing new orders.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:27pm revealed:
-The RCC should have been made aware Resident #4 did not have the Vitamin K2 plus Vitamin D3 to administer.
-The MA or the RCC should have contacted the PCP for the new medication order and not waited.
-The facility was responsible for getting Resident #4's Vitamin K2 plus Vitamin D3.
-She did not understand why Resident #4's

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

(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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medications were not at the facility if they were on the eMAR.
-The RCC or a MA were responsible for auditing the medication carts to ensure medications were on the medication cart.
-When medication was delivered from the pharmacy the RCC or the MA checked the delivered medication against the eMAR.
-If a medication was not delivered from the pharmacy then the RCC was responsible for contacting the pharmacy and the PCP.
-It was the facility's responsibility to ensure Resident #4's medications were available for administration.

Refer to interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:58pm.

Refer to interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm.
2. Review of Resident #3's FL-2 dated 04/14/23 revealed diagnoses of atrial fibrillation and chronic kidney disease.

a. Review of Resident #3's FL-2 dated 04/14/23 revealed there was an order for fluticasone (a medication used to treat allergies) 50mcg 2 sprays in each nostril daily.

Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone 50mcg 2 sprays in each nostril daily.
-Fluticasone 50mcg was documented as administered from 06/01/24 to 06/30/24.
-There were no refusals documented.

Review of Resident #3's July 2024 eMAR from

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07/01/24 to 07/08/24 revealed:
-There was an entry for fluticasone (a medication used to treat allergies) 50mcg 2 sprays in each nostril daily.
-Fluticasone 50mcg 2 sprays in each nostril daily was documented as administered from 07/01/24 to 07/08/24.
-There were no refusals documented.

Observation of Resident #3's medications on hand on 07/08/24 at 11:45am revealed:
-There was one bottle of fluticasone 50mcg spray available to administer.
-The dispensed date on the bottle of fluticasone 50mcg spray was 05/10/24.
-The bottle was almost full.

Telephone interview with a representative from the facility's contracted pharmacy on 07/09/24 at 10:30am revealed:
-Resident #3 had an order for fluticasone 50mcg 2 sprays in both nostrils daily.
-Fluticasone nasal spray was used to treat seasonal allergies.
-One bottle of fluticasone nasal spray 50mcg was dispensed for Resident #3 on 05/10/24.
-The facility was not currently on cycle refill and had to request refills.
-The facility had not requested more fluticasone nasal spray for Resident #3.
-One bottle of fluticasone nasal spray 50mcg would last one month.
-Resident #3 should not have any fluticasone nasal spray available to administer if it was being administered as ordered.

Interview with Resident #3 on 07/10/24 at 11:30am:
-She did not keep up with her medications.
-She did not think she received nasal spray from

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the medication aides (MAs).
-She had allergies and her nose got stuffed up.

Telephone interview with Resident #3's primary care provider (PCP) on 07/09/24 at 2:15pm revealed:
-He ordered fluticasone nasal spray for Resident #3 for seasonal allergies.
-He expected Resident #3 to receive her medications as ordered.

Interview with a MA on 07/10/24 at 11:00am revealed:
-Resident #3 had an order for fluticasone 50mcg nasal spray 2 sprays daily.
-She administered the fluticasone 50mcg nasal spray when she worked.
-Resident #3 did not refuse her fluticasone.
-She could not explain why there was still fluticasone nasal spray on the medication cart from May 2024.

b. Review of Resident #'3s FL-2 dated 04/13/23 revealed there was an order for Miralax (a medication used to treat constipation) 17gm in 4 ounces of liquid daily.

Review of Resident #3's June 2024 eMAR revealed:
-There was an entry for Miralax 17gm in 4 ounces of liquid daily.
-Miralax 17gm was documented as administered from 06/01/24 to 06/30/24.
-There were no refusals documented.

Review of Resident #3's July 2024 eMAR for 07/01/24 to 07/08/24 revealed:
-There was an entry for Miralax 17gm in 4 ounces of liquid daily.
-Miralax 17gm was documented as administered

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from 07/01/24 to 07/08/24.
-There were no refusals documented.

Observation of Resident #3's medications on hand on 07/08/24 at 11:45am revealed:
-There was one bottle of Miralax available to administer with a dispensed date of 03/19/24.
-The bottle of Miralax was almost full.

Telephone interview with a representative from the facility's contracted pharmacy on 0709/24 at 10:30am revealed:
-Resident #3 had an order for Miralax 17gm in 4 ounces of liquid daily.
-Miralax was used to treat constipation.
-One bottle of Miralax was dispensed for Resident #3 on 03/19/24.
-The pharmacy had not dispensed Miralax for Resident #3 on other dates.
-The facility was not currently on cycle refill and had to request refills.
-The facility had not requested more fluticasone nasal spray for Resident #3.
-One bottle of Miralax would last Resident #3 one month if administered as ordered.

Interview with Resident #3 on 07/10/24 at 11:30am:
-She did not keep up with her medications.
-She did not know if she received Miralax from the MAs.
-She was constipated sometimes and would ask a family member to bring in exlax for her to take.

-Telephone interview with Resident #1's PCP on 07/09/24 at 2:15pm revealed:
-Resident #3 had an order for Miralax 17gm daily to prevent constipation.
-It was important for Resident #3 to receive her Miralax as ordered to prevent episodes of

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constipation.

Interview with a MA on 07/10/24 at 11:00am revealed:
-Resident #3 had an order for Miralax 17gm in 4 ounces of liquid daily.
-She administered Miralax to Resident #3 when she worked.
-Resident #3 did not refuse her Miralax.
-She could not explain why there was still Miralax on the medication cart from March.

Refer to interviews with the Assistant to the Administrator on 07/08/24 at 4:17pm and on 07/10/24 at 3:58pm.

Refer to interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm.

____
Interview with Assistant to the Administrator on 07/08/24 at 4:17pm revealed:
-She was promoted into the Assistant to the Administrator's position by the Administrator/Regional Director of Operations when the previous Administrator left the position in the middle of May 2024.
-She had previously been responsible for transporting residents to their appointments and monitoring the front desk.
-She had not taken the Administrator's certification exam.
-She did not plan on taking the licensing exam because she had too much to do right now with being the Assistant to the Administrator.
-She had not had any training for the position; the RCC was helping her learn what needed to be done.
-She was at the facility alone most of the time; the RCC had missed work due to a family illness.
-She was in charge when the

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Administrator/Regional Director of Operations was not in the building.

Interview with the Assistant to the Administrator on 07/10/24 at 3:58pm revealed:
-The MAs were supposed to complete audits of the medication carts to check that each resident had the medications ordered and they received it as ordered.
-She expected the residents to receive their medications as ordered.

Interview with the Administrator/Regional Director of Operations on 07/10/24 at 4:30pm revealed:
-The MAs were responsible for completing medication cart audits.
-The Resident Care Coordinator (RCC) was responsible for making sure the medication cart audits were completed but had been out and things were getting missed.
-She expected the residents to receive their medications as ordered.