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WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 complaint investigation from 07/09/24 through 07/12/24.	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: Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff F) had a criminal background check completed upon hire. The findings are: Review of Staff F's, on-call supervisor, personnel file revealed: -There was no documentation of a hire date. -She was hired as the on-call supervisor for the facility. -There was no documentation a criminal background check was completed upon hire. Interview with Staff F on 07/12/24 at 10:16am revealed: -She started working at the facility in September or October of 2023. -She was hired as the on-call Supervisor when needed at night. -She signed a consent for a criminal background check to be completed upon hire with the previous Executive Director (ED).	D 139		

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D 139	Continued From page 1 -She did not know if the former ED completed a criminal background check for her. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed: -She did not know why there was not a criminal background check on file for Staff F. -Staff F was already working when the RCC came to the facility. -She never thought about checking to see if Staff F had a criminal background check on file. -She was still in training and would not have known what to look for with Staff F because she was a registered nurse (RN). -The ED at the time Staff F was hired would have been responsible for making sure paperwork was completed. Interview with the Administrator on 07/12/24 at 10:54am and 3:34pm revealed: -He was responsible to complete the criminal background checks for new employees upon hire. -He did not know why Staff F did not have a criminal background check completed. -He thought Staff F was hired before he came to the facility. -He became one of four owner's of the facility in July 2023 and the contract for on-call Supervisor was signed by Staff F on 09/15/23. -Staff F did not have a personnel file because she was "on call" and did not work on a shift. -At the time Staff F was hired, it was the responsiblity of the former Administrator to ensure criminal background checks were completed upon hire.	D 139		
D 140	10A NCAC 13F .0407(a)(8) Other Staff Qualifications	D 140		

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D 140	Continued From page 2 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation of an examination and screening for the presence of controlled substances was completed for 1 of 4 sampled staff (Staff F). The findings are: Review of Staff F's, on-call supervisor, personnel file revealed: -There was no documentation of a hire date. -She was hired as the On-Call Supervisor for the facility. -There was no documentation a drug screening was completed upon hire. Interview with Staff F on 07/12/24 at 10:16am revealed: -She started working at the facility in September 2023 or October of 2023. -She was hired to as the On-Call Supervisor when needed at night. -She remembered having a drug screening completed upon hire with the previous Executive Director (ED). Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed: -She did not know why there was not a drug screening on file for Staff F. -Staff F was already working when the RCC	D 140		

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D 140	Continued From page 3 came to the facility. -She never thought about checking to see if Staff F had a drug screening on file. -She was still in training and would not have known what to look for with Staff F because she was a registered nurse (RN). -The ED at the time Staff F was hired would have been responsible for making sure paperwork was completed. Interview with Administrator on 07/12/24 at 10:54am and 3:34pm revealed: -He was responsible to complete the drug screenings for new employees upon hire. -He did not know why Staff F did not have a drug screen completed. -He thought Staff F was hired before he came to the facility. -He became one of four owners of the facility in July 2023 and the contract was signed by Staff F on 09/15/23. -Staff F did not have a personnel file because she was "on call" and did not work on a shift. -At the time Staff F was hired, it was the responsiblity of the former Administrator to ensure drug screenings were completed upon hire.	D 140		
D 218	10A NCAC 13F .0605 (g) Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (g) A supervisor shall meet the following qualifications: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program, or have passed an	D 218		

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alternative examination established by the Department;
(3) meet the general health requirements according to Rule .0406 of this Section;
(4) have at least six months of experience in performing or supervising the performance of duties to be supervised during a period of three years prior to the effective date of this Rule or the date of hire, whichever is later, or be a licensed health professional or a licensed nursing home administrator;
(5) meet the same minimum training and competency requirements of the aides being supervised; and
(6) earn at least 12 hours a year of continuing education credits related to the care of aged and disabled persons in accordance with procedures established by the Department of Health and Human Services.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff met the qualifications of a supervisor (Staff F.).

The findings are:

Review of the facility census dated 07/09/24 revealed there were 32 residents residing in the facility.

Review of Staff F's, on-call supervisor, personnel file revealed:
-There was no documentation Staff F was 21 years or older.
-There was no documentation Staff F was a high school graduate or certified under the G.E.D. program or had passed an alternative

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examination established by the Department.
-There was no documentation Staff F met the general health requirements according to Rule .0406 of this Section.
-There was no documentation Staff F had at least six months of experience in performing or supervising the performance of duties to be supervised during a period of three years prior to the effective date of this rule or the date of hire, whichever was later, or be a licensed health professional or a licensed nursing home adminstrator.
-There was no documentation Staff F met the same minimum training and competency requirements of the aides being supervised.
-There was no documentation Staff F earned at least 12 hours year of continuing education credits related to the care of aged and disabled persons in accordance with procedures established by the Department of Health and Human Services.

Interview with Staff F on 07/12/24 at 10:16am revealed:
-She was hired September 2023 or October of 2023.
-She was a registered nurse (RN).
-She was hired as an on-call supervisor on night shifts when needed.
-She did not complete infection control training within 30 days of hire.
-She signed a consent with the former Executive Director (ED) to have a criminal background check but she was not sure it was completed.
-She completed a drug screening with the previous Executive Director (ED) at the facility.

Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed:
-She did not know why Staff F did not have a

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personnel file.
-Staff F was already employed at the facility when she (RCC) was hired.
-She did not know what qualifications Staff F would have been required to qualified as a supervisor because she was a registered nurse (RN).
-When Staff F was hired, the Executive Director at that time would have been responsible for making sure paperwork was completed.

Interview with the facility's registered nurse (RN) on 07/11/24 at 3:34pm revealed:
-She was one of the facility's four owners.
-Staff F did not have a personnel file.
-The facility did not keep personnel files for staff who fulfilled an "on-call" position.

Interview with the Administrator on 07/11/24 at 10:23am revealed:
-Staff F did not have a personnel file because she did not work "shifts" at the facility.
-He thought Staff F was hired for her position before he became Co-Owner of the facility in July 2023.
-He became a Co-Owner of facility in July 2023 and Staff F signed a contract for the on-call supervisor's position on 09/15/23.
-When he was not present in the facility at night, Staff F, the on-call supervisor, was available for staff assistance.
-He did not know if Staff F was current with all qualifications required to fulfill the on-call supervisor's position other than her professional status as a registered nurse (RN).
-He did not know if Staff F had a criminal background check, drug screening, infection control training, or 12 hours of continuing education.
-He thought she had all of the staffing

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D 218	Continued From page 7 requirements because she was licensed as a RN.	D 218		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to provide personal care and supervision in accordance with the resident's care plan for 1 of 5 sampled residents (#2) related to providing assistance for dressing and bathing. The findings are: Review of Resident #2's current FL2 dated 05/30/24 revealed diagnoses included diabetes, high blood pressure and obesity. Review of Resident #2's care plan dated 07/21/23 revealed: -Resident #2 required extensive assistance with dressing and bathing. -There was no documentation related to care of Resident #2's left great toe. Interview with Resident #2 on 07/09/24 during the facility tour at 9:02am revealed: -She had diabetes. -She had a history of medical complications due	D 269		

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D 269	Continued From page 8 to her diabetes, including amputation of her right great toe. Observation of Resident #2's left foot on 07/09/24 at 9:02am revealed: -There was a small bandage wrapped around her left great toe. -When Resident #2 removed the bandage, she had a calloused area on the bottom of her left great toe. -There was an opening in the center of the calloused area approximately 0.5 centimeters by 0.5 centimeters in size. -There was no drainage or bleeding from the opening. Interview with Resident #2 on 07/10/24 at 11:50am revealed: -She took a shower at least twice a week or more. -She did not need assistance and was independent with her showers. -Staff would assist her with a shower if she asked them to. -She was independent with dressing. Interview with a personal care aide (PCA) on 07/11/24 at 10:11am revealed: -There was a shower schedule for all residents, but Resident #2 did not need assistance with dressing or bathing. -Resident #2 was assisted in and out of the shower but no other assistance was provided. -Resident #2 was not assisted with washing her feet or putting on socks. -There was no documentation about skin observations during showers that she was aware of. -She was not aware Resident #2 had an open area on the bottom of her left great toe.	D 269		

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D 269	Continued From page 9 Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 9:29am revealed: -Resident #2 was independent with dressing and bathing. -If Resident #2 needed assistance with dressing or bathing she would ask staff to assist her. Interview with a Registered Nurse (RN)/Owner #2 on 07/10/24 at 1:07pm revealed: -Resident #2 was seen by home health for a wound on her left great toe in March 2024 and April of 2024. -The wound had healed to a "tiny scab" and Resident #2 was discharged from home health in April 2024. -If the personal care aides (PCAs) provided assistance for Resident #2 with bathing and dressing according to her care plan, the area on her left great toe would have been discovered. Intereview with the Primary Care Provider (PCP) on 07/11/24 at 10:53am revealed: -Resident #2 had diabetes. -She had not been made aware of Resident #2's left great toe wound until 07/11/24. Interview with the Administrator/Owner #1 on 07/12/24 at 3:23pm revealed: -Resident #2 self-showered daily. -If she needed personal care assistance, Resident #2 was able to ask for staff assistance.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 10 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up was completed for 1 of 5 sampled resident (#4) related to failure to notify the Primary Care Provider (PCP) of blood sugar values greater than 450, insulin refusals, and reporting medication errors involving two blood pressure medications. The findings are: Review of Resident #4's current FL2 dated 06/06/24 revealed diagnoses included essential hypertension, hypotension, and type II diabetes with neuropathy. a. Review of Resident #4's current FL2 dated 06/06/24 revealed: -There was an order for insulin aspart (used to lower blood sugar) 100 unit/ml pen inject subcutaneously per sliding scale: fingerstick blood sugar (FSBS) checks less than 150=0 unit, 151-200=1 unit, 201-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled daily at 8:15am, 12:45pm, and 5:45pm. -There was an order for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale at bedtime: FSBS less than 200=0 unit, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled at 8:00pm.	D 273		

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D 273	Continued From page 11 Review of Resident #4's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for insulin aspart (used to lower blood sugar) 100 unit/ml pen inject subcutaneously per sliding scale: FSBS checks less than 150=0 unit, 151-200=1 unit, 201-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled daily at 8:15am, 12:45pm, and 5:45pm. -There was an entry for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale at bedtime: FSBS less than 200=0 unit, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled at 8:00pm. -On 06/09/24 at 8:15am, the documented FSBS was 460, there was no documentation PCP was notified. -On 06/14/24 at 5:45pm, the documented FSBS was 466, there was no documentation PCP was notified. -On 06/15/24 at 8:15am, the documented FSBS was 476, there was no documentation PCP was notified. Review of Resident #4's July 2024 eMAR revealed: -There was an entry for insulin aspart (used to lower blood sugar) 100 unit/ml pen inject subcutaneously per sliding scale: FSBS checks less than 150=0 unit, 151-200=1 unit, 201-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled daily at 8:15am, 12:45pm, and 5:45pm. -There was an entry for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale at bedtime: FSBS checks less than 200=0 unit, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP	D 273		

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scheduled at 8:00pm.
-On 07/02/24 at 12:45pm, the documented FSBS was 566, there was no documentation PCP was notified.

Review of Resident #4's chart note entries dated 06/06/24-07/10/24 revealed there was no documentation the PCP was notified for the FSBS results greater than 450 on 06/09/24, 06/14/24, 06/15/24, and 07/02/24.

Interview with a medication aide (MA) on 07/11/24 at 10:04am revealed:
-There was an order to notify the PCP when Resident #4's FSBS was greater than 450.
-If she took Resident #4's FSBS and the result was greater than 450, she would notify the PCP through the telehealth application.

Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 10:16am revealed:
-The MAs were responsible for notifying the PCP of Resident #4's elevated FSBS's according to the parameters in the order.
-The MAs were to use the telehealth application to report the elevated FSBS results.
-Any issue reported through the telehealth application would produce a note for the resident's record.

Interview with Resident #4's PCP on 07/11/24 at 11:10am revealed:
-She was not notified of Resident #4's FSBS greater than 450 on 06/09/24, 06/14/24, 06/15/24, and 07/02/24.
-If she had known about the elevated FSBS, it would have prompted her to consider revising his meal time insulin dosage.

Interview with the Administrator on 07/12/24 at

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3:24pm revealed:
-He had reviewed Resident #4's telehealth communications for 06/09/24-07/10/24 and could find no staff communications reporting high FSBS values to the PCP.
-The medication aide (MA) staff received training on notifying the PCP when parameters were ordered.
-The MAs all acknowledged on 06/02/24 they understood they needed to report ordered parameter values and how to report the information to the PCP.
-He and his staff met weekly with the PCP to discuss resident concerns.

b. Review of Resident #4's current FL2 dated 06/06/24 revealed:
-There was an order for insulin aspart 100 unit/ml pen inject 4 units subcutaneously with meals scheduled at 8:15am, 12:45pm, and 5:45pm.
-There was an order for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale (SSI): fingerstick blood sugar (FSBS) checks less than 150=0 unit, 151-200=1 unit, 201-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled daily at 8:15am, 12:45pm, and 5:45pm.
-There was an order for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale at bedtime: FSBS checks less than 200=0 unit, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled at 8:00pm.

Review of Resident #4's June 2024 electronic medication administration record (eMAR) from 06/08/24-06/30/24 revealed:
-There was an entry for insulin aspart 100 unit/ml pen inject 4 units subcutaneously with meals scheduled at 8:15am, 12:45pm, and 5:45pm.

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D 273	Continued From page 14 -There was an entry for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale: FSBS checks less than 150=0 unit, 151-200=1 unit, 201-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled daily at 8:15am, 12:45pm, and 5:45pm. -There was an entry for insulin aspart 100 unit/ml pen inject subcutaneously per sliding scale at bedtime: FSBS checks less than 200=0 unit, 201-250=1 unit, 251-300=2 units, 301-350=3 units, 351-400=5 units, 450 or more call PCP scheduled at 8:00pm. -On 06/11/24 at 6:29pm, FSBS 102, premeal insulin aspart 4 units was documented as not administered due to resident refusal. -On 06/11/24 at 7:49pm, no documented FSBS, premeal insulin aspart per SSI was documented as not administered due to resident refusal. -On 06/13/24 at 1:19pm, FSBS 194, premeal insulin aspart 4 units and per SSI was documented as not administered due to resident refusal. -On 06/19/24 at 6:41pm, FSBS 179, premeal insulin aspart 4 units and per SSI was documented as not administered due to resident refusal. -On 06/20/24 at 1:55pm, FSBS 288, premeal insulin aspart 4 units was documented as not administered due to resident refusal. -On 06/20/24 at 6:15pm, FSBS 128, premeal insulin aspart 4 units was documented as not administered due to resident refusal. -On 06/26/24 at 9:18pm, no documented FSBS, insulin aspart per SSI was documented as not administered due to resident refusal. Interview with the Resident Care Coordinator (RCC) on 07/11/24 at 10:16am revealed Resident #4 refused to take his scheduled and SSI insulin on occasion.	D 273		

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D 273	Continued From page 15 Interview with Resident #4's Primary Care Provider (PCP) on 07/11/24 at 11:10am revealed: -She was not notified of Resident #4's refused insulin doses in June 2024. -There was nothing anyone could do if Resident #4 refused doses of insulin. -She may need to revise Resident #4's premeal doses if he frequently refused SSI. Interview with the Administrator on 07/12/24 at 3:24pm revealed: -He could find no telehealth documentation to the PCP about Resident #4's insulin refusals in June 2024. -The State regulations did not specifically say the facility was responsible to report all insulin refusals to the PCP. -The facility policy was for staff to report three consecutive refusals of the same medication to the PCP. c. Review of Resident #4's current FL2 dated 06/06/24 revealed there was an order for midodrine (used to treat low blood pressure) 5mg take one tablet twice daily. Review of Resident #4's Primary Care Provider's (PCP) order dated 06/27/24 revealed midodrine 5mg one tablet three times daily. Review of Resident #4's PCP order dated 06/28/24 revealed: -Discontinue midodrine 5mg twice daily. -Start midodrine 10mg every morning. -Start midodrine 5mg midday and at bedtime. -Check blood pressure prior to administration and hold for systolic blood pressure greater than 120. Review of Resident #4's June 2024 electronic	D 273		

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medication administration record (eMAR) from 06/09/24-06/28/24 revealed:
-There was an entry for midodrine 5mg one tablet twice daily; hold dose if systolic blood pressure was greater than 140, scheduled at 8:00am and 6:00pm (with a start date of 05/17/24).
-There was an entry for midodrine 5mg one tablet twice daily; hold for systolic blood pressure greater than 120; notify PCP if systolic blood pressure was less than 90 or greater than 140, scheduled at 2:00pm and 8:00pm (with a start date of 06/28/24).
-There was an entry for midodrine 10mg one tablet once daily; hold for systolic blood pressure greater than 120; notify PCP if systolic blood pressure was less than 90 or greater than 140 (with a start date of 06/28/24).
-On 06/27/24 at 8:00am, the documented blood pressure was 89/42, midodrine 5mg was documented as not administered due to withheld per order.

Review of Resident #4's record revealed there was no documentation the PCP was notified the midodrine was not administered as ordered on 06/12/24 at 8:00am, 06/17/24 at 8:00am, 06/18/24 at 8:00am, 06/26/24 at 8:00am, and 06/27/24 at 8:00am.

Interview with Resident #4 on 07/09/24 at 9:07am revealed:
-His blood pressure was constantly low.
-His low blood pressure made him feel weak, light headed, and dizzy.
-These symptoms made it very difficult for him to walk down to the dining room for meals.

Interview with Resident #4's PCP on 07/11/24 at 11:10am revealed:
-Resident #4 was prescribed midodrine to

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increase his blood pressure.
-If the midodrine was not administered as ordered Resident #4 could experience more hypotension.
-The risk associated with hypotension were poor perfusion (the passage of blood through the blood vessels or other natural channels in an organ or tissue) and decreased level of consciousness.
-She was not notified of the occurrences when the facility MAs had not administered the midodrine as ordered in June 2024.
-There were no triage telehealth notes related to issues with Resident #4's midodrine in June 2024.
-She had received multiple telehealth communications "last week" (06/30/24-07/07/24) about Resident #4's blood pressures being low.

Review of Resident #4's Nurses Note dated 06/28/24 revealed:
-On 06/20/24, there was an order to alert the PCP if systolic blood pressure was less than 90.
-The PCP was made aware today (06/28/24) of blood pressure results for systolic blood pressures less than 90.
-On 06/21/24, the blood pressure was 76/38.
-On 06/22/24, the blood pressure was 84/68.
-On 06/23/24, the blood pressure was 88/45.
-On 06/24/24, the blood pressure was 72/41 and 55/30.
-On 06/26/24, the blood pressure was 61/27 and 88/48.
-On 06/27/24, the blood pressure was 89/42 and 82/65.
-On 06/28/24, the blood pressure was 84/50.

Interview with the Administrator on 07/12/24 at 3:24pm revealed Resident #4's low blood pressures were discussed with the PCP on 06/20/24, 06/27/24, and 06/28/24.

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D 273	Continued From page 18 d. Review of Resident #4's current FL2 dated 06/06/24 revealed there was an order for losartan (used to treat high blood pressure) 25mg one tablet daily hold for systolic blood pressure less than 120. Review of Resident #4's Primary Care Provider (PCP) order dated 06/20/24 revealed discontinue losartan. Review of Resident #4's June 2024 electronic medication administration record (eMAR) from 06/09/24-06/20/24 revealed: -There was an entry for losartan 25mg one tablet daily at 8:00am hold for systolic blood pressure less than 120. -The losartan was documented as administered 11 occurrences out of 12 opportunities from 06/09/24-06/20/24. -On 06/09/24, the documented blood pressure was 78/41; losartan was documented as administered. -On 06/10/24, there was no documented blood pressure; losartan was documented as "done not charted on MAR." -On 06/11/24, the documented blood pressure was 80/45; losartan was documented as administered. -On 06/13/24, the documented blood pressure was 107/85; losartan was documented as administered. -On 06/14/24, the documented blood pressure was 98/71; losartan was documented as administered. -On 06/15/24, the documented blood pressure was 85/54; losartan was documented as administered. -On 06/16/24, the documented blood pressure was 71/57; losartan was documented as administered.	D 273		

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-On 06/17/24, the documented blood pressure was 95/58; losartan was documented as administered.
-On 06/18/24, the documented blood pressure was 61/28; losartan was documented as administered.
-On 06/19/24, the documented blood pressure was 89/88; losartan was documented as administered.
-On 06/20/24, the documented blood pressure was 92/87; losartan was documented as administered.

Observation of Resident #4's medications on hand on 07/10/24 at 3:44pm revealed there was no losartan.

Interview with Resident #4 on 07/09/24 at 9:07am revealed:
-His blood pressure was constantly low.
-His low blood pressure made him feel weak, light headed, and dizzy.
-These symptoms made it very difficult for him to walk down to the dining room for meals.

Interview with a medication aide (MA) on 07/11/24 at 10:26am revealed:
-She had worked as a MA in the facility since May 2024.
-She documented administration of Resident #4's losartan on 06/11/24, 06/18/24, and 06/20/24.
-She did not realize she was supposed to hold the losartan if the systolic blood pressure was less than 120.

Interview with Resident #4's PCP on 07/11/24 at 11:10am revealed:
-Resident #4's blood pressure was "typically" hypotensive (low blood pressure)
-Resident #4 was at risk for more hypotension

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D 273	Continued From page 20 when the losartan was administered outside the ordered parameter. -She was not notified there were multiple incidents from 06/09/24-06/20/24 when the losartan was administered to Resident #4 when it should have been held based on the resident's blood pressure. -The risks of low blood pressures to Resident #4 included decreased perfusion (the mechanism that keeps blood flowing to every part of the body) and a decreased level of consciousness. -Resident #4 could experience weakness, dizziness, lightheadedness, and could be at an increased risk for falls when his blood pressure was low. -She discontinued Resident #4's losartan on 06/20/24 after she was notified by the facility Resident #4 was experiencing low blood pressures. Interview with the Administrator on 07/12/24 at at 3:24pm revealed: -Resident #4's continued hypotension was discussed with the PCP on 06/20/24. -Resident #4's PCP discontinued the losartan on 06/20/24. The facility failed to notify Resident #4's PCP of multiple medication errors involving two blood pressure medications during the month of June 2024 which put the resident at risk for decreased blood flow and decreased level of consciousness. This failure resulted in substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/24 for this violation.	D 273		

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D 344	Continued From page 21	D 344		
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: Based on interviews and record reviews, the facility failed to ensure clarification of medication orders for 1 of 6 sampled residents (#2) related to a medication used for fluid retention and monthly weights. The findings are: Review of Resident #2's current FL-2 dated 05/30/24 revealed diagnoses included diabetes, hypertension, chronic obstructive pulmonary disease and obesity. Review of physician's orders dated 05/30/24 revealed: -An order for monthly weights. -An order for furosemide (used to treat fluid retention) 40mg take one-half tablet daily (20mg) as needed for a weight gain of two pounds (lbs.) within 24 hours.	D 344		

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D 344	Continued From page 22 Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check and record weight once a month. -Staff documented a weight of 231.4 lbs. on 06/08/24 at 8:00am. -There was an entry for furosemide 40mg take one-half tablet daily (20mg) as needed for a weight gain of two lbs. in 24 hours. -There was no documentation weights were obtained daily or that furosemide was administered. Review of Resident #2's July 2024 eMAR revealed: -There was an entry to check and record weight once a month. -Staff documented a weight of 219.8 lbs. on 07/08/24 at 8:00am. -There was an entry for furosemide 40mg take one-half tablet daily (20mg) as needed for a weight gain of two lbs. in 24 hours. -There was one entry on 07/05/24 that indicated Resident #2 did not receive as needed furosemide due to being out of the facility. -There was no documentation weights were obtained daily or that furosemide was adnministered. Interview with a medication aide (MA) on 07/09/24 at 3:45pm revealed when weights were scheduled to be obtained for a resident, the eMAR indicated how often the weight was due. Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 9:11am revealed: -She noticed the discrepancy in the order for monthly weights and the order for as needed	D 344		

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furosemide if Resident #2 had a weight gain of more than two lbs. in 24 hours.
-She did not know how long it had been since she noticed the discrepancy, but she asked the primary care provider (PCP) to clarify the two orders.
-She never received a response from the PCP about the two orders.

Interview with Resident #2 on 07/10/24 at 11:50am revealed:
-Staff at the facility were checking her weight once a month.
-She was hospitalized "last week" for difficulty breathing and hand cramping.
-She was feeling better since returning to the facility, but was still weak.
-She was receiving a weekly injectable diabetic medication that was helping her lose weight.

Review of the hospital discharge record dated 07/05/24 revealed Resident #2 had been discharged with diagnoses that included heart failure, lung disease, and acute kidney injury.

Interview with the PCP on 07/11/24 at 10:53am revealed:
-Resident #2 had a diagnosis of congestive heart failure.
-She needed to have daily weights taken for monitoring to determine if she was retaining fluid.
-No one had tried to clarify the order for the furosemide as needed when the resident gained two lbs. in 24 hours.
-She would have expected the facility staff or herself to catch the discrepancies in the two orders.

Interview with the Administrator on 07/12/24 at 3:23pm revealed:

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D 344	Continued From page 24 -The eMAR was reviewed daily by staff. -He expected the RCC to review orders and address any discrepancies with the PCP.	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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2 and #4) related to medications used to treat high and low blood pressure and neuropathy (#4), medications used to treat infection and pain (#1), and a medication for high blood pressure that was discontinued (#2). The findings are: Review of the facility's Medication Administration policy and procedures dated 06/21/23 revealed: -Medications, prescriptions and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's	D 358		

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orders.
-The medication administration record will be updated and changed when medication or treatment orders from the prescribing practitioner changes.

1. Review of Resident #4's current FL2 dated 06/06/24 revealed diagnoses included essential hypertension, hypotension, and type II diabetes with neuropathy.

a. Review of Resident #4's current FL2 dated 06/06/24 revealed there was an order for losartan (used to treat high blood pressure) 25mg one tablet daily; hold for systolic blood pressure less than 120.

Review of Resident #4's Primary Care Provider (PCP) order dated 06/20/24 revealed discontinue losartan.

Review of Resident #4's June 2024 electronic medication administration record (eMAR) from 06/09/24-06/20/24 revealed:
-There was an entry for losartan 25mg one tablet daily at 8:00am; hold for systolic blood pressure less than 120.
-The losartan was documented as administered 11 occurrences out of 12 opportunities from 06/09/24-06/20/24.
-On 06/09/24, the documented blood pressure was 78/41, and losartan was documented as administered.
-On 06/10/24, there was no documented blood pressure, and losartan was documented as "done not charted on MAR."
-On 06/11/24, the documented blood pressure was 80/45, and losartan was documented as administered.
-On 06/13/24, the documented blood pressure

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was 107/85, and losartan was documented as administered.
-On 06/14/24, the documented blood pressure was 98/71, and losartan was documented as administered.
-On 06/15/24, the documented blood pressure was 85/54, and losartan was documented as administered.
-On 06/16/24, the documented blood pressure was 71/57, and losartan was documented as administered.
-On 06/17/24, the documented blood pressure was 95/58, and losartan was documented as administered.
-On 06/18/24, the documented blood pressure was 61/28, and losartan was documented as administered.
-On 06/19/24, the documented blood pressure was 89/88, and losartan was documented as administered.
-On 06/20/24, the documented blood pressure was 92/87, and losartan was documented as administered.

Observation of Resident #4's medications on hand on 07/10/24 at 3:44pm revealed there was no losartan.

Interview with Resident #4 on 07/09/24 at 9:07am revealed:
-His blood pressure was constantly low.
-His low blood pressure made him feel weak, light headed, and dizzy.
-These symptoms made it very difficult for him to walk down to the dining room for meals.

Interview with a medication aide (MA) on 07/11/24 at 10:26am revealed:
-She had worked as a MA in the facility since May 2024.

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D 358	Continued From page 27 -She documented administration of Resident #4's losartan on 06/11/24, 06/18/24, and 06/20/24. -She did not realize she was supposed to hold the losartan if the systolic blood pressure was less than 120. Interview with Resident #4's PCP on 07/11/24 at 11:10am revealed: -She did not know why losartan was ordered for Resident #4. -Resident #4's blood pressure was "typically" hypotensive (low blood pressure). -Resident #4 was at risk for more hypotension when the losartan was administered outside the ordered parameter. -The risks of low blood pressures to Resident #4 included decreased perfusion (the passage of blood through the blood vessels or other natural channels in an organ or tissue) and a decreased level of consciousness. -Resident #4 could experience weakness, dizziness, lightheadedness, and could be at an increased risk for falls when his blood pressure was low. -She discontinued Resident #4's losartan on 06/20/24 after she was notified by the facility Resident #4 was experiencing low blood pressures. Interview with the Administrator on 07/12/24 at at 3:24pm revealed: -Resident #4's continued hypotension was discussed with the PCP on 06/20/24. -Resident #4's PCP discontinued the losartan on 06/20/24. b. Review of Resident #4's current FL2 dated 06/06/24 revealed there was an order for midodrine (used to treat low blood pressure) 5mg take one tablet twice daily.	D 358		

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D 358	Continued From page 28 Review of Resident #4's Primary Care Provider's (PCP) order dated 06/27/24 revealed midodrine 5mg one tablet three times daily. Review of Resident #4's PCP order dated 06/28/24 revealed: -Discontinue midodrine 5mg twice daily. -Start midodrine 10mg every morning. -On 06/28/24 midodrine 5mg midday and at bedtime. -Check blood pressure prior to administration and hold for systolic blood pressure greater than 120. Review of Resident #4's June 2024 electronic medication administration record (eMAR) from 06/09/24-06/30/24 revealed: -There was an entry for midodrine 5mg one tablet twice daily; hold dose if systolic blood pressure greater than 140 scheduled at 8:00am and 6:00pm (with a start date of 05/17/24). -There was an entry for midodrine 5mg one tablet twice daily; hold for systolic blood pressure greater than 120 notify PCP if systolic blood pressure less than 90 or greater than 140 scheduled at 2:00pm and 8:00pm (with a start date of 06/28/24). -There was an entry for midodrine 10mg one tablet once daily; hold for systolic blood pressure greater than 120 notify PCP if systolic blood pressure is less than 90 or greater than 140 (with a start date of 06/28/24). -On 06/12/24 at 8:00am, the documented blood pressure was 100/53; midodrine 5mg was documented as not administered due to withheld per order. -On 06/16/24 at 6:00pm, the documented blood pressure was 96/62; midodrine 5mg was documented as not administered due to medication on order from pharmacy.	D 358		

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D 358	Continued From page 29 -On 06/17/24 at 8:00am, the documented blood pressure was 95/58; midodrine 5mg was documented as not administered due to withheld per order. -On 06/18/24 at 8:00am, the documented blood pressure was 61/28, midodrine 5mg was documented as not administered due to withheld per order. -On 06/26/24 at 8:00am, the documented blood pressure was 61/27, midodrine 5mg was documented as not administered due to withheld per order. -On 06/27/24 at 8:00am, the documented blood pressure was 89/42, midodrine 5mg was documented as not administered due to withheld per order. Review of Resident #4's July 2024 eMAR from 07/01/24-07/10/24 revealed: -There was an entry for midodrine 10mg one tablet daily scheduled at 8:00am; hold for systolic blood pressure greater than 120 and notify PCP for systolic blood pressure less than 90 or greater than 140. -There was an entry for midodrine 5mg one tablet twice daily scheduled at 2:00pm and 8:00pm; hold for systolic blood pressure greater than 120 and notify the PCP if systolic blood pressure less than 90 or greater than 140. -On 07/05/24 at 8:00am, the documented blood pressure was 81/56; the midodrine 10mg was documented as not administered due to withheld per order. Observation of Resident #4's medications on hand on 07/10/24 at 3:44pm revealed: -There was one bubble pack of midodrine 10mg tablets with 31 tablets remaining with a dispense date of 06/28/24. -There was one bubble pack of midodrine 5mg	D 358		

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tablets with 59 tablets remaining with a delivery date of 07/12/24.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/24 at 4:39pm revealed:
-The pharmacy dispensed midodrine 5mg 60 tablets on 05/09/24 and 06/12/24.
-The pharmacy did not dispense additional midodrine 5mg tablets on 06/28/24 when the order changed because the facility should use up the previous supply until cycle fill delivery around the 10th day of the month.
-The pharmacy dispensed midodrine 10mg 60 tablets on 06/28/24.

Interview with Resident #4 on 07/09/24 at 9:07am revealed:
-His blood pressure was constantly low.
-His low blood pressure made him feel weak, light headed, and dizzy.
-These symptoms made it very difficult for him to walk down to the dining room for meals.
-He was taking a medication to help to raise his blood pressure, but the medication was not working.

Interview with the Administrator on 07/10/24 at 5:51pm revealed:
-He and the Resident Care Coordinator (RCC) had recognized Resident #4's blood pressure fluctuations during a care audit.
-Most of the MAs had received training on Resident #4's blood pressure parameters and midodrine administration on 07/01/24.
-He spoke with the last MA who had not received the training on 07/01/24 by phone on 07/06/24 and provided the training to him.

Interview with Resident #4's PCP on 07/11/24 at

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D 358	Continued From page 31 11:10am revealed: -Resident #4 was prescribed midodrine to increase his blood pressure. -If the midodrine was not administered as ordered Resident #4's could experience more hypotension (abnormally low blood pressure). -She received multiple telehealth messages concerning low blood pressures from the facility staff "last week" (06/30/24-07/07/24). -The risks associated with hypotension was decreased blood flow through the blood vessels and decreased level of consciousness. -She was not notified of the occurrences when the facility MAs had not administered the midodrine as ordered in June 2024. -There were no triage telehealth notes related to issues with Resident #4's midodrine in June 2024. Review of Resident #4's Nurses Note dated 06/28/24 revealed: -On 06/20/24, there was an order to alert the PCP if systolic blood pressure was less than 90. -The PCP was made aware today (06/28/24) of blood pressure results for systolic blood pressures less than 90. -On 06/21/24, the blood pressure was 76/38. -On 06/22/24, the blood pressure was 84/68. -On 06/23/24, the blood pressure was 88/45. -On 06/24/24, the blood pressure was 72/41 and 55/30. -On 06/26/24, the blood pressure was 61/27 and 88/48. -On 06/27/24, the blood pressure was 89/42 and 82/65. -On 06/28/24, the blood pressure was 84/50. Interview with the Administrator on 07/12/24 at 3:24pm revealed: -Resident #4's low blood pressures were	D 358		

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discussed with the PCP on 06/20/24.
-He implemented training with staff on 07/01/24 concerning administration of Resident #4's medications.

c. Review of Resident #4's current FL2 dated 06/06/24 revealed there was an order for gabapentin (used to treat nerve pain) 600mg four times daily.

Review of Resident #4's PCP order dated 05/06/24 revealed gabapentin 600mg four times daily.

Review of Resident #4's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 600mg one tablet four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm from 05/06/24 at 12:00pm to 05/31/24 at 8:00pm.
-The gabapentin was documented as administered 100 occurrences out of 103 opportunities.
-On 05/05/24 at 1:00pm, the gabapentin was documented as not administered "see chart notes."
-On 05/06/24 at 4:00pm, the gabapentin was documented as not administered due to the resident being out of the facility.
-On 05/08/24 at 8:00pm, the gabapentin was documented as not administered "see chart notes."

Review of Resident #4's June 2024 eMAR revealed:
-There was an entry for gabapentin 600mg one tablet four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The gabapentin was documented as

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administered 116 occurrences out of 120 opportunities from 06/01/24-06/30/24.
-On 06/01/24 at 7:13pm and 06/14/24 at 7:03pm, the gabapentin was documented not administered due to resident being out of facility.
-On 06/19/24 at 8:00pm, the gabapentin was documented as not administered due to resident blood pressure 87/70.
-On 06/26/24 at 9:18pm, the gabapentin was documented as not administered due to resident refusal.

Review of Resident #4's July 2024 eMAR from 07/01/24-07/10/24 at 12:00pm revealed:
-There was an entry for gabapentin 600mg 1 tablet four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm.
-The gabapentin was documented as administered 36 occurrences out of 38 opportunities.
-On 07/04/24 at 8:00pm, the gabapentin was documented as not administered due to resident refusal.
-On 07/05/24 at 9:31am, the gabapentin was documented as not administered due to being withheld per physician order.

Observation of Resident #4's medications on hand 07/10/24 at 3:44pm revealed:
-There was one bubble pack of gabapentin 600mg tablets with 2 out of 30 tablets remaining dispensed 06/15/24 labeled "AM" with instructions to take one tablet four times a day.
-There was one bubble pack of gabapentin 600mg tablets with 30 out of 30 tablets remaining dispensed on 06/15/24 labeled "NOON" with instructions to take one tablet four times a day.
-There was one bubble pack of gabapentin 600mg tablets with 24 out of 30 tablets remaining dispensed on 06/15/24 labeled "BEDTIME" with

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instructions to take one tablet four times a day.
-There was one bubble pack of gabapentin 600mg tablets with 9 tablets out of 63 tablets remaining dispensed on 05/06/24 with a handwritten label "12N" with instructions to take four times a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/10/24 at 4:11pm revealed:
-The pharmacy received a prescription on 02/16/24 for Resident #4 for gabapentin 600mg one tablet three times a day.
-On 02/16/24, the pharmacy dispensed 83 gabapentin 600mg tablets.
-On 03/13/24, the pharmacy dispensed 90 gabapentin 600mg tablets.
-On 04/12/24, the pharmacy dispensed 90 gabapentin 600mg tablets.
-The pharmacy received a prescription on 05/06/24 for Resident #4 for gabapentin 600mg one tablet four times a day.
-On 05/06/24, the pharmacy dispensed 35 gabapentin 600mg tablets.
-On 05/14/24, the pharmacy dispensed 120 gabapentin 600mg tablets.
-On 06/12/24, the pharmacy dispensed 120 gabapentin 600mg tablets.

Interview with Resident #4 on 07/10/24 at 5:15pm revealed:
-He was ordered gabapentin to numb or eliminate neuropathy pain in his feet.
-The neuropathy was caused by poor control of his diabetes early in his life.
-Neuropathic pain in his feet made it difficult for him to walk.
-He currently received gabapentin three times a day.
-The gabapentin tablet was a large white tablet.

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-The gabapentin tablet was the same white tablet he had taken for the last "35 years."
-He did not receive gabapentin four times a day.

Interview with Resident #4's Primary Care Provider (PCP) on 07/11/24 at 11:10am revealed:
-Resident #4 was ordered gabapentin for neuropathy pain.
-If gabapentin was not being administered as ordered it could cause Resident #4 to have neuropathy pain.

2. Review of Resident #1's current FL2 dated 05/30/24 revealed diagnoses included dementia, congestive heart failure, polyneuropathy, and dysphagia.

a. Review of Resident #1's emergency department (ED) discharge summary dated 06/28/24 revealed:
-The resident was seen for the complaint of ear pain.
-There was an order for Augmentin (used to treat infection) 875mg-125mg one tablet every 12 hours for seven days to treat left sided ear infection.

Review of Resident #1's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Augmentin 875mg-125mg one tablet every 12 hours for 7 days scheduled at 8:00am and 8:00pm.
-The Augmentin was documented as administered as ordered from 06/28/24 8:00pm to 06/30/24 8:00pm.

Review of Resident #1's July 2024 eMAR revealed:
-There was an entry for Augmentin

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875mg-125mg one tablet every 12 hours for 7 days scheduled at 8:00am and 8:00pm from 07/01/24-07/05/24 at 8:00am.
-The Augmentin was documented as administered as ordered from 07/01/24-07/05/24 at 8:00am.

Observation of Resident #1's medications on hand on 07/09/24 at 2:45pm revealed:
-There was one bubble pack of 14 Augmentin 875mg-125mg tablets dispensed on 06/28/24.
-There were three Augmentin 875mg-125mg tablets in the bubble pack.

Review of Resident #1's ED discharge summary dated 07/07/24 revealed:
-The resident was seen for the complaint of ear pain.
-A differnent antibiotic was prescribed twice daily for 10 days.
-A consult with a local ear, nose, and throat provider was recommended.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/24 at 4:18pm revealed:
-They received an order for Resident #1's Augmentin 875mg-125mg one tablet every 12 hours for 7 days in the evening on 06/28/24.
-Resident #1's Augmentin was dispensed and delivered to the facility on 06/28/24.
-The Augmentin should have been started at 8:00pm on 06/28/24 and ended on 07/05/24 in the morning.

Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 8:34am revealed:
-She did not know why there were three doses of Augmentin left over for Resident #1.
-The facility policy was to create a control sheet

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for antibiotics to help her to keep track of who did not correctly administer an antibiotic.
-The antibiotics were stored with the controlled substances in the medication cart.
-She was on leave for two weeks from 06/21/24-07/08/24 and a control sheet was not created for Resident #1's Augmentin.
-If she had worked, she would have checked for administration of the Augmentin daily.

Interview with the Administrator on 07/10/24 at 10:52am revealed:
-The RCC duties were his responsibility while the RCC was on leave from 06/21/24-07/08/24.
-He did not know why Resident #1's Augmentin was documented as administered and completed on the eMAR on 07/05/24, but three doses remained.
-The MAs were not double checking all the medications they checked on the eMAR were actually placed into the medication cup prior to administration to the resident.

Interview with Resident #1 on 07/11/24 at 10:45am revealed:
-She went to the ED on 06/28/24 due to both of her ears hurting.
-The ED prescribed her an oral antibiotic on 06/28/24 for an ear infection.
-She did not know if she received all of the antibiotic ordered on 06/28/24.
-On 07/07/24, she returned to the hospital because both of her ears still "really hurt."
-Her left ear was still infected behind her eardrum.
-The ear infection caused her equilibrium to be "off" when she walked.

Interview with Resident #1's Primary Care Provider (PCP) on 07/11/24 at 11:10am revealed:

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-She was not aware Resident #1 did not complete the Augmentin ordered on 06/28/24 at the local ED for an ear infection.
-She liked to see all doses of an antibiotic administered so the infection being treated can be "completely cleared."
-She did not think three missed doses of the Augmentin would have caused Resident #1 to need another round of antibiotics to clear the ear infection.

b. Review of Resident #1's current FL2 dated 05/30/24 revealed there was an order for oxycodone 10mg one tablet every six hours as needed for pain.

Review of Resident #1's Resident Register revealed an admission date of 04/15/24.

Interview with Resident #1 on 07/12/24 at 2:05pm revealed:
-The facility did not administer her oxycodone for one week after being admitted on 04/15/24.
-The facility staff told her they were waiting on the facility's contracted pharmacy to deliver the oxycodone to the facility.
-She brought all of her medications with her from the prior skilled nursing facility where she lived.
-The staff told her they could not give her any of those medications from the prior facility, but had to get with a physician to get new prescriptions.
-The staff told her they could not administer any medications which did not come from their contracted pharmacy.
-She was prescribed oxycodone for pain in her back and legs.
-Her pain was very "bad" during the week without her medication.
-She was unable to sleep or eat due to pain.
-She did not want to be with anybody because of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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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the pain.

Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for oxycodone 10mg one tablet every six hours as needed for pain.
-There were 12 occurrences of documented administrations of oxycodone 10mg from 04/24/24-04/30/24.

Review of Resident #1's Controlled Substance Count Sheet (CSCS) for oxycodone 10mg tablets dispensed on 03/28/24 quantity of 30 revealed:
-Administration dates on the CSCS included 04/02/24 to 04/17/24 (prior facility documented administrations were 04/02/24 to 04/15/24).
-There was a balance of three oxycodone 10mg tablets upon admission to the facility.
-On 04/16/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/17/24 at 12:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/17/24 at 6:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 2:24pm revealed:
-On Resident #1's CSCS sheet, there were three oxycodone 10mg tablets which were available from a prior supply upon admission.
-She signed out three doses of oxycodone 10mg for Resident #1 on 04/16/24 at 6:00pm, on 04/17/24 at 12:00am, and on 04/17/24 at 6:00am.
-Resident #1 "probably" came with "pills from the other facility" was why she signed the oxycodone out on the prior facility's CSCS sheet.

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-She did not know why she did not document the administrations on the eMAR.
-At the time, she did not know how to contact Resident #1's Primary Care Provider (PCP) through use of the telehealth application.
-She put Resident #1's name on a list to be seen by the PCP on the PCP's next scheduled visit to the facility which was 04/23/24.

Telephone interview with Resident #1's PCP on 07/15/24 at 2:31pm revealed:
-She was not Resident #1's PCP when the resident was admitted to the facility.
-Resident #1 was currently ordered oxycodone for lower back pain.
-The first time she was made aware Resident #1 needed a prescription for oxycodone was on 04/23/24.
-Resident #1 could experience pain, rebound effects, and possibly go through withdrawal symptoms with an abrupt stop of oxycodone.
-She wrote a new prescription for oxycodone for Resident #1 on 04/23/24 and referred her out to a pain clinic.

Interview with the Administrator on 07/12/24 at 3:24pm revealed:
-Oxycodone was a schedule II drug.
-Resident #1 had to be seen by her PCP to get a new prescription for the medication.

3. Review of Resident #2's FL-2 dated 05/30/24 revealed diagnoses included diabetes, hypertension, chronic obstructive pulmonary disease and obesity.

Interview with Resident #2 on 07/09/24 at 9:02am revealed:
-She was admitted to the hospital "last week."
-She was admitted because she had cramping in

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her right hand.
-She was "weak" and had a "bad heart."
-She did not know all the medications she took.

Review of Resident #2's hospital discharge orders dated 07/05/24 revealed:
-She was admitted to the hospital on 07/03/24 for heart and respiratory failure and acute kidney injury.
-Resident #2's discharge orders dated 07/05/24 included discontinuing lisinopril (used to treat high blood pressure) 20mg tablet daily.

Review of Resident #2's July 2024 eMAR revealed:
-There was an entry for lisinopril 20mg tablet daily at 8:00am.
-There was documentation lisinopril was administered daily from 07/06/24 through 07/09/24 at 8:00am.
-The order was still active on the eMAR on 07/09/24.

Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 9:29am revealed:
-The medication aide (MA) on shift when Resident #2 returned from the hospital was responsible for letting all administrative staff know about the discharge orders and sending the orders to the pharmacy.
-She was not the shift supervisor when Resident #2 returned from the hospital on 07/05/24.
-She was not aware of the discontinuation of Resident #2's lisinopril since she was not here when Resident #2 returned to the facility after her hospitalization.

Interview with Resident #2 on 07/10/24 at 11:50am revealed:
-She was still feeling weak since her return to the

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facility from the hospital last week.
-She felt like her blood pressure had been running low since she returned to the facility.
-When her blood pressure was low, she felt very fatigued and had a bad headache.
-She felt bad on 07/08/24 but was feeling some better.

Review of Resident #2's July 2024 eMAR revealed her blood pressure was 98/57 on 07/08/24.

Interview with the primary care provider (PCP) on 07/11/24 at 10:53am revealed:
-She had not been notified about the discharge order for Resident #2's lisinopril.
-She was not notified of Resident #2's blood pressure of 98/57 on 07/08/24.
-The blood pressure of 98/57 was a low reading for Resident #2.
-She wrote an order on 07/11/24 to discontinue the lisinopril.

Telephone interview with a MA Supervisor on 07/11/24 at 11:16am revealed:
-He was working when Resident #2 returned from the hospital on 07/05/24.
-There was a MA who was from a staffing agency that was responsible for Resident #2's orders when she returned from the hospital on 07/05/24.
-He placed the hospital discharge orders for Resident #2 on the RCC's desk on 07/05/24.
-He assumed the hospital faxed the hospital discharge orders for Resident #2 to the facility's contracted pharmacy.

Interviews with the Administrator on 07/10/24 at 10:51am and 07/12/24 at 3:23pm revealed:
-The MA who was responsible for Resident #2 when she returned from the hospital on 07/05/24

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D 358	Continued From page 43 should have faxed the hospital discharge orders directly to the pharmacy or gave the hospital discharge orders to the RCC to scan them to the pharmacy. -He was responsible to complete the RCC duties when she was absent from the facility. -The hospital discharge orders dated 07/05/24 for Resident #2 were not scanned to the pharmacy. -The MA on duty when Resident #2 returned to the facility should have faxed the hospital discharge orders directly to the pharmacy or given the orders to a supervisor to send to the pharmacy. The facility failed to ensure medications were administered as ordered for three sampled residents including a resident who was administered a medication to lower his blood pressure when his blood pressure was below the parameter established by the PCP (#4) and failed to administer a medication to raise the resident's blood pressure when the blood pressure was low (#4). The facility failed to administer pain medication to a resident for 7 days due to failure to obtain a prescription from the PCP putting the resident at risk for pain and rebound effects (#1). The facility failed to discontinue a blood pressure medication resulting in a resident feeling weak and having a headache due to low blood pressure (#2). These failures resulted in substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/24 for this violation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 44 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (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). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 6 sampled residents (#2) related to documentation of administration of insulin (an injectable medication used to help control blood sugar levels). The findings are: Review of Resident #2's current FL-2 dated 05/30/24 revealed diagnoses included diabetes and obesity. Review of Resident #2's physician's orders dated 05/30/24 revealed:	D 367		

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-An order for lispro (a short acting insulin) inject 8 units subcutaneous (sub-q) at breakfast.
-An order for lispro inject 12 units sub-q at lunch and dinner.
-An order for lispro inject sub-q as directed per sliding scale insulin (SSI) before meals and at bedtime for fingerstick blood sugars (FSBS): less than 100 hold insulin and initiate hypoglycemia protocol, less than 250 administer 0 units, 250 to 299 administer 4 units, 300-350 administer 6 units, greater than 350 administer 8 units, and greater than 500 notify physician.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for lispro (a short acting insulin) inject 8 units subcutaneous (sub-q) at breakfast
-There was an entry for lispro inject sub-q as directed per SSI before meals and at bedtime for fingerstick blood sugars (FSBS): less than 100 hold insulin and initiate hypoglycemia protocol, less than 250 administer 0 units, 250 to 299 administer 4 units, 300-350 administer 6 units, greater than 350 administer 8 units, and greater than 500 notify physician..
-There was an entry for lispro inject 12 units sub-q at lunch and dinner.
-There was documentation staff administered SSI lispro 8 units on 06/10/24 at 8:00am for blood glucose level of 129.
-There was documentation staff administered SSI lispro 18 units on 06/10/24 at 5:00pm for blood glucose level of 326.
-There was documentation staff administered SSI lispro 12 units on 06/11/24 at 12:00pm for blood glucose level of 208.
-There was documentation staff administered SSI lispro 12 units on 06/11/24 at 5:00pm for blood

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glucose level of 240.

Review of Resident #2's July 2024 eMAR revealed:
-There was an entry for lispro inject 12 units sub-q at lunch and dinner.
-There was an entry for lispro inject sub-q as directed per SSI before meals and at bedtime for fingerstick blood sugars (FSBS): less than 100 hold insulin and initiate hypoglycemia protocol, less than 250 administer 0 units, 250 to 299 administer 4 units, 300-350 administer 6 units, greater than 350 administer 8 units, and greater than 500 notify physician.
-There was an entry for lispro inject 8 units sub-q at breakfast.
-There was documentation staff administered SSI lispro 8 units on 07/08/24 at 8:00am for blood glucose level of 182.

Interview with a medication aide (MA) on 07/09/24 at 3:45pm revealed:
-She documented the SSI and the scheduled insulin together.
-She did not have training until sometime in June 2024 and did not realize this was an incorrect way to document.
-The SSI and scheduled insulin had been given correctly but documented incorrectly on two occasions on 06/10/24 and two occasions on 06/11/24.

Telephone interview with a second MA on 07/10/24 at 10:13am revealed:
-He did receive training related to not documenting the SSI and scheduled insulin together.
-He documented 8 units of SSI lispro was administered on 07/08/24 at 8:00am but that was incorrect.

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D 367	Continued From page 47 -The 8 units of lispro documented was for the scheduled morning dose of lispro. Interview with the Administrator on 07/10/24 at 10:51am and 07/12/24 at 3:23pm revealed: -All MAs received diabetic training on 06/02/24. -The training included information on documentation of insulin on the eMAR. -There was a new MA who had not yet received his training documented administering SSI lispro incorrectly. -The MAs should have accurately documented the correct doses given for SSI lispro on the eMAR and should have not documented the scheduled dose with it.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 2 of 3 sampled residents (Resident #1 and #6) related to a controlled substances for pain and headache (#1) and controlled substances for anxiety and pain (#6).	D 392		

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D 392	Continued From page 48 The findings are: Review of the facility's medication policy on controlled substances dated 06/21/23 revealed: -The record of documentation will be kept in the resident's record (example eMAR or controlled drug sign-out record). -Documentation of receipt of the controlled substance by the pharmacy will be maintained. 1. Review of Resident #1's current FL2 dated 05/30/24 revealed diagnoses included dementia, congestive heart failure, polyneuropathy, and dysphagia. Review of Resident #1's Resident Register revealed an admission date of 04/15/24. a. Review of Resident #1's current FL2 dated 05/30/24 revealed oxycodone 10mg one tablet every six hours as needed for pain. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 2:24pm revealed: -Resident #1 was admitted from another facility. -Resident #1 came with oxycodone from another facility. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/09/24 at 11:58am regarding Resident #1's oxycodone 10mg one tablet every six hours as needed revealed: -The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document the administration for inventory control. -On 04/23/24, oxycodone 10mg was dispensed for a quantity of 56 tablets. -On 05/20/24, oxycodone 10mg was dispensed	D 392		

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for a quantity of 28 tablets.
-On 06/03/24, oxycodone 10mg was dispensed for a quantity of 12 tablets.
-On 06/10/24, oxycodone 10mg was dispensed for a quantity of 40 tablets.
-On 06/27/24, oxycodone 10mg was dispensed for a quantity of 40 tablets.

Review of Resident #1's Controlled Substance Count Sheet (CSCS) for oxycodone 10mg tablets dispensed on 03/28/24 quantity of 30 revealed:
-Administration dates on the CSCS included 04/02/24 to 04/17/24 (prior facility documented administrations were 04/02/24 to 04/15/24).
-There was a balance of three oxycodone 10mg tablets upon admission to the facility on 04/15/24.
-On 04/16/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/17/24 at 12:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/17/24 at 6:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 04/23/24 quantity of 30 revealed:
-Administration dates on the CSCS included 04/23/24-05/06/24.
-On 04/23/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/24/24 at 8:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 04/24/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.

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D 392	Continued From page 50 -On 04/25/24 at 12:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/25/24 at 7:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/27/24 at 7:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/28/24 at 12:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/28/24 at 2:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/29/24 at 8:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/30/24 at 6:31pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/31/24 at 12:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/02/24 at 3:31am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/04/24 at 9:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/05/24 at 6:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. Review of the pharmacy delivery sheet for Resident #1's oxycodone 10mg tablets quantity 56 dated 04/23/24 revealed there was no documented signature of facility staff who received the medication from the pharmacy.	D 392		

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D 392	Continued From page 51 Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every six hours as needed for pain. -There were 12 occurrences of documented administrations of oxycodone 10mg from 04/24/24-04/30/24. Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 04/23/24 quantity of 26 revealed: -Administration dates on the CSCS included 05/06/24-05/17/24. -On 05/06/24 at 6:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/07/24 at 8:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/07/24 at 4:21 (no specific time of day), a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/07/24 (no specific time of day), a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/08/24 at 9:23 (no specific time of day), a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/14/24 at 12:09 (no specific time of day), a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/16/24 at 10:45pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. Review of the pharmacy delivery sheet for Resident #1's oxycodone 10mg tablets quantity 28 dated 05/20/24 revealed the medication was received by facility staff at 7:00pm.	D 392		

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D 392	Continued From page 52 Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 05/20/24 quantity of 28 revealed: -There were two CSCS for the 28 oxycodone. -One CSCS had a pharmacy label and there was one administration date of 05/21/24 at 2:47am leaving a count of 27 tablets. -All of the information provided on the second CSCS label was handwritten and the starting count was 18 tablets. -Administration dates on the second CSCS included 05/22/24-05/29/24. -On 05/29/24, a dose was signed out on the CSCS (no documented time), documented on the eMAR as 4:35pm. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for oxycodone 10mg one tablet every six hours as needed for pain. -There were 50 occurrences of documented administrations of oxycodone 10mg from 05/01/24-05/31/24. Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 06/03/24 quantity of 12 revealed: -Administration dates on the CSCS included 06/03/24-06/09/24. -On 06/03/24 at 8:30pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 06/04/24 at 3:36 (no specific time) a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 06/04/24 at 4:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 06/04/24 at 1:00am, a dose was signed out	D 392		

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on the CSCS but not documented as administered on the eMAR.
-On 06/07/24 at 7:30pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/09/24 at 2:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed on 06/10/24 quantity of 40 revealed:
-Administration dates on the CSCS included 06/10/24-06/29/24.
-On 06/12/24 at 1:30am, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of the pharmacy delivery sheet for Resident #1's oxycodone 10mg tablets quantity 12 dated 06/03/24 revealed there was no documented signature of the facility staff who received the medication from the pharmacy.

Review of Resident #1's June 2024 eMAR revealed:
-There was an entry for oxycodone 10mg one tablet every six hours as needed for pain.
-There were 50 occurrences of documented administrations of oxycodone 10mg from 06/04/24-06/30/24.

Review of the pharmacy delivery sheet for Resident #1's oxycodone 10mg tablets dispensed on 06/27/24 quantity of 40 revealed there was not documented signature of the facility staff who received the medication from the pharmacy.

Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed 06/27/24 quantity of 20

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revealed administration dates on the CSCS included 06/29/24-07/07/24.

Review of Resident #1's CSCS for oxycodone 10mg tablets dispensed 06/27/24 quantity of 20 revealed one administration date of 07/08/24 at 3:05pm with a count of 19 remaining.

Review of Resident #1's July 2024 eMAR from 07/01/24 to 07/10/24 revealed:
-There was an entry for oxycodone 10mg one tablet every six hours as needed for pain.
-There were 18 occurrences of documented administrations of oxycodone 10mg.
-There was no documented administration of oxycodone on 07/09/24 at 12:03am.

Observation of Resident #1's oxycodone 10mg tablets on 07/09/24 at 2:45pm revealed there were 18 tablets available.

Interview with Resident #1 on 07/09/24 at 3:28pm revealed she received one tablet of oxycodone 10mg around midnight on 07/08/24.

Interview with the Administrator on 07/12/24 at 3:45pm revealed:
-There were nine oxycodone 10mg tablets that went missing from Resident #1's 05/20/24 delivery of 28 tablets.
-A MA reported the missing oxycodone tablets to the RCC and the Administrator.
-He notified the pharmacy about the missing oxycodone.
-On 06/12/24, the pharmacy performed an audit of all the residents controlled substances and did not find any discrepancies.

Refer to the interview with a medication aide (MA) on 07/09/24 at 3:05pm.

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D 392	Continued From page 55 Refer to the interview with the RCC on 07/10/24 at 8:34am. Refer to the interview with the Administrator on 07/10/24 at 10:52am. Refer to the interview with the Administrator on 07/12/24 at 3:24pm. b. Review of Resident #1's current FL2 dated 05/30/24 revealed Fiorinal (used to treat headaches) 50-325-40mg one capsule every eight hours as needed for headaches/migraine. Telephone interview with the facility's contracted pharmacy on 07/09/24 at 2:10pm regarding Resident #1's Fiorinal 50-325-40mg one capsule every eight hours as needed revealed: -The pharmacy provided Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document the administration for inventory control. -On 04/16/24, Fiorinal was dispensed for a quantity of 12 capsules. -On 04/30/24, Fiorinal was dispensed for a quantity of 30 capsules. -On 05/14/24, Fiorinal was dispensed for a quantity of 30 capsules. -On 05/30/24, Fiorinal was dispensed for a quantity of 20 capsules. -On 05/31/24, Fiorinal was dispensed for a quantity of 10 capsules. -On 06/17/24, Fiorinal was dispensed for a quantity of 15 capsules. -On 06/25/24, Fiorinal was dispensed for a quantity of 15 capsules. -On 07/02/24, Fiorinal was dispensed for a quantity of 15 capsules.	D 392		

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D 392	Continued From page 56 Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 04/16/24 quantity of 12 revealed: -There was no documented signature of the facility staff who received the medication from the pharmacy. -The quantity of 12 was marked through in and "on order" was handwritten beside capsules. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 04/16/24 quantity of 12 revealed: -Administration dates on the CSCS included 04/22/24-04/30/24. -On 04/22/24 at 8:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/22/24 at 7:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/23/24 at 2:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/24/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 04/30/24 at 6:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Fiorinal take 1 capsule every eight hours as needed for headaches do not take within an hour of oxycodone. -There were 8 occurrences of documented administrations of Fiorinal from 04/23/24-04/27/24.	D 392		

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D 392	Continued From page 57 Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules revealed there was no CSCS for quantity 30 dispensed on 04/30/24. Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 05/14/24 quantity of 30 revealed there was no documented signature of the facility staff who received the medication from the pharmacy. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 05/14/24 quantity of 30 revealed: -Administration dates on the CSCS included 05/15/24-05/29/24. -On 05/19/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/20/24 at 1:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for Fiorinal one capsule every eight hours as needed for headaches. -There were 56 occurrences of documented administrations of Fiorinal from 05/01/24-05/31/24. Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 05/30/24 quantity of 20 revealed there was no documented signature of the facility staff who received the medication from the pharmacy. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 05/30/24 quantity of 20 revealed: -Administration dates on the CSCS included	D 392		

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05/30/24-06/19/24.
-On 06/01/24 at 6:30 (no specific time), a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/01/24 at 1:20pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/02/24 at 2:00 (no specific time) and no name of staff, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/03/24 at 2:30am, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/03/24 at 3:36 (no specific time), a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/04/24 at 6:30am, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 06/19/24 at 3:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 05/31/24 quantity of 10 revealed:
-Administration dates on the CSCS included 06/12/24-06/19/24.
-On 06/12/24 at 6:00 (no specific time), a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 06/17/24 quantity of 15 revealed:
-Administration dates on the CSCS included 06/18/24-06/24/24.
-On 06/24/24 at 12:30am, a dose was signed out on the CSCS but not documented as

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D 392	Continued From page 59 administered on the eMAR. Review of the pharmacy delivery sheet for Resident #1's Fiorinal capsules dispensed on 06/25/24 quantity of 15 revealed there was no documented signature of the facility staff who received the medication from the pharmacy. Review of Resident #1's June 2024 eMAR revealed: -There was an entry for Fiorinal one capsule every eight hours as needed for headaches. -There were 46 occurrences of documented administrations of Fiorinal from 06/01/24-06/30/24. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 06/25/24 quantity of 15 revealed administration dates on the CSCS included 06/25/24-07/02/24. Review of Resident #1's CSCS for Fiorinal 50-325-40mg capsules dispensed on 07/02/24 quantity of 15 revealed: -Administration dates on the CSCS included 07/03/24-07/08/24. -The last documented administration date was 07/08/24 at 12:43pm with a count of two remaining. Review of Resident #1's July 2024 eMAR revealed: -There was an entry for Fiorinal one capsule every eight hours as needed for headaches. -There were 18 occurrences of documented administrations of Fiorinal from 07/01/24-07/07/24. Observation of Resident #1's Fiorinal 50-325-40mg capsules on 07/09/24 at 2:45pm	D 392		

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D 392	Continued From page 60 revealed there was one capsule available. Interview with Resident #1 on 07/09/24 at 3:28pm revealed she received one tablet of Fiorinal around midnight on 07/08/24. Refer to the interview with a MA on 07/09/24 at 3:05pm. Refer to the interview with the Resident Care Coordinator (RCC) on 07/10/24 at 8:34am. Refer to the interview with the Administrator on 07/10/24 at 10:52am. Refer to the interview with the Administrator on 07/12/24 at 3:24pm. 2. Review of Resident #6's current FL2 dated 04/24/24 revealed diagnoses included Alzheimer's disease, dementia with mood disturbance, benign prostatic hyperplasia, and chronic conjunctivitis. a. Review of Resident #6's current FL2 revealed lorazepam (used to treat anxiety) 1mg one tablet every four hours as needed for agitation. Review of Resident #6's CSCS for lorazepam 1mg tablets dispensed on 03/25/24 quantity of 20 revealed: -Administration dates on the CSCS included 04/07/24-07/02/24. -On 04/07/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 05/03/24 at 8:00am, a dose was signed out on the CSCS but not documented as administered on the eMAR. -The documented count on the CSCS was 16.	D 392		

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D 392	Continued From page 61 Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg take one tablet every four hours as needed for agitation/anxiety. -Lorazepam 1mg was documented as administered 0 occurrences on the eMAR from 04/01/24-04/30/24. Review of Resident #6's May 2024 eMAR revealed: -There was an entry for lorazepam 1mg take one tablet every four hours as needed for agitation/anxiety. -Lorazepam 1mg was documented as administered 1 occurrence on the eMAR from 05/01/24-05/31/24. Review of Resident #6's June 2024 eMAR revealed: -There was an entry for lorazepam 1mg take one tablet every four hours as needed for agitation/anxiety. -Lorazepam 1mg was documented as administered 0 occurrences on the eMAR from 06/01/24-06/30/24. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for lorazepam 1mg take one tablet every four hours as needed for agitation/anxiety. -Lorazepam 1mg was documented as administered 1 occurrence on the eMAR from 07/01/24-07/11/24. Observation of Resident #6's lorazepam 1mg tablets on 07/11/24 at 3:09pm revealed there	D 392		

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D 392	Continued From page 62 were 16 tablets. Interview with a medication aide (MA) on 07/11/24 at 10:04am revealed: -When administering a controlled substance, she would reference the eMAR to prepare the medication. -She would then document the CSCS with her name, the date and time she was signing the medication out, the number given, and documented the current count. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 2:24pm revealed: -The MA who signed out the lorazepam dose on the CSCS on 05/03/24 no longer worked at the facility. -The facility had two pharmacy reviews and two pharmacy cart audits in the last 30 days. -These issues had not been brought to their attention. Refer to the interview with the Administrator on 07/12/24 at 3:24pm. b. Review of Resident #6's current FL2 revealed morphine 100mg/5ml 0.25ml (5mg) every four hours as needed (used to treat pain). Review of Resident #6's CSCS for morphine 100mg/5ml 20mg/ml dispensed 03/25/24 quantity of 30ml revealed: -Administration dates on the CSCS included 04/04/24-07/08/24. -On 04/07/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR. -On 07/08/24 at 1:15am, a dose was signed out on the CSCS but not documented as administered on the eMAR.	D 392		

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D 392	Continued From page 63 Review of Resident #6's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for morphine 100mg/5ml 0.25ml (5mg) every four hours as needed. -Morphine 5mg was documented as administered 1 occurrence on the eMAR from 04/01/24-04/30/24. Review of Resident #6's May 2024 eMAR revealed: -There was an entry for morphine 100mg/5ml 0.25ml (5mg) every four hours as needed. -Morphine 5mg was documented as administered 3 occurrences on the eMAR from 05/01/24-05/31/24. Review of Resident #6's June 2024 eMAR revealed: -There was an entry for morphine 100mg/5ml 0.25ml (5mg) every four hours as needed. -Morphine 5mg was documented as administered 0 occurrences on the eMAR from 06/01/24-06/30/24. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for morphine 100mg/5ml 0.25ml (5mg) every four hours as needed. -Morphine 5mg was documented as administered 3 occurrences on the eMAR from 07/01/24-07/11/24. Interview with Resident #6 on 07/11/24 at 2:55pm revealed the resident denied having any pain at that time. Interview with a medication aide (MA) on 07/11/24 at 10:04am revealed:	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

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D 392	Continued From page 64 -When administering a controlled substance, she would reference the eMAR to prepare the medication. -She would then document the CSCS with her name, the date and time she was signing the medication out, the number given, and documented the current count. Refer to the interview with the Administrator on 07/12/24 at 3:24pm. _____ Interview with the medication aide (MA) on 07/09/24 at 3:05pm revealed: -On 07/09/24 at 8:00am, she accepted the keys and responsibility of the medication cart where Resident #1's medications were stored. -She and the night shift (8:00pm to 8:00am) MA did not count the controlled substances together and confirm matching counts on the CSCS's before she took possession of the medication cart keys that morning. -The night shift MA refused to count the cart with her because the night shift MA said she was not signed off yet as a MA. -She did not know why the night shift MA had the keys to the medication cart in her possession. -The night shift MA told her she did not pass any medications on night shift. Interview with the RCC on 07/10/24 at 8:34am revealed: -The night shift MA on 07/09/24 worked 8:00pm-8:00am. -The night shift MA called her during the night on 07/08/24 and explained that her login credentials to the eMAR were not working. -The night shift MA did not figure out her eMAR credentials were not working until she had already "popped" Resident #1's as needed pain medications into a medication cup.	D 392		

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D 392	Continued From page 65 -She told the MA to have Resident #1 confirm the administration of the dose of pain medications. -She told the MA not to administer any additional as needed medications and she would figure it out the following morning (07/09/24) when she arrived to work. -She had written up both the night shift MA and the day shift MA up for not counting the controlled substances prior to transfer of keys. -The night shift MA's 60 days to be able to pass medications ended on 07/10/24. Interview with the Administration on 07/10/24 at 10:52am revealed the MAs had all received training to count the controlled substances and verify the controlled substance counts at shift change with the oncoming staff. Interview with the Administrator on 07/12/24 at 3:24pm revealed: -The MAs documentation on the CSCS sheets did not violate facility policy. -The facility policy stated controlled substances could be documented on the CSCS sheet or the eMAR. _____ The facility failed to accurately document and reconcile controlled substances resulting in a total of 12 missing oxycodone tablets (Resident #1). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/24 for this violation. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 26, 2024.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 613	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 4 sampled staff (Staff F) within 30 days of hire. The findings are: Review of Staff F's file revealed: -There was no documentation of a hire date. -She was hired as the On-Call Supervisor for the facility. -There was no documentation a mandatory annual state approved infection control training was completed within 30 days of hire. Interview with Staff F on 07/12/24 at 10:16am revealed: -She started working at the facility in September or October of 2023.	D 613		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

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D 613	Continued From page 67 -She was hired to fill in as the On-Call Supervisor when needed at night. -She did not remember completing infection control training within 30 days of hire with the previous Executive Director (ED). Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 9:25am revealed: -She was unsure why they did not have infection control training on file for the Staff F. -Staff F was already working when the RCC came to the facility. -She never thought about checking to see if Staff F had infection control training on file. -She was still in training and would not have known what to look for with Staff F because she was a registered nurse (RN). -The ED at the time Staff F was hired would have been responsible for making sure paperwork was completed. Interview with Administrator on 07/12/24 at 10:54am and 3:34pm revealed: -His expectation was the infection control training should be completed within 30 days of hire. -He was not sure why Staff F did not have infection control training on file. -He thought Staff F was hired before he came to the facility. -He came to the facility in July 2023 and the contract was signed by Staff F on 09/15/23. -They did not keep a personnel file on Staff F because she was "on call" and did not work on a shift. -It would have been the responsibility of the Administrator to ensure infection control trainings were completed within 30 days of hire.	D 613		