STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL042005	A. BUILDING: _____ B. WING _____	R 08/08/2024

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CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up survey on 08/06/24 to 08/08/24 with an exit conference via telephone on 08/08/24.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure a sounding device was activated when 3 of 8 exit doors were opened to ensure the safety of residents who were identified as disoriented including a resident (#2) that exited the facility and fell. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 40 for assisted living (AL).	D 067		

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D 067	Continued From page 1 Review of the facility's census report dated 08/06/24 revealed there were 37 residents residing in the facility. Review of the facility's undated Wandering Resident Policy revealed: -The facility was not a locked door facility and did not admit any resident with a wandering diagnosis. -If a diagnosis is made after admission, the resident would be discharged immediately to a more appropriate facility. -All potential admissions were made aware that the facility was not a "secure facility". -A resident may leave the facilty and it could be up to 2 hours before staff were aware. Review of a second Wandering Resident Policy dated 02/16/99 revealed: -The purpose of the policy was to outline reasonable actions to be taken to assure residents with a history or medical diagnosis of wandering, disoriented or diagnosed with Alzheimer's disease were routinely observed for their safety an well being. -All exit doors were equipped with a sounding device that would activated when the door was opened. -All exit alarms were on 24 hours a day; there was a hand-written addendum that was not dated that read, " Front door alarm is on only from 11:00pm until 6:00am." Review of a typed document with the heading "Residents That May Be Disoriented: revealed: -There were 25 resident names listed on the paper. -There were 25 face sheets that included diagnoses and a picture for each of the residents	D 067		

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D 067	Continued From page 2 listed on the typed document. Observation of an exit door on 08/06/24 at 9:19am revealed: -The door was located at the end of the hall at the far end of the left side of the facility. -It was unlocked and there was no audible alarm when the door was opened. -There were no staff monitoring the door. -There was a red box labeled "STOP - ALARM WILL SOUND" at the top right side of the door. -The key turn switch was turned to the off position. Review of Resident #2's current FL-2 dated 08/16/23 revealed: -Diagnoses included Alzheimer's disease with agitation, hypertension and arthropathy. -She was constantly disoriented. -She was semi-ambulatory. Review of Resident #2's Resident Register revealed: -She was admitted to the facility on 08/07/23. -She had significant memory loss and needed direction. -She required assistance from staff for orientation to time and place. Review of Resident #2's assessment and care plan dated 08/12/23 revealed: -There was documentation she was oriented. -There was documentation she was forgetful and needed reminders. -She required supervision from staff with eating, ambulation and transfer. -She required limited assistance from staff with bathing, dressing and grooming. Review of Resident #2 Accident and Incident	D 067		

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D 067	Continued From page 3 Report dated 07/28/24 revealed: -Staff reported to the medication aide (MA) at 6:15pm that "a lady" was on the ground. -She found Resident #2 and was "in shock because she was bleeding so bad". Review of Resident #2's history and physical from a local hospital date 07/27/24 revealed: -Resident #2 presented to the hospital with end stage dementia following a fall with facial trauma. -Staff reported she was assisting the resident with a bath and left the patient to answer a phone call. -Resident #2 wandered outside and had apparently fallen as she was found lying on the ground face forward. -There were fractures of the bilateral nasal bones and fracture of the nasal septum. Interview with a resident on 08/06/24 at 9:22am revealed: -Another resident went out of the front door on C-hall the previous week. -The resident that went out of the door fell and was sent to the hospital. -There was no door alarm on when the resident went out. -The front door was not alarmed during the day. Interview with Resident #2's hospice nurse on 08/07/24 at 12:31pm revealed Resident #2 was oriented to self, walked independently at times and was able to follow directions. Interview with the facility Manager on 08/06/24 at 3:23pm revealed: -The front exit door alarms were turned off from 8:00am to 9:00pm each day. -A resident went out the front exit door, fell and broke her nose recently but she did not recall the date.	D 067		

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D 067	Continued From page 4 Based on observations, and staff interviews, it was determined that Resident #2 was not interviewable. Interview with the personal care aide (PCA) on 08/06/24 at 9:21am revealed the door should have been alarmed and she did not know why it was off. Interview with the facility Manager on 08/06/24 at 3:23pm revealed: -The front exit door alarms were turned off from 8:00am to 9:00pm each day. -Staff were not assigned to monitor the door while the alarm was turned off and there was no way to know when someone entered or exited the door. Second interview with the Facility Manager on 08/07/24 at 2:47pm revealed: -There were no residents in the facility with exit seeking behaviors but many were documented as disoriented. -The exit doors at the ends of each hall should always be alarmed and she did not know why it was not alarmed. Interview with the Administrator on 08/07/24 at 2:47pm revealed: -The exit doors at the ends of each hall should always be alarmed. -The two main doors (main front door and main entrance door on the left end of the facility) were not alarmed during the day because they were used so frequently and required staff to insert a key to silence the alarm each time. -Staff would be busy all day just with alarms. -Many residents in the facility were documented as disoriented because of their diagnoses but that did not mean they had wandering behaviors.	D 067		

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D 067	Continued From page 5 The facility failed to ensure the sounding device was activated on the all exit doors to the facility with residents that resided in the facility with diagnoses including dementia and documented constantly disoriented having potential access to an unlocked and unmonitored exit door without a device to alert staff when the door was opened including a resident (#2) that wandered outside the facility, fell and sustained fractures to her nose including fractures of the bilateral nasal bones and fracture of the nasal septum. This failure resulted in substantial risk for serious harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 08/07/24. THE PLAN OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED September 7, 2024.	D 067		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 113		

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D 113	Continued From page 6	D 113		

reviews the facility failed to ensure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 8 of 12 fixtures in the common residents' bathroom and shared residents' bathrooms with temperatures ranging from 118° degrees F to 123.1° degrees F.

The findings are:

Observation of men's shower/bathroom on 08/06/24 at 9:35am revealed:
-The hot water temperature of the 1st shower was 120.0°F.
-The hot water temperature of the 2nd sink was 123.1°F.

Observation of women's shower/bathroom on 08/06/24 at 9:39am revealed the hot water temperature of the 2nd sink was 122.7°F.

Observation of the shared bathroom sink for rooms 104 & 106 on 08/06/24 at 9:51am revealed the hot water temperature was 123.1°F.

Interview with a resident in room 104 on 08/06/24 at 9:53am revealed:
-The water was always too hot.
-He added cold water to bring the temperature down.
-He had not reported the issue to staff.

Observation of the shared bathroom for rooms 105 & 107 on 08/06/24 at 10:09am revealed the hot water temperature was 118.2°F.

Interview with a second resident 107 on 08/06/24 at 10:12am revealed:
-Sometimes the water was too hot.
-He has snatched his hand back from the water when trying to feel how hot the water was.

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D 113	Continued From page 7 -He did not inform staff about the water being hot. Interview with a third resident on 08/06/24 at 10:20am revealed: -The water was too hot. -When trying to feel the hotness of the water her hand has turned red but has not caused a burn or blistering. -She reported the water being too hot to a medication aide (MA). -The MA had the personal care aide (PCA) to check the water temperature. -The PCA did not use a thermometer but used her hand to feel if the water was too hot. Interview with the facility's contracted plumber on 08/06/24 at 2:59pm revealed: -The showers have a scalding valve that keeps the water too hot. -Scalding valves cannot be placed on the sink faucets. -He checked the hot water temperature when he was called for services. -He adjusted the hot water heater temperature. -The facility had one hot water heater for the entire building. Interview with the maintenance staff on 08/06/24 at 11:29am revealed: -The residents or staff had not complained to him about the hot water being too hot. -He did not complete hot water temperature checks. -He did not have access to adjust the hot water temperature. -The facility's contracted plumber completed hot water temperature checks. -He did not know when the plumber last checked the hot water temperature.	D 113		

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D 113	Continued From page 8 Interview with the Facility Manager on 08/06/24 at 9:59am revealed: -Hot water adjustments were completed by the contracted plumber at least once a month. -The contracted plumber completed hot water temperature checks but had not provided copies of the hot water temperature checks. -The hot water temperatures were completed by the maintenance staff at least once monthly. -The health department completed hot water temperatures every three months and only their hot water temperature checks were documented. Observation of the water thermometers being calibrated on 08/06/24 at 2:59pm to 3:10pm revealed: -The contracted plumber and surveyor's water thermometers were placed in a cup of ice water. -Both water thermometers temperatures were calibrated at 32°F. Observation of the re-check of water temperatures with the contracted plumber and surveyor on 08/06/24 at 3:11pm revealed: -At 3:11pm, "Caution Hot Water" sign had been placed on the door of the residents' rooms 105 & 107. -At 3:11pm, the hot water temperature at the bathroom sink was at 112.4°F completed by the contracted plumber and at 112.1°F completed by the surveyor. Observation of the re-check of water temperatures with the contracted plumber on 08/06/24 at 3:13pm revealed: -At 3:13pm, "Caution Hot Water" sign had been placed on the door of the residents' rooms 104 & 106. -At 3:13pm, the hot water temperature at the bathroom sink was at 118.4°F completed by the	D 113		

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D 113	Continued From page 9 contracted plumber and at 118.2°F completed by the surveyor. Observation of the re-check of water temperatures with the contracted plumber on 08/06/24 at 3:18pm revealed: -At 3:18pm, "Caution Hot Water" sign had been placed on the door of the men's shower/bathroom door. -At 3:18pm, the hot water temperature at the 2nd sink was at 116.7°F completed by the contracted plumber and at 116.4°F completed by the Surveyor. -At 3:19pm, the hot water temperature at the 1st shower was at 112.2°F completed by the contracted plumber and was at 112.5°F completed at by the surveyor. Observation of the re-check of water temperatures with the contracted plumber on 08/06/24 at 3:23pm revealed: -At 3:23pm, "Caution Hot Water" sign had been placed on the door of the women's shower/bathroom door. -At 3:23pm, the hot water temperature at the 2nd sink was at 116.4°F completed by the contracted plumber and at 116.1°F completed by the surveyor. Interview with the Administrator on 08/06/24 at 1:01pm revealed: -She did not know if hot water temperature checks were being completed. -The hot water temperature checks were to be completed and documented. -It was the Facility Manager's decision on how many hot water temperatures to be checked. -She called the contracted plumber to come and complete hot water temperature checks. _____	D 113		

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D 113	Continued From page 10 The facility failed to ensure hot water temperatures were monitored and maintained between 100° to 116° degrees Fahrenheit (F) which resulted in resident complaints of the water being too hot with hot water temperatures readings of 118.2°degrees F to 123.1° degrees F at 5 of 12 fixtures accessible on Hall A. 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 08/06/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2024.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 medication aides (Staff B) who administer medications	D 125		

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D 125	Continued From page 11 completed the medication 15-hour training or employment verification. The findings are: Review of Staff B's, medication aide (MA), personnel record on 08/08/24 at 10:05am revealed: -Staff B was hired as a medication aide (MA) on 01/12/24. -There was documentation of Staff B passing the medication aide examination on 09/22/20. -There was no documentation that Staff B had completed the 5 hour, 10 hour or 15 hour medication training. -There was no documentation of employment verification for Staff B. Review of June 2024 electronic medication administration records (eMAR) revealed Staff B administered medications on 08/04/24, 08/09/24 08/15/24, 08/16/24, 08/23/24 and 08/24/24. Review of July 2024 eMAR revealed Staff B administered medications on 07/07/24, 07/08/24, 07/15/24, 07/22/24, 07/23/24, and 07/25/24. Attempted telephone interview with Staff B on 08/08/24 at 1:16pm was unsuccessful. Interview with the facility Manager on 08/07/24 at 3:38pm revealed: -Staff B did not have to complete the 15-hour medication training because had prior experience as a medication aide (MA). -She did not complete an employment verification for Staff B. -Staff B had completed the clinical medication skills checklist and had passed the medication examination,	D 125		

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D 125	Continued From page 12 -Staff B had been administering medication to residents. Interview with the Administrator on 08/08/24 at 5:38pm revealed she had been informed MAs with previous experience did not have to have the 15-hour medication training.	D 125		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure 1 of 5 sampled residents (#3) resident rights' were maintained related to a resident not receiving incontinent care. The findings are: Review of Resident #3's current FL2 dated 04/19/24 revealed: -Diagnoses included anxiety, cerebrovascular disease, depression, chronic obstructive pulmonary disease (COPD), edema, gastroesophageal reflux disease (GERD), headache/migraine and hyperlipidemia. -Resident #3 was incontinent in both bladder and bowel. Review of Resident #3's care plan dated 05/15/24 revealed Resident #3 needed limited assistance with toileting.	D 338		

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D 338	Continued From page 13 Interview with Resident #3 on 08/06/24 at 10:20am revealed: -She had asked for toileting assistance from a medication aide (MA) on the morning of 07/30/24 when the MA had come into her room letting her know breakfast was being served. -The MA refused to assistance Resident #3 with incontinent care. -The MA told Resident #3 to get up and go to the bathroom to clean up herself on her own. -Resident #3 informed the Resident Care Coordinator (RCC) of the MA refusing to help her with incontinent care. Telephone interview with the MA on 08/08/24 at 4:11pm revealed: -Resident #3 had yelled out for help from her room. -She yelled back to Resident #3 and informed her she was busy and asked her to wait for a few minutes. -The MA asked a personal care aide (PCA) to assist Resident #3, but they were assisting the other residents with breakfast. -The MA went to assist Resident #3 after she finished passing medication. -The MA learned when she went to assist Resident #3 that she needed assistance with incontinent care. -Resident #3 was in her bathroom toileting herself and informed her she no longer needed help, and the MA left Resident #3's room without trying to further assist Resident #3. -She did not return to Resident #3's room or send a PCA to check on Resident #3. -Resident #3 had a fall at least 6 months ago. -She did not know why Resident #3 had called out for help until she went to her room at least 3 to 4 minutes after giving medications to another resident.	D 338		

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	HAL042005	A. BUILDING: _____ B. WING _____	R 08/08/2024

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-Resident #3 had yelled out at least three times for help.
-She made a judgement call to have Resident #3 to wait until she finished passing medication to another resident.
-The RCC made her aware of Resident #3's concern but she could not remember the date
-The facility Manager had not addressed the issue with her until 08/08/24.
-The incident occurred either on 08/03/24 or 08/04/24.

Telephone interview with the RCC on 08/08/24 at 1:59pm revealed:
-Resident #3 informed her on 08/05/24 about the MA refusing to offer her incontinent care.
-The incident occurred over the end of 08/03/24 and 08/04/24.
-Resident #3 informed the RCC she asked the MA for assistance with toileting when the MA came into her room to inform her about breakfast.
-She addressed the incident with the MA who stated she had been passing out medication to another resident and did not stop to assist Resident #3.
-The MA asked Resident #3 to wait a minute and she would help her because she was passing out medications.
-The MA called for a PCA to assist Resident #3 but the PCAs on duty were assisting serving residents their breakfast meal.
-After the MA finished passing out medications, she went to Resident #3's room to assist her but Resident #3 declined her help and saw that Resident #3 was toileting on her own.
-If a MA could not assist a resident with toileting, they were to immediately request help from a PCA.
-If the PCA was assisting with serving a meal, the PCA or MA were to stop and assist the resident

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D 338	Continued From page 15 with toileting. -The RCC informed the Manager about the incident on 08/05/24. -She did not know if the Manager completed an investigation. Telephone interview with the Manager on 08/08/24 at 3:00pm revealed: -She had not been informed about the MA refusing to provide incontinent care to Resident #3. -The MAs or PCAs were to never refuse providing incontinent care to residents. -If a PCA could not assist residents with any form of personal care, the MAs were to assist.	D 338		
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 observations, record reviews, and interviews, the facility failed to clarify an order for 1 of 5 sampled resident for an order to have for chocolate milk.	D 344		

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D 344	Continued From page 16 The findings are: Review of Resident #3's current FL2 dated 04/19/24 revealed diagnoses included anxiety, cerebrovascular disease, depression, chronic obstructive pulmonary disease (COPD), edema, gastroesophageal reflux disease (GERD), headache/migraine and hyperlipidemia. Review of a written physician order dated 07/17/24 to allow Resident #3 to drink 1 cup of chocolate milk at bedtime. Observation of kitchen refrigerator on 08/06/24 at 10:34am revealed there was not any chocolate milk. Interview with Resident #3 on 08/07/24 at 4:22pm revealed: -She has not been receiving chocolate milk at night. -She only receives regular white milk for breakfast and lunch. -The chocolate milk helps with bowel movements because she has problems with constipation. -Her primary care provider (PCP) had prescribed her to have a cup of chocolate milk at night. Interview with the cook on 08/07/24 at 3:48pm revealed: -There was no chocolate milk on site. -She had not ordered any chocolate milk. Interview with Resident #3 PCP's Nurse on 08/07/24 at 3:13pm revealed: -Resident #3's order to have a cup of chocolate milk at night was written on 07/17/24. -Resident #3 had bowel movements at least 2 to 3 times weekly and her drinking chocolate milk	D 344		

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D 344	Continued From page 17 would help to regulate her bowel movements. Interview with a medication aide (MA) on 08/07/24 at 4:00pm revealed: -She had not given Resident #3 chocolate milk to drink at bedtime. -She did not know that Resident # had an order to drink 1 cup on chocolate milk at bedtime. Interview with the Resident Care Coordinator (RCC) on 08/07/24 at 4:30pm revealed: -When residents return from the PCP with a new order, she compared pending orders to the medication administration record (MAR). -She would contact the pharmacy and forward the new order to the pharmacy if the order was not on the MAR. -She was not aware of Resident #3 having an order to drink 1 cup of chocolate milk at bedtime. -She did not know why Resident #3 would have an order to drink the cup of chocolate at bedtime. Interview with the facility Manager on 08/07/24 at 3:13pm revealed: -She did not know that Resident #3 had an order to drink chocolate milk at night. -Resident #3 normally drinks white regular milk and the chocolate mighty shakes. -There was not any chocolate milk on site. -The RCC was responsible for ensuring all PCP orders were accurate and placed on the MAR.	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	D 358		

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D 358	Continued From page 18	D 358		

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:
Based on observations, interviews, and record reviews, the facility failed to ensure medications and treatments were administered as ordered to 2 of 5 sampled residents including a medication to treat pain (#4) and an order for milk to regulate bowel movements (#3).

The findings are:

Review of the facility's medication administration policy dated 10/29/04 revealed medication would be administered in accordance wit the prescribing practioner's orders.

1.Review of Resident #4's current FL-2 dated 03/21/24 revealed:
-Diagnoses included metabolic encephalopathy, osteoarthritis, osteoporosis and Reiter's disease. (Reiter's disease is a reactive arthritis that causes pain and swelling in joints that is triggered by infection in other parts of the body.)
-There was an order for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times daily. (hydrocodone-acetaminophen is a controlled substance that is used to treat moderate to severe pain.)

Review of Resident #4's physician's order dated 06/18/24 revealed hydrocodone-acetaminophen 7.5mg-325mg was to be administered three times each day as needed for pain.

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D 358	Continued From page 19 Review of Resident #4's electronic medication administration record (eMAR) for June 2024 revealed: -There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 06/01/24 through 06/30/24. Review of Resident #4's controlled substance log for June 2024 revealed: -There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was documentation hydrocodone-acetaminophen 7.5mg-325mg was administered each day at 8:00am, 2:00pm and at 8:00pm from 06/01/24 through 06/30/24. Review of Resident #4's eMAR for July 2024 revealed: -There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 07/01/24 through 07/31/24. Review of Resident #4's controlled substance log for July 2024 revealed: -There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was documentation hydrocodone-acetaminophen 7.5mg-325mg was	D 358		

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D 358	Continued From page 20 administered each day at 8:00am, 2:00pm and at 8:00pm from 07/01/24 through 07/31/24. Review of Resident #4's eMAR for August 2024 revealed: -There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 08/01/24 through 08/06/24. Review of Resident #4's controlled substance log for August 2024 revealed: -There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was documentation hydrocodone-acetaminophen 7.5mg-325mg was administered each day at 8:00am, 2:00pm and at 8:00pm from 08/06/24 at 2:00pm through 08/08/24 at 2:00pm. Observations of medications on hand for Resident #4 on 08/08/24 at 3:20pm revealed that was a dispensing card labeled a quantity of 84 tablets of hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain and dispensing date of 07/16/24. Telephone interview with a medication aide (MA) on 08/08/24 at 4:34pm revealed: -She administered Resident #4 hydrocodone-acetaminophen 7.5mg-325mg at 8:00am, 2:00pm and at 8:00pm and documented the administration on the controlled substance log.	D 358		

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D 358	Continued From page 21 -She did not know the medication was ordered to be administered as needed and was not scheduled. -She should have read the label on the medication and the order on the eMAR. Telephone interview with Resident #4's pharmacist on 08/08/24 at 4:02pm revealed: -Resident #4 was to be administered hydrocodone-acetaminophen 7.5mg-325mg was to be administered three times each day as needed for pain per physician's order dated 06/18/24. -There were 84 tablets dispensed on 06/18/24 and again on 07/16/24; This was a 28 day supply if Resident #4 received the medication three times each day. -There had been no hydrocodone-acetaminophen 7.5mg-325mg returned to the facility. Telephone interview with the facility Manager on 08/08/24 at 5:09pm revealed: -She was not aware the medication continued to be administered as scheduled for Resident #4. -Resident #4's hydrocodone-acetaminophen 7.5mg-325mg was once scheduled for 8:00am, 2:00pm and at 8:00pm. -The MAs were expected to read the instructions for administration on the eMAR prior to administering medications and she did not know why that was not being done. -MAs were trained to read all the instructions on the label during medication aide training, when completing the medication administration validation checklist upon hire and in annual medication administration trainings. Attempted telephone interview with Resident #4's physician on 08/08/24 at 1:10pm was unsuccessful.	D 358		

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D 358	Continued From page 22 2. Review of Resident #3's current FL2 dated 04/19/24 revealed diagnoses included anxiety, cerebrovascular disease, depression, chronic obstructive pulmonary disease (COPD), edema, gastroesophageal reflux disease (GERD), headache/migraine and hyperlipidemia. Review of a written physician order dated 07/17/24 to allow Resident #3 to drink 1 cup of chocolate milk at bedtime. Observation of kitchen refrigerator on 08/06/24 at 10:34am revealed there was not any chocolate milk. Interview with Resident #3 on 08/07/24 at 4:22pm revealed: -She has not been receiving chocolate milk at night. -She only receives regular white milk for breakfast and lunch. -The chocolate milk helps with bowel movements because she has problems with constipation. -Her primary care provider (PCP) had prescribed her to have a cup of chocolate milk at night. Interview with the cook on 08/07/24 at 3:48pm revealed: -There was no chocolate milk on site. -She had not ordered any chocolate milk. Interview with Resident #3 PCP's Nurse on 08/07/24 at 3:13pm revealed: -Resident #3's order to have a cup of chocolate milk at night was written on 07/17/24. -Resident #3 had bowel movements at least 2 to 3 times weekly and her drinking chocolate milk would help to regulate her bowel movements.	D 358		

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D 358	Continued From page 23 Interview with a medication aide (MA) on 08/07/24 at 4:00pm revealed: -She had not given Resident #3 chocolate milk to drink at bedtime. -She did not know that Resident # had an order to drink 1 cup on chocolate milk at bedtime. Interview with the Resident Care Coordinator (RCC) on 08/07/24 at 4:30pm revealed: -When residents return from the PCP with a new order, she compared pending orders to the medication administration record (MAR). -She would contact the pharmacy and forward the new order to the pharmacy if the order was not on the MAR. -She was not aware of Resident #3 having an order to drink 1 cup of chocolate milk at bedtime. -She did not know why Resident #3 would have an order to drink the cup of chocolate at bedtime. Interview with the facility Manager on 08/07/24 at 3:13pm revealed: -She did not know that Resident #3 had an order to drink chocolate milk at night. -Resident #3 normally drinks white regular milk and the chocolate mighty shakes. -There was not any chocolate milk on site. -The RCC was responsible for ensuring all PCP orders were accurate and placed on the MAR.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	D 366		

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medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews and record review the facility failed to ensure the medication aide (MA) observed administration of medications for 1 of 5 sampled resident (#1) related medications left at the bedside.

The findings are:

Review of the facility's undated medication self-administration policy revealed self-administration would be ordered by a physician or other legally authorized person to prescribe and kept in the resident's record.

Review of Resident #1's current FL-2 dated 01/11/24 revealed:
-Diagnoses included multiple myeloma, antineoplastic pancytopenia, neutropenia, hypertension, hypokalemia, hypomagnesemia, dysphagia and hyperlipidemia.
-She was constantly disoriented.
-There was an order for aspirin 81mg to be administered each day. (Aspirin is used to thin the blood and reduce the risk of heart attack an stroke.)
-There was an order for famotidine 20mg to be administered each day. (Famotidine is used to treat acid indigestion.)
-There was an order for magnesium oxide 400mg to be administered twice daily. (Magnesium Oxide is used to treat low magnesium levels in the blood.)
-There was an order for potassium chloride 20mEq to be administered each day. (Potassium

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chloride is used to treat low potassium levels in the blood.)

Review of Resident #1's physician's orders dated 06/20/24 revealed:
-Calcium citrate 250-25mg was to be administered each day. (Calcium citrate is used as a supplement to support bone health.)
-Vitamin D 2000 units was to be administered each day. (Vitamin D is used to treat low vitamin D levels in the blood.)

Review of Resident #1's physician's orders dated 07/18/24 revealed:
-Farxiga 10mg was to be administered each day. (Farxiga is used to treat heart failure.)
-Entresto 24 mg-26mg was to be administered twice daily. (Entresto is used to treat heart failure.)
-Spironolactone 25mg was to be administered each day. (Spironolactone is used to treat high blood pressure.)
-Bumex 1mg was to be administered each day. (Bumex is used to treat fluid retention and high blood pressure.)

Review of Resident #1's physician's orders dated 07/25/24 revealed metoprolol XL 25mg, one-half tablet was to be administered each day. (Metoprolol is used to treat high blood pressure.)

Review of Resident #1 electronic medication administration (eMAR) record for August 2024 revealed:
-There was an electronic entry for aspirin 81mg to be administered each day scheduled for 8:00am.
-There was documentation aspirin 81mg was administered on 08/06/24 at 8:00am.
-There was an electronic entry for bumex 1mg was to be administered each day and scheduled

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D 366	Continued From page 26 for 8:00am. -There was documentation bumex 1mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for calcium citrate 250-25mg was to be administered each day and scheduled for 8:00am. -There was documentation calcium citrate 250-25mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for Entresto 24 mg-26mg was to be administered twice daily and scheduled for 8:00am and 8:00pm. -There was documentation Entresto 24 mg-26mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for famotidine 20mg to be administered each day and scheduled for 8:00am. -There was documentation famotidine 20mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for Farxiga 10mg was to be administered each day and scheduled for 8:00am. -There was documentation Farxiga 10mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for magnesium oxide 400mg to be administered twice daily and scheduled for 8:00am and 8:00pm. -There was documentation magnesium oxide 400mg was administered on 08/06/24 at 8:00am. -There was an electronic entry for metoprolol XL 25mg, one-half tablet was to be administered each day and scheduled for 8:00am. -There was documentation metoprolol XL 25mg, one-half tablet was administered on 08/06/24 at 8:00am. -There was an electronic entry for potassium chloride 20mEq to be administered each day and scheduled for 8:00am. -There was documentation potassium chloride 20mEq was administered on 08/06/24 at 8:00am.	D 366		

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-There was an electronic entry for Spironolactone 25mg was to be administered each day and scheduled for 8:00am
-There was documentation Spironolactone 25mg was administered on 08/06/24 at 8:00am.
-There was an electronic entry for vitamin D 2000 units was to be administered each day and scheduled for 8:00am.
-There was documentation vitamin D 2000 units was administered on 08/06/24 at 8:00am.

Observation of Resident #1's bedroom on 08/06/24 at 9:22am revealed there were 11 medications in a paper medication cup on a tray table that was beside Resident #1.

Interview with Resident #1 on 08/06/24 at 9:22am revealed:
-The medication aide (MA) left the medications for her because she was slow taking her medications.
-She liked to take her time swallowing her medications; the potassium tablet was big and "sticky".
-The MA did not stay to ensure she took her medications but they knew she would take them.
-She was not sure what all the medications were because there were new medications that had been prescribed recently.
-She was forgetful sometimes but she always took her medications that were left for her each day.

Telephone interview with the Pharmacist for the facility's contracted pharmacy on 08/08/24 at 4:02pm revealed:
-Resident #1 would need an order from the physician for self-administration of medications for medications to be left at the bedside.
-The physician needed to be involved in

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determining if that was a safe practice for the resident.

Interview with the medication aide (MA) on 08/06/24 at 10:12am revealed:
-She left the medications with Resident #1 that morning because it took her a long time to take her medications.
-She would often go to the next room to administer medications to another resident and return to Resident #1's room to ensure she took her medications.
-She knew she should not leave medications in the room for a resident to take without an order from the provider.

Interview with the facility Manager on 08/06/24 at 11:50am revealed:
-Resident #1 did not have an order to self-administer her medications.
-Medications were not supposed to be left at the bedside but it took Resident #1 awhile to take her medications some days.
-She was aware of two incidence in which medications had been left at the bedside for Resident #1 to take at her leisure.
-She was not aware this was a common occurrence.

Telephone interview with the facility Manager on 08/08/24 at 5:09pm revealed:
-Resident #1 wanted her food and liked to talk a lot during the medication pass so it took her a long time to take medications.
-She had instructed the MA to go ahead and give medications to other residents but to check in to be sure she took her medication.
-She told the MA to be sure another resident did not go into Resident #1's room because she was concerned another resident could take the

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D 366	Continued From page 29 medication. Interview with the Administrator on 08/07/24 at 2:47pm revealed: -Medications should not be left at a resident's bedside without an order from the resident's physician. -She was not aware this was being done in the facility. Attempted telephone interview with Resident #1's physician on 08/08/24 at 11:24am was unsuccessful.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 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).	D 367		

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D 367	Continued From page 30 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#4). The findings are: Review of the facility's medication administration policy dated 10/29/04 revealed documentation would be provided for each dose of medication by the staff who administered medications to residents on the medication administration record (MAR). Review of Resident #4's current FL-2 dated 03/21/24 revealed: -Diagnoses included metabolic encephalopathy, osteoarthritis, osteoporosis and Reiter's disease. (Reiter's disease is a reactive arthritis that causes pain and swelling in joints that is triggered by infection in other parts of the body.) -There was an order for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times daily. (hydrocodone-acetaminophen is a controlled substance that is used to treat moderate to severe pain.) Review of Resident #4's physician's order dated 06/18/24 revealed hydrocodone-acetaminophen 7.5mg-325mg was to be administered three times each day as needed for pain. Review of Resident #4's electronic medication administration record (eMAR) for June 2024 revealed: -There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be	D 367		

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administered three times each day as needed for pain.
-There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 06/01/24 through 06/30/24.

Review of Resident #4's controlled substance log for June 2024 revealed:
-There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain.
-There was documentation hydrocodone-acetaminophen 7.5mg-325mg was administered each day at 8:00am, 2:00pm and at 8:00pm from 06/01/24 through 06/30/24.

Review of Resident #4's eMAR for July 2024 revealed:
-There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain.
-There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 07/01/24 through 07/31/24.

Review of Resident #4's controlled substance log for July 2024 revealed:
-There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain.
-There was documentation hydrocodone-acetaminophen 7.5mg-325mg was administered each day at 8:00am, 2:00pm and at 8:00pm from 07/01/24 through 07/31/24.

Review of Resident #4's eMAR for August 2024 revealed:

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D 367	Continued From page 32 -There was a computerized entry for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was no documentation hydrocodone-acetaminophen 7.5mg-325mg was administered from 08/01/24 through 08/06/24. Review of Resident #4's controlled substance log for August 2024 revealed: -There was a label for hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain. -There was documentation hydrocodone-acetaminophen 7.5mg-325mg was administered each day at 8:00am, 2:00pm and at 8:00pm from 08/06/24 at 2:00pm through 08/08/24 at 2:00pm. Observations of medications on hand for Resident #4 on 08/08/24 at 3:20pm revealed that was a dispensing card labeled a quantity of 84 tablets of hydrocodone-acetaminophen 7.5mg-325mg to be administered three times each day as needed for pain and dispensing date of 07/16/24. Telephone interview with a medication aide (MA) on 08/08/24 t 4:34pm revealed: -She administered Resident #4 hydrocodone-acetaminophen 7.5mg-325mg at 8:00am, 2:00pm and at 8:00pm and documented the administration on the controlled substance log. -She did not know why she did not document the administration on the eMAR. -Medications should be documented on the eMAR.	D 367		

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D 367	Continued From page 33 Telephone interview with Resident #4's pharmacist on 08/08/24 at 4:02pm revealed: -Resident #4 was to be administered hydrocodone-acetaminophen 7.5mg-325mg was to be administered three times each day as needed for pain. -There were 84 tablets dispensed on 06/18/24 and again on 07/16/24; This was a 28 day supply if Resident #4 received the medication three times each day. -There had been no hydrocodone-acetaminophen 7.5mg-325mg returned to the facility. -Medications needed to be documented on the eMAR so the physician would know what medications were administered and when. Telephone interview with the facility Manager on 08/08/24 at 5:09pm revealed: -Resident #4's hydrocodone-acetaminophen 7.5mg-325mg was once scheduled for 8:00am, 2:00pm and at 8:00pm but was changed to "PRN" (as needed) in June. -All medications that were administered, including medications that were ordered as needed, were supposed to be documented on the eMAR. Attempted telephone interview with Resident #4's physician on 08/08/24 at 1:10pm was unsuccessful.	D 367		