STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041012	A. BUILDING: ______ B. WING ______	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD ADULT CARE #1	2322 NEWTON STREET GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow up survey from 07/23/24-07/24/24.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the floors were in good repair related to broken tiles in the kitchen area and not having a smooth transition between two rooms with a 2-inch difference in the floor level of the two rooms, resulting in a resident falling. The findings are: Review of the Environmental Health Inspection report dated 09/23/23 revealed: -The demerit score was 11 with a status code of A. -The facility received a demerit for floors not being in good repair and kept clean. -There was documentation that floor tile cracking was observed in the kitchen. -Different levels of floor damage were observed throughout the facility. Observation of the tile floor in the kitchen/dining	C 074		

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C 074	Continued From page 1 room on 07/23/24 at various times between 7:45am-5:00pm revealed: -There were multiple tiles in the room that were cracked with small pieces of tile missing. -There was one tile underneath a resident's chair at the dining room table, where a 3 x 3-inch piece of tile was missing. -A tile in front of the kitchen cabinet was loose and when weight was applied to one side of the tile, the other side of the tile lifted off the floor. -There was a floor vent cover that was not flush with the floor in the walkway between the kitchen and the living room. -There was a floor vent cover at the end of the table in the kitchen that was rusted and had broken tiles were observed around the vent cover. Observation of the doorway between the kitchen and another room on 07/23/24 at various times between 7:45am-5:00pm revealed: -Residents were observed going from the kitchen into the adjoining room to go down the hallway to the laundry room. -Residents were observed carrying baskets of laundry from the adjoining room through the kitchen to their rooms. -Residents were observed stepping from the kitchen into the adjoining room to be administered their medications. -There was a 2-inch step up from the adjoining room into the kitchen. -There was a metal transition plate at the doorway, one end of the transition plate was raised off the floor one half an inch. -The height difference between the flooring of the kitchen and the adjoining room posed a trip hazard. Review of Resident #2's current FL-2 dated	C 074		

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C 074	Continued From page 2	C 074		

11/16/23 revealed:
-Diagnoses included hypertension and diabetes.
-Resident #2 required assistance with bathing, dressing, and feeding.
-The resident was incontinent of the bladder.

Review of Resident #2's care plan dated 11/16/23 revealed:
-There was documentation that Resident #2 required assistance with eating, toileting, ambulation, bathing, dressing, grooming, personal hygiene, and transferring.
-There was no documentation for the level of assistance needed.
-The care plan was signed by the Primary Care Provider (PCP) on 11/16/23.

Observation of Resident #2 on 07/23/24 at various times between 7:45am-3:50pm revealed:
-Resident #2 walked without assistance from room to room.
-Resident #2 could get up and down from a seated position without assistance.
-Resident #2 wore a soft brace on her left ankle; she wore a tennis shoe on top of the brace.

Interview with Resident #2 on 07/23/24 at 8:07am revealed:
-She did not require assistance with bathing, dressing, or toileting.
-She needed assistance putting her socks and shoes on because she could not bend over.
-She wore an ankle brace to keep her ankle from turning.

Observation of Resident #2 on 07/23/24 at 3:50pm revealed Resident #2 was lying on the kitchen floor complaining of knee pain.

Interview with the Supervisor-in-Charge (SIC) on

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C 074	Continued From page 3 07/23/24 at 4:20pm revealed: -She heard the table and chairs being moved and when she came into the room, she saw Resident #2 lying on the floor. -The facility's protocol was any resident who had a fall was to be sent to the hospital for an evaluation after a fall. Review of Resident #2's emergency medical services (EMS) report dated 07/23/24 revealed: -Resident #2 reported she had a mechanical fall after tripping over the door frame while walking into the kitchen. -Resident #2 reported soreness in her right knee. -Resident #2 was transported to a local hospital via EMS. Review of Resident #2's hospital discharge summary dated 07/23/24 revealed: -Resident #2 was seen for a fall. -Resident #2's x-rays were negative for any abnormality from the fall. -It was recommended Resident #2 take Tylenol (used to treat mild pain) if the resident developed pain from the fall. Interview with Resident #2 on 07/24/24 at 10:47am revealed: -She was coming back from putting her clothes in the washing machine on 07/23/24 when she tripped over "the metal thing in the floor at the doorway." -She went into the adjoining room "about every day." -Her leg was hurting some, but the staff at the hospital told her she would be sore. Interview with the SIC on 07/24/24 at 2:44pm revealed: -She reviewed the Environmental Health	C 074		

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C 074	Continued From page 4 Inspection dated 09/23/23 and repairs were made to the floors. -The thresholds had been fixed for a smoother transition. -She thought Resident #2 tripped over her own feet. -She thought when Resident #2 went through the door, the resident tripped over her feet and pushed the table and chairs over before falling. -She did not see Resident #2 fall. -She thought Resident #2 tripped over her feet because of where the resident was lying on the floor. Attempted telephone interview with Resident #2's primary care provider (PCP) on 07/24/24 at 10:11am was unsuccessful. Attempted telephone interviews with the Environmental Health Inspector on 07/24/24 at 2:59pm and 5:51pm was unsuccessful. ______________________ The facility failed to ensure floors were kept in good repair related to uneven floors between the kitchen and the adjoining room causing a trip hazard resulting in a resident (#2) tripping on the doorway, falling, and being transported to the local hospital with complaints of knee pain. The facility's failure resulted in 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 07/25/24 for this violation. THE CORRECTION DATE FOR THIS A2 VIOLATION SHALL NOT EXCEED AUGUST 23, 2024.	C 074		

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C 249	Continued From page 5	C 249		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 3 sampled residents (#1, #2) related to fingerstick blood sugar monitoring for a resident who had a diagnosis of diabetes (#1); and blood pressure checks for a resident who had a diagnosis of hypertension (#2). The findings are: The findings are: 1. Review of Resident #1's current FL-2 dated 01/20/24 revealed diagnoses of diabetes. Review of Resident #1's signed physician's orders dated 01/25/24 revealed an order for a finger stick blood sugar (FSBS) check once daily. Review of Resident #1's May 2024 medication administration record (MAR) revealed: -There was an entry to check FSBS once daily with a scheduled administration time of 8:00am. -There was documentation Resident #1's FSBS was checked daily at 8:00am from 05/01/24-05/31/24.	C 249		

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C 249	Continued From page 6 -The FSBS results were documented on 05/01/24-05/08/24, ranges were 102-122. -There were no FSBS results documented for 05/09/24-05/31/24. Review of Resident #1's June 2024 MAR revealed: -There was an entry to check FSBS once daily with a scheduled administration time of 8:00am. -There was documentation that Resident #1's FSBS was checked daily at 8:00am from 06/01/24-06/30/24. -The FSBS results were documented on 06/01/24-06/19/24, ranges were 88-120. -There were no FSBS results documented for 06/20/24-06/30/24. Review of Resident #1's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry to check FSBS once daily with a scheduled administration time of 8:00am. -There was documentation that Resident #1's FSBS was checked daily at 8:00am from 07/01/24-07/24/24. -There were no FSBS results documented for 07/01/24-07/24/24. Observation of the Supervisor-in-Charge (SIC) during the morning medication pass on 07/23/24 at 9:43am revealed: -The SIC gathered supplies for a FSBS check. -The SIC checked Resident #1's FSBS with a reading of 121. Observation of Resident #1's glucometer on 07/24/24 at 11:02am revealed: -When the glucometer was turned on the display had a date of 12/01 and a time of 1:24pm. -The first FSBS displayed was a reading of 121 on 11/30 at 11:46am.	C 249		

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C 249	Continued From page 7 -There were no other FSBS readings for the month of November (which would have been July). -There next FSBS reading was dated 10/25 at 9:40am with a reading of 141. -The next FSBS readings were dated 10/07, 10/04-10/01. -There next 3 FSBS readings were dated 09/16 and two on 09/17. Interview with Resident #1 on 07/24/24 at 8:15am revealed: -His FSBS was checked once a week. -The SIC checked his FSBS yesterday, 07/23/24, and he thought his FSBS was 121. -His FSBS was not checked every day. Interview with the SIC on 07/24/24 at 11:08am revealed: -There was an order to check Resident #1's FSBS daily. -She checked Resident #1's FSBS daily. -She usually wrote down Resident #1's FSBS readings. -After showing the glucometer to the SIC she stated she did not have a specific reason why she did not check Resident #1's FSBS daily as ordered. -Sometimes she was in a rush to get out of the facility. -She checked Resident #1's FSBS 3-4 times per week. -Resident #1's FSBS never ran low and the highest she recalled the resident's FSBS being was 170-175. Attempted telephone interview with Resident #1's PCP on 07/24/24 at 10:13am was unsuccessful. Attempted telephone interview with the	C 249		

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C 249	Continued From page 8	C 249		

Administrator on 07/24/24 at 3:02pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 11/16/23 revealed:
-Diagnoses included hypertension.
-There was an order to check the resident's blood pressure (BP) daily.

Review of Resident #2's signed physician's orders dated 11/16/23 revealed an order to check the resident's BP daily and if the resident's BP was greater than 170-11 to go to the hospital and if less than 100/60 to call the primary care provider (PCP).

Review of Resident #2's May 2024 medication administration records (MAR) revealed:
-There was an entry order to check the resident's BP daily and if the resident's BP was greater than 170-11 to go to the hospital and if less than 100/60 to call the primary care provider (PCP).
-There was documentation Resident #2's BP was checked on 05/01/24-05/17/24 and 05/21/24-05/25/24; the ranges were 119/71-130/75.
-There was no documentation Resident #2's BP was checked on 9 of 31 days.

Review of Resident #2's June 2024 MAR revealed no documentation that the resident's BP had been checked.

Review of Resident #2's July 2024 MAR from 07/10/24-07/24/24 revealed the resident's BP was checked on 07/01/24 and 07/02/24; there was no other documentation the resident's BP had been checked.

Interview with Resident #2 on 07/24/24 at 1:49pm

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C 249	Continued From page 9 revealed: -Her BP was checked whenever the SIC gave her the BP cuff to check her BP. -She put the BP cuff on her wrist, and she showed the SIC the BP results. -Her BP was not checked every day. Observation of Resident #2's blood pressure on 07/24/24 at 4:15pm revealed the resident's BP was 138/89. Interview with the SIC on 07/24/24 at 2:32pm revealed: -She checked Resident #2's BP 4 times per week. -She gave Resident #2 the BP cuff and she looked at the results when the BP was finished. -She had checked Resident #2's BP and had just not written the results in the MAR. -She missed documenting the results of Resident #2's BP because she was in a hurry to get out of the facility. Attempted telephone interview with Resident #2's PCP on 07/24/24 at 10:11am was unsuccessful. Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the	C 254		

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C 254	Continued From page 10 residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 2 of 3 sampled residents (#1, #3) with a LHPS task of fingerstick blood sugar (FSBS) monitoring. The findings are: 1. Review of Resident #1's current FL-2 dated 01/20/24 revealed diagnosis of diabetes. Review of Resident #1's signed physician's orders dated 01/25/24 revealed an order for a finger stick blood sugar (FSBS) check once daily. Review of Resident #1's LHPS assessment dated 09/11/20 revealed Resident #1's FSBS was checked once weekly.	C 254		

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C 254	Continued From page 11 Review of Resident #1's record revealed no other LHPS evaluation available for review. Review of Resident #1's May 2024, June 2024, and July 2024 medication administration records (MAR) for 07/01/24-07/24/24 revealed: -There was an entry to check FSBS once daily with a scheduled administration time of 8:00am. -There was documentation Resident #1's FSBS was checked daily at 8:00am from 05/01/24-05/31/24, 06/01/24-06/30/24, and 07/01/24-07/24/24. Observation of the Supervisor-in-Charge (SIC) during the morning medication pass on 07/23/24 at 9:43am revealed: -The SIC gathered supplies for a FSBS check. -The SIC checked Resident #1's FSBS with a reading of 121. Interview with Resident #1 on 07/24/24 at 8:15am revealed: -His FSBS was checked once a week. -His FSBS was not checked every day. Interview with the SIC on 07/24/24 at 11:08am revealed: -There was an order to check Resident #1's FSBS daily. -She checked Resident #1's FSBS daily. -She had been trying to contact the LHPS nurse to schedule Resident #1's LHPS to be completed. Attempted telephone interview with the LHPS nurse on 07/24/24 at 2:52pm was unsuccessful. Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 254		

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2. Review of Resident #3's current FL-2 dated 05/30/24 revealed:
-Diagnoses included diabetes.
-There was no order to check Finger stick blood sugar (FSBS).

Review of Resident #1's LHPS assessment dated 02/13/19 revealed Resident #3's FSBS was checked daily.

Review of Resident #2's record revealed no other LHPS evaluation available for review.

Review of Resident #2's May 2024, June 2024, and July 2024 medication administration records (MAR) from 07/01/24-07/24/24 revealed:
-There was an entry to check FSBS once daily with a scheduled administration time of 8:00am.
-There was documentation Resident #2's FSBS was checked daily at 8:00am from 05/01/24-05/31/24, 06/01/24-06/30/24, and 07/01/24-07/23/24.

Observation of the Supervisor-in-Charge (SIC) during the morning medication pass on 07/23/24 at 9:43am revealed:
-The SIC gathered supplies for a FSBS check.
-The SIC attempted to check Resident #2's FSBS however she received an error message with the glucometer.

Interview with Resident #3 on 07/23/24 at 4:15pm revealed:
-Her FSBS was checked "every few weeks".
-The last time the SIC checked her FSBS was "about a month ago".

Interview with the SIC on 07/24/24 at 11:08am revealed:

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C 254	Continued From page 13 -She did not realize there was no order to check Resident #2's FSBS daily on the FL-2. -It was an oversight because she was the one who wrote out the FL-2's and had the PCP sign the FL-2's. -She checked Resident #2's FSBS daily. -She had been trying to contact the LHPS nurse to schedule Resident #1's LHPS to be completed. Attempted telephone interview with the LHPS nurse on 07/24/24 at 2:52pm was unsuccessful. Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 254		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on record reviews, observations, and	C 257		

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C 257	Continued From page 14 interviews, the facility failed to ensure the kitchen and food cooking areas were clean and free from contamination including the inside of the microwave oven, expired food in the refrigerator, leftover food not labeled and dated, and proteins in the same drawer with raw vegetables. The findings are: Review of the Environmental Health Inspection report dated 09/23/23 revealed: -The demerit score was 11 with a status code of A. -The facility received 4 demerits for food utensils and equipment should be in good repair and kept clean. Observation of the microwave on 07/23/24 at 8:02am revealed the inside of the microwave was covered in dark brown, dried, splatters on the sides, top, and bottom of the microwave. Observation of the refrigerator on 07/23/24 at 8:48am and 4:30pm revealed: -There was a two-door refrigerator. -The handles of the doors had a build-up of dirt and grime. -The refrigerator was packed on every shelf and every drawer. -There was a container of honey butter dated 02/22/22 from the grocery store where purchased. -There was a package of dark chocolate with marzipan filling that expired on 06/15/24. -There was a reusable food container that was dirty but contained no food. -There was a package of sliced deli meat with a package date of 07/12/24 and a sell-by date of 07/17/24; there was one slice of meat in the package.	C 257		

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C 257	Continued From page 15 -There was a reusable food container that was not labeled or dated, and the contents were not identifiable. -Multiple non-reusable food containers contained prepared foods that were not labeled with the contents or dated. -There was a container of potato salad that was not labeled or dated as to when the potato salad was purchased or opened. -There was a container of crab dip labeled by the manufacturer as used by 05/20/24. -There was a container of heavy whipping cream labeled by the manufacturer as used by 07/05/24. -There was a non-reusable food container that contained spaghetti; it was not labeled or dated as to when the spaghetti had been prepared. -Multiple containers of yogurt expired on 06/27/24. -There was a container of applesauce that expired on 06/25/24. -There was a second container of applesauce that expired on 07/06/24. -There was a container of hot dog chili with a manufacturer use-by date of 07/09/24. -There was a raw head of lettuce that had frozen and was now wilted; it was in the drawer with proteins. -There was a jar of spaghetti sauce that had been opened and was not labeled to know when it was opened. -The inside of all the drawers had various food crumbs/particles, splatters, and stains. -The inside of a drawer contained a rotten cucumber and bell pepper and the juices from the rotten vegetables had covered part of the inside of the drawer. -Inside the drawer were also multiple packages of deli meats, none were labeled as to when they were opened, individually packaged sliced cheese that was brown around the edges, four	C 257		

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C 257	Continued From page 16 oranges, two packages of carrots that appeared to have been frozen and were now dried out, as well as various other food containers. -There was a container disposable plastic bag that was not labeled or dated to know the contents and the contents were not identifiable. -All of the shelves on the doors had dried splattered food and crumbs of food. -Some of the shelves were broken. Observation of a second refrigerator on 07/23/24 at 8:10am revealed: -The outside of the refrigerator was rusted in multiple places. -The door handles had a build-up of dirt and grime. -The door was fastened closed with a large chain and padlock. Interview with the SIC on 07/23 24 at 8:45am revealed she did not have a key to the padlock of the second refrigerator. Observation of a freezer on 07/23/24 at 4:31pm revealed: -The freezer was latched and locked. -The SIC unlocked the freezer. -There was a strong odor coming from the inside of the freezer. -There were multiple bags of food inside the freezer. -The SIC began throwing the bags into the trash can. Interview with the SIC on 07/23/24 at 4:31pm revealed: -The freezer had been unplugged on Saturday, 07/20/24 because of a build-up of ice. -She thought one of the bags of food was	C 257		

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sauerkraut.
-She did not know what one of the bags contained.
-She thought one of the bags may have been shrimp, but she was not sure.
-The inside of the freezer was room temperature.

Interview with the SIC on 07/24/24 at 4:40pm revealed:
-Whoever was working was responsible for cleaning the kitchen.
-She knew the microwave was a "mess".
-She last cleaned the microwave about a week ago.
-She knew the microwave needed to be cleaned but she "just had not done it".
-She did not know why there was expired food in the refrigerator.
-When the food was opened, she knew the food was supposed to be labeled.
-She did not know why opened food had not been labeled.
-The staff were "just not following protocol".
-She knew leftovers were not supposed to be stored in non-reusable food containers like a butter container.
-There were sealable plastic bags and a permanent marker available to be used to seal opened containers and to date when the containers were opened.
-The staff were "just not following protocol".

C 272 | 10A NCAC 13G .0904(d)(2) Nutrition and Food Service | C 272

10A NCAC 13G .0904 Nutrition and Food Service
(d) Food Requirements in Family Care Homes:
(2) Foods and beverages shall be offered in

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accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day.

The finding are:

Review of the facility's menu revealed snacks were listed three times per day, between breakfast and lunch, between lunch and dinner and after dinner.

Observation on 07/23/24 at various times between 8:00am and 5:00pm revealed there were no snacks offered to the residents.

Interview with a resident on 07/23/24 at 7:53am revealed residents were served snacks once a day, and he got hungry between meals.

Interview with a second resident on 07/23/24 at 4:15pm revealed:
-The residents got snacks every night.
-She got hungry between meals.

Interview with a third resident on 07/24/24 at 8:05am revealed residents were served snacks once a day, "if we get them"; he got hungry at times.

Interview with a fourth resident on 07/24/24 at

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C 272	Continued From page 19 10:44am revealed snacks were only served once a day, at night. Interview with the Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed: -The residents were given snacks at bedtime and sometimes with lunch. -With lunch meant she might give the residents peanut butter crackers or pudding at lunch. -She did not give the residents peanut butter cookies yesterday, 07/23/24 at lunch because the residents had such a heavy lunch. -She thought the residents were supposed to be served snacks twice a day. Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 272		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (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	C 315		

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interviews, the facility failed to clarify orders for 1 of 3 sampled residents, including an antiplatelet medication and finger stick blood sugar (FSBS) (#3).

The findings are:

Review of Resident #3's FL-2 dated 05/30/24 revealed diagnoses of hypertension, diabetes, and coronary artery disease.

a. Review of Resident #3's FL-2 dated 05/16/24 revealed an order for Clopidogrel (a blood thinner used to reduce the risk of heart disease and stroke) 75mg once daily.

Review of Resident #3's FL-2 dated 05/30/24 revealed an order for Clopidogrel 75mg once daily.

Review of Resident #3's May 2024 medication administration record (MAR) revealed:
-There was an entry for Clopidogrel 75mg once daily with a scheduled administration time of 8:00am.
-There was documentation Clopidogrel 75mg was administered daily from 05/16/24-05/30/24.

Interview with the SIC on 07/24/24 at 12:22pm revealed:
-She had updated Resident #3's FL-2 on 05/16/24.
-She did not notice Resident #3's Clopidogrel was not listed on the FL-2.
-Fl-2s were completed using the resident's current MAR.

Telephone interview with another SIC on 07/24/24 at 1:25pm revealed:
-Whoever was working should compare the FL-2

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to the current MAR.
-When a new FL-2 was signed, the FL-2 should be faxed to the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/24 at 2:19pm revealed:
-Resident #3's Clopidogrel was being filled from a prescription dated 10/26/23.
-Resident #3's FL-2s dated 05/16/24 and 05/30/24 were not on file at the pharmacy.
-If Resident #3's FL-2 dated 05/16/24 had been received and Clopidogrel was not listed, the pharmacy would have contacted the primary care provider (PCP) for clarification.
-When the pharmacy received a FL-2, it was viewed as a new start, however since Resident #3 had been on the Clopidogrel for a while, she would have wanted to clarify the medication order.

b. Review of Resident #3's FL-2 dated 05/30/24 revealed no order for finger stick blood sugar (FSBS) testing.

Review of Resident #3's May 2024 medication administration record (MAR) revealed:
-There was an entry for FSBS check once daily with a scheduled administration time of 8:00am.
-There was documentation Resident #3's FSBS was checked at 8:00am daily from 05/16/24-05/23/24 and from 05/25/24-05/30/24.

Review of Resident #3's June 2024 MAR revealed:
-There was an entry for FSBS check once daily with a scheduled administration time of 8:00am.
-There was documentation Resident #3's FSBS was checked at 8:00am daily from 06/04/24-06/30/24.

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C 315	Continued From page 22 Review of Resident #3's July 2024 MAR from 01/01/24-07/23/24 revealed: -There was an entry for FSBS check once daily with a scheduled administration time of 8:00am. -There was documentation Resident #3's FSBS was checked at 8:00am daily from 07/01/24-07/23/24. Observation of the morning medication pass on 07/23/24 from 9:30am-10:30am revealed: -The SIC called Resident #3 into the room to check her FSBS. -Resident #3's glucometer had an error reading. -The SIC did not check the resident's FSBS. -The SIC contacted Resident #3's primary care provider (PCP) and pharmacy to obtain a new glucometer. Observation of Resident #3's medication on hand on 07/23/24 at 11:00am revealed: -Resident #3's glucometer had an error reading of E6 and showed a low battery. -There was a bottle of FSBS test strips in the glucometer bag labeled for Resident #3. -There were 27 of 50 strips remaining in the bottle. -There was a box of 50 test strips that were not opened. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/24 at 2:19pm revealed: -The most current order for Resident #3's supplies to check her FSBS was dated 05/06/24 with the directions to check FSBS once daily. -Resident #3's FL-2s dated 05/16/24 and 05/30/24 were not on file at the pharmacy. -If Resident #3's FL-2 dated 05/16/24 had been received and FSBS was not listed, the pharmacy	C 315		

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C 315	Continued From page 23 would have contacted the primary care provider (PCP) for clarification. -The pharmacy had not dispensed Resident #3's FSBS supplies since 10/13/22, however, the supplies may have been filled by the durable medical equipment (DME) section. Telephone interview with a representative from the facility's contracted pharmacy DME section on 07/23/24 at 2:19pm revealed: -On 03/01/24, two boxes of FSBS test strips were dispensed for Resident #3. -Each box dispensed contained 50 test strips. Interview with Resident #3 on 07/23/24 at 4:15pm revealed: -The Supervisor-in-Charge (SIC) checked her FSBS "every few weeks." -The last time the SIC checked her FSBS was "about a month ago." Interview with the SIC on 07/24/24 at 12:22pm revealed: -She checked Resident #3's FSBS daily. -She had updated Resident #3's FL-2 on 05/16/24, however, the resident then went to the hospital, and she completed a new FL-2 for the resident on 05/30/24. -She missed documenting Resident #3's FSBS order on both FL-2s, 05/16/24 and 05/30/24. Telephone interview with another SIC on 07/24/24 at 1:25pm revealed: -Resident #3's FSBS was done daily. -She did not know there was no order for daily FSBS for Resident #3 on the FL-2. -Whoever was working should compare the FL-2 to the current MAR. -When a new FL-2 was signed, the FL-2 should be faxed to the pharmacy.	C 315		

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C 315	Continued From page 24 Attempted telephone contact with Resident #3's PCP on 07/24/24 at 10:13am was unsuccessful. Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sample residents (#1, #2, and #3) including three eye drops (#1), an anti-depressant, a anticholinergic medication, and an allergy medication (#2) and an antihistamine eye drop (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 01/20/24 revealed diagnoses of gastroesophageal reflux disease (GERD), mild mental retardation, diabetes and depression.	C 330		

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C 330	Continued From page 25 a. Review of Resident #1's current FL-2 dated 01/20/24 revealed an order for Timolol eye drops (used to lower eye pressure caused by glaucoma) 0.5%, one drop in each eye twice daily. Review of Resident #1's May 2024 medication administration record (MAR) revealed: -There was an entry for Timolol 0.5% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Timolol 0.5% was administered at 8:00am from 05/01/24-05/19/24 and from 05/21/24-05/31/24. -There was documentation Timolol 0.5% was administered at 8:00pm from 05/01/24-05/17/24 and from 05/21/24-05/24/24. -There were no exceptions documented for the 8:00am missed dose on 05/20/24, and the 8:00pm missed doses from 05/18/24-05/20/24 and from 05/25/24-05/31/24. Review of Resident #1's June 2024 MAR revealed: -There was an entry for Timolol 0.5% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Timolol 0.5% was administered at 8:00am and 8:00pm from 06/01/24-06/30/24. Review of Resident #1's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Timolol 0.5% instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Timolol 0.5% was administered at 8:00am from 07/01/24-07/24/24. -There was documentation Timolol 0.5% was	C 330		

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administered at 8:00pm from 07/01/24-07/22/24.
-There were no exceptions documented for the missed dose on 07/23/24.

Observation of Resident #1's medication on hand on 07/23/24 at 10:16am and 4:00pm revealed:
-There was a 5 milliliter (ml) bottle of Timolol dispensed on 02/02/24 that was not opened.
-There was a 5ml bottle of Timolol dispensed on 04/01/24 that was opened and was over half full.
-There were three 5ml bottles of Timolol dispensed on 07/17/24 that were not opened.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 9:23am revealed:
-Timolol was used to treat glaucoma by lowering the intraocular pressure (fluid pressure) in the eye.
-Resident #2 had an order to administer one drop in each eye twice a day.
-Resident #2's Timolol was dispensed on 02/02/24, 04/01/24, and 07/17/24 and each dispensing was for (3) 5 ml bottles for a total of 15mls.
-Fifteen mls of Timolol was a 70-day supply, each 5ml bottle would last approximately 24 days.
-If Resident #2's Timolol was not administered as ordered the resident may experience increased inner ocular pressure.

Based on record reviews and interviews, Resident #1 was dispensed 9 bottles of Timolol between 02/02/24-07/17/24, and there were 5 bottles of Timolol remaining on 07/24/24.

b. Review of Resident #1's current FL-2 dated 01/20/24 revealed an order for Simbrinza eye drops (a combination medication used to lower eye pressure and treat glaucoma) 1%, one drop

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 27 in the left eye three times daily. Review of Resident #1's May 2024 medication administration record (MAR) revealed: -There was an entry for Simbrinza 1% instill one drop into the left eye three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation Simbrinza 1% was administered at 8:00am, 2:00pm and 8:00pm from 05/01/24-05/30/24. -There was no documentation that Simbrinza was administered on 05/31/24. -There were no exceptions documented for the 3 missed doses on 05/31/24. Review of Resident #1's June 2024 MAR revealed: -There was an entry for Simbrinza 1% instill one drop into the left eye three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation Simbrinza 1% was administered at 8:00am and 2:00pm from 06/01/24-06/30/24. -There was documentation Simbrinza 1% was administered at 8:00pm from 06/01/24-06/27/24. -There were no exceptions documented for the missed doses at 8:00pm from 06/28/24-06/30/24. Review of Resident #1's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Simbrinza 1% instill one drop into the left eye three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation Simbrinza 1% was administered at 8:00am from 07/01/24-07/24/24. -There was documentation Simbrinza 1% was administered at 2:00pm from 07/01/24-07/10/24.	C 330		

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C 330	Continued From page 28 -There was documentation Simbrinza 1% was administered at 8:00pm from 07/01/24-07/22/24. -There were no exceptions documented for the missed doses at 2:00pm from 07/11/24-07/23/24 and the 8:00pm dose on 07/23/24. Observation of Resident #1's medication on hand on 07/23/24 at 10:16am revealed there was a 8ml bottle of Simbrinza 1% dispensed on 04/01/24 that was opened and over half full. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 9:23am revealed: -Resident #2 had an order to administer one drop of Simbrinza 1% in the left eye three times daily. -Resident #2's Simbrinza 1% was dispensed on 02/02/24, 04/01/24, and 07/17/24 and each dispensing was for (1) 8 ml bottle. -Each ml would equal 15-20 drops, and if the resident was administered the medication three times per day that would be at the most 160 drops per 8 ml bottle which was a 25-26 day supply. Second observation of Resident #1's medication on hand on 07/23/24 at 4:00pm revealed: -There was an 8 ml bottle of Simbrinza 1% dispensed on 12/08/23 that was opened. -There was an 8 ml bottle of Simbrinza 1% dispensed on 02/02/24 that was not opened. -There was no 8 ml bottle of Simbrinza 1% dispensed on 07/17/24 available. Based on record reviews and interviews Resident #1 was dispensed 3 bottles of Simbrinza between 02/02/24-07/17/24. Each bottle would last 25-26 days. There were 2 of the 3 bottles of Simbrinza remaining on 07/24/24 and an unaccounted for bottle dispensed on 07/17/24.	C 330		

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C 330	Continued From page 29 c. Review of Resident #1's current FL-2 dated 01/20/24 revealed an order for Rocklatan eye drops (used to lower eye pressure caused by glaucoma) 0.02%, one drop in each eye at bedtime. Review of Resident #1's May 2024 medication administration record (MAR) revealed: -There was an entry for Rocklatan 0.02% instill one drop into each eye once daily at bedtime with a scheduled administration time of 8:00pm. -There was documentation Rocklatan 0.02% was administered at 8:00pm from 05/01/24-05/24/24. -There was no documentation Rocklatan 0.02% was administered at 8:00pm from 05/25/24-05/30/24. -There were no exceptions documented for the 6 missed doses. Review of Resident #1's June 2024 MAR revealed: -There was an entry for Rocklatan 0.02% instill one drop into each eye once daily at bedtime with a scheduled administration time of 8:00pm. -There was documentation Rocklatan 0.02% was administered at 8:00pm from 06/01/24-06/30/24. Review of Resident #1's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Rocklatan 0.02% instill one drop into each eye once daily at bedtime with a scheduled administration time of 8:00pm. -There was documentation Rocklatan 0.02% was administered at 8:00pm from 07/01/24-07/24/24. Observation of Resident #1's eye drops being administered on 07/23/24 at 10:16am revealed Resident #1 was administered Rocklatan 0.02% eye drops at 10:16am, not at bedtime as ordered.	C 330		

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C 330	Continued From page 30 Observation of Resident #1's medication on hand on 07/23/24 at 10:16am revealed a 2.5 milliliter (ml) bottle of Rocklatan dispensed on 03/15/23 that was opened; the bottle was labeled as expired on 03/15/24. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/24 at 3:41pm revealed: -Rocklatan was not cycle filled and staff would have to request for the medication to be refilled. -Rocklatan was used to treat glaucoma by lowering the pressure in the eye. -Resident #2 had an order to administer one drop in each eye at bedtime. -Resident #2's Rocklatan was dispensed on 02/02/24 and 04/01/24 and each dispensing was for (1) 2.5 ml bottle; each 2.5 ml bottle would last approximately 30 days. -If Resident #2's Rocklatan was not administered as ordered the resident may experience blurred vision. -Once opened, Rocklatan should be discarded if not used within 60-90 days. Second observation of Resident #1's medication on hand on 07/23/24 at 4:00pm revealed: -There was a 2.5 ml bottle of Rocklatan dispensed on 09/26/23 . -There was a 2.5 ml bottle of Rocklatan dispensed on 04/01/24 that was not opened. Based on record reviews and interviews Resident #1 was dispensed 1 bottle of Rocklatan between 02/02/24-04/01/24, and the bottle dispensed on 04/01/24 had not been opened. Interview with Resident #1 on 07/24/24 at 8:15am revealed he did not get eye drops at night; he only	C 330		

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C 330	Continued From page 31 took pills at night. Interview with a Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed she thought Resident #1's Rocklatan was scheduled to be administered in the morning. Interview with the lead technician from Resident #2's Ophthalmologist's office on 07/24/24 at 12:14pm revealed Resident #1's Rocklatan should be administered at bedtime as ordered. Interview with Resident #1 on 07/24/24 at 8:15am revealed: -He did not get eye drops every day. -He was administered 3 eye drops on 07/23/24. -Whenever the staff decided to put eye drops in was when he got eye drops. -He sometimes asked for his eye drops because he could not see as clearly. -Once the eye drop was put in, it did help a little. -When he was administered eye drops it was only once a day. Interview with a technician from Resident #2's Ophthalmologist's office on 07/24/24 at 12:14pm revealed: -Resident #1's eye pressure in his right eye had been as high as 26 on 07/06/23, at which time the resident's eye medications were changed to lower the pressure in the eyes. -On 11/08/23, Resident #1's eye pressure was 13/14 in his right eye and 11 in his left eye. -On 03/11/24, Resident #1's eye pressure was 16 in his right eye and 11 in his left eye. -On 07/17/24, Resident #1's eye pressure was 18/19 in his right eye and 11 in his left eye. -If Resident #1's eye drops were not administered as ordered, it could lead to blindness. -If Resident #1's eye drops were not administered	C 330		

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correctly, pressure built up in the eye and damaged the optic nerve which could result in permanent, irreversible damage.
-All of Resident #1's eye drops were "very" important as each eye drop contributed to lowering the pressure in the resident's eyes.
-It was important for Resident #1 to get his eye drops at the time the medication was scheduled every day.
-If Resident #1 missed any of his eye drops, or the time changed for the administration, Resident #1's pressure would fluctuate and that was almost as bad as missing the medication because pressure going up and down in the eyes was dangerous.

According to the American Academy of Ophthalmology normal eye pressure was usually considered to be between 10 and 20 millimeters

Interview with the same Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed:
-She administered Resident #1's eye drops every day, in the morning, in the middle of the day, and at bedtime.
-Resident #1 may have been administered his middle-of-the-day eye drops a little later because the staff and residents were out of the facility.
-She may have missed administering Resident #1's eye drops some mornings because she was in a hurry to get out of the facility with the residents to go to an appointment.

Telephone interview with another SIC on 07/24/24 at 1:25pm revealed:
-She administered three [named] eye drops for Resident #1.
-Resident #1 had "probably" missed some eye drops being administered when the residents and staff were "out and about" going to appointments

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and activities.

Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 11/16/23 revealed diagnoses included hypertension and diabetes.

a. Review of Resident #2's current FL-2 dated 11/16/23 revealed an order for Sertraline HCL (used to treat depression) 100mg take one tablet daily.

Review of Resident #2's May 2024 medication administration record (MAR) revealed:
-There was an entry for Sertraline HCL 100mg take one tablet daily with a scheduled administration time of 8:00am.
-Sertraline HCL 100mg was documented as administered daily at 8:00am from 05/01/24-05/30/24.
-There was no documentation Sertraline was administered on 05/31/24.

Review of Resident #2's June 2024 MAR revealed:
-There was an entry for Sertraline HCL 100mg take one tablet daily with a scheduled administration time of 8:00am.
-Sertraline HCL 100mg was documented as administered daily at 8:00am from 06/01/24-06/30/34.

Review of Resident #2's July 2024 MAR from 07/01/24-07/24/24 revealed:
-There was an entry for Sertraline HCL 100mg take one tablet daily with a scheduled administration time of 8:00am.

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C 330	Continued From page 34 -Sertraline HCL 100mg was documented as administered daily at 8:00am from 07/01/24-07/24/24. Observation of Resident #2's medications on hand on 07/23/24 at 10:32am revealed there was no Sertraline HCL 100mg available to be administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 9:23am revealed: -Resident #2's Sertraline HCL 100mg was last dispensed on 06/04/24 for a 30-day supply. -The prescription did not have any refills and the primary care provider (PCP) had been contacted by the pharmacy team about the medication needing refills -Sertraline was an antidepressant and if the medication was not administered as ordered, Resident #2 could experience symptoms of depression, like a change in her mood. Interview with Resident #2 on 07/24/24 at 1:49pm revealed: -She did not know what Sertraline was for or if she had missed taking any of the medication. -She took whatever medication she was given. -She had days she did not feel as good as others, "like feeling more tired." b. Review of Resident #2's current FL-2 dated 11/16/23 revealed an order for Vesicare (used to treat an overactive bladder) 10mg take one tablet daily. Review of Resident #2's May medication administration record (MAR) revealed: -There was an entry for Vesicare 10mg take one tablet daily with a scheduled administration time	C 330		

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C 330	Continued From page 35 of 8:00am. -Vesicare 10mg was documented as administered daily at 8:00am from 05/01/24-05/31/24. Review of Resident #2's June 2024 MAR revealed: -There was an entry for Vesicare 10mg take one tablet daily with a scheduled administration time of 8:00am. -Vesicare 10mg was documented as administered daily at 8:00am from 06/01/24-06/30/34. Review of Resident #2's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Vesicare 10mg take one tablet daily with a scheduled administration time of 8:00am. -Vesicare 10mg was documented as administered daily at 8:00am from 07/01/24-07/24/24. Observation of Resident #2's medications on hand on 07/23/24 at 10:32am revealed there was no Vesicare 10mg available to be administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 9:23am revealed: -Resident #2's Vesicare 10mg was last dispensed on 06/04/24 for a 30-day supply. -The prescription did not have any refills and the primary care provider (PCP) had been contacted by the pharmacy team about the medication needing refills -Vesicare was used for an overactive bladder and if the medication was not administered as ordered, Resident #2 could experience urinary incontinence.	C 330		

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C 330	Continued From page 36 Interview with Resident #2 on 07/24/24 at 1:49pm revealed: -She had some urinary incontinence at times. -She did not know if her urinary incontinence had been better, worse, or about the same over the past month. -She had urinary incontinence over the past month. c. Review of Resident #2's current FL-2 dated 11/16/23 revealed an order for Singulair (used to treat asthma) 5mg take one tablet daily. Review of Resident #2's May 2024 medication administration record (MAR) revealed: -There was an entry for Singulair 5mg take one tablet daily with a scheduled administration time of 8:00am. -Singulair 5mg was documented as administered daily at 8:00am from 05/01/24-05/31/24; there was no exception documented for 05/31/24. Review of Resident #2's June 2024 MAR for June 2024 revealed: -There was an entry for Singulair 5mg take one tablet daily with a scheduled administration time of 8:00am. -Singulair 5mg was documented as administered daily at 8:00am from 06/01/24-06/30/34. Review of Resident #2's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Singulair 5mg take one tablet daily with a scheduled administration time of 8:00am. -Singulair 5mg was documented as administered daily at 8:00am from 07/01/24-07/24/24. Observation of Resident #2's medications on	C 330		

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hand on 07/23/24 at 10:32am revealed there was no Singulair 5mg available to be administered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 9:23am revealed:
-Resident #2's Singulair 5mg was last dispensed on 06/04/24 for a 30-day supply.
-The prescription did not have any refills and the primary care provider (PCP) had been contacted by the pharmacy team about the medication needing refills
-Singulair was used to treat allergies and asthma and if the medication was not administered as ordered, Resident #2 could experience an increase in allergy symptoms such as congestion.

Interview with Resident #2 on 07/24/24 at 1:49pm revealed she got short of breath if she walked a lot; she had not had any congestion.

Interview with the Supervisor-in-Charge on 07/24/24 at 11:08am revealed:
-She thought Resident #2's medications were on the medication cart.
-She did not notice Resident #2's medications had not been delivered from the pharmacy.
-She could not explain why she had documented she administered medication that was not available to be administered.

Attempted telephone interview with Resident #2's PCP on 07/24/24 at 10:11am was unsuccessful.

Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.

3. Review of Resident #3's current FL-2 dated 05/30/24 revealed:

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C 330	Continued From page 38 -Diagnoses of diabetes, hypertension, coronary artery disease, schizophrenia, and myocardial infarction. -There was an order for Pazeo 0.7 % Eye Drops (an antihistamine used to treat itching in the eyes caused by allergies) place one drop in each eye daily. Review of Resident #3's May 2024 medication administration record (MAR) for 05/30/24-05/31/24 revealed: -There was an entry for Pazeo 0.7 % instill one drop in each eye daily with a scheduled administration time of 8:00am. - Pazeo 0.7 % was documented as administered daily at 8:00am on 05/30/24-05/31/24. Review of Resident #3's June 2024 MAR revealed: -There was an entry for Pazeo 0.7 % instill one drop in each eye daily with a scheduled administration time of 8:00am. - Pazeo 0.7 % was documented as administered daily at 8:00am from 06/01/24-06/30/34. Review of Resident #3's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Pazeo 0.7 % instill one drop in each eye daily with a scheduled administration time of 8:00am. - Pazeo 0.7 % was documented as administered daily at 8:00am from 07/01/24-07/24/24. Observation of the morning medication pass on 07/23/24 between 9:45am-10:30am revealed Resident #3 was not administered eye drops. Observation of Resident #3's medications on hand on 07/23/24 at 1:21pm revealed there was no Pazeo 0.7% available to be administered.	C 330		

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Interview with the Supervisor-in-Charge (SIC) on 07/23/24 at 1:21pm revealed she could not locate Resident #3's eye drops.

Second observation of Resident #3's medications on hand on 07/23/24 at 1:42pm revealed a bottle of Pazeo 0.7% was in the back of the medication cart drawer and was dispensed on 10/03/23; the medication had not been opened.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/23/24 at 2:19pm revealed:
-Resident #3's Pazeo 0.7% had not been dispensed since 10/03/23.
-Eye drops were considered a bulk item and refills had to be requested.
-They had received a new prescription for the Pazeo 0.7% dated 04/01/24, but the prescription had been profiled and had not been requested for a refill.
-Pazeo was not cycle filled and would need to be requested by staff for a refill.
- Pazeo 0.7% was an antihistamine used for itching and irritation.
-If Pazeo 0.7% was not administered as ordered the resident's symptoms would not be resolved.

Observation of Resident #3 on 07/23/24 at 2:15pm revealed the resident was standing outside the facility, rubbing both eyes with the palms of her hands.

Interview with Resident #3 on 07/24/24 at 4:15pm revealed:
-Her eyes "itched" at times.
-The last time she had eye drops was "about a year ago."
-She recalled the eye drops helped with the

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itching when she had gotten them.

Interview with the Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed:
-She did not know why she did not administer Resident #3's eye drops on 07/23/24.
-She thought she administered Resident #3's eye drops every day.

Attempted telephone interview with Resident #3's PCP on 07/24/24 at 10:13am was unsuccessful.

Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.

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The facility failed to ensure eye drops medications for glaucoma were administered as ordered to Resident #1 resulting in the resident having increased intra-ocular eye pressure from 16 in his right eye on 03/11/24 to 18/19 in his right eye on 07/17/24. Increased pressure damaged the optic nerves which could result in permanent, irreversible damage, which could lead to blindness. Resident #2 was not administered her medication for bladder control which increased her risk of urinary incontinence, and Resident #3 had not been administered her eye drops as ordered and was experiencing itching in her eyes. This failure resulted in substantial risk of physical harm and neglect to the residents and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131 D-34 on July 24, 2024, for this violation.

THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 23, 2024.

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C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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 electronic medication administration records were accurate for 2 of 3 sampled residents including an order for an antibiotic (#1) and a supplement (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 01/20/24 revealed: -Diagnoses included diabetes, depression, and mild mental retardation. -There was no order for Augmentin 500mg twice	C 342		

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C 342	Continued From page 42 daily. Review of Resident #1's May 2024 medication administration record (MAR) revealed: -There was an entry for Augmentin 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Augmentin 500mg was administered at 8:00am and 8:00pm from 05/01/24-05/30/24. Review of Resident #1's June 2024 MAR revealed: -There was an entry for Augmentin 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Augmentin 500mg was administered at 8:00am and 8:00pm from 06/04/24-06/30/24. Review of Resident #1's July 2024 MAR from 07/01/24-07/24/24 revealed: -There was an entry for Augmentin 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Augmentin 500mg was administered at 8:00am and 8:00pm from 07/01/24-07/24/24. Observation of Resident #1's medication on hand on 07/23/24 at 10:16am and 4:00pm revealed there was no Augmentin available to be administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/24/24 at 10:53am revealed: -Resident #1 had an order for Augmentin 500mg twice daily for 7 days dated 04/03/24. -The pharmacy only dispensed a 7-day supply of	C 342		

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the Augmentin when ordered on 04/03/24 and there was no other dispensing of Augmentin.
-He did not know why Augmentin was still being printed on Resident #1's MAR.

Interview with the Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed:
-She administered Resident #2's medications by looking at the MARs and the medications on hand, popped the medications into a cup, and signed the MAR after the resident had taken the medication.
-She had not noticed she was documenting Resident #1's Augmentin twice a day when the resident did not currently have an antibiotic.
-She did not know why she had documented she administered the medication daily.

Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.

2. Review of Resident #3's FL-2 dated 05/30/24 revealed:
-Diagnoses included hypertension, diabetes, and coronary artery disease.
-There was an order for Vitamin D 1.25mg (50,000) take one tablet weekly.

Review of Resident #3's May 2024 medication administration record (MAR) revealed:
-There was an entry for Vitamin D 1.25mg (50,000) take one tablet weekly with a scheduled administration time of 8:00am.
-There was documentation that Vitamin D 1.25mg (50,000) was administered daily from 05/16/24-05/30/24.

Review of Resident #1's June 2024 MAR from 06/01/24-06/27/24 revealed:

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-There was an entry for Vitamin D 1.25mg (50,000) take one tablet weekly with a scheduled administration time of 8:00am.
-There was documentation that Vitamin D 1.25mg (50,000) was administered daily from 06/03/24-06/27/24.

Review of Resident #1's July 2024 MAR from 07/01/24-07/23/24 revealed:
-There was an entry for Vitamin D 1.25mg (50,000) take one tablet weekly with a scheduled administration time of 8:00am.
-There was documentation that Vitamin D 1.25mg (50,000) was administered daily from 07/01/24-07/23/24.

Observation of Resident #1's medication on hand on 07/23/24 at 1:21pm revealed:
-There was a punch card dispensed on 07/22/24 for Vitamin D 1.25mg (50,000) with the directions to administer once weekly.
-There were 4 capsules in individual bubbles.

Interview with the Supervisor-in-Charge (SIC) on 07/24/24 at 11:08am revealed:
-She administered Resident #2's medications by looking at the MARs and the medications on hand, popped the medications into a cup, and signed the MAR after the resident had taken the medication.
-She administered Resident #3's Vitamin D 1.25mg (50,000) once weekly.
-Resident #3's Vitamin D 1.25mg was only dispensed for one tablet weekly.
-She had not noticed she was documenting Resident #3's Vitamin D daily when the order was for once weekly.
-She did not know why she had documented daily when she administered the medication weekly.

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C 342	Continued From page 45 Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 1 of 1 sampled resident (#2) related to pain medication. The findings are: Review of Resident #2's current FL-2 dated 11/16/23 revealed diagnoses included hypertension and diabetes. Review of Resident #2's signed physician's orders dated 01/03/24 revealed an order for Hydrocodone-Acetaminophen (a Schedule II controlled substance used to treat moderate to moderately severe pain) take one tablet three times daily as needed (prn). Telephone interview with a pharmacist from the	C 367		

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C 367	Continued From page 46 facility's contracted pharmacy on 09/27/24 at 9:23am revealed: -Resident #2 was dispensed 90 tablets of Hydrocodone-Acetaminophen with directions to administer one tablet three times a day as needed on 12/15/23; there were 30 tablets on three individual punch cards. -Resident #2 was dispensed 90 tablets of Hydrocodone-Acetaminophen with directions to administer one tablet three times a day as needed on 02/13/24; there were 30 tablets on three individual punch cards. -Resident #2 was dispensed 90 tablets of Hydrocodone-Acetaminophen with directions to administer one tablet three times a day as needed on 04/01/24; there were 30 tablets on three individual punch cards. -Resident #2 was dispensed 90 tablets of Hydrocodone-Acetaminophen with directions to administer one tablet three times a day as needed on 05/24/24; there were 30 tablets on three individual punch cards. -Resident #2's Hydrocodone-Acetaminophen had to be requested for a refill each time it was filled. -The pharmacy sent controlled substance count sheets (CSCS) with each package of controlled substance dispensed to assist the facility with tracking the administration of the medication. - Hydrocodone-Acetaminophen was a controlled medication because the medication could cause dependency and be abused. -If there were Hydrocodone-Acetaminophen unaccounted for it could be a red flag for diversion, but it would not be something the pharmacy looked at unless the medication was being ordered too soon. Review of Resident #2's Hydrocodone-Acetaminophen CSCS logs revealed:	C 367		

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C 367	Continued From page 47 -There were 3 CSCS dated 12/15/23, each CSCS was for 30 tablets. -On one of the CSCS dated 12/15/23, the start date was 01/05/24 with a beginning count of 30 and ended on 02/12/24 with a balance of 0; each dose administered was complete with the date, time administered, and the staff members name who administered the medication. -On a second CSCS dated 12/15/23, the start date was 02/13/24 with a beginning count of 30 and ended on 03/18/24 with a balance of 0; each dose administered was complete with the date, time administered, and the staff members name who administered the medication. -On a third CSCS dated 12/15/23, the start date was 03/20/24 with a beginning count of 30 and ended on 04/20/24 with a balance of 0; each dose administered was complete with the date, time administered, and the staff members name who administered the medication. -All the entries on the CSCS were signed by the same Supervisor-in-Charge (SIC). -There was no CSCS for the dispensing dated 02/13/24. -There were 2 CSCS dated 04/01/24, each CSCS was for 30 tablets; there was no documentation on either of the CSCS. -There was no CSCS for the dispensing dated 05/24/24. Review of Resident #2's medication administration record (MAR) for January 2024 and February 2024 revealed: -There was an entry for Hydrocodone-Acetaminophen take one tablet three times daily as needed. -There was no documentation Hydrocodone-Acetaminophen had been administered.	C 367		

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C 367	Continued From page 48 Review of Resident #2's MAR for March 2024 revealed there was no March 2024 MAR prn medication page available to be reviewed. Review of Resident #2's MAR for April 2024, May 2024, and June 2024 revealed: -There was no entry for Hydrocodone-Acetaminophen take one tablet three times daily as needed. -There was no documentation Hydrocodone-Acetaminophen had been administered. Review of Resident #2's MAR for July 2024 from 07/01/24-07/24/24 revealed: -There was no entry for Hydrocodone-Acetaminophen take one tablet three times daily as needed. -There was no documentation Hydrocodone-Acetaminophen had been administered from 07/01/24-07/24/24. Observation of Resident #2's medications on hand on 07/23/24 at 10:32am revealed: -There was a punch card of 30 Hydrocodone-Acetaminophen dispensed on 12/15/23. -There was a punch card of 30 Hydrocodone-Acetaminophen dispensed on 02/13/24. -There was a punch card of 30 Hydrocodone-Acetaminophen dispensed on 04/01/234. -There was a punch card of 30 Hydrocodone-Acetaminophen dispensed on 05/24/24; 16 tablets remained on the punch card. Based on record reviews and interviews, the following was revealed:	C 367		

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-There were 360 tablets of Hydrocodone-Acetaminophen dispensed between 12/15/23-05/24/24.
-There were 90 doses documented on the CSCS.
-There was no documentation on the MARs Hydrocodone-Acetaminophen had been administered.
-There was a total of 106 tablets of Hydrocodone-Acetaminophen available to be administered.
-There were 164 doses of Hydrocodone-Acetaminophen unaccounted for.

Interview with Resident #2 on 07/24/24 at 1:49pm revealed:
-If she was hurting, she asked for a pain pill.
-She did not know what the pain pills were.
-She usually asked for a pain pill at bedtime.
-She had pain in her back and knees.
-She "just took one pain pill a day."
-She took a pain pill yesterday, 07/23/24.

Telephone interview on 07/24/24 at 1:25pm with the Supervisor-in-Charge (SIC) who signed all the CSCS revealed:
-She last administered Resident #2's Hydrocodone-Acetaminophen on Thursday night, 07/18/24, when she last worked.
-Resident #2 usually asked for Hydrocodone-Acetaminophen 2-3 times per day, always after lunch, never in the mornings.
-She knew Resident #2's Hydrocodone-Acetaminophen should only be administered after four hours since the last administration.
-She could not recall if she had documented on the CSCS for the Hydrocodone-Acetaminophen she administered to Resident #2 on 07/18/24.
-She usually documented the administration on the CSCS, but not on the MAR.

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-She thought she remembered she was supposed to document on both the MAR and the CSCS, but she had only been documenting on the CSCS.

Interview with a second SIC on 07/24/24 at 12:47pm revealed:
-She administered Resident #2's Hydrocodone-Acetaminophen a couple of days ago.
-She did not document when she administered Resident #2's Hydrocodone-Acetaminophen because she could not find a CSCS that had been started.
-Prior to the administration a couple of days ago, it had been a while since she had administered Hydrocodone-Acetaminophen to Resident #2, she could not recall when.
-She could not locate any other CSCS or medication punch cards for Resident #2's Hydrocodone-Acetaminophen.
-She thought Resident #2's Hydrocodone-Acetaminophen had been administered but "just not documented."

Attempted telephone interview with the Administrator on 07/24/24 at 3:02pm was unsuccessful.

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The facility failed to ensure the CSCS for a resident (#2) accurately reconciled the administration, receipt, and disposal of controlled substances. The facility's failure resulted in 164 tablets of a controlled medication being unaccounted for and no documentation to know when the medication had been administered or the effectiveness of the medication. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD ADULT CARE #1	**2322 NEWTON STREET GREENSBORO, NC 27406**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 367	Continued From page 51 ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/24/24 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 7, 2024.	C 367		