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D 000	Initial Comments The Adult Care Licensure Section and Buncombe County Department of Social Services conducted a follow-up survey and a complaint investigation on 08/14/24 through 08/20/24. The complaint investigation was initiated by the Buncombe County Department of Social Servicies (DSS) on 07/25/24 and 08/09/24.	D 000		
D 188	10A NCAC 13F .0604(e)(1) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or	D 188		

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D 188	Continued From page 1 resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure minimum staff were present to meet the needs of residents for 3 of 42 shifts sampled for 07/04/24-07/17/24. The findings are: Review of the facility current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was licensed as an assisted living with a capacity of 99 beds. Observations during the initial tour on 08/14/24 from 8:30am to 10:00am revealed the facility was comprised of assisted living (AL) beds located in a locked unit on a basement floor, a first floor, a second floor, and a third floor accessible by an elevator and several staircases.	D 188		

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D 188	Continued From page 2 Review of the facility's current census on 08/14/24 revealed: -There were 22 residents who resided on the locked unit on the basement floor. -There were 10 residents who resided on the first floor. -There were 30 residents who resided on the second floor. -There were 20 residents who resided on the third floor. -There were a total of 82 residents who resided in the facility. Review of the staff time records from 07/04/24-07/17/24 revealed: -On 07/06/24, the census was 63 requiring 24 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 8 staff hours. -On 07/07/24, the census was 63 requiring 24 staff hours on third shift and a total of 20 hours were provided leaving a shortage of 4 staff hours. -On 07/11/24, the census was 63 requiring 24 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 8 staff hours. Interview with a resident 08/16/24 at 2:45pm revealed: -She required staff assistance with bathing, dressing, toileting, and transfers. -She had recently had to wait for an hour for staff to assist her off the toilet. -The staff routinely told her when they responded to her call light that they only had one staff member assigned to provide care for all the residents who lived on the first, second, and third floors. -The staffing was short at least one shift every day. -Tasks that were "not necessary" like making the bed were left undone by the staff.	D 188		

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D 188	Continued From page 3 Interview with a personal care aide (PCA) on 08/19/24 at 2:30pm revealed: -There were times when they worked short staffed on the first, second, and third floors. -Agency staff had been brought in to provide additional staff. -When they were short staffed, residents had to wait longer to receive care. -Residents would at times get tired of waiting for staff to come help them and they would try to get up without assistance. -When residents tried to do things on their own without waiting for staff, they were at an increased risk for falls. -Today (08/19/24), there was one medication aide (MA) assigned to administer medications to the residents on first and third floor. -There was a second MA who was assigned to administer medications to the residents on second floor. -Today there were two PCAs assigned to assist residents on first, second, and third floors. Interview with a MA on 08/19/24 at 2:50pm revealed: -The facility was short staffed. -Working short staffed gave you limited time with each resident. -All of the staff helped to care for the residents. -Management was trying to hire more staff. Interview with a second MA on 08/20/24 at 3:00pm revealed: -On the third floor, there were five residents who needed total assistance or extensive assistance from staff with their activities of daily living (ADLs). -On the first floor, there was one resident that required two person assistance for transfers, was	D 188		

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D 188	Continued From page 4 totally dependent for showers, and required extensive assistance with dressing in the mornings and at bedtime. -The normal staffing assignment was three MAs and one PCA for the first, second, and third floor AL residents. -If the third floor MA was administering medications and the PCA was on the third floor giving a shower, a resident who called out for assistance on the first floor might have to wait for 30-45 minutes for help. -Management hired new staff and they would quit after working a short while. -The regular staff constantly worked overtime to cover the shifts. -Agency staff had been brought in to help out with the staffing shortages. Interview with the Health and Wellness Director (HWD) on 08/19/24 at 2:15pm they were actively recruiting new staff at the local community college and at job fairs. Interview with the Administrator on 08/20/24 at 5:45pm revealed: -The HWD was responsible for ensuring there were enough staff to cover all the shifts. -Their corporate allowable hours were above what staffing hours required by the State. -Agency staffing was being utilized to ensure there was adequate staff until additional staff could be hired.	D 188		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within	D 259		

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D 259	Continued From page 5 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a care plan was signed by the physician within 15 days of completion (#3) and with a change in condition (#13) on 2 of 8 sampled residents (#3 & #13). The findings are: 1. Review of Resident #3's current FL2 dated 09/25/23 revealed diagnoses included diabetes mellitus 2, hypertension, hypothyroidism, dementia and a cognitive disorder. Review of Resident #3's care plan dated 02/21/24 revealed: -She required supervision with eating. -She required limited assistance with ambulation and transfers. -She required total care with toileting, bathing, dressing, and grooming. -The care plan was not signed by a physician. Observation of Resident #3 in her room on 08/1424 from 9:30am to 9:45am revealed she was totally dependant with getting dressed, grooming, and assistance with transfer to the wheelchair. Interview with the Resident Care Director (RCD) on 08/20/24 at 11:31am revealed: -She was responsible for ensuring care plans were updated and signed by the physician.	D 259		

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-Corporate staff and a contracted nursing agency helped to get care plans updated after the last survey.
-She had not reviewed Resident #3's care plan yet to see that it was not signed by the physician.

Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed the RCD was responsible for getting a care plan signed by the physician with 15 days of the assessment and updated with a change of condition within 10 days.

Interview with the Administrator on 08/16/24 at 2:31pm the RCD was responsible for getting a care plan signed by the physician with 15 days of the assessment and updated with a change of condition within 10 days.

2. Review of Resident #13's current FL2 dated 05/29/24 revealed diagnoses included vascular dementia, major depressive disorder, history of prostate cancer, hyperlipidemia, and carotid stenosis.

Review of Resident #13's current care plan dated 05/13/24 revealed:
-He required supervision while eating, ambulating and transferring.
-He required extensive assistance with toileting, bathing and dressing.
-He required limited assistance with personal hygiene.

Review of Resident #13's Incident and Accident report on 06/06/24 revealed:
-Resident had a major change in his behavior.
-Resident was engaging in aggressive behavior.
-Resident's aggressive behavior required him to have a sitter in place.

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D 259	Continued From page 7 Review of Resident #13's Incident and Accident report on 06/24/24 revealed: -Resident had a sitter due to behavior. -Resident required help during a choking episode. Review of Resident #13's record revealed no new care plan after sudden behavioral changes. Interview with Resident #13's primary care physician on 08/19/20 at 5:00pm revealed: -Resident #13 had shown a sudden and significant increase in aggression which required him to have a sitter. -The facility and resident's family member agreed to the need for a sitter. -She was unaware when the sitter was stopped by the facility. -She tried to encourage the facility staff to use the eTriage/telehealth option for follow-ups and check-ins after incidents. Interview with a medication aid (MA) on 08/19/24 at 2:30pm revealed: -The resident was very aggressive at times. -The resident had behavioral changes. -The resident had a sitter for a short period of time. Interview with Resident Care Director (RCD) on 08/20/24 at 11:31am revealed: -Residents who experienced major changes in behavior needed a new care plan. -She was responsible for ensuring care plans were updated. Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed the RCD was responsible for getting a care plan signed by the physician with 15 days of the assessment and	D 259		

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D 259	Continued From page 8 updated with a change of condition within 10 days. Interview with the Administrator on 08/16/24 at 2:31pm the RCD was responsible for getting a care plan signed by the physician with 15 days of the assessment and updated with a change of condition within 10 days.	D 259		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to provide care and intervene according to the facility's policy and procedures for 1 of 1 sampled residents who choked, lost consciousness and required the Heimlich Maneuver (#1). The finding are: Review of the facility's Medical Emergency Policy	D 271		

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dated 03/18/19 revealed:
-The resident would receive emergency medical care when needed to prevent further illness.
-The staff would notify emergency medical services (EMS, call 911) when the resident exhibits signs and symptoms of distress and/or emergency condition for choking or loss of consciousness.
-The Health and Wellness Director/Resident Care Director HWD/RCD or caregivers were not required to obtain permission from the family/responsible person before summoning EMS.

Review of Resident #1's FL-2 dated 07/03/23 revealed diagnoses included diabetes, vascular dementia and hypothyroidism.

Review of Resident #1's Resident Register revealed Resident #1 was admitted on 07/03/23.

Review of Resident #1's Medical Orders for Scope of Treatment (MOST) form dated 08/18/23 revealed:
-Resident #1 did not want to be resuscitated (DNR, no CPR) should Resident #1 stop breathing and/or have no pulse.
-There was a directive to use oxygen, suction and manual treatment of airway obstruction as needed for comfort.
-Do not transfer to the hospital unless comfort needs cannot be met in the current location.

Review of Resident #1's progress note dated 07/09/24 at 5:28pm revealed a medication aide (MA) documented Resident #1 had a choking episode, turned blue in the face and a third party Certified Nursing Assistant (CNA) performed the Heimlich Maneuver.

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Review of Resident #1's progress note dated 07/17/24 at 8:45pm revealed:
-The Resident Care Director (RCD) documented a late entry for 07/09/24.
-On 07/09/24, the staff notified her that Resident #1 choked while eating beets.
-The RCD was informed that a third party CNA performed the Heimlich Maneuver and Resident #1's airway was cleared.
-Afterwards she observed Resident #1 sitting in the dining room with no signs or symptoms of distress.

Attempted review of Resident #1's Incident/Accident Report dated 07/09/24 was unsuccessful and not provided prior to exit.

Interview with a medication aide (MA) on 08/14/24 at 4:19pm revealed:
-On 07/09/24, she was the MA from 7:00am to 7:00pm.
-On 07/09/24, she was on break while another MA covered the residents when Resident #1 was eating lunch.
-The MA reported to her, Resident #1 began choking during lunch, and a third party CNA performed the Heimlich Maneuver and 911 was not called.
-After a choking episode, their policy directed staff to notify EMS for choking.
-The policy directed staff and they did not require permission from the family/Responsible Person (RP)/Power of Attorney (POA) before calling EMS but she did not because the RCD instructed her to not send anyone out if they did not have family/RP/POA permission.

Telephone interview with a second MA on 08/15/24 at 12:03pm revealed:
-On 07/09/24, she was the MA covering the

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Special Care Unit (SCU) when Resident #1 choked.
-A personal care aide (PCA) and the Activity Director (AD) were responsible for supervising the residents at the time of Resident #1 choked.
-During lunch she was assisting another resident down the hall when the AD yelled Resident #1 was choking.
-When she arrived in the dining room, Resident #1 had a bluish tent to her skin and a third party CNA was performing the Heimlich Maneuver on her, the second third party CNA was assisting and performing finger sweep to get the food out of Resident #1's mouth.
-After the choking episode, she called the RCD and the MA assigned to the SCU.
-The RCD and the MA took Resident #1 to the day room.
-The facility did not call EMS for Resident #1 and she was not sent to the hospital for evaluation after the choking episode.
-Resident #1 had a cough and strangled some due to a history of esophageal cancer but she was always capable of getting her throat cleared by herself, without intervention, but this time was more serious because Resident #1 turned blue and lost consciousness.

Interview with the AD on 08/15/24 at 3:10pm revealed:
-On 07/09/24, she was working at the facility for about 2 weeks.
-She and a PCA were in the dining room during lunch.
-She was about 20 feet from Resident #1 and a PCA was beside Resident #1 when Resident #1 began choking and grabbed her chest.
-The PCA asked Resident #1 if she was ok and Resident #1 shock her head no.
-The PCA patted Resident #1 back and said

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"cough it up".
-She told the PCA to perform the Heimlich Maneuver because Resident #1 was not coughing it up at that time and then she stopped coughing.
-She ran to get the MA.
-As she yelled for the MA's assistance, two third party CNAs were passing her outside the dining room.
-The MA came running down the hall and Resident #1 was blue and not responding.
-She saw one of the third party CNAs move the PCA out of the way when the PCA said he did not know what to do.
-The second third party CNA cleared the food from Resident #1's mouth as the first CNA did the Heimlich Maneuver.
-She was trained on the Heimlich Maneuver but was not sure what she could do at this facility because she was the AD.

Telephone interview with the PCA on 08/16/24 at 3:39pm revealed:
-On 07/09/24, he was standing beside Resident #1 when she started choking on beets.
-Resident #1 had a history of esophageal cancer and frequently coughed while she was eating.
-He stood by Resident #1 and waited to see if Resident #1 could clear the food herself.
-After a few seconds, it was obvious that Resident #1 was not able to clear the food obstruction.
-He asked someone to get help because Resident #1 turned blue and became unresponsive.
-He was trained on the Heimlich Maneuver, but he had not performed it on a real person before.
-There were two third party CNAs that showed up and he let them take care of Resident #1 because he felt they were more qualified.

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-The two third party CNAs were able to do the Heimlich maneuver and cleared the food obstruction from Resident #1's throat.
-In CPR training, which included the Heimlich Maneuver, the first thing to do was to call 911.
-The facility staff did not call 911 and Resident #1 was not sent out to the hospital.

Telephone interview with a third party CNA on 08/16/24 at 1:46pm revealed:
-On 07/09/24, she and her co-worker were at the facility providing care for a resident.
-She and her co-worker were taking a resident to the dining room when they heard staff yelling "she's choking".
-There was a staff member beside the resident who was choking.
-The PCA stated he did not know what to do and Resident #1 was blue, her chin was to her chest and drooling, she was unresponsive.
-Her co-worker moved the PCA out of the way and began performing the Heimlich Maneuver and about the second abdominal thrust what looked liked chunks of beets and white meat came up.
-As her co-worked performed the abdominal thrusts, she cleared the chunks of food from Resident #1's mouth.
-On the third abdominal thrust, her co-worker was able to clear the airway of Resident #1, and she became responsive.
-She was able to clear a large mouth full of chunks of food from Resident #1's mouth.
-The RCD came to check on Resident #1 and gave Resident #1 some water and stated Resident #1 was "fine" and Resident #1 choked quite "a bit".
-She asked the RSD if Resident #1 was going to be sent out and the RSD replied "no" because Resident #1 choked "quite a bit" and Resident #1

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was "fine".
-The facility staff did not call 911 and Resident #1 did not go the hospital for evaluation after choking, turning blue, losing consciousness and having the Heimlich Maneuver performed.

Interview with the RCD on 08/16/24 at 9:46am revealed:
-She started working about 8-9 weeks ago and was the RCD for the Special Care Unit (SCU).
-She was in a meeting when Resident #1 choked at lunch on 07/09/24.
-About 15 to 20 minutes after Resident #1 choked at lunch, she checked on Resident #1.
-Resident #1 was in the dining room and she gave Resident #1 some water to see if there was still an issue with swallowing.
-She and the MA moved Resident #1 to the day room and Resident #1 was "fine".
-Resident #1 still was coughing and hoarse.
-She suspected aspiration pneumonia so she requested and order for a chest xray form mobile xray.
-With her experience, she knew Resident #1 was fine and did not need to be sent out for evaluation after choking.
-On 07/09/24, she was aware Resident #1 choked at lunch, required the Heimlich Maneuver after turning blue and became unresponsive, but did not send Resident #1 out to be evaluated at the hospital because Resident #1 was "fine".
-She knew the policy was to send Resident #1 out but it was also her understanding the MA notified Resident #1's family and they did not want Resident #1 sent to the hospital.
-She was aware that it could take some time for mobile xray to get to the facility and the emergency room was immediate and a physician would evaluate Resident #1 for aspiration and perform a chest xray as well as treatment for

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aspiration.

Telephone interview with Resident #1's primary care provider (PCP) on 08/19/24 at 8:25am revealed:
-When Resident #1 choked, turned blue, became non-responsive, and required the Heimlich Maneuver she also required an evaluation by a physician.
-On 07/09/24, she was not made aware of Resident #1's choking incident until 07/11/24.
-She would characterize Resident #1's 07/09/24 choking episode as a "severe choking" episode where her airway was completely obstructed resulting in her not be able to cough, and lose consciousness.
-When someone choked, the food blocks their airflow to their lungs and made it hard for them to breath or talk, their face would turn red until they could not breathe or talk decreasing the oxygen flow and then their face turned blue.
-When Resident #1's face turned blue she was at serious risk of decreased blood flow to the brain which could lead to death.
-It only takes 4-6 minutes before brain damage or death to happen after someone chokes.
-At the point Resident #1 turned blue and lost consciousness, the Heimlich Maneuver was to be performed and 911 should have been called.
-After Resident #1's severe choking episode Resident #1 needed to be evaluated for aspiration and other harmful effects of choking and a history of esophageal cancer.
-The other harmful effects of choking include the lungs filling up with fluid leading to inflammation and hypoxia from the decreased oxygen saturation, while both of those complications could lead to death.
-Resident #1 had a Medical Orders for Scope of Treatment (MOST) form which indicated Resident

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D 271	Continued From page 16 #1 should have been sent to the hospital for because comfort measures such as suctioning the airway and oxygen could have been provided at the hospital and could not have been provided at the facility. Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed: -The policy stated a resident was to be sent out to the hospital after a choking episode and or a loss of consciousness in order to be evaluated by a physician. -On 07/09/24, since Resident #1 choked, turned blue and lost consciousness, 911 was to be called while a staff member performed the Heimlich Maneuver, and she was not informed that 911 was not called and Resident #1 did not go to the hospital until 07/12/24 after Resident #1 died. Telephone interview with the previous Administrator on 08/16/24 at 2:40pm. -He was the Administrator on 07/09/24 and 07/12/24. -He did know about Resident #1's 07/09/24 choking episode and not sent out, through email, either that day or the next day. -911 should have been called on 07/09/24 and sent to the hospital for evaluation per the policy on choking and Resident #1 becoming unresponsive. Interview with the Administrator on 08/16/24 at 2:31pm. -She began working as the Administrator on 08/12/24. -It was important for the staff to call 911 and for Resident #1 to receive a medical evaluation after choking on 07/09/24.	D 271		

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D 271	Continued From page 17 Attempted telephone interview with Resident #1's Power of Attorney (POA) on 08/16/24 at 4:00pm and 08/16/24 at 5:05pm was unsuccessful. Review of Resident #1's death certificate revealed Resident #1 died on 07/12/24 at 7:55pm immediately due to rapid onset of hypoxia and sequentially over days due to aspiration pneumonia. [Refer to tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)] _____ The facility failed to immediately respond according to their policy and procedure which included notifying EMS for choking or loss of consciousness when Resident #1 began choking, turned blue and became unconscious on 07/09/24. The resident regained consciousness after the Heimlich Maneuver was administered, but was not sent to the emergency room for medical evaluation or measures to provide comfort. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/16/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024.	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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of residents.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, record reviews, and interviews, the facility failed to provide follow-up and referral for 8 of 13 sampled residents (#1, #2, #3, #4, #5, #6, #10 & #13) related to a resident who had two choking episodes (#1), notification of a primary care provider (PCP) about weight changes of three pounds, medications to treat blood pressure, and blood pressures and heart rates out of parameter to administer metoprolol (#2), notification to the primary care provider (PCP) about medications to treat blood pressure, anxiety, and diabetes (#3), about fall with a head injury (#4), weekly weights (#5), a diabetic medication with parameters (#6), a fall with head trauma for a resident on antiplatelet medications (#10) and weekly weights with parameters (#13).

The findings are:

1. Review of the facility's medical emergency policy dated 03/18/24 revealed the resident's physician was to be notified after 911 was called for a resident who became unconscious or choked.

Review of Resident #1's FL-2 dated 07/03/23 revealed diagnoses included diabetes, vascular dementia and hypothyroidism.

Review of Resident #1's Resident Register revealed Resident #1 was admitted on 02/05/24.

a. Review of Resident #1's progress note dated 07/09/24 at 5:28pm revealed a medication aide (MA) documented Resident #1 had a choking

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episode, turned blue in the face and a hospice Certified Nursing Assistant (CNA) performed cardio-pulmonary resuscitation (CPR).

Review of Resident #1's progress note dated 07/17/24 at 8:45pm revealed:
-The Resident Care Director (RCD) documented a late entry for 07/09/24.
-On 07/09/24, the staff notified her that Resident #1 choked while eating beets.
-The RCD was informed that a hospice nurse performed the Heimlich Maneuver and Resident #1's airway was cleared.
-Afterwards she observed Resident #1 sitting in the dining room with no signs or symptoms of distress.

Review of the facility's 24 hour report dated 07/09/24 revealed:
-The MA documented Resident #1 had a choking episode during the shift due to diet restrictions.
-There was no documentation Resident #1's Primary Care Provider (PCP) was notified.

Attempted review of Resident #1's Incident/Accident Report dated 07/09/24 was unsuccessful and not provided prior to exit.

Review of the Special Care Unit (SCU) nurses station physician book revealed:
-There was a three ring binder labeled as "physician book".
-On the outside of the binder, there were cards with contact information for two of the PCPs.
-The PCP contact information included phone number, email address, and fax number.
-Inside there were monthly dividers including January 2024-December 2024.
-There was at least one communication form under each monthly divider tab.

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-The form was labeled "request to be seen".
-There was a block of space for staff to enter the residents name, date of request, concern, and which staff it was requested by.
-There were no entries for Resident #1 for 07/09/24.

Interview with a medication aide (MA) on 08/14/24 at 4:19pm revealed:
-On 07/09/24, she was the MA from 7:00am to 7:00pm.
-On 07/09/24, she was off the floor while another MA covered the residents when Resident #1 was eating lunch.
-The MA reported to her, during lunch Resident #1 began choking, a 3rd party Certified Nursing Assistant (CNA) did the Heimlich Maneuver.
-The RCD was responsible to notify Resident #1's PCP of the choking episode on 07/09/24.

Telephone interview with a second MA on 08/15/24 at 12:03pm revealed:
-On 07/09/24, she was the MA covering the SCU when Resident #1 choked.
-The staff in the dining room responsible for supervising the residents at the time of Resident #1 choking was a personal care aide (PCA) and the Activity Director (AD).
-During lunch she was assisting another resident down the hall when the AD yelled Resident #1 was choking.
-When she arrived in the dining room Resident #1 was blue and a 3rd party CNA was performing the Heimlich Maneuver on Resident #1 and the second 3rd party CNA was assisting by doing a finger sweep to get the food out of Resident #1's mouth.
-After the choking episode, she called the RCD and the MA assigned to the SCU.
-She did not call Resident #1's PCP because she

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thought the RCD called.
-It was the MA responsibility to notify the PCP, but the RCD said she would take care of notification to the PCP.

Interview with the RCD on 08/16/24 at 9:46am revealed:
-She started working about 8-9 weeks ago and was the RCD for the SCU.
-On 07/09/24, when Resident #1 choked while lunch.
-About 15 to 20 minutes after Resident #1 choked at lunch, she went to check on Resident #1.
-Resident #1 was in the dining room and she gave Resident #1 some water to see if there was still an issue with swallowing.
-She and the MA moved Resident #1 to the day room and Resident #1 was fine.
-Resident #1 still was coughing and hoarse.
-She suspected aspiration pneumonia so she requested and order for a chest xray form mobile xray.
-After looking through the orders on 08/16/24, she found out there was no chest xray ordered on 07/09/24.
-She was probably confused about the chest xray and she did not notify the physician because she did not have access to the computer based triage system on 07/09/24.
-She was trained by the Corporate Clinical Specialist (CCS) to use the computer based triage system but was not given a login.
-Since she did not have a login for the computer based triage system she could have called Resident #1's PCP, but did not call the PCP because Resident #1 was not in distress anymore after the choking episode and she had requested the chest xray.
-She knew Resident #1 was fine and did not need to be sent out for evaluation after choking.

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D 273	Continued From page 22 -On 07/09/24, she was aware Resident #1 choked at lunch, required the Heimlich Maneuver after turning blue and became unresponsive, but did not send Resident #1 out to be evaluated at the hospital or call the PCP because Resident #1 was "fine". -The MAs were responsible for completing the Incident/Accident report which includes notification to the physician and documenting the choking episodes on the 24 hour report. -She was responsible for reviewing the Incident/Accident report, and the 24 hour report sheets the following morning and report all of the concerns to the Administrator at the morning stand up meeting. -She did not know the Incident/Accident report was not filled out. -She was responsible for following-up with any issues or concerns on those reports. -She did not follow-up to see that Resident #1's PCP was notified on 07/09/24 but Resident #1 was seen by a physician on 07/11/24 related to the choking episode on 07/09/24. Telephone interview with Resident #1's primary care provider (PCP) on 08/19/24 at 8:25am revealed: -Resident #1 had a choking episode on 07/09/24, turned blue, became non-responsive, required the Heimlich Maneuver required an evaluation by a physician and a chest xray. -She was not made aware of Resident #1's choking incident on 0/09/24 until 07/11/24 when her Supervisory Physician was at the facility and staff made the Supervisory Physician of Resident #1's choking episode on 07/09/24. -Resident #1's 07/09/24 choking episode was characterized as a "severe choking" episode where her airway was completely obstructed resulting in her not be able to cough, and lose	D 273		

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consciousness.
-When Resident #1 choked, the food blocked airflow to her lungs and making it hard for her to breath or talk, her face turned red until she could not breath or talk decreasing the oxygen flow and then her face turned blue.
-When Resident #1's face turned blue she was at serious risk of decreased blood flow to the brain which could lead to death.
-It only took 4-6 minutes before brain damage or death to occur after someone choked.
-At the point Resident #1 turned blue and lost consciousness, the Heimlich Maneuver was to be performed and 911 should have been called.
-After Resident #1's severe choking episode Resident #1 needed to be evaluated for aspiration and other harmful effects of choking.
-The other harmful effects of choking include the lungs filling up with fluid leading to inflammation and hypoxia from the decreased oxygen saturation, while both of those complications could lead to death.
-Resident #1 had a Medical Orders for Scope of Treatment (MOST) form which indicated Resident #1 should have been sent to the hospital to evaluate Resident #1's airway, and possibly provide comfort measures related to the build up of secretion such as suctioning and oxygen supplemental oxygen to treat the hypoxia.

b. Review of Resident #1's progress note dated 07/12/24 at 10:40pm revealed:
-The RCD documented a MA went into Resident #1's room to administer bedtime medications and found Resident #1 laying on her right side in her bed.
-The MA spoke to Resident #1 and did not get a response and noticed green vomit on Resident #1's clothes.
-The MA called for other staff to assist.

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-Resident #1 was positioned on her back and Resident #1 took two breaths and then breathing ceased.
-911 was called and Resident #1 was pronounced by the EMS at 7:55pm.
-The RCD arrived at the facility and found Resident #1 without a pulse and no respirations.

Review of the facility's 24 hour report dated 07/12/24 revealed:
-On the 7:00am to 7:00pm section, it was documented Resident #1 was coughing and throwing up.
-On the 7:00pm to 7:00am section, it was documented Resident #1 died at 7:55pm.
-There was no documentation the PCP was notified.

Review of Resident #1's death certificate revealed Resident #1 died on 07/12/24 at 7:55pm immediately due to rapid onset of hypoxia and sequentially over days due to aspiration pneumonia.

Telephone interview with a second MA on 08/15/24 at 12:03pm revealed:
-On 07/12/24, she was the MA on duty in the SCU, 7:00am to 7:00pm.
-On 07/12/24, Resident #1 was served a regular diet, from the serving containers, that was not pureed for breakfast and had maybe a bite or two out of it and and started having some heavy coughing episodes and choked.
-She removed the regular diet plate from Resident #1 and Resident #1 did not eat any more until lunch.
-Resident #1 was served a regular diet at lunch and she removed it once she noticed it.
-She spoke to a Physical Therapist (PT) that was in the MCU who clarified Resident #1 was to be

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served a pureed diet and notified the Dining Room (DM) and the diet was changed for supper.
-About and hour after lunch, a PCA informed her that Resident #1 was in the day room coughing and vomiting.
-She went to the day room and found Resident #1 coughing very bad and vomiting a lot.
-The RCD came into the dayroom and helped clean Resident #1 up and told to "keep an eye" on Resident #1 and the RCD went back to her office.
-She went to the RCD and asked at what point did she need to send Resident #1 to the hospital for evaluation and was told by the RCD that she thought Resident #1 had aspiration pneumonia and as long as the phlegm was coming out then Resident #1 was "ok" because with aspiration pneumonia it was normal for the phlegm to come out.
-The RCD told her to call the PCP's office and check to see if the results of a chest xray that was ordered on 07/09/24 after that choking episode was completed and read.
-Resident #1's PCP office told her that the chest xray results were not received.
-She was not told to do anything else and she did not tell the PCP's office that Resident #1 choked again and was vomiting.
-She informed the RCD about the PCP's office not having the chest xray results and again inquired if she could send Resident #1 to the hospital.
-The RCD denied her request because Resident #1 was "fine" now.

Telephone interview with a PT on 08/19/24 at 9:23am revealed:
-On 7/12/24, she was working with another resident before lunch, when the MA on duty in the MCU asked her for assistance to make sure

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D 273	Continued From page 26 Resident #1 was "ok". -The MA was concerned that Resident #1 was supposed to be on a pureed diet and was served a regular diet at breakfast and had a choking episode. -On 07/12/24, there was no Heimlich Maneuver performed on Resident #1 that she was aware of. -She called the Speech Therapist (ST) and Resident #1's PCP to verify the correct diet order. -On 07/12/24, the ST clarified he recommended a pureed diet on 07/11/24 due to a choking episode with Resident #1. -On 07/12/24, before she left the MCU right before lunch she clarified the diet for pureed with the kitchen staff but did not see what was served to Resident #1. Telephone interview with the facility's contracted ST on 08/19/24 at 4:19pm revealed: -On 07/11/24, he received a call from a physician from Resident #1's PCP office about Resident #1 choking on 07/09/24 and a request to change Resident #1's diet to a pureed diet. -On 07/11/24, Resident #1's diet was changed from mechanical soft to pureed by the PCP the RCD was responsible to take the new order to the kitchen manager to add to the therapeutic diet list in the kitchen. -On 07/12/24, the facility's contracted PT informed him about a choking episode Resident #1 experienced during breakfast due to being served a regular diet. -The PT wanted clarification of the diet order. -He told the PT that Resident #1 was to be served a pureed diet. -The PT said she would make sure dietary had the correct order. -If Resident #1 was not served a pureed diet, then Resident #1 could choke.	D 273		

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D 273	Continued From page 27 Interview with the RCD on 08/16/24 at 9:46am revealed: -On 07/12/24 about 1-2 hours after lunch, she was sitting in her office across from the day room and Resident #1 was sitting in the day room. -Resident #1 began vomiting and she went into the day room and cleaned Resident #1 up. -She asked the MA to call Resident #1's PCP and check to see if the chest xray report results were received and to let the PCP know Resident #1 was vomiting. -The MA came back in less than 30 minutes and told her that the chest xray was not received and she thought the MA informed them Resident #1 was vomiting. -On 07/11/24, a provider from Resident #1's PCP office was rounding on other residents when she informed the provider about Resident #1's choking episode on 07/09/24. -On 07/11/24, she requested a chest xray and the provider ordered a chest xray for evaluation of possible aspiration pneumonia. -Resident #1 was not in respiratory distress after the choking episode on 07/12/24 and she thought a chest xray was already completed so she felt Resident #1 did not need to be sent out for evaluation. -On 07/12/24, Resident #1 was in distress during the coughing and vomiting episode after lunch but shortly there after, she assessed Resident #1 as being "fine". -On 07/12/24, after her assessment of Resident #1, she did not notify Resident #1's PCP of her assessment. -On 07/12/24, she also felt that since Resident #1 already had a chest xray and a provider already suspected aspiration pneumonia, she chose not to send Resident #1 to the hospital for evaluation. -On 07/12/24, she left work about 5:40pm to 6:00pm and around 7:50pm she was notified that	D 273		

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Resident #1 had died.
-Today, 08/16/24, she determined the chest xray was never completed.
-She assumed the chest xray was completed when she put the order request in on 07/09/24 after Resident #1 choked and the on 07/11/24 found out it was not completed, she had a provider order another one.
-On 07/12/24, the MA informed her that the chest xray was not completed but she still did not notify the PCP.
-The MAs were responsible for completing the Incident/Accident report which included notification to the physician and documenting the choking episodes on the 24 hour report.
-She was responsible for reviewing the Incident/Accident report, and the 24 hour report sheets the following morning and to report all of the concerns to the Administrator at the morning stand up meeting.
-She was responsible for following-up with any issues or concerns on those reports.

Telephone interview with Resident #1's primary care physician (PCP) on 08/19/24 at 8:25am revealed:
-On 07/09/24, Resident #1's had choking episode was characterized as a "severe choking" episode where her airway was completely obstructed resulting in her not be able to cough, and loose consciences.
-She was notified about the 07/09/24 choking episode after her Supervisory Physician saw Resident #1 and ordered a chest xray on 07/11/24.
-On 07/12/24, she was not made aware of Resident #1's choking incident with breakfast or the vomiting episode until after Resident #1 died.
-When Resident #1 choked while eating, Resident #1 needed to be evaluated by a

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physician because Resident #1 was at higher risk of death related to aspiration and a history of esophageal cancer.
-On 07/09/24, Resident #1 had a severe choking episode and turned blue and lost consciousness, which put her at a very high risk for complications resulting from choking.
-The complications after Resident #1 were inflammation of the lungs and hypoxia related to aspiration.
-A complete blockage of Resident #1's airway, due to inflammation could occur with in 36 hours of a severe choking incident and death could happen within 36 hours of the severe choking incident.
-After the choking episode, Resident #1 should have been evaluated at the hospital or she should have been called and she could have completed a virtual visit at the very least to evaluate for complications after choking.
-She was informed Resident #1 died on 07/12/24 at 7:55pm.

Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed:
-The MA's were responsible for notifying the PCP about Resident #1 choking and receive new orders if there were some.
-The RCD was responsible for following-up with the PCP about the choking and make sure there were no new orders.

Telephone interview with the previous Administrator on 08/16/24 at 2:40pm.
-He was the Administrator on 07/09/24 and 07/12/24.
-The MA's were responsible for notifying the PCP about incidents such as chocking.
-The RCD was responsible for following-up with the PCP about the choking episode and ensure

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any new orders or directions were received and implemented.
-He was told by the RCD, Resident #1 had a choking episode on 07/09/24, 07/12/24 and the PCP was notified, but later found out that was not the case.
-There was no Incident/Accident report available for him to review for Resident #1's choking episode on 07/09/24.
-There was an Incident/Accident report available for him to review for Resident #1's death dated 07/12/24 but not a choking episode on 07/12/24.

Interview with the Administrator on 08/16/24 at 2:31pm.
-She began working as the Administrator on 08/12/24.
-The MA's were responsible for notifying the PCP about Resident #1 choking.
-The RCD was responsible for following-up with the PCP and for reviewing the Incident/Accident reports.

Attempted telephone interview with Resident #1's Power of Attorney (POA) on 08/16/24 at 4:00pm and 08/16/24 at 5:05pm was unsuccessful.

Attempted telephone interview with the Supervisory Physician on 08/19/24 at 1:00pm was unsuccessful.

2. Review of Resident #3's current FL2 dated 09/25/23 revealed diagnoses included diabetes mellitus 2, hypertension, hypothyroidism, dementia and a cognitive disorder.

a. Review of Resident #3's signed physician's order dated 05/20/24 revealed an order to check Resident #3's blood sugar three times a day.

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Review of Resident #3's signed physician's order dated 07/15/24 revealed an order to check Resident #3's blood sugar two times a day.

Review of Resident #3's June 2024 electronic Medication Record (eMAR) revealed:
-There was an entry to check a finger stick blood sugar (FSBS) three times a day at 8:00am, 2:00pm and 8:00pm.
-The FSBS was documented as refused on 06/11/24 and 06/12/24 at 8:00am.

Review of Resident #3's July 2024 eMAR revealed:
-There was an entry to check a FSBS three times a day, with an original date of 05/20/24, scheduled at 8:00am, 2:00pm and 8:00pm.
-On 07/04/24 at 8:00pm, the FSBS was documented as "refused".
-On 07/05/24 at 8:00am, the FSBS was documented as "refused".
-On 07/11/24 at 8:00am, the FSBS was documented as "unable to take medication".
-On 07/11/24 at 2:00pm, the FSBS was documented as "refused".
-On 07/12/24 at 2:00pm, the FSBS was documented as "refused".
-On 07/12/24 at 8:00pm, the FSBS was documented as "waiting on glucose strips".
-On 07/13/24 at 8:00am, the FSBS was documented as "no glucose strips on the cart".
-On 07/13/24 at 2:00pm, the FSBS was documented as "no test strips".
-On 07/14/24 at 8:00am, the FSBS was documented as "no lancets in cart".
-On 07/15/24 at 8:00am, the FSBS was documented as "waiting on the pharmacy".
-On 07/15/24 at 2:00pm, the FSBS was documented as "unable to check".
-On 07/15/24 at 8:00pm, the FSBS was

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documented as "need glucose strips".
-There was an entry to check FSBS two times a day with an original date of 07/16/24, documented at 8:00am, 2:00pm and 8:00pm.
-On 07/19/24 at 8:00am, the BS was documented as "refused".
-On 07/19/24 at 2:00pm, the BS was documented as "test strips not in cart".
-On 07/20/24 at 8:00am, the BS was documented as "already ate".
-On 07/21/24 at 8:00am, the BS was documented as "med not on cart".
-On 07/24/24 at 8:00pm, the BS was documented as "refused".

After review of Resident #3's July eMAR, and interview with the Pharmacist revealed:
-The BS was refused for 4 out of 45 opportunities 07/01/24 to 07/016/24.
-The BS was not obtained due to there were no test strips for 4 out of 45 opportunities.
-The BS was not obtained due to there were no lancets for 1 out of 45 opportunities.
-The BS was not obtained due to the staff were unable to obtain for 1 out of 45 opportunities.
-The BS was not obtained due to the staff were unable to check for 1 out of 45 opportunities.
-The BS was not obtained due to "waiting on the pharmacy" for 1 out of 45 opportunities.

Review of Resident #3's August 2024 eMAR revealed:
-There was an entry to check BS two times a day with an original date of 07/16/24, scheduled at 8:00am and 8:00pm.
-On 08/12/24 at 8:00am, the BS was documented as "unable to take medication".

Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20

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D 273	Continued From page 33 lancets and 25 test strips. Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: -There was an order dated 05/20/24 to check Resident #3's FSBS three times a day. -There was an order dated 07/16/24 to check Resident #3's FSBS two times a day. -On 05/28/24, a 16 days supply of 50 test strips, were dispensed to the facility. -On 05/29/24, a 33 days supply of 100 test strips, were dispensed to the facility. -On 06/06/24, a 33 days supply of 100 lancets, were dispensed to the facility. -On 07/24/24, a 50 days supply of 100 lancets, were dispensed to the facility. -On 07/15/24, a 50 days supply of 100 test strips, were dispensed to the facility. -The lancets and test strips were not on cycle fill and it was the facility's responsibility to request refills. -Resident #3 would have been out of lancets 07/07/24 to 07/16/24 used as ordered. Review of the memory care nurses station physician book revealed: -On the outside of the binder, there were cards with contact information for two of the Primary Care Provider (PCPs). -The PCP contact information included phone number, email address, and fax number. -Inside there were monthly dividers including January 2024-December 2024. -There was at least one communication form under each monthly divider tab. -The form was labeled "request to be seen". -There was a block of space for staff to enter the residents name, date of request, concern, and which staff if was requested by.	D 273		

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D 273	Continued From page 34 -There were no entries for Resident #3 for the month of June - July 2024. Interview with a medication aide (MA) on 08/14/24 at 4:19pm revealed: -The Resident Care Director (RCD) trained her to write missing supplies in the physician book and the 24 hour hour report log at the nurses station. -The PCP would look at that entry on the next visit which could be two weeks away. -She notified the RCD when Resident #3 was missing FSBS supplies and the RCD stated she would take care of it. Telephone interview with Resident #3's PCP on 08/19/24 at 8:25am revealed: -Resident #3 was being treated with oral diabetic medications along with a long acting insulin at night. -It was important for Resident #3 to have her BSs checked every day so she could regulate the diabetic medications administered and control Resident #3's BS. -She was not informed when Resident #3 ran out of diabetic test supplies. -After every visit with Resident #3, she educated the staff to closely monitor Resident #3's BS and report to her when there was an issue with diabetic supplies. Refer to a second interview with a MA on 08/20/24 at 8:00am. Refer to interview with a second MA on 08/20/24 at 8:30am. Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical	D 273		

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D 273	Continued From page 35 Specialist on 08/16/24 at 2:37pm. Refer to interview with the Administrator on 08/16/24 at 2:31pm. b. Review of Resident #3's signed physician's order dated 05/14/24 revealed an order for furosemide (a medication to treat high blood pressure) 10mg/ml solution, take 2ml = 20mg every morning. Review of Resident #3's signed physician's order dated 07/21/24 revealed an order for furosemide 10mg/ml solution, take 4ml = 40mg every morning. Review of Resident #3's signed physician's order dated 07/21/24 revealed an order for furosemide 10mg/ml solution, take 6ml = 60mg every morning. Review Resident #3's June 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml solution, take 2ml = 20mg every morning with an original date of 05/14/24 scheduled to be administered at 8:00am. -On 06/02/24 at 8:00am, the furosemide was documented as "refused". -On 06/08/24 at 8:00am, the furosemide was documented as "refused". -On 06/11/24 at 8:00am, the furosemide was documented as "refused". -On 06/12/24 at 8:00am, the furosemide was documented as "refused". -On 06/15/24 at 8:00am, the furosemide was documented as "refused". -On 06/30/24 at 8:00am, the furosemide was documented as "waiting on pharmacy". -The furosemide was not documented as administered for 6 out of 30 opportunities.	D 273		

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D 273	Continued From page 36 Review Resident #3's July 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml solution, take 2ml = 20mg every morning with an original date of 05/14/24 and a discontinue date of 07/22/24 scheduled to be administered at 8:00am. -On 07/01/24 at 8:00am, the furosemide was documented as "waiting on pharmacy". -On 07/02/24 at 8:00am, the furosemide was documented as "refused". -On 07/03/24 at 8:00am, the furosemide was documented as "not on cart, ordered from pharmacy". -On 07/05/24 at 8:00am, the furosemide was documented as "refused". -On 07/08/24 at 8:00am, the furosemide was documented as "ordered from pharmacy". -On 07/11/24 at 8:00am, the furosemide was documented as "unable to take medication". -On 07/19/24 at 8:00am, the furosemide was documented as "refused". -There was an entry for furosemide 10mg/ml solution, take 6ml = 40mg every morning with an original date of 07/22/24 and a discontinue date of 07/30/24 scheduled to be administered at 8:00am. -On 07/30/24 at 8:00am, the furosemide was documented as not administered "discontinued". -There was an entry for furosemide 10mg/ml solution, take 6ml = 60mg every morning with an original date of 07/30/24 documented as not administered at 8:00am "med not available, RCD followed up with pharmacy". -The furosemide was not documented as administered for 8 out of 31 opportunities. Review of Resident #3's August 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml	D 273		

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solution, take 6ml = 60mg every morning with an original date of 07/30/24 scheduled at 8:00am.
-On 08/03/24 at 8:00am, the furosemide was documented as "not on cart, refill requested by RCD".
-On 08/04/24 at 8:00am, the furosemide was documented as "med not available, RCD followed up with pharmacy".
-On 08/06/24 at 8:00am, the furosemide was documented as "RCD followed up with pharmacy".
-On 08/12/24 at 8:00am, the furosemide was documented as "unable to take".
-The furosemide was not administered for 4 out of 14 opportunities.

Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:
-On 05/14/24, there was an order for furosemide 10mg/ml solution, take 2ml = 20mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 6ml a 30 day supply on 05/14/24 and 07/01/24.
-On 07/21/24, there was an order for furosemide 10mg/ml solution, take 4ml = 40mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 120ml, a 30 day supply on 07/22/24.
-On 07/30/24, there was an order for furosemide 10mg/ml solution, take 6ml = 60mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 180ml, a 30 day supply on 07/30/24.
-Based on dispense history, Resident #3 would have been out of the furosemide 2ml 06/13/24 until 07/01/24.

Review of Resident #3's medications available for

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HARMONY AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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administration on 08/20/24 at 11:18am revealed there was a bottle of furosemide 10mg/1ml liquid, with a label dated 07/30/24 containing 60mls, to administer 6ml = 60mg every morning for hypertension with 8mls left to administer.

Review of the memory care nurses station physician book revealed there were no entries for Resident #3 for June 2024 - July 2024 requesting a furosemide refill.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/19/24 at 8:25am revealed:
-The furosemide was ordered to treat Resident #3's hypertension.
-On 07/21/24, Resident #3 was seen by virtual visit for weeping in her legs due to increased swelling and she increased the furosemide from 2ml = 20mg to 4ml = 40mg every morning.
-On 07/29/24, she saw Resident #3 at the facility and there was no documentation of Resident #3's blood pressure (BP) for the month of July 2024, she went off of June 2024's BP which was a little high, and the visit from 07/21/24 related to Resident #3's legs swelling and weeping, so she increased the furosemide to 6ml = 60mg every morning and sent the order to pharmacy.
-She did not know Resident #1 was out of furosemide at any time.
-She did not know of the furosemide 4ml = 40mg ordered on 07/21/24 was possibly administered as 6ml instead of 4ml for 8-9 days in July 2024.
-Resident #3 could have increased blood pressure causing fluid retention causing swelling and weeping in Resident #1's legs.

Interview with a MA on 08/14/24 at 4:19pm revealed she notified the RCD when Resident #3 refused and was out of furosemide, the RCD

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D 273	Continued From page 39 stated that she would take care of it. Refer to a second interview with a MA on 08/20/24 at 8:00am. Refer to interview with a second MA on 08/20/24 at 8:30am. Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm. Refer to interview with the Administrator on 08/16/24 at 2:31pm. c. Review of Resident #3's signed physician's order dated 06/10/24 for lorazepam gel (a medication used to treat anxiety/agitation) 0.5mg/0.5ml to forearm two times a day. Review of Resident #3's signed physician's orders dated 07/25/24 for lorazepam gel 1mg/1ml to inner wrist or other hairless area every night at bedtime. Review of the memory care nurses station physician book revealed there were no entries for Resident #3 for the month of July 2024 to request refills for lorazepam gel. Review of Resident #3's June 2024 eMAR revealed: -There was an entry for lorazepam gel 0.5mg/0.5ml to forearm two times a day with an original date of 06/11/24 documented as administered on 06/13/24 to 06/21/24 at 8:00am and 8:00pm, and 06/23/24 to 06/30/24 at 8:00am and 8:00pm.	D 273		

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D 273	Continued From page 40 -On 06/11/24 at 8:00am, the lorazepam was documented as "not in cart". -On 06/11/24 at 8:00pm, the lorazepam was documented as "med not on cart". -On 06/12/24 at 8:00am, the lorazepam was documented as "refused". -On 06/22/24 at 8:00am, the lorazepam was documented as "med not in cart". -The lorazepam was not administered for 4 out of 60 opportunities. Review Resident #3's July 2024 eMAR revealed: -There was an entry for lorazepam gel 0.5mg/0.5ml to forearm two times a day with an original date of 06/11/24 documented as administered on 07/01/24 to 07/13/24 at 8:00am and 8:00pm, 07/14/24 at 8:00pm, 07/17/24 to 07/18/24 at 8:00am and 8:00pm, 07/19/24 at 8:00pm, and 07/20/24 to 07/25/24 at 8:00am and 8:00pm. -On 07/14/24 at 8:00am, there was no documentation as to why the lorazepam was not administered. -On 07/15/24 at 8:00am, the lorazepam was documented as "waiting on pharmacy". -On 07/15/24 at 8:00pm, the lorazepam was documented as "med not on cart". -On 07/16/24 at 8:00am, the lorazepam was documented as "not in cart". -On 07/19/24 at 8:00am, the lorazepam was documented as "refused". -On 07/26/24 at 8:00am, the lorazepam was documented as "discontinued". -There was an entry for lorazepam gel 1mg/1ml to forearm at night with an original date of 07/25/24 scheduled to be administered at 8:00pm. -On 07/26/24 at 8:00pm, the lorazepam was documented as "discontinued". -On 07/27/24 to 07/28/24 at 8:00pm, there was	D 273		

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no documentation as to why the lorazepam was not administered.
-The lorazepam was not administered for 11 out of 60 opportunities.

Telephone interview with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:
-On 06/11/24, there was an order for lorazepam gel 0.5mg/0.5ml to forearm two times a day.
-The pharmacy dispensed lorazepam gel 0.5ml = 0.5mg, 30mls, 30 day supply on 06/11/24 and 07/16/24.
-On 07/28/24, there was an order for lorazepam gel 1mg/1ml to forearm at night.
-The pharmacy was unable to dispense lorazepam 1mg/1ml because the pharmacy could not compound the medication before it was discontinued on 07/31/24.
-According to their records, the lorazepam 1mg/ml was not available for administration 07/25/24 to 07/31/24.
-Lorazepam was used for anxiety/agitation and if not received as ordered dose the resident could display increased behaviors.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/19/24 at 8:25am revealed:
-The lorazepam was ordered to help with Resident #3's agitation and anxiety.
-If Resident #3 did not get the lorazepam as ordered then that could increase the risk of behaviors.
-She was not notified of the refusals of medications and being out of the medications.

Telephone interview with a representative from the facility's contracted mental health (MH) provider on 08/15/24 at 2:00pm revealed:

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-The lorazepam was order for agitation and anxiety.
-He was not aware of Resident #3 refusing the lorazepam which caused him to make medication changes.
-If the lorazepam was not administered as ordered the Resident #3 would have an increase in behaviors which was the reason he had to change the lorazepam to clonazepam on 07/31/24.

Refer to a second interview with a MA on 08/20/24 at 8:00am.

Refer to interview with a second MA on 08/20/24 at 8:30am.

Refer to interview with the RCD on 08/16/24 at 9:46am.

Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm.

Refer to interview with the Administrator on 08/16/24 at 2:31pm.

d. Review of Resident #3's signed physician's order dated 05/14/24 for metformin (a medication used to treat diabetes) 500mg/5ml, administer 10ml two times a day.

Review of Resident #3's signed physician's order dated 05/14/24 for metformin 500mg/5ml, administer 10ml twice daily with breakfast and supper to decrease GI upset.

Review of the memory care nurses station physician book revealed there were no entries for Resident #3 for the month of July 2024 in regard to metformin refill request or refusals.

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D 273	Continued From page 43 Review Resident #3's June 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 10 ml = 1000mg two times a day, with an original date of 05/13/24 scheduled as administered at 8:00am and 8:00pm. -On 06/02/24 at 8:00am, the metformin was documented as "refused". -On 06/02/24 at 8:00pm, the metformin was documented as "not in cart". -On 06/08/24 at 8:00am, the metformin was documented as "refused". -On 06/08/24 at 8:00pm, the metformin was documented as "not in cart". -On 06/09/24 at 8:00pm, the metformin was documented as "not in cart". -On 06/11/24 at 8:00am, the metformin was documented as "refused". -On 06/12/24 at 8:00am, the metformin was documented as "refused". -On 06/17/24 at 8:00am, the metformin was documented as "on order". Review Resident #3's July 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 10 ml = 1000mg two times a day with an original date of 05/13/24 and a discontinue date of 07/03/24 scheduled to be administered at 8:00am and 8:00pm. -On 07/02/24 at 8:00am, the metformin was documented as "refused". -On 07/03/24 at 8:00pm, the metformin was documented as "discontinued". -There was an entry for metformin 500mg/5ml solution, administer 5 ml = 500mg two times a day with meals, breakfast and supper with an original date of 07/03/24 scheduled to be administered at 8:00am and 5:00pm. -On 07/05/24 at 8:00am, the metformin was documented as "refused".	D 273		

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D 273	Continued From page 44 -On 07/11/24 at 8:00am, the metformin was documented as "unable to take medication". -On 07/16/24 at 5:00pm, the metformin was documented as "not on cart". -On 07/17/24 at 5:00pm, the metformin was documented as "not on cart". -On 07/18/24 at 5:00pm, the metformin was documented as "not on cart". -On 07/19/24 at 8:00am, the metformin was documented as "refused". -On 07/20/24 at 5:00pm, the metformin was documented as "not in cart". -On 07/21/24 at 8:00am, the metformin was documented as "not on cart". -On 07/22/24 at 8:00am, the metformin was documented as "not in cart". -On 07/22/24 at 5:00pm, the metformin was documented as "not in cart". Review Resident #3's August 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 5ml = 500mg two times a day with meals, breakfast and supper with an original date of 07/03/24 scheduled to be administered at 8:00am and 5:00pm. -On 08/02/24 at 8:00am, the metformin was documented as "refused". -On 08/11/24 at 5:00pm, the metformin was documented as "refused". -On 08/12/24 at 8:00am, the metformin was documented as "unable to take". -On 08/13/24 at 5:00pm, the metformin was documented as "resident asleep". Review of Resident #3's medications available for administration on 08/20/24 at 11:18am revealed there was a bottle of metformin 500mg/5ml liquid, with a label dated 07/22/24 containing 200ml, to administer 5ml = 500mg every morning for	D 273		

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D 273	Continued From page 45 hypertension with 8ml left to administer. Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/19/24 at 8:25am revealed: -The metformin was ordered to treat Resident #3's high blood sugars. -On 07/03/24, she changed Resident #3's metformin from 8:00am and 8:00pm to twice a day with breakfast and lunch to help prevent digestive issues related to taking the medication on an empty stomach. -On 07/29/24, she saw Resident #3 at the facility and there was documentation of refusals and being out of the medication. -She was not notified of the refusals, administered incorrectly or being out of the medications prior to this visit. -Resident #3's last Hemoglobin A1C (HbA1C is a test that measures the average of glucose or blood sugar in a person's blood over 3 months) was on 04/29/24, and it was 7.9 (normal was 4.8-5.6). Refer to a second interview with a MA on 08/20/24 at 8:00am. Refer to interview with a second MA on 08/20/24 at 8:30am. Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm. Refer to interview with the Administrator on 08/16/24 at 2:31pm. _____	D 273		

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D 273	Continued From page 46 A second interview with a MA on 08/20/24 at 8:00am revealed: -She was trained by the Health and Wellness Director (HWD) to order supplies and mediations using the eMAR system and to notify him and the RCD when she saw that supplies/medications were down to two doses, she informed the RCD. -She was not aware she could call the pharmacy about refills for medications until late July 2024 when the PCP told her, during a visit, to call the pharmacy and check on a medications and supplies that were not available to administer to Resident #3. -She spoke to the RCD and was told to contact pharmacy or PCP, and document it in the 24 hour report sheet and the physician's book at the desk. -Since late July 2024 when she notified the pharmacy or physician, she documented it in the physician's book at the desk and put it on the 24 hour report sheet. -If a medication or supplies were not available to administer, she documented medication "not in cart" on the eMAR. -If a resident's medication or supplies ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication. -Third shift staff were responsible to ensure the supplies and medications from pharmacy were placed in the medication carts. Interview with a second MA on 08/20/24 at 8:30am revealed: -The pharmacy delivered medications in the middle of the night and the third shift MAs were responsible for making sure the medications were placed on the correct medication cart. -She had started her morning shift and had to complete the morning medication pass and then had to stock medications that were brought in by	D 273		

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D 273	Continued From page 47 the pharmacy and the third shift MA did not put them away. Interview with the RCD on 08/16/24 at 9:46am revealed she was still learning her responsibilities, and putting out all the "fires", she could not complete all the follow-ups related to notification to the PCP, medications and supplies. Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed: -The MAs were responsible for notifying the PCP about Resident #3 lack of supplies, missing or refused medications. -The RCD was responsible for following-up with the PCP about the medication refusals and or medications/supplies missing. -She did not know the MAs were notifying the RCD and the RCD did not follow-up with the physician related to the residents missed or refused medications or missing supplies. Interview with the Administrator on 08/16/24 at 2:31pm. -She began working as the Administrator on 08/12/24. -The MAs were responsible for notifying the PCP about Resident #3's medication refusals and missing medications/supplies. -The RCD was responsible for ensuring contact was made with the PCP and supplies were available. -She did not know the RCD did not follow-up with the physician related to the residents missed or refused medications or missing supplies. 3. Review of Resident #2's current FL2 dated 06/05/24 revealed: -Diagnoses included multiple fractured ribs, cellulitis, and dementia.	D 273		

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D 273	Continued From page 48 -There was an order for metoprolol (used to treat high blood pressure) 25mg one tablet every 12 hours. -Resident #2 was admitted from a skilled nursing facility on 06/05/24. a. Review of Resident #2's primary care provider (PCP) order dated 06/10/24 revealed: -Start twice weekly weight. -Notify the PCP via telehealth application for weight change of three pounds or more. Review of Resident #2's PCP order dated 06/24/24 revealed: -Start twice weekly weights. -Notify the PCP via telehealth application for weight change of three pounds or more. Review of Resident #2's PCP order dated 07/01/24 revealed: -Please make sure to notify PCP via telehealth application for weight gain or loss of greater than three pounds. -Resident #2 had significant weight gain from 07/01/24-07/02/24. -He has had highly variable weight in June 2024 and PCP was never notified. Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for weight check (starting 04/15/24) once daily for monitoring and notify the PCP of weight gain greater than three pounds scheduled at 8:00am. -The documented weight range was 240.1lbs.-269lbs. -On 06/10/24, the documented weight was 263.6lbs and on 06/11/24 the documented weight was 243.4lbs. a decrease of 20.2lbs.	D 273		

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-On 06/13/24, the documented weight was 243.2lbs and on 06/14/24 the documented weight was 240.1lbs. a decrease of 3.1lbs.
-On 06/14/24, the documented weight was 240.1 lbs and on 06/15/24 the documented weight was 265.4lbs. an increase of 25.3lbs.
-On 06/15/24, the documented weight was 265.4lbs and on 06/18/24 the documented weight was 241lbs. a decrease of 24.4lbs.
-On 06/18/24, the documented weight was 241lbs and on 06/19/24 the documented weight was 260.2lbs. an increase of 19.2lbs.
-On 06/19/24, the documented weight was 260.2lbs and on 06/21/24 the documented weight was 264.6lbs. and increase of 4.4lbs.
-On 06/23/24, the documented weight was 265lbs and on 06/24/24 the documented weight was 261lbs. a decrease of 4lbs.
-On 06/26/24, the documented weight was 265.4lbs and on 06/27/24 the documented weight was 269lbs. an increase of 3.6lbs.
-On 06/29/24, the documented weight was 268lbs and on 06/30/24 the docuemnted weight was 265lbs. a decrease of 3lbs.

Review of Resident #2's July 2024 eMAR revealed:
-There was an entry for weight check (starting 04/15/24) once daily for monitoring and notify the PCP of weight gain greater than three pounds scheduled at 8:00am.
-The documented weight range was 236.4lbs-272lbs.
-On 07/01/24, the documented weight was 264.6lbs. and on 07/02/24 the documented weight was 271lbs an increase of 6.8lbs.
-On 07/04/24, the documented weight was 272.1lbs and on 07/05/24 the documented weight was 236.4lbs a decrease of 35.7lbs.
-On 07/05/24, the documented weight was

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236.4lbs and on 07/06/24 the documented weight was 244.1lbs an increase of 7.7lbs.
-On 07/07/24, the documented weight was 238.1lbs and on 07/08/24 the documented weight was 263.2lbs an increase of 25.1lbs.
-On 07/11/24, the documented weight was 263.9lbs and on 07/13/24 the documented weight was 269.6lbs an increase of 5.7lbs.
-On 07/19/24, the documented weight was 272.2lbs and on 07/21/24 the documented weight was 254.8lbs a decrease of 17.4lbs.
-On 07/21/24, the documented weight wa 254.8lbs and on 07/22/24 the documented weight was 270.4lbs an increase of 15.6lbs.

Review of Resident #2's August 2024 eMAR from 08/01/24-08/13/24 revealed:
-There was an entry for weight check (starting 04/15/24) once daily for monitoring and notify the PCP of weight gain greater than three pounds scheduled at 8:00am.
-The documented weight range was 252.4lbs-273.8lbs.
-On 08/02/24, the documented weight was 273.8lbs and on 08/03/24 the documented weight was 253.1lbs a decrease of 20.7lbs.
-On 08/06/24, the documented weight was 254.2lbs and on 08/08/24 the documented weight was 259.0lbs an increase of 4.8lbs.
-On 08/08/24, the documented weight was 259.0lbs and on 08/09/24 the documented weight was 255.2lbs a decrease of 3.8lbs.
-On 08/09/24, the documented weight was 255.2lbs and on 08/10/24 the documented weight was 263.8lbs an increase of 8.6lbs.
-On 08/10/24, the documented weight was 263.8lbs and on 08/13/24 the documented weight was 258.2lbs a decrease of 5.6lbs.

Interview with the Resident Care Director (RCD)

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D 273	Continued From page 51 on 08/15/24 at 2:38pm revealed she and the HWD received access to communicate directly with primary care providers (PCP) through the telehealth application "today" (08/15/24). Interview with the Health and Wellness Director (HWD) on 08/16/24 at 8:32am revealed: -There was a chair scale for the medication aides (MA) to perform weights for residents with orders. -The MAs were supposed to report weight variances according to the parameters given by making an entry in the physician book. -If there were no entries in the physician book or in the facility's electronic documentation application, he did not know if the weight changes were reported to the PCP. -Resident #2's PCP was in the facility weekly on Mondays to see residents about health concerns. Interview with a medication aide (MA) on 08/16/24 at 10:14am revealed: -She was aware of the order to weigh Resident #2 and report weight changes of 3lbs. -She had not had an occurrence when she had taken Resident #2's weight which required PCP notification. -If she needed to report a weight change, she had been trained to make an entry in the physician book that was kept at the nurses station. -The PCP looked at the physician book on their weekly visits to the facility. Review of the memory care nurses station physician book revealed there were no entries for Resident #2 from June 2024-August 2024 regarding weight changes. Review of Resident #2's electronic progress note entries from 05/09/24-08/14/24 revealed there were no entries regarding weight changes.	D 273		

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D 273	Continued From page 52 Telephone interview with Resident #2's PCP on 08/15/24 at 4:36pm revealed: -Resident #2 was diagnosed with heart failure. -She had written orders on three occasions for the staff to check weights and notifiy her of changes of three pounds or more. -She was not notified of Resident #2's three pound weight changes in June 2024-August 2024. -Resident #2 was at an increased risk of congestive heart failure, shortness of breath, pulmonary edema, and potential hospitalization when she was not properly notified of the resident's weight gains and losses. Telephone interview with Resident #2's hospice registered nurse (RN) on 08/16/24 at 12:16pm revealed the facility staff had not reported Resident #2's weight fluctuations to her. Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed: -The order written for Resident #2's weight checks twice weekly and report weight gain or loss of three pounds should have been clarified by staff. -The MAs needed a base weight to go by to evaluate the exact increase and decrease. Interview with the Administrator on 08/20/24 at 5:45pm revealed: -The MAs were responsible for notifying the PCP of Resident #2's weight gains or losses of three pounds or more. -The MAs were responsible for notifying the HWD and the RCD the weight fluctuations which occurred with Resident #2. -The HWD and RCD were responsible for following up with the PCP to ensure all the weight	D 273		

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fluctuations were reported to the PCP.

Based on observations, interviews and record review it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's current FL2 dated 06/05/24 revealed there was an order for metoprolol (used to treat high blood pressure) 25mg one tablet every 12 hours.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic blood pressure was greater than 130 and or if heart rate (HR) was less than 65 hold medication and notify MD if systolic blood pressure (BP) greater than 160.
-On 06/15/24 at 8:00am, the documented BP was 174/111 and the HR was 82.
-On 06/18/24 at 8:00am, the documented BP was 183/82 and the HR was 75.
-On 06/22/24 at 8:00am, the documented BP was 176/100 and the HR was 73.
-On 06/22/24 at 8:00pm, the documented BP was 170/110 and the HR was 73.
-On 06/23/24 at 8:00am, the documented BP was 169/99 and the HR was 70.
-On 06/25/24 at 8:00pm, the documented BP was 175/108 and the HR was 94.
-On 06/27/24 at 8:00am, the documented BP was 163/88 and the HR was 69.
-On 06/28/24 at 8:00pm, the documented BP was 184/104 and the HR was 82.

Review of Resident #2's July 2024 eMAR

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D 273	Continued From page 54 revealed: -There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic blood pressure was greater than 130 and or if heart rate (HR) was less than 65 hold medication and notify MD if systolic blood pressure (BP) greater than 160. -On 07/04/24 at 8:00am, the documented BP was 164/106 and the HR was 73. -On 07/05/24 at 8:00am, the documented BP was 164/108 and the HR was 87. -On 07/08/24 at 8:00am, the documented BP was 166/95 and the HR was 73. -On 07/08/24 at 8:00pm, the documented BP was 162/104 and the HR was 68. -On 07/13/24 at 8:00pm, the documented BP was 187/108 and the HR was 80. -On 07/18/24 at 8:00am, the documented BP was 170/76 and the HR was 73. -On 07/19/24 at 8:00am, the documented BP was 167/100 and the HR was 73. -On 07/30/24 at 8:00am, the documented BP was 171/98 and the HR was 93. Review of Resident #2's August 2024 eMAR revealed: -There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic blood pressure was greater than 130 and or if heart rate (HR) was less than 65 hold medication and notify MD if systolic blood pressure (BP) greater than 160. -On 08/10/24 at 8:00am, the documented BP was 190/119 and the HR was 99. -On 08/13/24 at 8:00am, the documented BP was 170/99 and the HR was 70.	D 273		

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D 273	Continued From page 55 According to the National Institute of Health, a normal blood pressure for most adults is less than 120/80 mmHg. Interview with a medication aide (MA) on 08/16/24 at 9:08am revealed: -She routinely administered medications to Resident #2. -She was aware Resident #2 was ordered to have BP and HR checks prior to administration of some of his medication. -Resident #2's BP was "always high." -She did not think she had ever reported any high BPs for Resident #2 to the PCP. -She was trained to write entries about resident concerns in the physician book at the nurses station. -The physician book was the way they were trained to communicate concerns to the PCP. Review of the physician book at the memory care nurses station revealed there were no entries for Resident #2 from June 2024-August 2024 regarding elevated BPs. Review of Resident #2's electronic progress note entries from 05/09/24-08/14/24 revealed there were no entries regarding elevated BPs. Interview with the Health and Wellness Director (HWD) on 08/16/24 at 8:32am revealed: -The MAs were supposed to follow the guidelines in the order for reporting BPs to the PCP. -If the PCP wrote an order to contact them when a BP was outside of a certain parameter, then that was what should be done. Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed if there was an	D 273		

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order to report parameters to the PCP, the MAs were expected to reach out to the PCP by phone to report values outside the parameters.

Telephone interview with Resident #2's PCP on 08/19/24 at 8:55am revealed:
-She was not notified of Resident #2's high blood pressures during June-August 2024.
-Resident #2 had an increased risk of heart attack, stroke, and worsening kidney disease when his blood pressures were systolically greater than 160.
-She would have expected the facility staff to notify Hospice of the high blood pressures and the PCP triage so that adjustments could have been made to Resident #2's medications.

Telephone interview with Resident #2's hospice registered nurse (RN) on 08/16/24 at 12:16pm revealed:
-The facility staff had not reported Resident #2's high blood pressures to her.
-She was more concerned with staff reporting low BP as it might increase Resident #2's risk of falls.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:
-The MAs should notify the PCP when they took an abnormal BP or HR.
-The RCD should email or call the PCP to let the PCP know what's going on with a resident.
-It was also acceptable for the MAs or RCD to fax vital sign results to the PCP and follow-up with a call to make sure they knew about abnormal values.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The MAs were responsible to follow the order the PCP wrote for Resident #2 concerning notification

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of BP's and HR outside the parameters.
-The MAs were supposed to notify the HWD and RCD about the BP's and HR's, so the HWD and RCD could follow up with the PCP.

Based on observations, interviews and record review it was determined that Resident #2 was not interviewable.

c. Review of Resident #2's primary care provider (PCP) order dated 07/01/24 revealed please notify PCP via telehealth application if Resident #2 refused metoprolol or if his blood pressure (BP) or heart rate (HR) are out of parameters to administer the metoprolol.

Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic BP was greater than 130 and or if HR was less than 65 hold medication and notify MD if systolic BP greater than 160.
-On 07/02/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "patient refused medication."
-On 07/06/24 at 8:00am, the documented BP was 117/77 and the HR was 60, metoprolol was documented as not administered due to "BP out of range."
-On 07/07/24 at 8:00am, the documented BP was 122/78 and the HR was 69, metoprolol was documented as not administered due to "BP out of range."
-On 07/12/24 at 8:00am, the documented BP was 105/62 and the HR was 73, metoprolol was

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D 273	Continued From page 58 documented as not administered due to "BP not in range." -On 07/18/24 at 8:00pm, the documented BP was 111/80 and the HR was 105, metoprolol was documented as not administered due to "held per order." -On 07/21/24 at 8:00am, the documented BP was 126/80 and the HR was 66, metoprolol was documented as not administered due to "held per order." -On 07/25/24 at 8:00pm, the documented BP was 122/83 and the HR was 102, metoprolol was documented as not administered due to "BP not in range." -On 07/28/24 at 8:00pm, the documented BP was 128/80 and the HR was 99, metoprolol was documented as not administered due to "out of range." -On 07/31/24 at 8:00pm, the documented BP was 93/73 and the HR was 99, metoprolol was documented as not administered due to withheld per order. Review of Resident #2's August 2024 eMAR revealed: -There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic BP was greater than 130 and or if HR was less than 65 hold medication and notify MD if systolic BP greater than 160. -On 08/02/24 at 8:00am, the documented BP was 148/76 and the HR was 56, metoprolol was documented as not administered due to "patient refused medication." -On 08/02/24 at 8:00pm, the documented BP was 103/65 and the HR was 90, metoprolol was documented as not administered due to withheld per order.	D 273		

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D 273	Continued From page 59 -On 08/04/24 at 8:00pm, the documented BP was 99/57 and the HR was 61, metoprolol was documented as not administered due to "BP not in range." -On 08/05/24 at 8:00am, the documented BP was 124/80 and the HR was 66, metoprolol was documented as not administered due to "held per order." -On 08/05/24 at 8:00pm, the documented BP was 125/84 and the HR was 84, metoprolol was documented as not administered with no reason given. -On 08/07/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "patient refused medication." -On 08/08/24 at 8:00pm, the documented BP was 120/83 and the HR was 81, metoprolol was documented as not administered due to withheld per order. -On 08/12/24 at 8:00pm, the documented BP was 108/75 and the HR was 87, metoprolol was documented as not administered due to "held per order." -On 08/13/24 at 8:00pm, the documented BP was 97/78 and the HR was 75, metoprolol was documented as not administered due to "held per order." -On 08/14/24 at 8:00am, the documented BP was 129/82 and the HR was 71, metoprolol was documented as not administered due to "med under required level." Interview with a medication aide (MA) on 08/16/24 at 10:14am revealed: -She had not contacted Resident #2's primary care provider (PCP) to report BPs and HRs outside of ordered parameters during July and August 2024. -She was told to communicate issues concerning	D 273		

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a resident by documenting a note in the physician book.

Review of the entries in the physician book at the nurses station in memory care on 08/16/24 at 10:38am revealed there were no entries in the book for Resident #2 for June 2024-August 2024 regarding instances of metoprolol not being administered due to BP or HR or resident refusals of the medication.

Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed:
-If there was an order to report parameters to the PCP, the MAs were expected to reach out to the PCP by phone to report values outside the parameters.
-The MAs did not have access to the telehealth application Resident #2's PCP wrote in the order written 07/01/24.
-She and the Health and Wellness Director (HWD) had just been given access to the telehealth application themselves today (08/15/24).

Telephone interview with Resident #2's PCP on 08/15/24 at 4:36pm revealed:
-She had requested the facility notify her of BP and HR parameters out of parameter to administer the metoprolol.
-She had requested the facility notify her if Resident #2 refused the metoprolol.
-The facility staff "never" notified her of blood pressures and heart rates outside the parameters she had established for Resident #2 or of the refused doses of metoprolol.

Interview with the HWD on 08/16/24 at 8:32am revealed:
-The RCD was primarily responsible for follow-up

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with Resident #2's PCP as she was over the day to day operations in the memory care area.
-Resident #2's PCP visited the facility weekly on Mondays.
-There might be entries in the provider book concerning issues that required follow-up for Resident #2.
-The MAs should follow the guidelines in the PCP order and notify the PCP as per the order.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:
-The MAs could notify the PCP when they took an abnormal BP or HR or when a resident refused a medication.
-The HWD could email or call the PCP to let the PCP know what's going on with a resident.
-It was also acceptable for the MAs or HWD to fax vital sign results to the PCP and follow-up with a call to make sure they knew about abnormal values.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The MAs were responsible to follow the order the PCP wrote for Resident #2 concerning notification of BP's and HR outside the parameters and about any refused medications.
-The MAs were supposed to notify the HWD and RCD about the BP's, HR's, and missed medications so the HWD and RCD could follow up with the PCP.

Based on observations, interviews and record review it was determined that Resident #2 was not interviewable.

4. Review of Resident #10's current FL2 dated 11/27/23 revealed:
-Diagnoses included coronary artery disease and

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hypertension.
-There was an order for clopidogrel (prevents platelets from sticking together and forming a blood clot) 75mg one tablet once daily.
-There was an order for aspirin (used to lower risk of heart attack, stroke, or blood clot) 81mg one tablet daily at bedtime.

Review of the facility's fall response procedure policy dated 03/18/19 revealed:
-Should a resident experience a fall, staff will provide immediate care and follow through with care planning.
-Should a resident fall, caregivers are instructed to summon immediate assistance from the Health Care Coordinator or Med Aide on duty.
-Caregivers do not move the resident , except to protect against further injury.
-The Health Care Coordinator (HCC) or Medication Aide (MA) performs a brief overview and inspection for bleeding and obvious deformities.
-The HCC or MA checks for range of motion ability.
-The HCC or MA may allow the resident to be assisted up to a chair if the head did not receive any trauma or injury, nor was struck during the fall.
-The physician is contacted immediately for further instructions.
-If the resident had trauma resulting in deformity, exhibits any change in level of consciousness or received obvious head or significant trauma, the HCC or caregivers will summon emergency medical services.
-If the resident is on anticoagulants and there is a question of head trauma, the HCC or caregiver will summon emergency medical services.
-For forty-eight hours after any fall, the HCC or MA on each shift will monitor the resident and

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D 273	Continued From page 63 made a brief narrative charting entry. Review of Resident #10's Incident Report dated 07/29/24 revealed: -Resident #10 fell in the parking lot onto the pavement. -The incident report indicated injury to the head. -There was no documentation the physician was notified about the incident. -There was documentation 911 was contacted on 07/29/24 at 1:30pm, but the resident was not taken to the hospital for evaluation. -There was documentation the family was notified about the incident. Review of the 911 call entry dated 07/29/24 at 1:37pm revealed "assist subject up." Telephone interview with Resident #10's primary care provider (PCP) on 08/19/24 at 8:55am revealed: -On 07/29/24, she visited Resident #10 for a routine health visit. -She observed Resident #10 with bruises on his face. -She assumed he had gone to the emergency room for evaluation. -The staff did not report Resident #10's fall and injuries to her prior to her visit. -The only information she received about the incident was from the resident. Interview with the Health and Wellness Director (HWD) on 08/20/24 at 10:02am revealed: -He recalled Resident #10 had a fall in the parking lot as he was trying to start his car. -Resident #10 said the battery was dead in the car, but actually his family removed the battery from the car so he could not drive it. -He did not know if Resident #10 went to the	D 273		

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hospital for evaluation after the fall.
-The facility policy was to send residents out for evaluation when they hit their head with a fall.
-The resident's PCP should have been notified about the fall.
-He did not know if the PCP was notified about the fall.
-The incident report about the fall should have documentation as to whether or not the PCP was notified about the fall.

Telephone interview with Resident #10's power of attorney (POA) on 08/20/24 at 10:14am revealed:
-Facility staff notified him of Resident #10's fall on 07/29/24.
-They told him Resident #10 fell in the parking lot and "appeared to be ok."
-Resident #10 was not sent out to the hospital for evaluation after the fall.
-He did not know if Resident #10 refused to go to the hospital or he did not need to go to the hospital.
-He did not refuse to allow Resident #10 to be sent to the hospital for evaluation.

Telephone interview with Resident #10's PCP on 08/20/24 at 11:17am revealed:
-Resident #10 should have been sent out to the hospital for evaluation on 07/29/24 because he hit his head on pavement.
-Resident #10 hit his face hard enough during the fall to cause "significant" bruising on his face.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:
-It was the facility's policy when a resident fell and struck their head during the fall they should go to the hospital to be "checked out."
-The POA could refuse to allow a resident be sent to the hospital for evaluation by communicating

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this to the EMS responder(s).
-The medication aide (MA) was responsible for calling 911, filling out the incident report, contacting the family, and notifying the PCP.
-The HWD guides the MA through the process of the facility's response to the fall.
-The PCP should be notified about every fall .
-If the resident went to the hospital for evaluation, the hospital discharge summary should be placed in the physician book for the PCP to see on their next visit to the facility.
-If the resident did not go out to be evaluated the MA should fill out a health care concerns form with the date and time of the fall and circumstances surrounding the fall and place it in the physician book for the PCP to see on their next visit to the facility.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The MA and HWD should have followed the facility's policy in their response to Resident #10's fall on 07/29/24.
-The MA should have notified the PCP about Resident #10's fall.
-The MA should have notified the HWD about Resident #10's fall.
-The HWD was responsible to follow-up with the PCP about all issues reported to them.

Based on observations, interviews and record review it was determined that Resident #10 was not interviewable.
5. Review of Resident #5's current FL2 dated 06/10/24 revealed diagnoses included severe depression, sleep apnea, adenocarcinoma, cerebrovascular accident, and systematic lupus.

Review of physician's orders dated 06/10/24 revealed an order to check weekly weights.

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D 273	Continued From page 66 Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for weekly weights. -There was a documented weight of 92 lbs. on 06/12/24. -There was no documented weight recorded on 06/19/24. -There was a documented weight of 94.8 lbs. on 06/26/24. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for weekly weights. -There was no documented weight recorded on 07/03/24. -There was no documented weight recorded on 07/10/24. -There was no documented weight recorded on 07/17/24. -There was a documented weight of 93.6 lbs. on 07/24/24. -There was no documented weight recorded on 07/31/24. Review of Resident #5's August 2024 eMAR revealed: -There was an entry for weekly weights. -There was a documented weight of 90.6 lbs. on 08/07/24. -There was no documented weight recorded on 08/14/24. Interview with Resident #5 on 08/20/24 at 10:28am revealed: -She thought she was getting weekly weights but was not sure. -She had never refused to be weighed.	D 273		

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D 273	Continued From page 67 Interview with a medication aide (MA) on 08/15/24 at 3:10pm revealed: -Resident #5 "often" refused to be weighed. -She did not inform the PCP when Resident #5 refused to be weighed because there were no instructions on the eMAR to inform the PCP and she had never been told to notify the PCP. Interview with the facility's contracted Primary Care Provider (PCP) on 08/15/24 at 4:35pm and on 08/19/24 at 4:39pm revealed: -She had not been notified of any weight refusals for Resident #5. -Resident #5 was in advanced stage of lung cancer. -Weekly weight recordings could help her become Hospice eligible and could help determine if she was declining in her health. -She expected staff to report weight refusals. 6. Review of Resident #13's current FL2 dated 11/27/23 revealed diagnoses of acute and chronic systolic and diastolic heart failure, muscle weakness, depression, insomnia, acute respiratory failure and hypoxia. Review of physician's order dated 05/13/24 revealed: -An order to obtain daily weights for monitoring. -An order to notify Primary Care Provider (PCP) of weight gain of 3 lbs. in 24 hours or 5 lbs. in one week. Review of Resident #13's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for daily weights. -There was an entry to notify physician of weight gain of 3 lbs. in 24 hours or 5 lbs. weight gain in one week.	D 273		

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D 273	Continued From page 68 -There was no documented weight recorded on 06/01/24, 06/02/24, 06/04/24, 06/06/24, 06/07/24, 06/09/24, 06/10/24, 06/14/24-06/24/24, 06/26/24, 06/27/24, or 06/30/24. -There was a weight recorded of 178.2 lbs. on 06/03/24. -There was a weight recorded of 180.0 lbs. on 06/05/24. -There was a weight recorded of 178.6 lbs. on 06/08/24. -There was a weight recorded of 177.0 lbs. on 06/11/24. -There was a weight recorded of 179.2 lbs. on 06/12/24. -There was a weight recorded of 178.8 lbs. on 06/13/24 -There was a weight recorded of 179.2 lbs. on 06/25/24. -There was a weight recorded of 180.2 lbs. on 06/28/24. -There was a weight recorded of 179.6 lbs. on 06/29/24. Review of Resident #13's July 2024 eMAR revealed: -There was an entry for daily weights. -There was an entry to notify physician of weight gain of 3 lbs. in 24 hours or 5 lbs. weight gain in one week. -There was an entry dated 07/15/24 for morning weight checks at 11:30am. -There was a weight recorded of 178.4 lbs. on 07/01/24. -There was no documented weight recorded on 07/02/24-07/06/24, 07/08/24, 07/10/24-07/14/24, 07/16/24-07/19/24, 07/22/24, 07/23/24, 07/25/24, 07/28/24, 07/30/24, or 07/31/24. -There was a weight recorded of 180.6 lbs. on 07/07/24. -There was a weight recorded of 181.4 lbs. on	D 273		

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D 273	Continued From page 69 07/09/24. -There was a weight recorded of 181.0 lbs. on 07/15/24. -There was a weight recorded of 134 lbs. on 07/20/24. -There was a weight recorded of 178.8 lbs. on 07/21/24. -There was a weight recorded of 181.3 lbs. on 07/24/24. -There was a weight recorded of 181.2 lbs. on 07/26/24. -There was a weight recorded of 181.0 lbs. on 07/27/24. -There was a weight recorded of 182.2 lbs. on 07/29/24. Review of Resident #13's August 2024 eMAR revealed: -There was an entry for daily weights. -There was an entry to check weight daily at 11:30am. -There was an entry to notify physician of weight gain of 3 lbs. in 24 hours or 5 lbs. weight gain in one week. -There was no documented weight recorded on 08/01/24-08/15/24. -There was a weight recorded of 209.2 lbs. on 08/16/24. -There was a weight recorded of 182.6 lbs. on 08/17/24. -There was a weight recorded of 181.4 lbs. on 08/18/24. -There was a weight recorded of 182.0 lbs. on 08/19/24. Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/15/24 at 4:35pm revealed: -Resident #13 had congestive heart failure. -She wrote an order for daily weight checks and	D 273		

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asked to be notified of weight gains so she could monitor for early symptoms of a congestive heart failure exacerbation.
-Signs and symptoms she was watching for with Resident #13 included weight gain, edema, shortness of breath, cough, increased heart rate and fatigue.
-Resident #13 had developed a slight shortness of breath, peripheral edema, and cough.
-Without knowing Resident #13's weight, she could easily miss if she was having early onset of congestive heart failure and could possibly need hospitalization.
-She was not notified of weight refusals or weight gains.
-She expected to be notified when residents refused weights or weight gains was obtained.

Interview with the Resident Care Director (RCD) on 08/20/24 at 10:46am revealed:
-She did not weigh Resident #13 on 06/20/24.
-An agency staff member signed in under her name so she could have access to the eMAR, and that staff member was the one who weighed her.
-Weights should be obtained as ordered.
-Staff were supposed to notify the RCD or the Health and Wellness Director (HWD) for weight gains and weight refusals.
-She would then notify the Primary Care Physician (PCP).
-It was the HWD's responsibility to notify the PCP of weight refusals or weight gain for Resident #13.
-She asked staff to notify her when her residents refuse 3 times in a row.
-She expected staff to keep attempting to try weights if weights were refused.

Telephone interview with a medication aide (MA)

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D 273	Continued From page 71 on 08/20/24 at 4:39pm revealed: -She accidentally put another resident's weight on Resident #13's eMAR on 08/16/24. -She reported the incident to the HWD. -She reported any weight refusals to the HWD. _____ Interview with the medication aide (MA) on 08/20/24 at 3:10pm revealed: -She was aware she should notify the Primary Care Provider (PCP) about weight refusals or missed weights. -She had not been notifying the Health and Wellness Director (HWD) or PCP because she did not have time. -She had to administer medications to residents on two separate floors. Interview with the facility's contracted Primary Care Provider (PCP) on 08/15/24 at 4:35pm and on 08/19/24 at 4:39pm revealed: -She was not notified of any weight refusals. -She expected orders to be followed as instructed. -She expected staff to report weight refusals. Interview with the HWD on 08/20/24 at 11:10am revealed: -He was never told to ensure staff obtained weights as ordered. -He decided to "take that over" about a month ago when he realized it was an issue. -He expected MA's to complete weights as ordered. -He expected MA's to notify the PCP. -When he found orders were not completed, he would talk to the supervisor and the supervisor would go to the MA's and talk to them about it. -It was his responsibility to be sure weights were done and the PCP was notified.	D 273		

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D 273	Continued From page 72 Interview with the supervisor on 08/20/24 at 11:39am revealed: -She did not notify the PCP's each time weights were not obtained as ordered. -She notified the PCP weekly when they came to the facility to see residents. -She had never been told to notify the PCP after each refusal or missed weight. -It was the responsibility of the HWD to make sure the PCPs were notified when weights were not obtained. Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Missed or refused weights, and weight gains, needed to be documented and the PCP needed to be notified every time. -It was the HWD's responsibility to be sure the PCPs were notified of missed or refused weights. Interview with the Administrator on 08/20/24 at 5:41pm revealed: -The PCP should be notified right away of missed or refused weights. -Lack of training and accountability could be reasons why PCP's had not been notified of weights. -The MAs were responsible to notify PCP's right away on each missed or refused weights and weight gains. -The HWD and the Resident Care Director (RCD) were responsible for making sure PCPs were notified. 7. Review of Resident #4's current FL2 dated 05/13/24 diagnoses included hyperlipidemia and memory impairment. Review of Resident #4's Resident Register revealed an admission date of 06/19/23.	D 273		

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D 273	Continued From page 73 Review of emergency room discharge summary dated 07/04/24 revealed: -She was brought to the emergency room following a fall where she hit her head. -Resident was assessed for injury with no injuries found. -Resident was discharged to the facility on 07/04/24. Review of emergency room discharge summary dated 07/16/24 revealed: -She was brought to the emergency room following a fall where she hit her head. -CT showed a "closed head injury with no fracture". -An order was given for follow-up with PCP within 48 hours. -Resident #4 was discharged back to the facility on 07/16/24. Review of an incident report for Resident #4 dated 07/04/24 revealed: -Resident #4 was found sitting on the floor in her bathroom after an unwitnessed fall. -She stated to staff she had hit her head, and her legs hurt. -Resident #4 was sent to the emergency room. Review of an incident report for Resident #4 dated 07/16/24 revealed: -Resident #4 had activated her emergency pendant. -Responding facility staff found her on the floor of her room. -The resident was observed to have a "bump on her head and it was bleeding". -Resident #4 was sent to the ER. Interview with the Primary Care Provider (PCP)	D 273		

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on 08/19/24 at 05:00pm revealed:
-She was not informed of either fall.
-She was not informed of resident being sent to the ER on either occasion.
-She was not informed of the "closed head injury".
-An untreated closed head injury could result in headaches, confusion, possible bleeding, mental status changes.
-A follow-up examination within 48 hours was necessary to ensure appropriate treatment and for safety of the resident.

Interview with Health and Wellness Director (HWD) on 08/20/24 at 4:45pm revealed:
-He was responsible for ensuring the PCP was notified of any resident related health concerns including hospitalizations.
-He would review the hospital discharge notes for orders if resident returned to the facility on a day he was working.
-He didn't realize Resident #4 required a 48 hour follow-up with the PCP after the head injury, he "missed" it.
-Staff working at the time of the resident's return could place the resident on the physicians list for the week.
-He was responsible for ensuring provider notification for resident concerns.

8. Review of Resident # 6's current FL2 dated 05/29/24 revealed diagnoses included diabetes mellitus type 2, Parkinson's disease, hypertension, and balance instability.

Review of Primary Care Provider (PCP) order dated 06/24/24 revealed:
-There was an order for Jardiance (used to lower blood sugar) 10mg tablet, take one tablet once daily for diabetes, hold and notify physician in

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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
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blood sugar was less than 200.

Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Jardiance (used to lower blood sugar) 10mg tablet, take one tablet once daily at 8:00am for diabetes, hold and notify physician in blood sugar was less than 200.
- On 06/26/24 at 11:08am, the documented FSBS was 181, there was documentation Jardiance was administered, and there was no documentation PCP was notified.
-On 06/27/24 at 08:21am, the documented FSBS was 123, there was documentation Jardiance was administered, and there was no documentation PCP was notified.
-On 06/28/24 at 08:34 am, the documented FSBS was 136, there was documentation Jardiance was administered, and there was no documentation PCP was notified.
-On 06/29/24 at 07:36am, the documented FSBS was 123, there was documentation Jardiance was administered, and there was no documentation PCP was notified.
- On 06/30/24 at 8:00am, the documented FSBS was 156, there was documentation Jardiance was administered, and there was no documentation PCP was notified.

Review of Resident #6's July electronic medication administration record (eMAR) revealed:
-There was an entry for Jardiance 10mg tablet, take one tablet once daily at 8:00am for diabetes, hold and notify physician in blood sugar is less than 200.
-On 07/02/24 at 08:31am, the documented FSBS was 110, there was documentation Jardiance was administered, and there was no documentation

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D 273	Continued From page 76 PCP was notified. -On 07/03/24 at 08:24am, the documented FSBS was 117, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 07/04/24 at 10:32am, the documented FSBS was 102, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 07/05/24 at 9:19am, the documented FSBS was 133, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 07/06/24 at 8:21am, the documented FSBS was 147, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/07/24 at 7:59am, the documented FSBS was 130, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 07/08/24 at 10:57am, the documented FSBS was 110, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/09/24 at 10:46am, the documented FSBS was 170, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/10/24 at 8:49am, the documented FSBS was 134, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/11/24 at 8:25am, the documented FSBS was 110, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/12/24 at 8:32am, the documented FSBS was 124, there was documentation Jardiance was administered, and there was no	D 273		

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documentation PCP was notified.
-On 07/13 at 07:45am, the documented FSBS was 153, the medication was held, and there was no documentation PCP was notified.
-On 07/14/24 at 8:24am, the documented FSBS was 102, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/15/24 at 8:00am, the documented FSBS was "not recorded", there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/16/24 at 8:09am, the documented FSBS was 127, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/17/24 at 8:36am, the documented FSBS was 132, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/18/24 at 08:28am, the documented FSBS was 130, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/19/24 at 07:57am, the documented FSBS was 107, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/20/24 at 7:47am, the documented FSBS was 119, there was documentation Jardiance was administered, and there was no documentation PCP was notified.
-On 07/21/24 at 07:42am, the documented FSBS was 146, there was documentation the Jardiance was held, and there was no documentation PCP was notified.
-On 07/22/24 at 09:06am, the documented FSBS was 115, there was documentation the Jardiance was held, and there was no documentation PCP was notified.

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D 273	Continued From page 78 -On 07/23/24 at 8:27am, the documented FSBS was 126, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/24/24 at 7:53am, the documented FSBS was "not recorded", there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/25/24 at 8:01am, the documented FSBS was 110, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/26/24 at 7:54am, the documented FSBS was 116, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/27/24 at 8:20am, the documented FSBS was 123, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/28/24 at 8:25am, the documented FSBS was 136, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/29/24 at 8:27am, the documented FSBS was 148, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/30/24 at 8:03am, the documented FSBS was 118, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 07/31/24 at 8:00am, the documented FSBS was 120, there was documentation the Jardiance was held, and there was no documentation PCP was notified. Review of Resident #6's August electronic medication administration record (eMAR) revealed:	D 273		

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D 273	Continued From page 79 -There was an entry for Jardiance 10mg tablet, take one tablet once daily at 8:00am for diabetes, hold and notify physician in blood sugar is less than 200. -On 08/01/24 at 8:00am, the documented FSBS was 110, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/02/24 at 9:08am, the documented FSBS was 121, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/03/24 at 9:09am, the documented FSBS was 103, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 08/04/24 at 7:52am, the documented FSBS was 109, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/05/24 at 9:06am, the documented FSBS was 106, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/06/24 at 8:18am, the documented FSBS was 99, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/07/24 at 7:44am, the documented FSBS was "not recorded", there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/08/24 at 7:53am, the documented FSBS was 132, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/09/24 at 7:04am, the documented FSBS was 111, there was documentation the Jardiance was held, and there was no documentation PCP was notified.	D 273		

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D 273	Continued From page 80 -On 08/10/24 at 7:08am, the documented FSBS was 114, there was documentation Jardiance was administered, and there was no documentation PCP was notified. -On 08/11/24 at 8:08am, the documented FSBS was 136, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/12/24 at 8:08am, the documented FSBS was 132, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/13/24 at 7:44am, the documented FSBS was 140, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/14/24 at 8:05am, the documented FSBS was 135, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/15/24 at 8:53am, the documented FSBS was 140, there was documentation the Jardiance was held, and there was no documentation PCP was notified. -On 08/16/24 at 8:35am, the documented FSBS was 143, there was documentation the Jardiance was held, and there was no documentation PCP was notified. Interview with PCP on 08/19/24 at 05:00pm revealed: -She was not informed of any FSBS under 200 in June, July or August 2024. -She was not informed the medication was being administered despite the resident's FSBS <200. -Unaddressed blood sugar issues could result in uncontrolled diabetes. -Communication regarding Jardiance administration was essential for controlling Resident #6's diabetes.	D 273		

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D 273	Continued From page 81 Interview with the medication aide (MA) on 08/16/24 at 10:48am revealed: -She did not realize she had given the medication when it was to be held because she was not paying attention to the parameters. -She was responsible for contacting the physician if medications were held, administered late, or missed. -She was responsible for communication with administration regarding resident issues. Interview with the Health and Wellness Director (HWD) on 08/20/24 at 4:45pm revealed: -He instructed the MAs to complete eMAR audits on a daily basis. -Ultimately he was responsible for auditing MARs but he was not consistent with the eMAR audits. -When he audited the eMARs, he looked for holes and refusals and he did not pay close attention to any parameters to hold medications, just that they were administered. -He was responsible for ensuring PCP was notified of any resident related health concerns including missed or held medications. [Refer to tag 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)] _____ The facility failed to notify a physician of Resident #3's choking episodes on 07/09/24 choking, turned blue, became unresponsive, the Heimlich Maneuver was performed, the PCP was not notified and on 07/12/24 a second choking episode and the PCP was not notified resulted in a delay of care and treatment for aspiration and hypoxia leading to Resident #1's death on 07/12/24 at 7:55pm. This failure resulted in serious physical harm and neglect and	D 273		

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D 273	Continued From page 82 constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 08/15/24. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement orders for 5 of 13 sampled residents (#2, #3, #6, #9, and #11) related to urinalysis lab collections (#2 and #11) and application and removal of compression stockings (#2, #6, #9, and #11) and obtaining finger stick blood sugars (#3). The findings are: 1. Review of Resident #2's current FL2 dated 06/05/24 revealed diagnoses included multiple fractured ribs, cellulitis, and dementia.	D 276		

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a. Review of Resident #2's primary care provider (PCP) progress note dated 06/10/24 revealed staff had noticed an odor to Resident #2's urine and increased incontinence.

Review of Resident #2's PCP order dated 06/10/24 revealed:
-Please obtain urine sample for urinalysis and reflex to culture.
-Call lab when ready.

Review of Resident #2's PCP progress note dated 06/24/24 revealed Resident #2 continued to have issues with frequency with urination.

Review of Resident #2's PCP order dated 06/24/24 revealed:
-Please obtain urine sample for urinalysis and reflex to culture.
-Call lab when ready.

Review of Resident #2's record revealed there were no urinalysis results or urine culture results for June 2024 or July 2024.

Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed:
-She did not see the urinalysis and culture for Resident #2 written down on the staff's 24 hour report sheets around the dates of 06/10/24 and 06/24/24.
-She did not know if the staff collected urine samples on Resident #2 for 06/10/24 or 06/24/24.
-She did not know if the staff were properly trained on putting orders on the 24 hour report sheets to help ensure staff were aware the urine samples needed to be collected.
-Resident #2's orders for urinalysis and cultures was prior to her starting to work at the facility.
-The Health and Wellness Director (HWD) would

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have been responsible at that time to ensure the labs were completed as ordered.

Review of Resident #2's record revealed the resident was admitted to Hospice on 07/05/24.

Telephone interview with Resident #2's PCP on 08/19/24 at 8:55am revealed:
-The urinalysis and reflex cultures she ordered for Resident #2 in June 2024 were never collected.
-Staff reported Resident #2 had symptoms of a urinary tract infection including odor and increased frequency.
-A benign urinary tract infection could turn into a kidney infection.
-Kidney infection could cause delirium and put Resident #2 at an increased risk for falls.
-A kidney infection could turn into sepsis (a life threatening condition that happened when the body's immune system had an extreme response to infection, causing organ dysfunction).

Telephone interview with Resident #2's hospice Registered Nurse (RN) on 08/16/24 at 12:16pm revealed:
-The staff reported Resident #2 was experiencing urinary frequency and urgency.
-She obtained an order for Bactrim DS (used to treat urinary tract infection) on 08/06/24 for him.
-She was not sure if a urinalysis was obtained recently.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:
-Resident #2's orders for urinalysis and reflex cultures ordered on 06/10/24 and 06/24/24 were not completed.
-The staff were to attempt to collect a urine sample for three days.
-If the staff were unable to collect the urine within

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three days, they were supposed to notify the PCP they had been unable to collect the urine sample.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The medication aides (MAs) were responsible for collecting urine samples for ordered labs.
-If the MAs were unable to collect a urine sample, they were responsible to tell the Health and Wellness Director (HWD).
-The HWD was responsible for notifying the PCP they were unable to collect a urine sample.

Based on observations, interviews, and record review it was determined Resident #2 was not interviewable.

b. Review of Resident #2's primary care provider (PCP) order dated 10/11/23 revealed an order to encourage leg elevation and compression hose.

Review of Resident #2's PCP order dated 05/09/24 revealed apply compression stockings (TED hose-thrombo-embolic deterrent hose are stockings that help prevent blood clots and swelling in the legs) in the morning and remove at bedtime.

Review of Resident #2's PCP order dated 07/01/24 revealed:
-Please measure Resident #2 for TED hose.
-Order TED hose.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) from 06/17/24-06/30/24 revealed:
-There was an entry for TED hose apply to each leg every morning for edema and remove at bedtime scheduled at 8:00am and 8:00pm.
-The TED hose were documented as applied 10

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occurrences out of 13 opportunities.
-On 06/23/24, the TED hose were not applied due to "not in cart."
-On 06/24/24, the TED hose were not applied due to "waiting on measurements."
-On 06/30/24, the TED hose were not applied due to "not in cart."

Review of Resident #2's July 2024 eMAR revealed:
-There was an entry for TED hose knee hi (1 pair) (starting 06/17/24) apply to each leg every morning for edema and remove at bedtime scheduled at 8:00am and 8:00pm.
-The TED hose were documented as applied 19 occurrences out of 31 opportunities.
-On 07/02/24, TED hose were not applied due to "patient refused."
-On 07/03/24, TED hose were not applied due to "waiting on pharmacy refill requested."
-On 07/04/24, TED hose were not applied due to "not in cart."
-On 07/06/24, TED hose were not applied due to "not in cart."
-On 07/07/24, TED hose were not applied due to "not in cart."
-On 07/08/24, TED hose were not applied due to "need measurements."
-On 07/12/24, TED hose were not applied due to "not in cart."
-On 07/15/24, TED hose were not applied due to "need measurements."
-On 07/18/24, TED hose were not applied due to "not in cart."
-On 07/21/24, TED hose were not applied due to "not in cart."
-On 07/26/24, TED hose were not applied due to "resident does not have TED hose."

Review of Resident #2's August 2024 eMAR

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revealed:
-There was an entry for TED hose knee hi (1 pair) (starting 06/17/24) apply to each leg every morning for edema and remove at bedtime scheduled at 8:00am and 8:00pm.
-The TED hose were documented as applied 1 occurrence out of 1 opportunity.
-The TED hose were discontinued on 08/02/24.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/15/24 at 1:50pm revealed:
-They received the measurements for Resident #2's TED hose on 06/10/24.
-Resident #2's TED hose were sent to the facility on 06/17/24.

Telephone interview with Resident #2's PCP on 08/19/24 at 8:55am revealed:
-Resident #2 had heart failure which caused swelling in his legs.
-She ordered TED hose to try and keep the swelling under control without having to order more diuretic medication which could increase Resident #2's fall risk.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:
-The Health and Wellness Director (HWD) was responsible for measuring residents to obtain TED hose for residents.
-The facility's contracted pharmacy was responsible for supplying the correctly sized TED hose to the facility for the resident.
-It should not take anymore than 72 hours once an order was written to have correctly sized TED hose in the facility.

Based on observations, interviews, and record review it was determined Resident #2 was a not

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D 276	Continued From page 88 interviewable. 2. Review of Resident #11's current FL2 dated 10/10/23 revealed diagnoses included chronic pulmonary disease, Alzheimer's disease, and essential hypertension. a. Review of Resident #11's primary care provider (PCP) order dated 05/09/24 revealed please collect urinalysis with reflex to culture. Review of Resident #11's PCP order dated 05/15/24 revealed: -Please collect urine for urinalysis with reflex to culture. -Please call lab when ready. Review of Resident #11's PCP orders dated 05/20/24 revealed: -Please collect urine for urinalysis and culture. -Call lab when ready. -Start ciprofloxacin (used to treat infection) 500mg one tablet twice a day for 7 days. Telephone interview with Resident #11's PCP on 08/19/24 at 8:55am revealed: -The collection of a urine sample for a urinalysis and culture for Resident #11 was "dragged out for weeks." -A benign urinary tract infection could turn into a kidney infection. -A kidney infection could turn into sepsis (a life threatening condition that happened when the body's immune system had an extreme response to infection, causing organ dysfunction). Interview with the Resident Care Director (RCD) on 08/19/24 at 4:24pm revealed: -Resident #11's orders for urinalysis and reflex cultures ordered on 05/09/24, 05/15/24, and	D 276		

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D 276	Continued From page 89 05/20/24 were not collected until 05/29/24. -This occurred prior to her employment at the facility and she did not know why the urine was not collected at the time of the first order. Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed: -The staff were to attempt to collect a urine sample for three days. -If the staff were unable to collect the urine within three days, they were supposed to notify the PCP they had been unable to collect the urine sample. Interview with the Administrator on 08/20/24 at 5:45pm revealed: -The medication aides (MAs) were responsible for collecting urine samples for ordered labs. -If the MAs were unable to collect a urine sample, they were responsible to tell the Health and Wellness Director (HWD). -The HWD was responsible for notifying the PCP they were unable to collect a urine sample. Based on observations, interviews, and record review it was determined Resident #11 was a not interviewable. b. Review of Resident #11's primary care provider (PCP) order dated 05/09/24 revealed TED hose (thrombo-embolic deterrent hose are stockings that help prevent blood clots and swelling in the legs) knee hi apply to each leg every morning for edema and remove at bedtime. Review of Resident #11's Licensed Health Professional Support (LHPS) evaluation dated 05/24/24 revealed: -TED hose were not applied. -Measurements needed to order them.	D 276		

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D 276	Continued From page 90 Review of Resident #11's PCP order dated 06/10/24 revealed discontinue order for TED hose. Review of Resident #11's PCP order dated 07/15/24 revealed discontinue order for TED hose. Review of Resident #11's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for TED hose knee hi apply to each leg every morning for edema and remove at bedtime need measurements scheduled at 8:00am and 8:00pm. -TED hose were documented as applied 14 occurrences out of 30 opportunities. -On 06/02/24, TED hose were documented as not applied due to "not in cart." -On 06/03/24, TED hose were documented as not applied due to "need measurements waiting on pharmacy." -On 06/04/24, TED hose were documented as not applied due to "not in cart." -On 06/05/24, TED hose were documented as not applied due to "not in cart." -On 06/06/24, TED hose were documented as not applied due to "not in cart." -On 06/07/24, TED hose were documented as not applied due to "not in cart." -On 06/08/24, TED hose were documented as not applied due to "on order." -On 06/09/24, TED hose were documented as not applied due to "not in cart." -On 06/10/24, TED hose were documented as not applied due to "need measurements." -On 06/11/24, TED hose were documented as not applied due to "not in cart." -On 06/13/24, TED hose were documented as not applied due to "not in cart."	D 276		

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D 276	Continued From page 91 -On 06/14/24, TED hose were documented as not applied due to "not in cart." -On 06/17/24, TED hose were documented as not applied due to "not available." -On 06/23/24, TED hose were documented as not applied due to "not in cart." -On 06/24/24, TED hose were documented as not applied due to "waiting on pharmacy." -On 06/30/24, TED hose were documented as not applied due to "waiting on pharmacy." Review of Resident #11's July 2024 eMAR revealed: -There was a discontinued entry (start date 07/16/24) for TED hose knee hi apply to each leg every morning for edema and remove at bedtime scheduled at 8:00am and 8:00pm. -TED hose were documented as applied 7 occurrences out of 16 opportunities. -On 07/01/24, TED hose were documented as not applied due to "need measurements." -On 07/03/24, TED hose were documented as not applied due to "need measurements." -On 07/04/24, TED hose were documented as not applied due to "not in cart." -On 07/06/24, TED hose were documented as not applied due to "not in cart." -On 07/08/24, TED hose were documented as not applied due to "need measurements." -On 07/12/24, TED hose were documented as not applied due to "not on cart." -On 07/15/24, TED hose were documented as not applied due to "not in cart." -On 07/16/24, TED hose were documented as not applied due to "discontinued." Telephone interview with Resident #11's PCP on 08/15/24 at 4:36pm revealed she had written an order for TED hose for Resident #11 and it was never implemented.	D 276		

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D 276	Continued From page 92 Interview with the Health and Wellness Director (HWD) on 08/16/24 at 8:32am revealed: -He remembered measuring Resident #11 for TED hose. -He sent the measurements to the pharmacy. -He did not know if the TED hose were ever delivered by the pharmacy for Resident #11. Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed: -The HWD was responsible for measuring residents to obtain TED hose for residents. -The facility's contracted pharmacy was responsible for supplying the correctly sized TED hose to the facility for the resident. -It should not take anymore than 72 hours once an order was written to have correctly sized TED hose in the facility. Based on observations, interviews, and record review it was determined Resident #11 was a not interviewable. 3. Review of Resident #9's current FL2 dated 05/13/24 revealed diagnoses included benign prostatic hyperplasia, hypertension, dementia, and coronary artery disease. Review of Resident #9's physician order dated 05/29/24 revealed an order for knee length TED hose (apply to bilateral legs in the morning and remove at bedtime for circulation). Review of Resident #9's June 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for TED hose knee high (apply to bilateral legs in the morning and remove at bedtime for circulation).	D 276		

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D 276	Continued From page 93 -There was documentation the resident refused TED hose on 06/03/24 at 8:00am. -There was documentation the TED hose were removed on 06/03/24 at 8:00pm. -There was documentation the resident refused TED hose on 06/09/24 at 8:00am. -There was documentation the TED hose were removed on 06/09/24 at 8:00pm. -There was no documentation recorded on 06/14/24 at 8:00am. -There was documentation the TED hose were removed on 06/14/24 at 8:00pm. -There was documentation the resident refused TED hose on 06/18/24 at 8:00am. -There was documentation the TED hose were removed on 06/18/24 at 8:00pm. -There was documentation the resident refused TED hose on 06/21/24-06/22/24 at 8:00am. -There was documentation the TED hose were removed on 06/21/24-06/22/24 at 8:00pm. -There was no documentation recorded on 06/23/24 at 8:00am. -There was documentation the TED hose were removed on 06/23/24 at 8:00pm. -There was documentation the resident refused TED hose on 06/25/24 at 8:00am. -There was documentation the resident self-administered the TED hose on 06/26/24 at 8:00am. -There was documentation the TED hose were removed on 06/25/24-06/26/24 at 8:00pm. -There was documentation the resident self-administered the TED hose on 06/28/24 at 8:00am. Review of Resident #9's July 2024 eMAR revealed: -There was an entry for TED hose knee high (apply to bilateral legs in the morning and remove at bedtime for circulation).	D 276		

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D 276	Continued From page 94 -There was documentation the resident self administered the TED hose on 07/07/24 at 8:00am. -There was documentation the TED hose were removed on 07/07/24 at 8:00pm. -There was no documentation the TED hose were removed on 07/14/24 at 8:00pm. -There was documentation the resident self-administered the TED hose on 07/15/24 at 8:00am. -There was documentation the TED hose were removed on 07/15/24 at 8:00pm. -There was no documentation the TED hose were removed on 07/18/24 at 8:00pm. -There was documentation the resident self-administered the TED hose on 07/20/24-07/21/24 at 8:00am. -There was documentation the TED hose were removed on 07/20/24-07/21/24 at 8:00pm. -There was documentation the TED hose were refused by the resident on 07/26/24 at 8:00am. -There was documentation the TED hose were removed on 07/26/24 at 8:00pm. Review of Resident #9's August 2024 eMAR revealed: -There was an entry for TED hose knee high (apply to bilateral legs in the morning and remove at bedtime for circulation). -There was documentation the resident self administered the TED hose 08/07/24 at 8:00am. -There was documentation the TED were removed on 08/07/24 at 8:00pm. Interview with Resident #9 on 08/16/24 at 9:00am revealed: -He used to wear TED hose but had not worn them in a while. -He was not sure the last time he wore them. -He did not know where his TED hose were.	D 276		

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D 276	Continued From page 95 -He could not recall anytime recently that anyone had helped him apply TED hose or take them off. Observation of Resident #9 on 08/16/24 at 3:14pm revealed: -He was not wearing TED hose. -Edema to his bilateral extremities was not observed. Interview with a MA on 08/16/24 at 3:18pm revealed: -She documented on the eMAR that she put TED hose on Resident #9 on 08/16/24 at 8:00am. -She just assumed he put them on himself, but she never checked. -Resident #9 was independent and wanted to put his TED hose on himself. Interview with a second MA on 08/20/24 at 3:10pm revealed: -Resident #9 always applied his TED hose independently. -Anytime she had documented on the eMAR she had put TED hose on Resident #9, she would always check to make sure he was wearing them. Interview with a personal care aide (PCA) on 08/16/24 at 3:26pm revealed: -She had never noticed Resident #9 wearing TED hose. -He had been forgetful at times and required reminders to go to meals. -He did most activities of daily living (ADLs) himself. -She was not sure if he could apply his own TED hose. Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/19/24 at 4:39pm revealed:	D 276		

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D 276	Continued From page 96 -Resident #9 suffered from heart failure. -He had swelling in his legs. -She wrote an order on 05/13/24 for Resident #9 to have TED hose. -The order required measurements of his legs to be taken. -She was unsure if the measurements ever got done. -She did not think Resident #9 was getting TED hose put on him at all. -She wanted him to wear TED hose so he would not have to be put on higher doses of fluid pills. -The fluid pills could cause blood pressure to lower, resulting in dizziness and falls. -Fluid pills could also cause Resident #9 to go to the bathroom more frequently. -She did not think Resident #9 could put his own TED hose on. Interview with the Health and Wellness Director (HWD) on 08/20/24 at 11:10am revealed: -He expected staff to apply TED hose to Resident #9 daily. -He completed the measurements for TED hose on 06/10/24. -He was not sure why it took so long to get measurements when the order was written on 05/13/24. -He thought he maybe had to send the measurements twice, but he was unsure. -He did not know Resident #9 was not getting TED hose applied daily. -He did not think Resident #9 could put TED hose on himself. -It was the responsibility of the MA to apply TED hose to Resident #9. -It was his responsibility to check behind the MAs to be sure Resident #9 was wearing TED hose. Interview with the Corporate Clinical Specialist	D 276		

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D 276	Continued From page 97 (CCS) on 08/20/24 at 3:35pm revealed: -It was the MA's responsibility to make sure TED hose were followed as ordered. -It was the HWD's responsibility to make sure the TED hose are applied and go behind the MA's to ensure this was implemented. Interview with the Administrator on 08/20/24 at 5:46pm revealed: -MAs should make sure TED hose were applied daily. -It was the HWD's responsibility to follow up to make sure MAs had applied the TED hose. -It should be reported to the physician if Resident #9 was refusing his TED hose. -She expected staff to report non-compliance to their supervisors. -Lack of training and accountability could be factors as to why the TED hose had not been applied. Attempted telephone interview with Resident #9's Power of Attorney (POA) on 08/16/24 at 10:41am and 08/16/24 at 2:38pm was unsuccessful. 3. Review of Resident #3's current FL2 dated 09/25/23 revealed diagnoses included diabetes mellitus 2, hypertension, hypothyroidism, dementia and a cognitive disorder. Review of Resident #3's signed physician's order dated 05/20/24 revealed an order to check Resident #3's finger stick blood sugar (FSBS) three times a day. Review of Resident #3's signed physician's order dated 07/15/24 revealed an order to check Resident #3's FSBS two times a day. Review of Resident #3's June 2024 electronic	D 276		

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D 276	Continued From page 98 Medication Administration Record (eMAR) revealed: -There was an entry to check a (FSBS) three times a day at 8:00am, 2:00pm and 8:00pm. -There was no documentation FSBSs were obtained at 8:00am on 06/11/24 and 06/12/24. -The FSBSs were documented as refused for 2 out of 90 opportunities. Review of Resident #3's July 2024 eMAR revealed: -There was an entry to check a FSBS three times a day, with an original date of 05/20/24, at 8:00am, 2:00pm and 8:00pm. -There was no documentation FSBS were obtained on 07/05/24, 07/11/24, 07/13/24, 07/14/24, and 07/15/24, at 8:00am. -There was no documentation FSBS were obtained on 07/11/24, 07/12/24, 07/13/24, and 07/15/24 at 2:00pm. -There was no documentation FSBS were obtained on 07/12/24, and 07/15/24 at 8:00pm. -There was an entry to check FSBS two times a day with an original date of 07/16/24, documented as obtained 07/16/24 to 07/18/24 at 8:00am and 8:00pm. -There was no documentation FSBS were obtained on 07/19/24, 07/20/24, and 07/21/24 at 8:00am. -There was no documentation FSBS were obtained on 07/24/24 at 8:00pm. -The FSBS was documented as "refused" for 4 out of 45 opportunities 07/01/24 to 07/16/24. -The FSBS was documented as "no test strips" for 4 out of 45 opportunities. -The FSBS was documented as "no lancets" for 1 out of 45 opportunities. -The FSBS was documented as "staff were unable to obtain" for 1 out of 45 opportunities. -The FSBS was documented as "staff were	D 276		

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unable to check" for 1 out of 45 opportunities.
-The FSBS was documented as "waiting on the pharmacy" for 1 out of 45 opportunities.

Review of Resident #3's August 2024 eMAR revealed:
-There was an entry to check FSBS two times a day with an original date of 07/16/24 at 8:00am and 8:00pm.
-There was no documentation the FSBS was obtained on 08/12/24 at 8:00am.
-The FSBS was documented as "unable to take medication" for 1 out of 28 opportunities.

Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20 lancets and 25 test strips.

Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:
-There was an order dated 05/20/24 to check Resident #3's FSBS three times a day.
-There was an order dated 07/16/24 to check Resident #3's FSBS two times a day.
-On 05/28/24, a 16 days supply of 50 test strips, were dispensed to the facility.
-On 05/29/24, a 33 days supply of 100 test strips, were dispensed to the facility.
-On 06/06/24, a 33 days supply of 100 lancets, were dispensed to the facility.
-On 07/24/24, a 50 days supply of 100 lancets, were dispensed to the facility.
-On 07/15/24, a 50 days supply of 100 test strips, were dispensed to the facility.
-The lancets and test strips were not on cycle fill and it was the facility's responsibility to request refills.
-Resident #3 would have been out of lancets 07/07/24 to 07/16/24 used as ordered.

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D 276	Continued From page 100 Interview with a medication aide (MA) on 08/20/24 at 8:00am revealed: -She was trained by the Health and Wellness Director (HWD) to "hit" the refill button on the eMAR and let the HWD and RCD know when diabetic supplies needed to be refilled. -When she observed that supplies were down to two lancets and or strips, she informed the RCD. -She was not aware she could call the pharmacy about refills for diabetic supplies until late July 2024 when the PCP told her during a visit to call the pharmacy and check on diabetic supplies that were not available for Resident #3. -She spoke to the RCD and was then told to contact pharmacy or PCP, and document it in the 24 hour report sheet and the physician's book at the desk. -Since late July 2024 when she notified the pharmacy or physician, she documented it in the physician's book at the desk and put it on the 24 hour report sheet. -If diabetic supplies were not available, she documented the diabetic supplies were "not in cart" on the eMAR. -Third shift staff were responsible to ensure the diabetic supplies from pharmacy were placed in the medication carts. Interview with the Resident Care Director (RCD) on 08/16/24 at 9:46am revealed: -She had only been in the position of RCD for 6-8 weeks in the Special Care Unit (SCU). -The Health and Wellness Director (HWD) was responsible for ensuring diabetic supplies were available prior to her being employed by the facility. -The MAs on third shift were responsible for receiving diabetic supplies from the pharmacy and putting them in the correct medication cart for	D 276		

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use.
-If the MAs found that diabetic supplies were not available, they were supposed to use the refill feature in the eMAR.
-If the diabetic supplies did not arrive as expected from the pharmacy, the MAs were supposed to call the pharmacy to find out why the supplies were not delivered.
-The MA who worked third shift on Monday nights in the SCU was responsible for performing a medication cart audit of all residents' diabetic supplies.
-The MA was then supposed to turn in the audit results to the previous RCD and to her now.
-She had not completed a medication cart audit or reviewed the medication cart audits since she began working at the facility.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:
-If any resident did not have diabetic supplies available to use, the MAs should call the pharmacy and tell them to send the diabetic supplies and bill the facility.
-There was no reason for any resident to be without their diabetic supplies.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-She became the Administrator a week ago.
-The MAs were responsible for weekly medication cart audits and had failed to identify missing diabetic supplies.
-The RCD and Health and Wellness Director (HWD) were responsible to follow up on missing diabetic supplies identified on the medication cart audits.
-The RCD and HWD were responsible for ensuring diabetic supplies were available to use.
-The RCD and HWD were responsible to report in

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D 276	Continued From page 102 daily standup meetings issues identified on the medication cart audits. -She was responsible for ensuring the issues found on medication cart audits were followed-up on by the RCD and HWD. -The staff were not being trained correctly and were not held accountable could be one of the reasons as to why the medication cart audits were not being completed. _____ The facility failed to obtain a urine sample as ordered on 06/10/24 and there was no treatment until 08/06/24 for Resident #2, placing him at risk for increased falls and sepsis and failed to assist Resident #9 with application of thrombo-embolytic hose which resulted in the resident requiring a high dosage of medication to decrease edema in his legs which could cause dizziness and falls due to increased need to urinate. This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024. 5. Review of Resident #6's current FL2 dated 05/29/24 revealed diagnoses included diabetes mellitus type 2, Parkinson's disease, hypertension, and balance instability. Review of Resident #6's physician's order dated	D 276		

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D 276	Continued From page 103 08/12/24 revealed an order for thrombo-embolic deterrent (TED) hose knee high, apply to lower leg in the morning and remove at bedtime for edema. Review of August 2024 electronic medication administration record (eMAR) revealed: -On 08/14/24 at 8am, the TED hose were documented as "not here". -On 08/14/24 at 8pm, the TED hose were documented as being taken off. -On 08/15/24 at 8am, the TED hose were documented as "waiting on pharmacy". -On 08/15/24 at 8pm, the TED hose were documented as being taken off. -On 08/16/24 at 8am, the TED hose were documented as being put on the resident. Observation of Resident #6 on 08/16/24 at 10:36am revealed the resident was not wearing ted hose. Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed: -The Health and Wellness Director (HWD) was responsible for measuring residents to obtain TED hose for residents. -The facility's contracted pharmacy was responsible for supplying the correctly sized TED hose to the facility for the resident. -It should not take anymore than 72 hours once an order was written to have correctly sized TED hose in the facility. Interview with the Administrator on 08/20/24 at 5:46pm revealed: -MAs should make sure TED hose were applied daily. -It was the HWD's responsibility to follow up to make sure MAs had applied the TED hose.	D 276		

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D 276	Continued From page 104 -It should be reported to the physician if Resident #6 was refusing his TED hose. -She expected staff to report non-compliance to their supervisors. -Lack of training and accountability could be factors as to why the TED hose had not been applied.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents related to a pureed diet (Resident #1). The findings are: Review of the facility's Special Diet policy dated 06/13/19 revealed: -Residents would be provided with appropriate diets. -Special diets to be provided by Dining Services included a pureed diet. -Modified diets were to be served as ordered by the physician. -The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 310		

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D 310	Continued From page 105 -All therapeutic diets were to be served as ordered by the physician. Review of the Resident Diets policy dated May 2020 revealed: -All staff were to be trained on the Physician's Diet Order form. -Immediately upon receipt of a new Physician's Diet Order form, a copy would be placed on the diet board designated by the Dietary Service Director (DSD) in the kitchen. -All dining staff were to be trained to check the diet board at the beginning of each shift, as this would alert them to new or diet changes. -The DSD was responsible for updating the diet card and placing the diet card on the board. -The DSD was responsible for placing the Physician's Diet Order form in the diet binder kept in the DSD's office. -The DSD was responsible for keeping a Master Diet Listing which included the diet in a designated area in the kitchen and staff were to be trained to the placement of the document and to be reviewed by the staff prior to each meal. Review of Resident #1's FL-2 dated 07/03/23 revealed diagnoses included diabetes, vascular dementia and hypothyroidism. Review of Resident #1's Resident Register revealed Resident #1 was admitted on 07/03/23. Review of Resident #1's signed diet order dated 05/09/24 revealed an order for a mechanical soft diet. Review of Resident #1's signed diet order dated 07/11/24 revealed an order to change Resident #1's mechanical soft diet to a pureed diet.	D 310		

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D 310	Continued From page 106 Review of the facility's 24 hour report dated 07/12/24 revealed: -On the 7:00am to 7:00pm section, it was documented Resident #1 was coughing and throwing up. -On the 7:00pm to 7:00am section, it was documented Resident #1 died at 7:55pm. Review of Resident #1's death certificate revealed Resident #1 died on 07/12/24 at 7:55pm immediately due to rapid onset of hypoxia and sequentially over days due to aspiration pneumonia. Interview with Adult Home Specialist (AHS) on 08/14/24 at 8:30am revealed: -On 08/09/24, she initiated the complaint into not serving diets as ordered. -She reviewed the therapeutic diet list located on the dietary board in the kitchen. -Resident #1's diet was listed as a mechanical soft diet with thin liquids. Review of the facility's Week at a Glance breakfast menu for 07/12/24 revealed for a regular diet of mini kale caramelized onion frittata, strawberry baked oatmeal hot cereal, sausage patty, gravy or sauce of choice, canned fruit of choice, and bread. Review of the facility's Week at a Glance breakfast menu for 07/12/24 revealed for a pureed diet of pureed mini kale caramelized onion frittata, pureed strawberry baked oatmeal hot cereal with no lumps, pureed sausage patty, gravy or sauce of choice, pureed canned fruit of choice (no pineapple or fruit cocktail) pureed or slurried soft bread (no nuts, seeds, raisins, or tough crusty breads).	D 310		

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D 310	Continued From page 107 Review of the facility's undated therapeutic diet list on 08/09/24 at 9:42am revealed Resident #1 was on a mechanical soft diet with thin liquids. Review of Resident #1's triage note dated 07/11/24 revealed: -The triage note documented the speech therapist requested a diet change from mechanical soft to pureed. -The triage note was documented as faxed on 07/11/24 at 1:42pm and a copy was given to dietary on 07/11/24. Telephone interview with a medication aide (MA) on 08/15/24 at 12:03pm revealed: -On 07/12/24, she was the MA on duty in the Memory Care Unit (MCU), 7:00am to 7:00pm. -On 07/12/24, Resident #1 was served a regular diet, from the serving containers, that was not pureed for breakfast and had maybe a bite or two out of it and and started having some heavy coughing episodes and choked. -She removed the regular diet plate from Resident #1 and Resident #1 did not eat any more until lunch. -Resident #1 was served a regular diet at lunch and she removed it once she noticed it. -She spoke to a Physical Therapist (PT) that was in the MCU who clarified Resident #1 was to be served a pureed diet and notified the Dining Room (DM) and the diet was changed for supper. -About an hour after lunch, a personal care aide (PCA) informed her that Resident #1 was in the day room coughing and vomiting. -She went to the day room and found Resident #1 profusely coughing and vomiting. Telephone interview with a PT on 08/19/24 at 9:23am revealed: -On 7/12/24, she was working with another	D 310		

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resident before lunch, when the MA on duty in the MCU asked her for assistance to make sure Resident #1 was "ok".
-The MA was concerned that Resident #1 was supposed to be on a pureed diet and was served a regular diet at breakfast and had a choking episode.
-On 07/12/24, there was no Heimlich Maneuver performed on Resident #1 that she was aware of.
-She called the Speech Therapist (ST) and Resident #1's PCP to verify the correct diet order.
-On 07/12/24, the ST clarified he recommended a pureed diet on 07/11/24 due to a choking episode with Resident #1.
-On 07/12/24, before she left the MCU right before lunch she clarified the diet for pureed with the kitchen staff but did not see what was actually served to Resident #1.

Telephone interview with the facility's contracted ST on 08/19/24 at 4:19pm revealed:
-On 07/11/24, he received a call from a physician from Resident #1's PCP office about Resident #1 choking on 07/09/24 and a request to change Resident #1's diet to a pureed diet.
-On 07/11/24, Resident #1's diet was changed from mechanical soft to pureed by the PCP the RCD was responsible to take the new order to the kitchen manager to add to the therapeutic diet list in the kitchen.
-On 07/12/24, the facility's contracted PT informed him about a choking episode Resident #1 experienced during breakfast due to being served a regular diet.
-The PT wanted clarification of the diet order.
-He told the PT that Resident #1 was to be served a pureed diet.
-The PT said she would make sure dietary had the correct order.
-If Resident #1 was not served a pureed diet,

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D 310	Continued From page 109 then Resident #1 could choke. Telephone interview with Resident #1's primary care provider (PCP) on 08/19/24 at 8:25am revealed: -On 07/09/24, Resident #1 had a choking episode, turned blue, became non-responsive, required the Heimlich Maneuver, an evaluation by a physician and a chest xray. -Resident #1's 07/09/24 choking episode was characterized as a "severe choking" episode during which her airway was completely obstructed, resulting in loss of consciousness due to an inability to cough. -When Resident #1 choked, the food blocked airflow to her lungs and made it difficult for her to breath or talk; her face would turn red because she could not breath or talk, decreasing her oxygen flow and then her face turned blue. -When Resident #1's face turned blue, she was at serious risk of decreased blood flow to the brain which could lead to death. -It only took 4-6 minutes before brain damage or death to occur after someone choked. -The other harmful effects of choking include the lungs filling up with fluid leading to inflammation and hypoxia from the decreased oxygen saturation, and both of those complications could lead to death within 36 hours. -On 07/11/24, Resident #1 was seen by a facility contracted provider and a pureed diet was ordered. -On 07/12/24, Resident #1 choked during breakfast after being served a regular diet and died on the same day at 7:55pm. -Resident #1 was a great risk for complications, after choking because Resident #1 had a severe choking episode on 07/09/24 where Resident #1 turned blue and lost consciousness.	D 310		

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D 310	Continued From page 110 Interview with the Dietary Service Director (DSD) on 08/19/24 at 4:30pm revealed: -When a diet changed, the dietary staff who received the order was to place the new diet order in the diet order book located in the dietary office and the diet order board was to be updated with the new diet order. -All dietary staff were responsible for reviewing the diet board before each meal to alert the staff of new diet orders or changes. -On 07/09/24, the cook was responsible for preparing the meal according to Resident #1's therapeutic diet, which was a mechanical soft diet. -The regular diets were sent in large containers and dished out in the kitchen by servers and handed to the MCU staff to give to the residents. -All therapeutic diets were prepared separately and placed on a tray for an individual resident. -There were no dietary cards on the separate therapeutic meals prepared in the main kitchen and sent to the MCU. -On 07/11/24, there was an order in the diet order book for Resident #1 to receive a pureed diet. -On 07/12/24, all meals were prepared in the kitchen and transported to the MCU dining room. -On 07/11/24, he did not know the diet order board was not changed for Resident #1. -On 07/12/24, he did not know Resident #1 received a regular diet at breakfast and choked. -On 07/12/24, he did know there was an issue with Resident #1's diet at lunch but it was taken care of before Resident #1 received the lunch plate. -There was no way to verify the pureed meal was given to Resident #1 in the MCU. Interview with the Resident Care Director (RCD) on 08/16/24 at 9:46am revealed: -When a new diet order was received, the MAs	D 310		

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were responsible for writing it in the 24 hour report and take a copy of the new diet order to the dietary manager.
-The dietary staff were responsible for handing out trays according to the dietary card posted in the kitchen.
-On 07/12/24, for breakfast, lunch and supper, a separate pureed diet was to be made specifically by the dietary staff and given to Resident #1.
-The MAs and PCAs were responsible for making sure the resident received the correct diet from the dietary staff.
-On 07/12/24, she did not know why Resident #1 received a regular diet for breakfast.
-She was responsible for reviewing the 24 hour report every morning and reporting the new diet order or issues to the Administrator and Dietary Manager every morning in the standup meeting.
-She did not know there was a problem with Resident #1 receiving the wrong therapeutic diet order on 07/12/24 during breakfast and had a choking episode.

Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed:
-The MAs were responsible for notifying the RCD about a new diet order.
-The RCD was responsible for making sure the Dietary Manager had a copy of the new order.
-The RCD was responsible for reporting all new diet orders in the morning standup meetings to the Administrator and Dietary Manager.

Telephone interview with the former Administrator on 08/16/24 at 2:40pm revealed:
-He was the Administrator on 07/09/24 and 07/12/24.
-The MAs were responsible for receiving a new diet order, write it on the 24 hour sheet and notify the RCD.

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D 310	Continued From page 112 -The RCD was responsible for reviewing the 24 hour report every morning and report the new diet order to the Administrator and if the new diet order was received before the next meal, then take copy of the order to the DSD for immediate processing. -He did not know the Resident #1 did not receive the correct diet on 07/12/24 at breakfast. Attempted telephone interview with Resident #1's Power of Attorney (POA) on 08/16/24 at 4:00pm and 08/16/24 at 5:05pm was unsuccessful. [Refer to tag 0271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)] _____ The facility failed to serve a pureed diet as ordered to Resident #1 who experienced coughing and vomiting secondary to a severe choking episode with aspiration on 07/09/24. Resident #1 was served a regular diet for breakfast on 07/12/24 and again experienced difficulty swallowing and died on the day same. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/15/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024,	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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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
D 358	Continued From page 113 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 13 sampled residents (#2, #3, #5, #6, #10) related to medications used to treat high blood pressure, anxiety and elevated blood sugar (#3), medications used to treat high blood pressure and fluid retention (#2), medication used to treat urinary incontinence (#5), medications used to treat high blood sugars and nerve pain (#6), and a medication used to reduce increased eye pressure (#10). The findings are: 1. Review of Resident #3's current FL2 dated 09/25/23 revealed diagnoses included diabetes mellitus 2, hypertension, hypothyroidism, dementia and a cognitive disorder. a. Review of Resident #3's signed physician's order dated 05/14/24 revealed an order for furosemide (a medication to treat high blood pressure) 10mg/ml solution, take 2mls = 20mg every morning. Review of Resident #3's signed physician's order dated 07/21/24 revealed an order for furosemide	D 358		

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D 358	Continued From page 114 10mg/ml solution, take 4ml = 40mg every morning. Review of Resident #3's signed physician's order dated 07/21/24 revealed an order for furosemide 10mg/ml solution, take 6ml = 60mg every morning. Review Resident #3's June 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml solution, take 2mls = 20mg every morning with an original date of 05/14/24 documented at 8:00am. -There was no documentation the furosemide was administered on 06/02/24, 06/08/24, 06/11/24, 06/12/24, 06/15/24 and 06/30/24 at 8:00am. -The furosemide was documented as "refused" for 5 out of 30 opportunities. -The furosemide was documented as "waiting on pharmacy" for 1 out of 30 opportunities. Review Resident #3's July 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml solution, take 2mls = 20mg every morning with an original date of 05/14/24 and a discontinue date of 07/22/24 documented at 8:00am. -There was no documentation the furosemide was administered on 07/01/24, 07/02/24, 07/03/24, 07/05/24, 07/08/24, 07/11/24, and 07/19/24 at 8:00am. -The furosemide was documented as "refused" for 3 out of 22 opportunities. -The furosemide was documented as "waiting on pharmacy" for 3 out of 22 opportunities. -The furosemide was documented as "unable to take medication" for 1 out of 22 opportunities. -There was an entry for furosemide 10mg/ml solution, take "6mls = 40mg" every morning with an original date of 07/22/24 and a discontinue date of 07/30/24 at 8:00am.	D 358		

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D 358	Continued From page 115 -There was no documentation the furosemide was administered on 07/30/24 at 8:00am. -The furosemide was documented as "discontinued" for 1 out of 8 opportunities. -There was an entry for furosemide 10mg/ml solution, take 6mls = 60mg every morning with an original date of 07/30/24 documented at 8:00am. -There was no documentation the furosemide was administered on 07/31/24 at 8:00am. -The furosemide was documented as "med not available, RCD followed up with pharmacy" for 1 out of 1 opportunities. Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: -On 07/21/24, an electronic prescription was received from Resident #3's primary care physician (PCP) for furosemide 10mg/ml solution, take 4mls = 40mg every morning. -There was a transcription error on the pharmacy side that was not caught by pharmacy staff or facility staff as of 08/20/24 and the label of the furosemide dispensed on 07/21/24 and the entry on the eMAR was for furosemide 10mg/ml solution, take 6mls = 40mg every morning instead of the 4mls = 40mg. -Since the furosemide was a liquid the facility staff could have administered the furosemide 6mls instead of the 4mls for 8-9 days which could lead to an increase of urination, dehydration and a decrease in potassium in body. -The PCP order documented the furosemide was used for hypertension and taking too much furosemide could lower Resident #3's blood pressure more than the intended range. Review of Resident #3's August 2024 eMAR revealed: -There was an entry for furosemide 10mg/ml	D 358		

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solution, take 6mls = 60mg every morning with an original date of 07/30/24 documented at 8:00am.
-There was no documentation the furosemide was administered on 08/03/24, 08/04/24, 08/06/24, and 08/12/24 at 8:00am.
-The furosemide was documented as "med not available, RCD followed up with pharmacy", "not on cart, refill requested by RCD", "RCD followed up with pharmacy", and "unable to take" for 4 out of 14 opportunities.

Review of Resident #3's medications available for administration on 08/20/24 at 11:18am revealed there was a bottle of furosemide 10mg/1ml liquid, with a label dated 07/30/24 containing 60mls, to administer 6ml = 60mg every morning for hypertension with 8mls left to administer.

Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:
-On 05/14/24, there was an order for furosemide 10mg/ml solution, take 2mls = 20mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 60mls, a 30 day supply on 05/14/24 and 07/01/24.
-On 07/21/24, there was an order for furosemide 10mg/ml solution, take 4mls = 40mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 120mls, a 30 day supply on 07/22/24.
-On 07/30/24, there was an order for furosemide 10mg/ml solution, take 6mls = 60mg every morning.
-The pharmacy dispensed furosemide 10mg/ml solution, 180mls, a 30 day supply on 07/22/24.
-Based on dispense history, Resident #3 would have been out of the furosemide 2mls 06/13/24 until 07/01/24.

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D 358	Continued From page 117 Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/19/24 at 8:25am revealed: -The furosemide was ordered to treat Resident #3's hypertension by lowering the blood pressure. -On 07/21/24, Resident #3 was seen by virtual visit for weeping in her legs due to increased swelling and she increased the furosemide from 2mls = 20mg to 4mls = 40mg every morning. -On 07/29/24, she saw Resident #3 at the facility and there was no documentation of Resident #3's blood pressure (BP) for the month of July 2024, she went off of June 2024's BP which was a little high, and the visit from 07/21/24 related to Resident #3's legs swelling and weeping, and no reported falls, so she increased the furosemide to 6mls = 60mg every morning and sent the order to pharmacy. -She was not aware of the furosemide 4mls = 40mg ordered on 07/21/24 was possibly administered as 6mls instead of 4mls for 8-9 days in July 2024. -Resident #3 could have increased blood pressure causing fluid retention causing swelling and weeping in Resident #1's legs leading which could increase risk of developing congestive heart failure. Interview with a medication aide (MA) on 08/20/24 at 8:00am revealed: -She was trained by the Health and Wellness Director (HWD) to "hit" the refill button when a medication needed to be refilled and let the HWD and RCD know. -When she saw that medications were down to two doses, she informed the RCD. -She was not aware she could call the pharmacy about refills for medications until late July 2024 when the PCP told her, during a visit, to call the	D 358		

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pharmacy and check on a medication that was not available to administer to Resident #3.
-She spoke to the RCD and was then told to contact pharmacy or PCP, and document it in the 24 hour report sheet and the physician's book at the desk.
-Since late July 2024 when she notified the pharmacy or physician, she documented it in the physician's book at the desk and put it on the 24 hour report sheet.
-If a medication was not available to administer, she documented medication "not in cart" on the eMAR.
-If a resident's medication ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication.
-Third shift staff were responsible to ensure the medications from pharmacy were placed in the medication carts.

Interview with the Resident Care Director (RCD) on 08/16/24 at 9:46am revealed:
-She had been in the position of RCD for 6-8 weeks.
-The Health and Wellness Director (HWD) was responsible for ensuring medications were available for administration prior to her being employed by the facility.
-The MAs on third shift were responsible for receiving medications from the pharmacy and putting the medication in the correct medication cart for administration.
-If the MAs found a medication that was not available, they were supposed to use the refill feature in the eMAR.
-If a medication did not arrive as expected from the pharmacy, the MAs were supposed to call the pharmacy to find out why the medications were not delivered.
-The MA who worked third shift on Monday

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nights in the Special Care Unit (SCU) was responsible for performing a medication cart audit of all residents' medications.
-Then, the MA was to turn in the audit results to the previous RCD, but now the MA was to turn the audit results in to her now.
-She was not sure of the process or who was responsible for discrepancies found on the medication cart audits since she began working at the facility.
-She had not completed a medication cart audit or reviewed the medication cart audits since she started work.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:
-If any resident did not have a medication available to administer the MAs should call the pharmacy and tell them to send the medication and bill the facility.
-There was no reason for any resident to be without their medications.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The MAs were responsible for weekly medication cart audits and had failed to identify missing medications.
-The RCD and the Health and Wellness Director (HWD) were responsible to follow up on missing medications identified on the medication cart audits.
-The RCD and HWD were responsible for ensuring medications were available to administer.
-The RCD and HWD were responsible to report in daily standup meetings issues identified on the medication cart audits.
-She was responsible for ensuring the issues found during medication cart audits were

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followed-up on by the RCD and HWD.
-The staff were not being trained correctly and were not held accountable could be one of the reasons as to why the medication cart audits were not being completed.

b. Review of Resident #3's signed physician's order dated 06/10/24 for lorazepam gel (a medication used to treat anxiety/agitation) 0.5mg/0.5ml to forearm two times a day.

Review of Resident #3's signed physician's orders dated 07/25/24 for lorazepam gel 1mg/1ml to inner wrist or other hairless area every night at bedtime.

Review of Resident #3's June 2024 eMAR revealed:
-There was an entry for lorazepam gel 0.5mg/0.5ml to forearm two times a day with an original date of 06/11/24 documented as administered on 06/13/24 to 06/21/24 at 8:00am and 8:00pm, and 06/23/24 to 06/30/24 at 8:00am and 8:00pm.
-On 06/11/24 at 8:00am, the lorazepam was documented as "not in cart".
-On 06/11/24 at 8:00pm, the lorazepam was documented as "med not on cart".
-On 06/12/24 at 8:00am, the lorazepam was documented as "refuse".
-On 06/22/24 at 8:00am, the lorazepam was documented as "med not in cart".
-The lorazepam was not administered for 4 out of 60 opportunities.

Review Resident #3's July 2024 eMAR revealed:
-There was an entry for lorazepam gel 0.5mg/0.5ml to forearm two times a day with an original date of 06/11/24 documented as administered at 8:00am and 8:00pm.

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D 358	Continued From page 121 -There was no documentation the lorazepam was administered on 07/14/24, 07/15/24, 07/16/24, 07/19/24 and 07/26/24 at 8:00am. -There was no documentation the lorazepam was administered on 07/15/24, 07/26/24, 07/27/24 and 07/28/24 at 8:00pm. -There was an entry for lorazepam gel 1mg/1ml to forearm at night with an original date of 07/25/24 and a discontinued date of 07/31/24 documented at 8:00pm. -The lorazepam was documented as "not on cart" for 2 out of 60 opportunities. -The lorazepam was documented as "refused" for 1 out of 60 opportunities. -The lorazepam was documented as "discontinued" for 2 out of 60 opportunities. -The lorazepam was documented as "waiting on pharmacy" for 1 out of 60 opportunities". -The lorazepam was not documented as administered and no reason provided for 3 out of 60 opportunities. Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: -On 06/11/24, there was an order for lorazepam gel 0.5mg/0.5ml to forearm two times a day. -The pharmacy dispensed lorazepam gel 0.5ml = 0.5mg, 30mls, 30 day supply on 06/11/24 and 07/16/24. -On 07/28/24, there was an order for lorazepam gel 1mg/1ml to forearm at night. -The pharmacy was unable to dispense lorazepam 1mg/1ml because the pharmacy could not compound the medication before it was discontinued on 07/31/24. -According to their records, the lorazepam 1mg/ml was not available for administration 07/25/24 to 07/31/24. -Lorazepam was used for anxiety/agitation and if	D 358		

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not received as ordered dose the resident could display increased behaviors.

Telephone interview with a representative from the facility's contracted mental health (MH) provider on 08/15/24 at 2:00pm revealed:
-The lorazepam was order for agitation and anxiety.
-He was not aware of Resident #3 refusing the lorazepam which caused him to make medication changes.
-If the lorazepam was not administered as ordered the Resident #3 would have an increase in behaviors which was the reason he had to change the lorazepam to clonazepam on 07/31/24.

Interview with a medication aide (MA) on 08/20/24 at 8:00am revealed:
-She was trained by the Health and Wellness Director (HWD) to "hit" the refill button when a medication needed to be refilled and notify the HWD and RCD know.
-When she saw that medications had two doses remaining, she informed the RCD.
-She was not aware she could call the pharmacy about refills for medications until late July 2024 when the PCP told her, during a visit, to call the pharmacy and check on a medication that was not available to administer to Resident #3.
-She spoke to the RCD and was then told to contact pharmacy or PCP, and document it in the 24 hour report sheet and the physician's book at the desk.
-Since late July 2024 when she notified the pharmacy or physician, she documented it in the physician's book at the desk and put it on the 24 hour report sheet.
-If a medication was not available to administer, she documented medication "not in cart" on the

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D 358	Continued From page 123 eMAR. -If a resident's medication ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication. -Third shift staff were responsible to ensure the medications from pharmacy were placed in the medication carts. Interview with the Resident Care Director (RCD) on 08/16/24 at 9:46am revealed: -She had only been in the position of RCD for 6-8 weeks. -The Health and Wellness Director (HWD) was responsible for ensuring medications were available for administration prior to her being employed by the facility. -The MAs on third shift were responsible for receiving medications from the pharmacy and putting the medication in the correct medication cart for administration. -If the MAs found a medication that was not available, they were supposed to use the refill feature in the eMAR. -If a medication did not arrive as expected from the pharmacy, the MAs were supposed to call the pharmacy to find out why the medications were not delivered. -The MA who worked third shift on Monday nights in the SCU was responsible for performing a medication cart audit of all residents' medications. -The MA was then supposed to turn in the audit results to the previous RCD and to her now. -She was not sure about follow through with discrepancies found during the medication cart audits prior to her employment as the RCD. -She had not completed a medication cart audit or reviewed the medication cart audits since she began working at the facility.	D 358		

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D 358	Continued From page 124 Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed: -If any resident did not have a medication available to administer the MAs should call the pharmacy and tell them to send the medication and bill the facility. -There was no reason for any resident to be without their medications. Interview with the Administrator on 08/20/24 at 5:45pm revealed: -She became the Administrator a week ago. -The MAs were responsible for weekly medication cart audits and had failed to identify missing medications. -The RCD and HWD were responsible to follow up on missing medications identified during the medication cart audits. -The RCD and HWD were responsible for ensuring medications were available to administer. -The RCD and HWD were responsible to report in daily standup meetings issues identified on the medication cart audits. -She was responsible for ensuring the issues found on medication cart audits were followed-up on by the RCD and HWD. -The staff were not being trained correctly and were not held accountable could be one of the reasons as to why the medication cart audits were not being completed. c. Review of Resident #3's signed physician's order dated 05/14/24 for metformin (a medication used to treat diabetes) 500mg/5ml, administer 10mls two times a day. Review of Resident #3's signed physician's order dated 07/08/24 for metformin 500mg/5ml, administer 10mls twice daily with breakfast and	D 358		

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D 358	Continued From page 125 supper to decrease gastrointestinal (GI) upset. Review Resident #3's June 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 10mls = 1000mg two times a day, with an original date of 05/13/24 documented at 8:00am and 8:00pm. -There was no documentation the metformin was administered on 06/02/24, 06/08/24, 06/11/24, 06/12/24, and 06/17/24 at 8:00am. -There was no documentation the metformin was administered on 06/02/24, and 06/08/24 at 8:00pm. -The metformin was documented as "refused" for 4 out of 60 opportunities. -The metformin was documented as "not in cart" for 3 out of 60 opportunities. -The metformin was documented as "on order" for 1 out of 60 opportunities. -An entry for FSBS three times daily obtained at 8:00am, 2:00pm and 8:00pm, with a range between 98 and 261. Review Resident #3's July 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 10mls = 1000mg two times a day with an original date of 05/13/24 and a discontinue date of 07/03/24 documented at 8:00am and 8:00pm. -There was no documentation the metformin was administered on 07/02/24 at 8:00am. -There was no documentation the metformin was administered on 07/03/24 at 8:00pm. -There was an entry for metformin 500mg/5ml solution, administer 5mls = 500mg two times a day with meals, breakfast and supper with an original date of 07/03/24 documented as administered at 8:00am and 5:00pm. -There was no documentation the metformin was administered on 07/05/24, 07/11/24, 07/19/24,	D 358		

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D 358	Continued From page 126 07/21/24, and 07/22/24 at 8:00am. -There was no documentation the metformin was administered on 07/16/24, 07/17/24, 07/18/24, 07/20/24 and 07/22/24 at 5:00pm. -The metformin was documented as administered incorrectly or 31 out of 54 opportunities. -The metformin was documented as "refused" for 3 out of 62 opportunities. -The metformin was documented as "not on cart" for 7 out of 62 opportunities. -The metformin was documented as "unable to take" for 1 out of 62 opportunities. -The metformin was documented as "discontinued" for 1 out of 62 opportunities. -An entry for FSBS three times daily obtained 07/01/24 to 07/16/24 at 8:00am, 2:00pm and 8:00pm, and two times daily, 07/16/24 to 07/31/24 with a range between 61 and 368. Review Resident #3's August 2024 eMAR revealed: -There was an entry for metformin 500mg/5ml solution, administer 5mls = 500mg two times a day with meals, breakfast and supper with an original date of 07/03/24 documented as administered at 8:00am and 5:00pm. -There was no documentation the metformin was administered on 08/02/24, and 08/12/24 at 8:00am. -There was no documentation the metformin was administered on 08/11/24 and 08/13/24 at 5:00pm. -The metformin was documented as administered incorrectly or 24 out of 28 opportunities. -The metformin was documented as "refused" for 2 out of 28 opportunities. -The metformin was documented as "unable to take" for 1 out of 28 opportunities. -The metformin was documented as "resident asleep" for 1 out of 28 opportunities.	D 358		

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D 358	Continued From page 127 -An entry for FSBS two times daily, 07/16/24 to 07/31/24 with a range between 81 and 301. Review of Resident #3's medications available for administration on 08/20/24 at 11:18am revealed there was a bottle of metformin 500mg/5ml liquid, with a label dated 07/22/24 containing 200mls, to administer 5ml = 500mg every morning for diabetes with 8ml left to administer. Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: -On 06/11/24, there was an order for metformin 500mg/5ml solution, administer 10mls = 1000mg two times a day. -The pharmacy dispensed metformin 600mls, 30 day supply on 05/25/24 and 06/22/24. -On 07/08/24, there was an order for metformin 500mg/5ml solution, administer 10mls = 1000mg two times a day with breakfast and supper to prevent GI upset. -The pharmacy dispensed metformin 300mls, 15 day supply on 07/08/24 and 07/22/24. Telephone interview with the facility's contracted PCP on 08/19/24 at 8:25am revealed: -The metformin was ordered to treat Resident #3's high blood sugars. -On 07/03/24, she changed Resident #3's metformin from 8:00am and 8:00pm to twice a day with breakfast and lunch to help with digestive issues Resident #3 experienced from taking this medication. -On 07/29/24, she saw Resident #3 at the facility and there was documentation of refusals and being out of the medication. -She was not notified of the refusals, administered incorrectly, or being out of the medication.	D 358		

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D 358	Continued From page 128 -Resident #3's last hemoglobin A1C drawn on 04/29/24 was 7.9 (HbA1C is a test that measures the average of glucose or blood sugar in a person's blood over 3 months, normal 4.8-5.6). Interview with a MA on 08/20/24 at 8:00am revealed: -She was trained by HWD to "hit" the refill button when a medication needed to be refilled and notify the HWD and RCD know. -When she saw that medications were down to two doses, she informed the RCD. -She was not aware she could call the pharmacy about refills for medications until late July 2024 when the PCP told her, during a visit, to call the pharmacy and check on a medication that was not available to administer to Resident #3. -She spoke to the RCD and was then told to contact pharmacy or PCP, and document it in the 24 hour report sheet and the physician's book at the desk. -Since late July 2024 when she notified the pharmacy or physician, she documented it in the physician's book at the desk and put it on the 24 hour report sheet. -If a medication was not available to administer, she documented medication "not in cart" on the eMAR. -If a resident's medication ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication. -Third shift staff were responsible to ensure the medications from pharmacy were placed in the medication carts. Interview with the RCD on 08/16/24 at 9:46am revealed: -She had only been in the position of RCD for 6-8 weeks. -The HWD was responsible for ensuring	D 358		

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medications were available for administration prior to her being employed by the facility.
-The MAs on third shift were responsible for receiving medications from the pharmacy and putting the medication in the correct medication cart for administration.
-If the MAs found a medication that was not available, they were supposed to use the refill feature in the eMAR.
-If a medication did not arrive as expected from the pharmacy, the MAs were supposed to call the pharmacy to find out why the medications were not delivered.
-The MA who worked third shift on Monday nights in the SCU was responsible for performing a medication cart audit of all residents' medications.
-The MA was then supposed to turn in the audit results to the previous RCD and to her now.
-She was not sure about follow through with discrepancies found during the medication cart audits prior to her employment as the RCD.
-She had not completed a medication cart audit or reviewed the medication cart audits since she began working at the facility.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:
-If any resident did not have a medication available to administer the MAs should call the pharmacy and tell them to send the medication and bill the facility.
-There was no reason for any resident to be without their medications.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-The MAs were responsible for weekly medication cart audits and had failed to identify missing medications.

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-The RCD and HWD were responsible to follow up on missing medications identified on the medication cart audits.
-The RCD and HWD were responsible for ensuring medications were available to administer.
-The RCD and HWD were responsible to report in daily standup meetings issues identified on the medication cart audits.
-She was responsible for ensuring the issues found on medication cart audits were followed-up on by the RCD and HWD.
-The staff were not being trained correctly and were not held accountable could be one of the reasons as to why the medication cart audits were not being completed.

2. Review of Resident #10's current FL2 dated 11/27/23 revealed diagnoses included coronary artery disease and hypertension.

a. Review of Resident #10's current FL2 dated 11/27/23 revealed there was an order for brimonidine (used to reduce pressure in the eye) 0.2% eye drops instill one drop in each eye three times daily for eye pressure.

Review of a subsequent order dated 05/30/24 revealed continue brimonidine 0.2% eye drops one drop in both eyes three times daily.

Review of Resident #10's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for brimonidine 2% eye drop instill one drop in each eye three times a day scheduled at 7:00am, 1:00pm, and 7:00pm.
-The brimonidine was documented as administered as ordered for 68 occurrences out of 90 opportunities.

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D 358	Continued From page 131 -On 06/01/24 at 7:00am, 1:00pm, and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/02/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/03/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/04/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/05/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/06/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/07/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/08/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/09/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/10/24 at 7:00am and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/11/24 at 7:00am and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 06/14/24 at 7:00am, the brimonidine was documented as not administered due to "patient refused medication." -On 06/18/24 at 7:00am, the brimonidine was documented as not administered due to "patient refused medication."	D 358		

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D 358	Continued From page 132 Review of Resident #10's July 2024 eMAR revealed: -There was an entry for brimonidine 2% eye drop instill one drop in each eye three times a day scheduled at 7:00am, 1:00pm, and 7:00pm. -The brimonidine was documented as administered as ordered for 64 occurrences out of 93 opportunities. -On 07/05/24 at 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/12/24 at 7:00am, the brimonidine was documented as not administered due to "patient refused medication." -On 07/13/24 at 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/14/24 at 7:00am, the brimonidine was documented as not administered due to "patient refused medication." -On 07/16/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/17/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/18/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/19/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/22/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/23/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/24/24 at 1:00pm, the brimonidine was documented as not administered due to "patient	D 358		

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refused medication."
-On 07/25/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 07/26/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 07/27/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 07/28/24 at 7:00am and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 07/31/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."

Review of Resident #10's August 2024 eMAR from 08/01/24-08/16/24 revealed:
-There was an entry for brimonidine 2% eye drop instill one drop in each eye three times a day scheduled at 7:00am, 1:00pm, and 7:00pm.
-The brimonidine was documented as administered as ordered for 17 occurrences out of 46 opportunities from 08/01/24 to 08/16/24 at 7:00am.
-On 08/01/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/02/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/03/24 at 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/04/24 at 7:00am, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/05/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered

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due to "patient refused medication."
-On 08/06/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/08/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/09/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/11/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/12/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/13/24 at 7:00am, 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/14/24 at 1:00pm and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."
-On 08/15/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication."

Observation of Resident #10's medications on hand on 08/19/24 at 10:00am revealed:
-There was one open bottle of brimonidine 0.2% eye drops.
-The label directions were brimonidine 0.2% instill one drop in both eyes three times a day with a dispense date of 03/26/24.
-There was no date documented on the bottle when the eye drops were initially opened by staff.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/19/24 at 10:28am revealed:
-Resident #10's brimonidine eye drops were last

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dispensed on 03/26/24, which would have been a 17-day supply.
-The brimonidine eye drops were also dispensed 12/13/23, 01/09/24, 02/21/24 each supplying a 17-day supply.
-The brimonidine eye drops were safe to use for up to four weeks after the date they were opened being stored at room temperature.
-Using the brimonidine eye drops stored at room temperature after four weeks could cause a burning sensation in the eyes.

Telephone interview with the triage Registered Nurse (RN) who worked at Resident #10's ophthalmologist's office on 08/19/24 at 11:10am revealed:
-Resident #10 was ordered the brimonidine eye drops to control the pressure in his eyes.
-If Resident #10 missed a large number of doses of the brimonidine, he ran a higher risk of increased pressure in his eyes.
-Resident #10 ran an increased risk of losing his eyesight if the pressures inside his eyes increased.

Based on observations, interviews and record review it was determined that Resident #10 was not interviewable.

b. Review of Resident #10's current FL2 dated 11/27/23 revealed there was an order for ketorolac (used to reduce inflammation and swelling in the eye) 0.5% instill one drop in each eye twice daily for inflammation.

Review of Resident #10's primary care provider (PCP) order dated 05/30/24 revealed:
-Discontinue ketorolac 0.5% eye drops.
-Start ketorolac 0.4% eye drops instill one drop into left eye four times per day while awake.

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D 358	Continued From page 136 Review of Resident #10's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for ketorolac 0.4% instill one drop into left eye four times a day while awake scheduled at 7:00am, 11:00am, 4:00pm, and 7:00pm. -The ketorolac was documented as administered for 84 occurrences out of 120 opportunities. -On 06/01/24 at 7:00am, 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/02/24 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/03/24 at 4:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/04/24 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/05/25 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/06/24 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/07/24 at 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/08/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/09/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/10/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."	D 358		

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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
D 358	Continued From page 137 -On 06/11/24 at 11:00am and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/12/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/14/24 at 7:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/18/24 at 7:00am and 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/21/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 06/22/24 at 4:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 06/25/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." Review of Resident #10's July 2024 eMAR revealed: -There was an entry for ketorolac 0.4% instill one drop into left eye four times a day while awake for conjunctivitis scheduled at 7:00am, 11:00am, 4:00pm, and 7:00pm. -The ketorolac was documented as administered for 79 occurrences out of 124 opportunities. -On 07/05/24 at 11:00am and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 07/09/24 at 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 07/12/24 at 7:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 07/13/24 at 4:00pm and 7:00pm, the	D 358		

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ketorolac was documented as not administered due to "patient refused medication."
-On 07/14/24 at 7:00am, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/16/24 at 4:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/17/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/18/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/19/24 at 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/20/24 at 4:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/22/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/23/24 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/24/24 at 11:00am, 4:00pm, and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/25/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/26/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/27/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication."
-On 07/27/24 at 4:00pm, the ketorolac was documented as not administered due to "med not

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D 358	Continued From page 139 on my shift." -On 07/28/24 at 7:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 07/31/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." Review of Resident #10's August 2024 eMAR from 08/01/24-08/19/24 revealed: -There was an entry for ketorolac 0.4% instill one drop into left eye four times a day while awake for conjunctivitis scheduled at 7:00am, 11:00am, 4:00pm, and 7:00pm. -The ketorolac was documented as administered for 24 occurrences out of 73 opportunities. -On 08/01/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/02/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/03/24 at 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/04/24 at 7:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 08/05/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/06/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/08/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/09/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."	D 358		

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D 358	Continued From page 140 -On 08/10/24 at 4:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/11/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/12/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/13/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/14/24 at 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/15/24 at 11:00am, the ketorolac was documented as not administered due to "patient refused medication." -On 08/16/24 at 11:00am, 4:00pm, 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/17/24 at 7:00am and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." -On 08/19/24 at 7:00am, 11:00am, 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication." Observation of Resident #10's medications on hand on 08/19/24 at 10:00am revealed: -There was one open bottle of ketorolac 0.5% eye drops with label directions to instill one drop in each eye twice daily with a dispense date of 03/26/24 and no date initially opened by staff. -There was one bottle of ketorolac 0.4% eye drops with label directions to instill one drop four times a day in the left eye with a dispense date of 05/30/24 and no date initially opened by staff. Telephone interview with a pharmacy technician	D 358		

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from the facility's contracted pharmacy on 08/19/24 at 10:28am revealed the dispense of Resident #10's brimonidine eye drops on 05/30/24 and was a 25-day supply of the medication.

Telephone interview with the triage Registered Nurse (RN) who worked at Resident #10's ophthalmologist's office on 08/19/24 at 11:10am revealed:
-Resident #10 was ordered the ketorolac 0.4% eye drops to keep inflammation down in the left eye.
-Keeping inflammation and swelling down in the left eye helped to keep the eye pressure within the desired range to maintain the resident's vision.

Based on observations, interviews and record review it was determined that Resident #10 was a not interviewable.

c. Review of Resident #10's primary care provider (PCP) order dated 05/30/24 revealed latanoprost (used to reduce pressure in the eye) 0.005% one drop to both eyes once daily.

Review of Resident #10's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for latanoprost 0.005% one drop into both eyes at bedtime scheduled at 7:00pm.
-The latanoprost was documented as administered for 22 occurrences out of 29 opportunities.
-On 08/01/24, 08/02/24, 08/04/24-08/07/24, and 08/10/24-08/11/24, the latanoprost was documented as not administered due to "patient refused medication."

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D 358	Continued From page 142 Review of Resident #10's July 2024 eMAR revealed: -There was an entry for latanoprost 0.005% one drop into both eyes at bedtime scheduled at 7:00pm. -The latanoprost was documented as administered for 22 occurrences out of 29 opportunities. -On 07/05/24, 07/09/24, 07/13/24, 07/17/24-07/19/24, 07/22/24-07/26/24, 07/28/24, and 07/31/24, the latanoprost was documented as not administered due to "patient refused medication." Review of Resident #10's August 2024 eMAR from 08/01/24-08/18/24 revealed: -There was an entry for latanoprost 0.005% one drop into both eyes at bedtime scheduled at 7:00pm. -The latanoprost was documented as administered for 4 occurrences out of 18 opportunities. -On 08/01/24-08/03/24, 08/05/24-08/06/24, 08/08/24-08/09/24, 08/11/24-08/18/24, the latanoprost was documented as not administered due to "patient refused medications." Observation of Resident #10's medications on hand on 08/19/24 at 10:00am revealed there was one open bottle of latanoprost 0.005% eye drops with label directions to instill one drop to both eyes daily with a dispense date of 05/30/24. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/19/24 at 10:28am revealed: -The latanoprost 0.005% dispensed for Resident #10 on 05/30/24 was a 25 to 28 day supply of the medication.	D 358		

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D 358	Continued From page 143 -The latanoprost could be used for six weeks when left at room temperature. -Using latanoprost after six weeks at room temperature could cause the medication to lose its effectiveness. Telephone interview with the triage Registered Nurse (RN) who worked at Resident #10's ophthalmologist's office on 08/19/24 at 11:10am revealed Resident #10 was ordered the latanoprost 0.005% eye drops to keep eye pressure down in the eye to prevent angle closure glaucoma (when the iris bulges and partially or completely blocks the eye's drainage angle preventing fluid from circulating through the eye causing pressure to increase and potentially damaging the optic nerve). Based on observations, interviews and record review it was determined that Resident #10 was not interviewable. _____ Interview with a Medication Aide (MA) on 08/19/24 at 9:52am revealed: -Resident #10 had been refusing his scheduled eye drops for "about a week." -Resident #10 told her the eye drops burned his eyes and that's why he refused them. Interview with another MA on 08/20/24 at 3:00pm revealed: -Resident #10 refused his eye drops "all the time." -Resident #10 would not let staff instill the eye drops in his eyes unless they caught him "in the right mood." Interview with the Health and Wellness Director (HWD) on 08/19/24 at 2:15pm revealed: -He was not aware Resident #10's eye drops	D 358		

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were not being administered.
-He was not aware some of Resident #10's eye drops were not dated when opened.
-He was responsible for ensuring the third shift MAs conducted weekly medication cart audits for assisted living.
-He had not received any documentation recently from the third shift staff concerning medication cart audits.
-He did not know for sure if staff had completed recent medication cart audits.
-The weekly medication cart audits were supposed to include checking every residents medications on hand and compare it to the entries on the eMAR and the current orders.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:
-It was the responsibility of the HWD to perform weekly medication cart audits.
-It was the responsibility of the HWD to ensure the medications were available, dated correctly, and not expired.
-The HWD should administer medications "once in awhile to know what was happening."
-When third shift staff performed medication cart audits, it was the HWD's responsibility to follow-up with all the medication issues found on the audit.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-She became the Administrator "one week ago."
-She was not aware of the concerns with Resident #10's medications.
-The Resident Care Director (RCD) and HWD were responsible for ensuring medications were available to administer.
-The RCD and HWD were responsible to follow up on missing medications identified on the

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medication cart audits.
-If the staff had been doing medication cart audits, the problems with Resident #10's medications would have been found.
-It was their policy for the HWD to run a medication variance report daily.
-The variance report would have shown issues with Resident #10 getting his medications.
-The HWD was responsible to go over the issues discovered in the variance report and actions taken to follow-up with the Administrator daily in their stand-up meeting.
-She was responsible for ensuring the issues found on medication cart audits were followed-up on by the RCD and HWD.

3. Review of Resident #2's current FL2 dated 06/05/24 revealed:
-Diagnoses included multiple fractures ribs, cellulitis, and dementia.
-Resident #2 was admitted from a skilled nursing facility on 06/05/24.

a. Review of Resident #2's current FL2 dated 06/05/24 revealed there was an order for metoprolol (used to treat high blood pressure) 25mg one tablet every 12 hours.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) from 06/05/24 to 06/30/24 revealed:
-There was an entry for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic blood pressure (BP) was greater than 130 and or if heart rate (HR) was less than 65 hold medication.
-The metoprolol was documented as administered as ordered for 22 occurrences out of 42 opportunities from 06/05/24 at 8:00pm

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D 358	Continued From page 146 through 06/30/24 at 8:00pm. -From 06/05/24-06/30/24, the blood pressure (BP) range was 105/60-184/104 and heart rate (HR) range was 54-107. -On 06/06/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/06/24 at 8:00pm, there was no documented BP or HR, metoprolol was documented as not administered due to "bp not in range." -On 06/09/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/10/24 at 8:00am, the documented BP was 133/94 and the HR was 75, metoprolol was documented as not administered due to "waiting on pharmacy." -On 06/10/24 at 8:00pm, the documented BP was 140/100 and the HR was 87, metoprolol was documented as not administered due to "held per order." -On 06/11/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/11/24 at 8:00pm, the documented BP was 144/89 and the HR was 86, metoprolol was documented as not administered due to "med not on cart." -On 06/12/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/12/24 at 8:00pm, the documented BP was 144/89 and the HR was 86, metoprolol was documented as not administered due to "med not on cart."	D 358		

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D 358	Continued From page 147 -On 06/13/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/13/24 at 8:00pm, the documented BP was 140/78 and the HR was 78, metoprolol was documented as not administered due to "med not on cart." -On 06/14/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/14/24 at 8:00pm, the documented BP was 145/75 and the HR was 105, metoprolol was documented as not administered due to "med not on cart." -On 06/15/24 at 8:00am, the documented BP was 174/111 and the HR was 82, metoprolol was documented as not administered due to "not in cart." -On 06/15/24 at 8:00pm, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/16/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/16/24 at 8:00pm, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." -On 06/17/24 at 8:00pm, there was no documented BP or HR, metoprolol was documented as not administered due to "med not on cart." -On 06/27/24 at 8:00am, the documented BP was 163/88 and the HR was 69, metoprolol was documented as not administered due to "patient didn't need."	D 358		

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D 358	Continued From page 148 -On 06/28/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "not in cart." Review of Resident #2's July 2024 eMAR revealed: -There was an entry for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic BP was greater than 130 and or if HR was less than 65 hold medication. -The metoprolol was documented as administered as ordered for 38 occurrences out of 40 opportunities. -From 07/01/24-07/31/24, the BP range was 111/80-171/98 and the HR range was 57-107. -On 07/01/24 at 8:00pm, there was no documented BP or HR, metoprolol was documented as not administered due to "held per order." -On 07/02/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "patient refused medication." Review of Resident #2's August 2024 eMAR revealed: -There was an entry for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic BP was greater than 130 and or if HR was less than 65 hold medication. -The metoprolol was documented as administered as ordered for 12 occurrences out of 13 opportunities. -From 08/01/24-08/14/24, the BP range was 97/78-190/119 and the HR range was 56-99.	D 358		

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-On 08/07/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "patient refused medication."

Observation of Resident #2's medications on hand on 08/15/24 at 11:08am revealed:
-There was one bubble pack labeled "morning" of metoprolol 50mg one half tablets with nine half tablets remaining with a dispense date of 07/23/24 quantity 30.
-There was a second bubble pack labeled "bedtime" of metoprolol 50mg one half tablets with 11 half tablets remaining with a dispense date of 07/23/24 quantity 30.

Review of Resident #2's repack summary report from the facility's contracted pharmacy revealed:
-There was a quantity of 30 tablets of metoprolol 50mg dispensed to the facilty on 05/24/24.
-There was a quantity of 30 tablets of metoprolol 50mg dispensed to the facility on 06/23/24.

Telephone interview with Resident #2's primary care provider (PCP) on 08/19/24 at 8:55am revealed:
-Resident #2 had a diagnosis of heart failure.
-Resident #2 was ordered metoprolol to treat high blood pressure.
-Missed doses of the metoprolol increased Resident #2's risk of heart attack, stroke, and worsening kidney disease from high blood pressure.

Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.

b. Review of Resident #2's current FL2 dated 06/05/24 revealed there was an order for

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valsartan (used to treat high blood pressure) 160mg one tablet every night at bedtime.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for valsartan 160mg one tablet every night at bedtime hold if systolic blood pressure (BP) less than 110 or diastolic BP less than 60 scheduled at 8:00pm.
-The valsartan was documented as administered as ordered for 13 occurrences out of 25 opportunities.
-From 06/05/24-06/30/24, the BP range was 112/69-184/104.
-On 06/10/24, the documented BP was 140/100; the valsartan was documented as not administered due to "med not on cart."
-On 06/11/24, the documented BP was 144/89; the valsartan was documented as not administered due to "med not on cart."
-On 06/12/24, the documented BP was 144/89; the valsartan was documented as not administered due to "med not on cart."
-On 06/13/24, the documented BP was 140/78; the valsartan was documented as not administered due to "med not on cart."
-On 06/14/24, the documented BP was 145/75; the valsartan was documented as not administered due to "med not on cart."
-On 06/15/24, there was no documented BP; the valsartan was documented as not administered due to "not in cart."
-On 06/16/24, there was no documented BP; the valsartan was documented as not administered due to "not in cart."
-On 06/17/24, there was no documented BP; the valsartan was documented as not administered due to "med not on cart."
-On 06/18/24, the documented BP was 122/77;

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the valsartan was documented as not administered due to "med not on cart."
-On 06/19/24, the documented BP was 157/109; the valsartan was documented as not administered due to "med not in cart."
-On 06/20/24, the documented BP was 155/96; the valsartan was documented as not administered due to "med not on cart."
-On 06/21/24, the documented BP was 151/102; the valsartan was documented as not administered due to "not in cart."

Review of Resident #2's July 2024 eMAR revealed:
-There was an entry for valsartan 160mg one tablet every night at bedtime hold if systolic BP less than 110 or diastolic BP less than 60 scheduled at 8:00pm.
-The valsartan was documented as administered as ordered for 29 occurrences out of 30 opportunities.
-From 07/01/24 to 07/31/24, the BP range was 93/73-187/108.
-On 07/01/24, there was not documented BP; the valsartan was documented as not administered due to "held per order."

Review of Resident #2's August 2024 eMAR revealed:
-There was an entry for valsartan 160mg one tablet every night at bedtime hold if systolic BP less than 110 or diastolic BP less than 60 scheduled at 8:00pm.
-The valsartan was documented as administered as ordered for 7 occurrences out of 7 opportunities.
-From 08/01/24-08/14/24, the BP range was 97/78-160/103.

Observation of Resident #2's medications on

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hand on 08/15/24 at 11:08am revealed:
-There was one bubble pack of valsartan 160mg tablets with a dispense date of 07/23/24 quantity of 30.
-The label directions were valsartan 160mg one tablet daily at bedtime hold if systolic BP less than 110 or diastolic BP less than 60.

Review of Resident #2's repack summary report from the facility's contracted pharmacy revealed:
-There was a quantity of 30 tablets of valsartan 160mg dispensed to the facilty on 05/24/24.
-There was a quantity of 30 tablets of valsartan 160mg dispensed to the facility on 06/23/24.

Telephone interview with Resident #2's primary care provider (PCP) on 08/19/24 at 8:55am revealed:
-Resident #2 had a diagnosis of heart failure.
-Resident #2 was ordered valsartan to treat high blood pressure.
-Missed doses of the valsartan increased Resident #2's risk of heart attack, stroke, and worsening kidney disease from high blood pressure.

Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.

c. Review of Resident #2's current FL2 dated 06/05/24 revealed there was an order for torsemide (a diuretic used to reduce swelling from multiple causes and also used to treat high blood pressure) 20mg take one and one-half tablets (30mg) daily for fluid.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 153 -There was an entry for torsemide 20mg take one and one-half tablets (30mg) daily for fluid scheduled at 8:00am. -The torsemide was documented as administered 20 occurrences out of 22 opportunities from 06/07/24-06/30/24. -On 06/20/24, torsemide was documented as not administered due to "not in cart." -On 06/21/24, torsemide was documented as not administered due to "not in cart." Review of Resident #2's repack summary report from the facility's contracted pharmacy revealed: -There was a quantity of 60 tablets of torsemide 20mg dispensed to the facilty on 05/24/24. -There was a quantity of 26 tablets of torsemide 20mg dispensed to the facility on 06/08/24, due to an order change from two per day to one and one-half tablets per day. -There was a quantity of 45 tablets of torsemide 20mg dispensed to the facility on 06/19/24. Observation of Resident #2's medications on hand on 08/15/24 at 11:08am revealed: -There was one bubble pack of torsemide 20mg tablets with a dispense date of 07/23/24 for a quantity of 45. -The label directions were torsemide 20mg take one and one-half tablets (30mg) daily. Telephone interview with Resident #2's primary care provider (PCP) on 08/19/24 at 8:55am revealed: -Resident #2 had a diagnosis of heart failure. -It was "very dangerous" for Resident #2 to miss even two doses of the torsemide. -Missed doses of the torsemide increased Resident #2's risk of heart attack, stroke, and worsening kidney disease from high blood pressure.	D 358		

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D 358	Continued From page 154 Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable. _____ Review of the facility's Medication Services policy dated 03/18/19 revealed: -Community provides medication ordering and medication assistance services. -All medications for residents receiving medication assistance from Community staff are requested to be unit-dose packaged prior to distribution. -Any medication provided to the Community for staff assistance that was not unit-dose packaged will be sent to the Community's preferred pharmacy for repackaging, if the pharmacy agrees to and/or is able to repackage per regulations. -All medications that staff members handle, store, and assist with will be documented on the electronic medication administration record (MAR) and in accordance with state regulations and the Community's preferred pharmacy policy and procedure manual. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/15/24 at 1:50pm revealed: -Resident #2's medications were mailed directly to the facility by an outside pharmacy. -Resident #2's medications arrived to the facility in bottles. -Resident #2's bottled medications were sent to the facility's contracted pharmacy and repackaged into bubble packs. -The pharmacy sent out repackaged medications for Resident #2 for May, June, and July 2024. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 155 08/16/24 at 10:14am revealed: -If a medication was not available to administer, she documented medication "not in cart" on the eMAR. -To order refills of medications, she would click on the refill button within the electronic eMAR. -If a resident's medication ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication. -They received Resident #2's medications in bottles from an outside pharmacy and then sent them to the facility's contracted pharmacy to repackage the medications into bubble packs. -Resident #2's medications arrived in quantities of a three month supply. -The facility would send the entire three month supply to the facility's contracted pharmacy and they would repackage the medications and send the repackaged medications back to the facility in quantities of a 30-day supply. -The repackaged medications were received from the pharmacy by third shift staff. -Third shift staff were responsible to ensure the repackaged medications were placed in the medication carts. Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed: -She had been in the position of RCD for eight weeks. -The Health and Wellness Director (HWD) was responsible for ensuring medications were available for administration prior to her being employed by the facility. -Resident #2's medications were delivered to the facility from an outside pharmacy. -The MAs were responsible to send Resident #2's bottled medications to the facility's contracted pharmacy for repackaging into bubble packs. -The MAs were responsible for making sure	D 358		

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medications were in the facility and available for administration.
-If the MAs found a medication was not available for administration, they were supposed to use the refill feature in the eMAR.
-If a demanded medication did not arrive as expected from the facility's contracted pharmacy, the MAs were supposed to call the pharmacy to find out why the medications were not delivered.
-The MA who worked third shift on Monday nights was responsible for performing a medication cart audit of all residents medications.
-The MA was then supposed to turn in the audit results to the RCD.
-She was not sure about follow through with discrepancies found during the medication cart audits prior to her employment as the RCD.

Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:
-If any resident did not have a medication available to administer, the MAs should call the pharmacy and tell them to send the medication and bill the facility.
-There was no reason for any resident to be without their medications.

Interview with the Administrator on 08/20/24 at 5:45pm revealed:
-She became the Administrator "one week ago."
-The weekly medication cart audits had failed to identify Resident #2's missing medications.
-The RCD and Health and Wellness Director (HWD) were responsible to follow up on missing medications identified on the medication cart audits.
-The RCD and HWD were responsible for ensuring medications were available to administer.
-The RCD and HWD were responsible to report in

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daily standup meetings issues identified on the medication cart audits.
-She was responsible for ensuring the issues found on medication cart audits were followed-up on by the RCD and HWD.

4. Review of Resident # 6's current FL2 dated 05/29/24 revealed diagnoses included diabetes mellitus type 2 (DM2), Parkinson's disease, hypertension (HTN), and balance instability.

a. Review of primary care provider (PCP) order dated 06/24/24 revealed there was an order for Jardiance (used to lower blood sugar) 10mg tablet, take one tablet by mouth once daily for diabetes, hold and notify physician if blood sugar was less than 200.

Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Jardiance 10mg tablet, take one tablet by mouth once daily at 8:00am for diabetes, hold and notify physician if blood sugar was less than 200.
- On 06/26/24 at 11:08am, the documented FSBS was 181; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 06/27/24 at 08:21am, the documented FSBS was 123; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 06/28/24 at 08:34 am, the documented FSBS was 136; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 06/29/24 at 07:36am, the documented FSBS was 123; Jardiance was documented as

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administered, and there was no documentation PCP was notified.
- On 06/30/24 at 8:00am, the documented FSBS was 156; Jardiance was documented as administered, and there was no documentation PCP was notified.

Review of Resident #6's July electronic medication administration record (eMAR) revealed:
- There was an order for Jardiance 10mg tablet, take one tablet by mouth once daily at 8:00am for diabetes, hold and notify physician if blood sugar was less than 200.
-On 07/02/24 at 08:31am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/03/24 at 08:24am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/04/24 at 10:32am, the documented FSBS was 102; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/05/24 at 9:19am, the documented FSBS was 133; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/07/24 at 7:59am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/12/24 at 8:32am, the documented FSBS was 124; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 07/15/24 at 8:00am, the documented FSBS was "not recorded", the Jardiance was held, and

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there was no documentation PCP was notified.
-On 07/20/24 at 7:47am, the documented FSBS was 119, the Jardiance was administered incorrectly, and there was no documentation PCP was notified.
-On 07/24/24 at 7:53am, the documented FSBS was "not recorded", the Jardiance was held, and there was no documentation PCP was notified.

Review of Resident #6's August electronic medication administration record (eMAR) revealed:
-On 08/03/24 at 9:09am, the documented FSBS was 103; Jardiance was documented as administered, and there was no documentation PCP was notified.
-On 08/07/24 at 7:44am, the documented FSBS was "not recorded", the Jardiance was held, and there was no documentation PCP was notified.
-On 08/10/24 at 7:08am, the documented FSBS was 114; Jardiance was documented as administered, and there was no documentation PCP was notified.

Interview with PCP on 08/19/24 at 05:00pm revealed:
-She was not informed of any FSBS under 200 in June.
-She was not informed the medication was being administered incorrectly and was given even though FSBS was under 200.
-Unaddressed blood sugar issues could result in uncontrolled diabetes.
-Communication regarding Jardiance administration was essential for controlling Resident #6's diabetes.

Interview with a medication aide (MA) on 08/16/24 at 10:48am revealed:
-She was responsible for contacting the physician

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if medications were held, administered late, or missed.
-She was responsible for communication with the facility management regarding resident issues.

Interview with the Health and Wellness Director on 08/20/24 at 4:45pm revealed:
-He was responsible for auditing MARs.
-He was responsible for ensuring the PCP was notified of any resident related health concerns including missed or held medications.
-He was responsible for faxing new orders to the pharmacy.
-He was unaware the medications were being administered incorrectly.

b. Review of Resident #6's PCP order dated 05/16/24 revealed there was an order for gabapentin (used to treat nerve pain) 600mg tablet, one tablet by mouth each day at bedtime.

Review of June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 600 mg tablet, take one tablet by mouth once daily at 9:00am.
-The gabapentin was documented as administered daily from 06/01/24 to 06/25/24.

Interview with Resident #6's PCP on 08/19/24 at 05:00pm revealed:
-She noted the gabapentin was not being administered appropriately and brought it to the attention of staff.
-The gabapentin was supposed to be administered at bedtime.
-The time of gabapentin administration was never addressed by the facility staff.
-She attempted multiple times to have staff administer the gabapentin at the proper time.

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D 358	Continued From page 161 -She stated the early administration greatly increased the resident's risk of falls. -She chose to D/C gabapentin on 06/25/24 as staff continued to administer incorrectly. Interview with a MA on 08/16/24 at 10:48am revealed: -She was responsible for communication with the facility management regarding resident medication issues. -She was unaware any medications were administered incorrectly. -She administered medications as shown on the MAR and physician orders. Interview with HWD on 08/20/24 at 4:45pm revealed: -He was responsible for auditing MARs. -He was responsible for ensuring the PCP was notified of any resident related health concerns including missed or held mediations. -He was responsible for faxing new orders to the pharmacy. -He was unaware the medications were being administered incorrectly. 5. Review of Resident #5's current FL2 dated 06/10/24 revealed diagnoses included severe depression, sleep apnea, adenocarcinoma, systematic lupus, and cerebrovascular accident. Review of Resident #5's physician's order dated 07/12/24 revealed tamsulosin (used to treat urinary incontinence) 0.4 mg. 1 tablet once daily; move administration time to bedtime. Review of Resident #5's July 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for tamsulosin 0.4 mg, take one capsule at bedtime for urinary incontinence.	D 358		

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-There was an entry for tamsulosin 0.4 mg, administer daily at 9:00am.
-There was documentation tamsulosin 0.4 mg was administered at 9:00am 07/01/24 through 07/31/24.

Review of Resident #5's August 2024 eMAR revealed:
-There was an entry for tamsulosin 0.4 mg, take one capsule at bedtime for urinary incontinence.
-There was an entry for tamsulosin 0.4 mg administer daily at 9:00am.
-There was documentation tamsulosin 0.4 mg was administered at 9:00am 08/01/24 through 08/14/24.

Telephone interview with the Pharmacist from the facility's contracted pharmacy on 08/15/24 at 11:25am revealed:
-He received an dated 07/15/24 for tamsulosin 0.4 mg. to be given at bedtime for Resident #5.
-He was not aware the time did not change on the eMAR.
-He was not sure why the eMAR still had the administration time as 9:00am, instead of 9:00pm.
-He changed the time to be administered on the eMAR on 08/15/24 to be given on 08/16/24 at 9:00pm.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/15/24 at 4:35pm revealed:
-Resident #5 had advanced lung cancer and chronic obstructive pulmonary disease.
-She changed the administration time for tamsulosin 0.4 mg to be given at bedtime because it could cause orthostatic hypotension (a condition that causes a person's blood pressure to drop when they stand up or sit down) and could

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increase the risk of falls due to dizziness.
-Taking tamsulosin at bedtime would decrease the risk of falling.
-She was not aware that tamsulosin 0.4 mg was still being administered in the mornings.
-She expected staff make sure orders were implemented and followed through.

Interview with a medication aide (MA) on 08/20/24 at 3:10pm revealed:
-She was not aware tamsulosin 0.4 mg was changed to be administered at bedtime.
-She followed what the eMAR said, and it had instructions to administer the tamsulosin at 9:00am.

Interview with the Health and Wellness Director (HWD) on 08/20/24 at 11:10am revealed:
-He remembered seeing the order for tamsulosin 0.4 mg with an administration time at bedtime.
-He remembered faxing the order to the Pharmacy.
-He was not sure why the administration time for tamsulosin 0.4 mg was not changed to bedtime on the eMAR.
-It was his responsibility to ensure orders were correct on the eMAR's.

Interview with a supervisor on 08/20/24 at 11:39am revealed:
-She was responsible for collecting all new orders and making a copy and placing it in the HWD's box for processing.
-She was not aware of an order to change the tamsulosin administration time to be given at bedtime.
-The HWD was responsible to ensure orders were correct on the eMAR's.

Interview with the Corporate Clinical Specialist

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D 358	Continued From page 164 (CCS) on 08/20/24 at 3:35pm revealed: -She was not aware the administration time for tamsulosin 0.4 mg. was changed to bedtime. -It was the HWD's responsibility to ensure orders were changed on the eMAR to reflect current changes. Interview with the Administrator on 08/20/24 at 5:46pm revealed: -She became the Administrator a week ago. -She was not aware tamsulosin had the wrong administration time on the eMAR for Resident #5. -She expected orders to be up to date and reflect on eMAR's so the medications would be given correctly. -Not being trained correctly or held accountable could be reasons why eMAR's are not being checked for accuracy. -It was the HWD's responsibility to make sure eMAR's reflected the correct administration times. [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. _____ The facility failed to ensure that a physician's order was transcribed accurately on the eMAR and the furosemide was available for administration which resulted in the physician unnecessarily increasing the dosage for Resident #3 and the resident not receiving the furosemide as ordered which resulted in her lower extremities swelling and weeping and increased her risk of developing congestive heart failure. The facility failed to ensure lorazepam was available for administration for Resident #3, resulting in behavior and subsequent changes in dosages, and an increase to a stronger medication as well as continued behaviors. The facility failed to	D 358		

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D 358	Continued From page 165 ensure the physician ordered metformin changes with the administration time to 5:00pm was completed to prevent GI upset and failured to correct the dosage of metformin resulted in FSBSs as high as 368. This failure resulted in substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the prescribed time for 2 of 3 sampled residents related to a medication used to treat symptoms of Parkinson's disease such as stiffness and tremors (#5) and medications to treat Parkinson's disease and diabetes (#6). The findings are:	D 364		

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D 364	Continued From page 166 Review of the facility's Medication Services policy dated 03/18/19 revealed medications were to be administered up to one hour before and after their prescribed time, unless the physician ordered a specific time. 1. Review of Resident #5's current FL2 dated 06/10/24 revealed diagnoses included severe depression, sleep apnea, cerebrovascular accident, systematic lupus, and adenocarcinoma. Review of Resident #5's signed physician's orders dated 06/10/24 revealed there was an order for carbidopa-levodopa (used to treat symptoms of Parkinson's disease such as stiffness and tremors) 25mg-100mg tablet, take 2 tablets, three times a day. Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for carbidopa-levodopa 25-100 tablet, take 2 tablets three times daily at 8:00am, 12:00pm, and 5:00pm. -Carbidopa-levodopa was documented as administered at 9:00am, 12:00pm, and 5:00pm 06/01/24 through 06/21/24 and documented as administered at 8:00am on the 06/22/24. -Carbidopa-levodopa was documented as not administered on 06/22/24 at 12:00pm or 5:00pm due to "leave of absence." -Carbidopa-levodopa was documented as not administered on 06/23/24 at 8:00am and 12:00pm due to "leave of absence." -Carbidopa-levodopa was documented as administered on 06/23/24 at 5:00pm. -Carbidopa-levodopa was documented as administered on 6/24/24-06/30/24 at 8:00am, 12:00pm, and 5:00pm.	D 364		

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D 364	Continued From page 167 Review of Resident #5's June 2024 Medication Administration Audit Report revealed: -Carbidopa-levodopa 25-100 tablet was administered outside of the one hour before/one hour after time frame for 38 occurrences out of 84 opportunities with the latest administration being on 06/30/24 at 1:15pm. -There was no entry on the June 2024 Medication Administration Audit Report for 06/01/24 at 8:00am or 12:00pm. Review of Resident #5's July 2024 eMAR revealed: -There was an entry for carbidopa-levodopa 25-100 tab, take 2 tablets three times daily at 8:00am, 12:00pm, and 5:00pm. -Carbidopa-levodopa was documented as administered on 07/01/13-07/31/24 at 9:00am, 12:00pm, and 5:00pm. Review of Resident #5's July 2024 Medication Administration Audit Report revealed: -Carbidopa-levodopa 25-100 tablet was administered outside the one hour before/one hour after time frame for 46 occurrences out of 91 opportunities with the latest administration being 07/29/24 at 9:16am. -There was no entry on the July 2024 Medication Administration Audit Report for 07/01/24 at 8:00am or 12:00pm. Review of Resident #5's August eMAR revealed: -There was an entry for carbidopa-levodopa 25-100 tablet, take 2 tablets three times daily at 8:00am, 12:00pm, and 5:00pm. -Carbidopa-levodopa was documented as administered on 08/01/24-08/13/24 at 8:00am, 12:00pm, and 5:00pm. -Carbidopa-levodopa was documented as administered at 8:00am and 12:00pm on	D 364		

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D 364	Continued From page 168 08/14/24. Review of Resident #5's August Medication Administration Audit Report revealed: -Carbidopa-levodopa 25-100 tablet was administered outside the one hour before/one hour after time frame for 18 occurrences out of 39 opportunities with the latest administration being 08/14/24 at 9:16am. -There was no entry on the August 2024 Medication Administration Audit Report for 08/01/24 at 8:00am and 12:00pm. Telephone interview with the facility's contracted mental health provider (MHP) on 08/15/24 at 2:00pm revealed: -Resident #5 was started on the carbidopa-levodopa by another physician. -The carbidopa-levodopa must be taken at the same time every day to prevent "wearing off" which is when the symptoms such as difficulty with walking, standing, stiff and achy muscles, involuntary movements, muscle rigidity, problems with coordination and gait, and difficulty with talking and swallowing would reoccur because benefits of the medication would be diminished. -If there was not a constant level of the carbidopa-levodopa in Resident #5's blood stream then it could cause very painful and debilitating symptoms. Interview with a medication aide (MA) on 08/20/24 at 3:10pm revealed: -She was aware she administered Resident #5's carbidopa-levodopa "late" on multiple occasions. -There were not enough staff to assist with medication administration. Interview with the Health and Wellness Director (HWD) on 08/20/24 at 11:10am revealed:	D 364		

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D 364	Continued From page 169 -He was aware Resident #5's carbidopa-levodopa was not administered in a timely manner. -He thought it was due to Resident #5 preference to sleep late. -He did not know Resident #5's cabidopa-levodopa was administered late for the 12:00pm and 5:00pm doses. -It was his responsibility to ensure medications were administered on time. Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Medications were considered late if not administered within a one-hour window before and after the time the medication was due. -She was not aware medications were not being administered on time. -The HWD was responsible to ensure medications were administered on time. Interview with the Administrator on 08/20/24 at 5:46pm revealed: -She was not aware Resident #5's carbidopa-levodopa was administered late on multiple occasions. -She expected her staff to administer medications within the one-hour before and one hour after window. -Lack of training and not being held accountable could be reasons why the medications were being administered late. -The HWD was responsible for running a time variance check daily to ensure medications were administered on time. 2. Review of Resident # 6's current FL2 dated 05/29/24 revealed diagnoses included diabetes mellitus type 2, Parkinson's disease, hypertension, and balance instability.	D 364		

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Review of Resident #6's Resident Register revealed an admission date of 05/14/24.

a. Review of Resident #6's primary care provider (PCP) orders dated 05/14/24 revealed there was an order for carbidopa-levo extended release (ER) 25-100mg tablets take two tablets three times daily for Parkinson's symptoms such as, stiffness and tremors.

Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed there was an entry for carbidopa-levo ER 25-100mg tablets two tablets at 9:00am, 12:00pm, and 8:00pm.

Review of Resident #6's June 2024 Medication Administration Audit Report revealed carbidopa-levo ER 25mg-100mg was administered outside of the one-hour before/one-hour after time frame for 16 of 86 opportunities with the latest administration time being on 06/27/24 order for 8pm and administered at 10:33pm.

Review of Resident #6's July 2024 eMAR revealed there was an entry for carbidopa-levo ER 25-100mg tablets two tablets at 9:00am, 12:00pm, and 8:00pm.

Review of Resident #6's July 2024 Medication Administration Audit Report revealed carbidopa-levo ER 25mg/100mg was administered outside of the one-hour before/one-after time frame for 30 of 90 opportunities with the latest administration time being on 07/01/24 order for 8pm and administered at 10:28pm.

Review of Resident #6's August 2024 eMAR

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revealed there was an entry for carbidopa-levo ER 25-100mg tablets two tablets at 9:00am, 12:00pm, and 8:00pm.

Review of Resident #6's August 2024 Medication Administration Audit Report revealed carbidopa-levo ER 25mg/100mg was administered outside of the one-hour before/one-hour after time frame for 21 of 54 opportunities with the latest administration time being on 08/04/24 order for 12:00pm and administered at 2:45pm.

Interview with a medication aide (MA) on 08/16/24 at 10:48am revealed:
-Medications should to be administered one hour before or one hour after the time for administration on the eMAR.
-She was responsible for contacting the physician if medications were administered outside of the ordered time.
-This medication required more accurate administration times, 15 minutes before/after administration time noted on MAR.
-She could not recall why the medication required more accurate administration times.

b. Review of Resident #6's primary care provider (PCP) order dated 06/19/24 revealed Lantus Solostar 100 unit/ml (a long acting insulin to treat diabetes) inject 10 units every night at bedtime for diabetes, hold if blood sugar is less than 100.

Review of Resident #6's June 2024 electronic Medication Administration Record (eMAR) revealed there was an entry for Lantus Solostar 100 unit/ml inject 10 units every night at 8:00pm for diabetes, hold if blood sugar is less than 100.

Review of Resident #6's June 2024 Medication

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D 364	Continued From page 172 Administration Audit Report revealed Lantus solostar was administered outside of the one hour before/one-hour after time frame for 1 of 10 opportunities with the latest administration time on 06/27/24 documented as administered at 10:33pm, two and a half hours late. Review of Resident #6's July 2024 eMAR revealed there was an entry for Lantus Solostar 100 unit/ml inject 10 units every night at 8:00pm for diabetes, hold if blood sugar is less than 100. Review of Resident #6's July 2024 medication administration audit report revealed Lantus solostar was administered outside of the one hour before/one-hour after time frame for 4 of 28 opportunities with the latest administration time being on 07/17/24 order for 8pm and administered at 11:52pm. Review of Resident #6's August 2024 eMAR revealed there was an entry for Lantus Solostar 100 unit/ml inject 10 units every night at 8:00pm for diabetes, hold if blood sugar is less than 100. Review of Resident #6's August 2024 medication administration audit report revealed Lantus solostar was administered outside of the one hour before/one-hour after time frame for 2 of 13 opportunities with the latest administration time being on 08/15/24 order for 8:00pm and administered on 08/16/24 at 2:00am. Interview with Resident #6's PCP on 08/19/20 at 5:00pm revealed: -She was not informed of Resident #6's Lantus Solostar was not being administered within the one-hour before/one-hour after timeframe making it difficut to control the blood sugars. -Inconsistant administration times of Lantus	D 364		

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D 364	Continued From page 173 Solostar could lead to uncontrolled blood sugars. Interview with a medication aide (MA) on 08/16/24 at 10:48am revealed: -Medications should be administered one hour before or one hour after the time for administration on the MAR. -She was responsible for contacting the physician if medications were administered late or missed. c. Review of Resident #6's Primary Care Provider (PCP) order dated 05/29/24 revealed there was an order for entacapone 200mg tablet three times per daily (used in combination with carbidopa-levodopa to treat "end of dose" effects in patients with Parkinson's disease. Review of Resident #6's June 2024 electronic Medication Administration Record (eMAR) revealed there was an entry for entacapone 200mg tablet at 8:00am, 12:00pm, and 8:00pm. Review of Resident #6's June 2024 Medication Administration Audit Report revealed entacapone was administered outside of the one hour before/one-after time frame for 12 of 86 opportunities with the latest administration time being on 06/17/24 documented as administered at 1:59pm, an hour an fifty-nine minutes late. Review of Resident #6's July 2024 eMAR revealed there was an entry for entacapone 200mg tablet at 8:00am, 12:00pm, and 8:00pm. Review of Resident #6's July 2024 Medication Administration Audit Report revealed entacapone was administered outside of the one hour before/one-hour after time frame for 19 of 90 opportunities with the latest administration time being on 07/08/24 documented as administered	D 364		

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D 364	Continued From page 174 at 10:48am, two hours and forty-eight minutes late. Review of Resident #6's August 2024 eMAR revealed there was an entry for entacapone 200mg tablet at 8:00am, 12:00pm, and 8:00pm. Review of Resident #6's August 2024 Medication Administration Audit Report revealed entacapone was administered outside of the one hour before/one-hour after time frame for 8 of 54 opportunities with the latest administration time being on 08/15/24 documented as administered on 08/16/24 at 2:00am, six hours late. Interview with a medication aide (MA) on 08/16/24 at 10:48am revealed: -Medications should to be administered one hour before or one hour after the time for administration on the MAR. -She was responsible for contacting the physician if medications were late or missed. Interview with Resident #6's PCP on 08/19/20 at 5:00pm revealed: -Entacapone was used in combination with carbidopa-levodopa to treat "end of dose" effects in patients with Parkinson's symptoms such as, stiffness and tremors. -She was not aware the medication was not administered within the one hour before or one hour after the scheduled administration time which, could cause Resident #6 to experience an increase of tremors and stiffness and increased the risk of falls. d. Review of Resident #6's primary care provider's (PCP) order dated 05/29/24 revealed there was an order for amantadine 100mg	D 364		

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D 364	Continued From page 175	D 364		

capsule three times per daily (used to treat movement disorders associated with Parkinson's disease).

Review of Resident #6's June 2024 electronic Medication Administration Record (eMAR) revealed there was an entry for amantadine 100mg capsule take 1 capsule by mouth three times per day at 7am, 1pm, and 7pm for Parkinson's.

Review of Resident #6's June 2024 Medication Administration Audit Report revealed amantadine was administered outside of the one hour before/one-hour after time frame for 5 of 89 opportunities with the latest administration time being on 06/18/24 order for 7am and administered at 9:32 pm.

Review of Resident #6's July 2024 eMAR revealed there was an entry for amantadine 100mg capsule take 1 capsule by mouth three times per day at 7am, 1pm, and 7pm for Parkinson's.

Review of Resident #6's July 2024 Medication Administration Audit Report revealed amantadine was administered outside of the one hour before/one-hour after time frame for 5 of 91 opportunities with the latest administration time being on 07/09/24 order for 1pm and administered at 3:46pm.

Review of Resident #6's August 2024 eMAR revealed there was an entry for amantadine 100mg capsule take 1 capsule by mouth three times per day at 7am, 1pm, and 7pm for Parkinson's.

Review of Resident #6's August 2024 Medication

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D 364	Continued From page 176 Administration Audit Report revealed amantadine was administered outside of the one hour before/one-hour after time frame for 3 of 46 opportunities with the latest administration time being on 08/04/24 order for 1pm and administered at 3:01pm. Interview with a medication aide (MA) on 08/16/24 at 10:48am revealed: -Medications should be administered one hour before or one hour after the time for administration on the MAR. -She was responsible for contacting the physician if medications were late or missed. Interview with Resident #6's PCP on 08/19/20 at 5:00pm revealed: -Amantadine was used to treat movement disorders associated with Parkinson's disease. -She was not aware amantadine was not administered within the one hour before or one hour after the scheduled administration time which, could cause Resident #6 to experience an increase of tremors and involuntary movements and increase the risk of falls. _____ The facility failed to administer medications used to treat Parkinson's disease, one-hour before or within one-hour after the scheduled time placed Resident #5 and #6 at increased risk for developing debilitating symptoms due to "wearing-off" effect of the medication. The debilitating symptoms include difficulty with walking, standing, stiff and achy muscles, involuntary movements, muscle rigidity, problems with coordination and gait, and difficulty with talking and swallowing. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.	D 364		

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D 364	Continued From page 177 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 4, 2024.	D 364		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an incident/accident report was sent to the department of social services (DSS) for 3 of 4 sampled residents (#1, #4 and #6) who required the Heimlich Maneuver after a choking episode (#1), and residents who had falls with injuries (#4 and #6). The findings are: Review of the facility's Medical Emergency policy dated 03/18/19 revealed:	D 451		

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-The incident/accident form was to be completed and given to the Resident Care Director (RCD)/Health and Wellness Director (HWD).
-The incident/accident report was to be sent to the local DSS.

1. Review of Resident #1's FL-2 dated 07/03/23 revealed diagnoses included diabetes, vascular dementia and hypothyroidism.

Review of Resident #1's Resident Register revealed Resident #1 was admitted on 07/03/23.

Review of Resident #1's progress note dated 07/09/24 at 5:28pm revealed a medication aide (MA) documented Resident #1 had a choking episode, turned blue in the face and a third party hospice Certified Nursing Assistant (CNA) performed Heimlich Maneuver.

Review of Resident #1's progress note dated 07/17/24 at 8:45pm revealed:
-The Health Care Coordinator (HCC) for the locked unit documented a late entry for 07/09/24.
-On 07/09/24, the staff notified her that Resident #1 choked while eating beets.
-The HCC for the locked unit was informed that a hospice nurse performed the Heimlich Maneuver and Resident #1's airway was cleared.
-Afterwards she observed Resident #1 sitting in the dining room with no signs or symptoms of distress.

Review of the facility's 24 hour report dated 07/09/24 revealed:
-The MA documented Resident #1 had a choking episode during the shift due to diet restrictions.
-There was no documentation 911 was called.

Attempted review of Resident #1's

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D 451	Continued From page 179 incident/accident report dated 07/09/24 revealed there was no incident/accident report completed or that DSS was notified. Interview with a medication aide (MA) on 0814/24 at 4:19pm revealed: -On 07/09/24, she was the MA from 7:00am to 7:00pm. -On 07/09/24, she was off the floor while another MA covered the residents when Resident #1 was eating lunch. -She did not fill out an incident/accident report because the other MA completed one. Telephone interview with a second MA on 08/15/24 at 12:03pm revealed: -On 07/09/24, she was the MA covering the Memory Care Unit (MCU) when Resident #1 choked. -The MAs were responsible for completing incident/accident reports but she forgot to because she was only filling in for another MA that was on lunch. Interview with the Adult Home Specialist on 08/14/24 at 8:30am revealed: -On 07/09/24, Resident #1 had a choking episode which resulted in her loss of consciousness and the Heimlich Maneuver was performed and there was no incident/accident report completed. -There was no incident/accident report completed or faxed to DSS on 07/09/24. Interview with the RCD on 08/16/24 at 9:46am revealed: -On 07/09/24, when Resident #1 choked during lunch she was in a meeting. -The MA that witnessed the choking was responsible for competing the incident/accident report and give it to her to review.	D 451		

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D 451	Continued From page 180 -She was responsible for faxing the incident/accident report to DSS. -She did not know it was not completed and she did not know why. Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed: -On 07/09/24, after Resident #1 choked, lost consciousness and the Heimlich Maneuver was performed, the MA was responsible for completing the incident/accident report and give the report to the RCD. -The RCD was responsible for faxing the incident/accident report to DSS. -She did not know a incident/accident report was not completed for 07/09/24 choking episode for Resident #1. Telephone interview with the previous Administrator on 08/16/24 at 2:40pm. -He was the Administrator on 07/09/24 and 07/12/24. -The MA on duty at the time of the incident/accident was responsible for completeing the incident/accident report and giving it to the RCD. -The RCD was responsible for faxing the incident/accident report to DSS and documenting on the report, the date and time it was faxed. -He did not know a incident/accident report was not completed for 07/09/24 choking episode for Resident #1. Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm. Refer to telephone interview with the previous	D 451		

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D 451	Continued From page 181 Administrator on 08/16/24 at 2:40pm. 2. Review of Resident #4's current FL2 dated 05/13/24 revealed -Diagnoses included hyperlipidemia and memory impairment. -She required assistance with bathing. Review of Resident #4's care plan dated 04/30/24 revealed: -She used a walker for ambulation. -She required extensive assistance with bathing. -She required limited assistance with dressing. a. Review of Resident #4's incident/accident report dated 07/04/24 revealed: -Resident #4 was found sitting on the floor in her bathroom after an unwitnessed fall. -She stated to staff she had hit her head, and her legs hurt. -Resident was sent to the emergency room (ER). -There was no documentation the incident/accident report was sent to DSS. -There was no notification to primary care physician. Review of ER discharge summary dated 07/04/24 revealed: -She was brought to the emergency room following a fall during which she hit her head. -Resident was assessed for injury with no injuries were found. -Resident was discharged to the facility on 07/04/24. b. Review of Resident #4's incident/accident report dated 07/16/24 revealed: -She activated her emergency pendant. -Responding facility staff found her on the floor of	D 451		

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D 451	Continued From page 182	D 451		

her room.
-Resident was observed to have a "bump on her head and it was bleeding".
-Resident was sent to the emergency room (ER).
-There was no documentation the incident/accident report was sent to DSS.

Review of Resident #4's ER discharge summary dated 07/16/24 revealed:
-She was brought to the emergency room following a fall where she hit her head.
-CT showed a "closed head injury with no fracture".
-Order was given for follow-up with PCP within 48 hours.
-Resident was discharged back to the facility on 07/16/24

c. Review of Resident #4's incident/accident report on 07/25/24 revealed:
-Resident #4 had an unwitnessed fall and hit her head.
-911 was called and Resident #4 was transported to the ER.
-There was no documentation the incident/accident report was sent to DSS.
-There was no notification to primary care physician.

Interview with Health and Wellness Director (HWD) on 08/20/24 at 4:45pm revealed:
-The MAs were responsible for completing the incident/accident reports and giving them to him.
-He was responsible for faxing incident reports to DSS and had not faxed the incident/accident reports because he was still working on a better process to make sure the incident/accident reports were completed and faxed to DSS when necessary.

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D 451	Continued From page 183 Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm. Refer to telephone interview with the previous Administrator on 08/16/24 at 2:40pm. 3. Review of Resident # 6's current FL2 dated 05/29/24 revealed diagnoses included diabetes mellitus type 2, Parkinson's disease, hypertension, and balance instability. Review of Resident #6's care plan dated 05/29/24 revealed: -She used a walker for ambulation. -She required supervision with toileting, ambulating and dressing. -She required extensive assistance with bathing. Review of Resident #6's licensed health professional support plan dated 06/25/24 revealed: -Resident used a rollator walker for ambulation. -Resident had multiple falls in her home prior to admission. -Resident had her blood sugar checked daily. -Resident received insulin to control blood sugar. Review of Resident #6's incident/accident reports revealed there was no documentation of an incident/accident report completed or sent to DSS related to the fall when she hit her head. Refer to interview with the RCD on 08/16/24 at 9:46am. Refer to interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm.	D 451		

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D 451	Continued From page 184 Refer to telephone interview with the previous Administrator on 08/16/24 at 2:40pm. 3. Review of Resident #13's current FL2 dated 05/29/24 revealed diagnoses included vascular dementia, major depressive disorder, history of prostate cancer, hyperlipidemia, and carotid stenosis. Review of Resident #13's current care plan dated 05/13/24 revealed: -He required supervision with eating, ambulating, and transfers. -He required extensive assistance with toileting, bathing and dressing. -He required limited assistance with personal hygiene. a. Review of Resident #13's incident and accident report dated 07/17/24 at 3:25am revealed: -The resident slid out of a wheelchair and fell to the ground. -He was complaining of hip and side pain. -His blood pressure was 136/61, pulse 59. -There was no documentation the incident/accident report was sent to DSS. b. Review of Resident #13's incident and accident report on 07/28/24 at 9:00am revealed: -He was found by staff on the floor with a "small laceration above right eye with mild swelling". -He had been incontinent following the unwitnessed fall. -His blood pressure was 142/80, pulse 96. -There was no documentation the incident/accident report was sent to DSS. c. Review of Resident #13's incident and accident report on 08/07/24 at 7:30am revealed:	D 451		

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D 451	Continued From page 185 -He was found between his bed and the side table. -He had an abrasion noted on his upper abdomen toward his armpit. -He was complaining of pain in his hip. -There was no documentation the incident/accident report was sent to DSS. d. Review of Resident #13's incident and accident report on 08/08/24 at 5:24am revealed: -Staff found the resident sitting on the floor next the end of the bed when they came in to administer morning medications. -His blood pressure was 160/94, pulse 90. -There was no documentation the incident/accident report was sent to DSS. _____ Interview with the RCD on 08/16/24 at 9:46am revealed: -The MA that witnessed a fall, any injury or accident was responsible for competing the incident/accident report and give it to the RCD/HWD to review. -She and the HWD were responsible for faxing the incident/accident reports to DSS. Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed: -The MA was responsible for completing the incident/accident report and give the report to the RCD/HWD. -The RCD/HWD was responsible for faxing the incident/accident report to DSS and notifying the Administrator in the next morning standup. Telephone interview with the previous Administrator on 08/16/24 at 2:40pm revealed: -The MA was responsible for completing the incident/accident report and give the report to the	D 451		

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D 451	Continued From page 186 RCD. -The RCD was responsible for faxing the incident/accident report to DSS and notifying the Administrator in the next morning standup.	D 451		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the Administrator failed to ensure the overall management, operations, policies and procedures of the facility were implemented, maintained in substantial compliance with the rules and statutes to meet and maintain rules related to personal care and other staffing, personal care and supervision, health care, nutrition and food services, and medication administration. The findings are: Review of the facility's license revealed: -The facility's licensed was effective 01/01/24 through 12/31/24 for a capacity of up to 99 residents. -The expiration date of the facility's license was 12/31/24. -The Administrator was not listed on the license.	D980		

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D980	Continued From page 187 Review of the Administrator's certificate on 08/14/24 at 10:00am hanging on the wall in the facility revealed the Administrator's name. Interview with an agency personal care aide (PCA) on 08/14/24 at 9:30am revealed she was hired to be a private sitter for the first time at the facility and no one gave her instructions on what the resident required or the capabilities of the resident. Interview with a second MA on 08/15/24 at 12:03pm revealed she wanted to send Resident #1 out after a choking episode per the policy but was told "no" by the Resident Care Director (RCD) because the RCD was the "nurse". Telephone interview with the facility's contracted mental health provider (MHP) on 08/15/24 at 2:00pm revealed: -The staff at the facility told him they could not get weights, or vital signs for him because there were not enough staff to obtain them for him. -While he was at the facility, the RCD or Health and Wellness Director (HWD) were not available to give report on the residents issues and concerns and had to rely on 3rd party individuals. Interview with the Activity Director (AD) on 08/15/24 at 3:10pm revealed: -She was certified in cardiopulmonary resuscitation (CPR) but did not provide the Heimlich Maneuver on a resident that was choking because she was new and did not know if she was allowed to because she did not receive the orientation about each resident or if she could as the AD. -There were two Certified Nursing Assistants (CNAs) with hospice that performed the Heimlich	D980		

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	HAL011361	A. BUILDING: _____ B. WING _____	R 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

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D980	Continued From page 188 Maneuver since three staff present did not do it. Telephone interview with the facilty's contracted primary care physician (PCP) on 08/15/24 at 4:35pm revealed there was not enough trained staff to process orders, administer medications, implement orders or notify her about issues or concerns with the residents. Interview with the Administrator on 08/15/24 at 2:31pm revealed: -There was a web based computer program used for scheduling that was available for use in November 2023. -The program allowed the HWD or designee to use the program to set staff schedules. -All staff had access to their schedules through that and request time off. -The HWD could see request for time off, pick up extra shifts, staff who were CPR certified and when staffing ratios were not going to be met. -The web based program was not being utilized because the staff were not trained by the previous administration on how to use it. Interview with the RCD on 08/16/24 at 9:46am revealed: -She started working at the facility 6 to 8 weeks ago. -Since she was hired 6 to 8 weeks ago, she has been putting out "fires" in the memory care unit (MCU) and not able to perform her required duties. -It was hard for her to focus on her issues at hand because she was performing an increase of admissions to the facility, staffing issues, and getting her training completed. -When she first started, everything was a mess and she had not made much progress in improving the issues.	D980		

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D980	Continued From page 189 -When she began working at the facility there were issues with staff documentation, resident record keeping, facility documents such as increased monitoring and incident accident reports, physician's orders not being filed and medications being delivered from the pharmacy that were not put on the medication cart. -There was a facility electronic documentation system that was supposed to be used by her, the HWD, MAs and PCAs, but she was not given access and training to it until 08/15/24 and the other staff received the training on 08/16/24. -Staff were not trained on policies and procedures. -Agency staff were used and not trained on policies and procedures. -When she first started at the facility, she spoke to the Corporate Clinical Specialist (CCS) and requested that all staff be trained in CPR because the CCS only wanted to train the MAs. -She was concerned only training the MAs in a building this size would result in someone not receiving CPR when they needed it. Telephone interview with the facility's contracted Physical Therapist (PT) on 08/19/24 at 9:23am revealed: -On 7/12/24, she was working with another resident before lunch, when the MA on duty in the MCU asked her for assistance to make sure Resident #1 was ok. -The MA was concerned that Resident #1 was supposed to be on a pureed diet and was served a regular diet at breakfast and had a choking episode. -Her biggest concern was that staff were not trained to send residents out per issue/policy, notify the PCP with concerns, or process orders when written.	D980		

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D980	Continued From page 190 Interview with MA on 08/19/24 at 2:30pm revealed: -There was not enough staff. -There had recently been a lot of falls. -Quite a few residents on the "memory care" floor were very close to needing skilled level of care. -Some of the residents on the "memory care" floor already need skilled level of care. -The facility was not prepared for the level of need. -The facility would not allow lifts. -"We do not have enough staff by any stretch of the imagination". -Sometimes there was only 1 MA and 1 PCA on this floor. -Staff had tried to explain this to administration. Interview with the RCD on 08/20/24 at 10:46am revealed: -She did not feel she has been trained appropriately to meet the requirements of her job. -She felt staff were too busy to train. -She expressed her feelings to corporate, and the corporate clinical specialist. -She did not feel she had any support from upper management. Interview with the HWD on 08/20/24 at 11:10am revealed: -He did know he was supposed to be making sure weights were done. -He started checking into resident weights to ensure they were getting done after he found out it was an issue. -No one had told him it was his responsibility. Interview with a medication aide (MA) on 08/20/24 at 3:10pm revealed: -She often did not have time to notify the doctors of medication refusals or weight refusals due to	D980		

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D980	Continued From page 191 her work load. -She did not feel she had time to do everything she was required to do. -A lot of medications was late because she was medicating so many residents and she does not have time. -She was giving medications out to resident residing on 2 different floors, 1st and 3rd floors. Interview with the Administrator on 08/20/24 t 5:46pm revealed: -All staff should follow the policies. -It boiled down to the staff not being trained and did not know what to do in the case of notifying the physician, medication management, responding in an emergency, staffing, implementation of orders, diets and notification to the Department of Social Services (DSS). Non-compliance was identified at a violation level in the following rule areas: 1. Based on record reviews and interviews the facility failed to provide care and intervene according to the facility's policy and procedures for 1 of 1 sampled residents who choked, lost consciousness and required the Heimlich Maneuver (#1). [Refer to tag 271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, record reviews, and interviews, the facility failed to provide follow-up and referral for 8 of 13 sampled residents (#1, #2, #3, #4, #5, #6, #10 & #13) related to a resident who had two choking episodes (#1), notification of a primary care provider (PCP) about weight changes of three pounds, medications to treat blood pressure, and blood pressures and heart rates out of parameter to administer metoprolol	D980		

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D980	Continued From page 192 (#2), notification to the primary care provider (PCP) about medications to treat blood pressure, anxiety, and diabetes (#3), about fall with a head injury (#4), weekly weights (#5), a diabetic medication with parameters (#6), a fall with head trauma for a resident on antiplatelet medications (#10) and weekly weights with parameters (#13). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to implement orders for 5 of 13 sampled residents (#2, #3, #6, #9, and #11) related to urinalysis lab collections (#2 and #11) and application and removal of compression stockings (#2, #6, #9, and #11) and obtaining finger stick blood sugars (#3). [Refer to tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type A2 Violation)]. 4. Based on interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents related to a pureed diet (Resident #1). [Refer to tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type A1 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 13 sampled residents (#2, #3, #5, #6, #10) related to medications used to treat high blood pressure, anxiety and elevated blood sugar (#3), medications used to treat high blood pressure and fluid retention (#2), medication used to treat urinary incontinence (#5), medications used to treat high blood sugars and nerve pain (#6), and a medication used to reduce increased eye pressure (#10). [Refer to tag 358, 10A NCAC 13G .1004(a) Medication Administration (Type A2	D980		

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D980	Continued From page 193 Violation)]. 6. Based on interviews and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the prescribed time for 2 of 3 sampled residents related to a medication used to treat symptoms of Parkinson's disease such as stiffness and tremors (#5) and medications to treat Parkinson's disease and diabetes (#6). [Refer to tag 364, 10A NCAC 13G .1004(g) Medication Administration (Type B Violation)]. The Administrator failed to ensure the overall management and operations of the facility by allowing staff to not respond immediately to residents' life threatening events after a choking episode where a resident turned blue, became unresponsive, the Heimlich Maneuver performed by a 3rd party person and was not transported to the hospital, and a second choking episode three days later, was not send to the hospital and died later that day (#1), not serving therapeutic diets as ordered resulting in one resident choking and died later that day (#1), not providing care to meet the healthcare needs for Resident (#1, #2, #3, #4, #5, #6, #10 & #13), not administering medications to residents (#2, #3, #5, and #10), and not providing staffing to meet the personal care and supervision needs of the residents. This failure resulted in death and serious neglect which constitutes a Type A1 Violation. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/24 for this Violation.	D980		

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D980	Continued From page 194 THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2024.	D980		