STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	R 09/19/2024

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation from September 17 to September 19, 2024.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors, doors, walls and windowsills were kept clean and in good repair in the hallway and in three resident rooms. The findings are: Review of the environmental inspection report from the local county health department dated 06/24/24 revealed: -The facility received three demerits. -There was documentation of an observation of gaps in the flooring allowing dirt and debris to collect and needed repair. Observations of hallways and the common areas during the initial tour of the facility on 09/17/24 at 8:00am revealed: -There were two hallways where the resident	D 074		

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rooms were; the north hall and the south.
-The flooring in the hallways was a brown laminate flooring with individual planks.
-There were several gaps, chips and a raised area that were trip hazards on the floor on the south hall.
-There was an area in the south hall where the flooring was wet, and the laminate planks had warped and were curling up and were a trip hazard.
-There was a corner missing from a piece of laminate planking that had collected dirt and debris leading into the bathroom next to a vending machine on the south hall.
-There was a seam in the middle of the south hall and the north hall that had a raised strip of flooring to cover the seam; the raised strip ran from wall to wall across each hallway.
-The raised strip of flooring had dirt and debris accumulated under the edge.
-Residents were observed lifting their walkers up and over the raised strip with both hands to cross over them.
-There were numerous chips and missing sides and corners of the laminate planks on the north hall.
-There was dirt and debris collected in the missing pieces of laminate.
-There were four chips of missing laminate in the flooring leading from the south hall into the resident common area.
-Two corners of the laminate flooring were chipped and missing where they were supposed to come together but had separated and the edges had begun to curl upward.
-There was dirt and debris collected in the area where the missing laminate was.
-There was a large piece of chipped and missing laminate near the medication room on the south hall that had dirt and debris.

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-There were two pieces of laminate plank in front of the sofa in the common area that had separated where they came together and had curled up in opposite directions; dirt and debris had collected under the raised section.

Observations of resident room #N2 on 09/18/24 at 12:04pm revealed:
-There was dirt and debris on the floors around furniture and behind the beds in room #N2.
-There was a thick buildup of dust on the baseboards.
-There were three dead flies and a thick buildup of dust on the windowsills.

Observations of resident room #N3 on 09/18/24 at 12:08pm revealed:
-There was a thick buildup of dirt and debris on the floors around the furniture and behind the beds.
-There were empty coat hangers on the floor in front of the closet.
-There were dead flies and gnats on the windowsills.
-There was a layer of brown residue that coated the door around the doorknob on the inside and outside of the door.
-There were two piles of clothes on the floor near a full laundry basket at the foot of the bed.

Observations of resident room #N5 on 09/18/24 at 12:11pm revealed:
-There was a thick buildup of dust, dirt and debris on the floors around the furniture and the beds.
-There was a buildup of dust and debris on the windowsill.
-There were heavy black marks on the wall above the headboard and on the wall next to one of the beds.
Interview with a resident on 09/17/24 at 2:42pm

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revealed:
-He usually cleaned his room not housekeeping.
-He had not seen a housekeeper this week.
-The housekeepers did not sweep and mop the halls or his room every day.
-He knew to step over the strip in the hallway so he would not trip.
-He did not know if the housekeepers cleaned under his bed or the windowsills.
-He had not noticed the dirty floors or the windowsills.

Review of the September 2024 housekeeping cleaning schedule revealed:
-The floors were to be swept and dust mopped daily; there was nothing indicating the location of the floors.
-There were initials documenting the floors were swept and dust mopped once daily from 09/01/24 to 09/16/24
-The floors were to be mopped once daily; there was nothing indicating the location of the floors.
-There were initials documenting the floors were mopped once daily from 09/01/24 to 09/16/24
-All furniture was to be moved and cleaned under in each of the resident room; there was nothing documenting the frequency.
-There were initials documenting the furniture was moved and cleaned under on 09/14/24 and 09/15/24.

Interview with a second resident on 09/18/24 at 9:00am revealed he thought the housekeeper swept and mopped the halls and his room about every day, but he did not pay too much attention to them.

Interview with a third resident on 09/18/24 at 5:05pm revealed:
-Sometimes he used a wheelchair to move

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around the facility.
-He used his hands and his feet to propel his wheelchair.
-He struggled with getting the wheelchair over the raised strips across the floor in the hallways.
-He would keep pushing until he could get over the raised strip or get help from another resident.
-When he used his walker to ambulate, he would have to stop at the raised strip and pick his walker up and over it so he would not trip.
-He had not tripped over the raised strip but he was always very careful when he crossed it so he would not trip and fall.

Telephone interview with a resident's family member on 09/17/24 at 10:59am revealed:
-She visited the resident at the facility in July 2024.
-The flooring in the resident's room was dirty and had hair on the floor from a haircut the resident was given two weeks before by another family member.
-There were piles of clothing on the floor; she did not know if they were clean or dirty.
-She did not recall seeing housekeeping at the facility when she visited.

Interview with the facility's maintenance staff on 09/18/24 at 4:21pm revealed:
-He received a list from the Manager when there were repairs that needed to be done in the facility.
-He knew there were pieces of the flooring that were damaged and were coming up in the hallway.
-There was a large chip missing from the flooring near the bathroom and the vending machine.
-He would replace the flooring pieces all at once when there were more planks that were damaged and needed replacing.
-The raised strip on the flooring that ran across

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the halls was installed by the company that installed the flooring.

Telephone interview with the facility's primary care provider (PCP) on 09/19/24 at 1:30pm revealed:
-The facility was not very clean and orderly.
-She had noticed the floors needed to swept and dust webs in the facility.
-The resident's rooms were not clean.
-The resident's room were cluttered with clothes lying on the floor.
-The clutter in the rooms increased the risk of falls for the residents.
-A clean environment would go a long way in increasing the morale of the residents.

Interview with a housekeeper on 09/19/24 at 11:17am revealed:
-She had only worked at the facility for a few days and worked until 2:30pm each day.
-She swept and mopped the residents' rooms daily.
-She used a cleaning schedule to do the daily cleaning.
-The first day she worked she moved the beds in some of the residents' rooms and swept under them.
-She swept under as many beds as she could, but she did not move every bed.
-She had not moved all the beds and swept under them yet.
-She had noticed some damaged flooring; she did not report it to anyone.
-She had not noticed the dirty doors.
-She noticed a lot of the cleaning had been neglected and undone.
-She was trying to get the cleaning caught up.

Interview with the Manager on 09/19/24 at 2:25pm revealed:

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-The housekeeper was new and had only worked at the facility for a few days and was off that day, on 09/17/24.
-When there was not a housekeeper usually, she or one of the other staff would take over the responsibility of housekeeping. .
-There was a cleaning schedule for the facility; she checked the cleaning schedule daily.
-She did not know if the doors and windowsills were on the cleaning schedule.
-She walked around the facility daily and even went into the residents' rooms.
-The floor planks snapped together; the Maintenance staff was working on the flooring.
-She did not know what he was doing exactly.
-She gave him a list on 09/05/24 or 09/06/24 but she did not know when he was going to work on the flooring.
-She did not know the purpose of the raised strip that ran across the hallway.
-She had not had any complaints from anyone about the raised strip or difficulty maneuvering over it with a walker or a wheelchair.
-Residents had never fallen over the raised strip in the flooring

Telephone interview with the Administrator on 09/19/24 at 11:40am revealed:
-He knew the flooring in the hallways needed to be replaced in places that were chipped and separated.
-He was going to have the maintenance staff replace the chipped flooring in the next 90 days; he did not have a date set.
-The raised strip in the hallways was an expansion so the flooring planks could expand and contract.
-There had been no complaints of the flooring or the raised strip.
-There had been no reports of trips or falls from

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D 074	Continued From page 7 the residents due to the flooring. -The floors were swept and mopped every day by housekeeping. -The resident rooms were deep cleaned monthly; the beds and furniture were moved and cleaned under. -The doors and windowsills were cleaned when the rooms were deep cleaned.	D 074		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to maintain an environment which was free from unpleasant odors. The findings are: Review of the environmental inspection report from the local county health department dated 06/24/24 revealed: -The facility received three demerits. -There was documentation of two demerits for an observation of carpets not being odor free. Observation of the facility on 09/17/24 at various times from 8:00am to 4:30pm revealed there was a strong smell of urine upon entrance to the	D 075		

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facility and throughout the day that lingered in the hallways.

Observation of the facility on 09/18/24 at various times from 8:00am to 6:45pm revealed:
-There was a strong smell of urine upon entrance to the facility and during the day that lingered in the hallways.
-There was a housekeeper that mopped the floors to the hallways, but the urine odor returned after she had mopped.

Observation of the facility on 09/1/24 at various times from 8:00am to 5:00pm revealed:
-There was a strong smell or urine upon entrance to the facility.
-The housekeeper mopped the halls and the resident rooms with a strong scented cleaning product earlier in the morning.
-There was a strong odor of urine in the hallways after lunch.

Review of the September 2024 housekeeping cleaning schedule revealed:
-The bathrooms including the baseball boards, walls sink, base of the toilet and shower were to be cleaned after each use.
-There were initials documented the task in the bathrooms were completed once daily from 09/01/24 to 09/17/24.
-The bathrooms were to be spot checked every 30 minutes to an hour, there were initials documenting the task was done once daily from 09/01/24 to 09/17/24.
-The trash cans in the residents' rooms were to be emptied periodically through each shift, there were initials documenting the task was done once daily from 09/01/24 to 09/16/24.
-The trash cans in the bathrooms were to be emptied periodically throughout each shift, there

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were initials documenting the task was done once daily from 09/01/24 to 09/16/24.

Interview with a resident on 09/18/24 at 6:15pm revealed he thought the facility had a smell like a bathroom toilet that had not been flushed.

Telephone interview with a resident's family member on 09/17/24 at 10:59am revealed:
-She had visited the facility in July 2024.
-There was a strong smell of urine in the facility.
-She complained to the staff about the smell of urine while she was at the facility.

Telephone interview with a resident's guardian on 09/17/24 at 11:23am revealed she had noticed the odor of urine in the facility when she had visited a resident earlier that week.

Telephone interview with the facility's primary care provider (PCP) on 09/19/24 at 1:30pm revealed:
-She had noticed a strong odor of urine in the facility when she visited, but not every time.
-She thought the facility was doing a better job of cleaning and controlling the urine odor.

Telephone interview with an ancillary services provider on 09/19/24 at 3:36pm revealed
-When she entered the facility, it was an awful smell.
-The facility smelled like urine every time she was at the facility.
-The facility smelled "awful."

Interview with a housekeeper on 09/19/24 at 11:17am revealed:
-She had only worked at the facility for a few days.
-She had noticed an odor when she came to work; the odor smelled like used adult briefs in

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D 075	Continued From page 10 the trashcans. -She had a check list she followed to do the cleaning. -She emptied the trash in the residents' rooms and bathrooms every day she worked. -The Manager gave her a cleaning product to use on the floors to help with the odor. Interview with the Manager on 09/19/24 at 2:34pm revealed: -The housekeeper was new and had only worked at the facility for a few days and was off that day, 09/17/24. -When there was not a housekeeper usually, she or one of the other staff would take over the responsibility of housekeeping. -There was a cleaning schedule for the facility. -She had not noticed an odor. -There was expected to be a smell of urine in the facility due to heavy bed wetting. -An inspector from another agency had complained recently of a strong urine smell in one area. -There was a named cleaning product she gave to the housekeeper to help clean urine and eliminate the odor in the facility. Telephone interview with the Administrator on 09/19/24 at 11:40am revealed: -He had not noticed an odor in the facility. -A sewer line had backed up the previous week, the odor may have come from be sewage when it backed up. -No one had complained to him about an odor in the facility.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings	D 079		

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D 079	Continued From page 11 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live flies and gnats, and unsecured oxygen tanks in a resident's room. The findings are: 1. Observations of resident room #N3 on 09/18/24 at 12:08pm revealed: -There five live gnats on the wall beside one of the beds in resident room #N3. -There were multiple gnats flying around the room and landing on the furniture and walls. Observations of resident room #N5 on 09/18/24 at 12:11pm revealed there were live flies flying around the room and landing on the furniture and lights. Interview with a resident on 09/17/24 at 2:42pm revealed: -He had seen flies and gnats everywhere in the facility. -He had seen the flies in the common area while he was watching television. -He had to swat them away with his hands so they would not land on him. -He had never seen a pest control company spray for the flies.	D 079		

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-He had not complained to the staff, but he had asked them if they saw the flies and gnats and they told him "yes they saw them".

Interview with a second resident on 09/18/24 at 9:00am revealed:
-He saw flies in the dining room and would wave them away.
-He would see one to two flies in his room.
-The staff had flyswatters they used to kill flies inside.

Interview with a third resident on 09/18/24 at 9:07am revealed:
-He saw gnats and flies in the facility.
-He had not complained because the staff knew there were gnats and flies; he had seen them shoo them away.

Telephone interview with a resident's family member on 09/17/24 at 10:59am revealed:
-She had observed flies around a trash can in the resident's room in July 2024.
-There were flies in the bathroom and around the trashcan in the bathroom.
-There were flies around the resident's bed.

Interview with a housekeeper on 09/19/24 at 11:17am revealed:
-She had only worked at the facility for a few days.
-She had not noticed flies or gnats in the facility.

Interview with the Manager on 09/19/24 at 2:20pm revealed:
-The gnats had gotten bad over the last two weeks.
-She had been swatting at flies in her office and had seem them at the windows.
-She had a spray she used to keep the gnats and

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flies away from her office.
-There had been no complaints of gnats and flies.
-The pest control company did not spray for gnats and flies in the facility because it was not bad the last time they were at the facility.
-She had not contacted the pest control company about the flies and gnats.

Telephone interview with the Administrator on 09/19/24 at 11:40am revealed:
-He was not aware there was an issue with live gnats or flies.
-The Manager should have reported any issues to him.
-The pest control company could be contacted to handle the gnats and flies.

2. According to guidance from the National Fire Protection Association (NFPA) compressed oxygen (O2) cylinders must be secured in a rack or stand to prevent tipping over.

Observation of resident room C on 09/17/24 at 8:12am revealed:
-Three O2 cylinders were standing on the floor, one was by the foot of the resident's bed and two were by the door.
-There was no gauge on the cylinders to indicate the amount of oxygen in the tanks.
-There were two O2 cylinders beside the resident's bed in a metal rack.

Observation of resident room C on 09/18/24 at 2:24pm revealed:
-Three O2 cylinders were standing on the floor, one was by the foot of the resident's bed and two were by the door.
-There was no gauge on the cylinders to indicate the amount of oxygen in the tanks.

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D 079	Continued From page 14 -There were two O2 cylinders beside the resident's bed in a metal rack. Interview with a medication aide (MA) on 09/18/24 at 2:28pm revealed no one told her how to store oxygen tanks. Interview with the Manager on 09/18/24 at 2:48pm revealed: -She had seen oxygen stored in a crate at other facilities. -She did not know oxygen needed to be secured in a crate. Telephone interview with a representative from the facility's contracted oxygen provider on 09/19/24 at 8:30am revealed: -Oxygen tanks should be secured upright. -Oxygen tanks "definitely" needed to be secured in a way that would prevent the tanks from falling. -Depending on what was around the tank if it was knocked over, it could cause damage. Telephone interview with the local Fire Marshal on 09/19/24 at 1:56pm revealed: -Oxygen tanks should always be secured to something to prevent them from tipping over and fracturing the head. -Oxygen tanks that were three to four feet tall had pressure of 2000 psi (pounds per square inch) when full but could still contained oxygen and pressure when the indicator gage reads empty. -Empty tanks should be secured because even with a gage reading at zero there was truly no way of knowing if the tanks were completely empty. - "An oxygen tank with a fractured head could become a projectile." Telephone interview with the Administrator on	D 079		

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D 079	Continued From page 15 09/19/24 at 11:24am revealed: -Oxygen tanks should be stored in the rack provided by the oxygen provider. -If one of the oxygen tanks fell over, it could cause problems, "it could launch like a missile."	D 079		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide window coverings for a resident room that had blinds that were damaged. The findings are: Observation of the outside of the facility on 09/17/24 at 8:00am revealed: -There was a window with blinds that were missing a large area in the middle of the blinds; they were in a set of double windows. -The large area of broken blinds was visible from the outside of the facility. Observation of a resident room 3 on 09/18/24 at 12:04pm revealed: -There was a double window in the room. -There was a set of blinds hung on each window. -There was an area that was three feet by three	D 083		

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feet on the set of blinds on the left window of the room had many slats missing and multiple damaged slats that would not close.
-There was a pillow case folded in half and hanging across one of the damaged slats.
-The parking lot and the road in front of the facility could be seen around the pillow case and through the opening caused by the missing and damaged slats.

Interview with the resident who resided in room 3 on 09/18/24 at 5:05pm revealed:
-He had hung the pillow case on the broken blind in attempt to have some privacy and block out the light.
-The blinds had been broken for a while.
-The staff knew because he complained about the broken blinds about a month ago.
-He wanted the blinds repaired because he did not want someone to look in and see him while he slept.

Interview with the facility's maintenance staff on 09/18/24 at 4:21pm revealed:
-He ordered a large number of blinds at one time.
-The Manager would give him a list of rooms that had damaged blinds that needed to be replaced.
-He replaced blinds when there was a large enough list to do all at one time.

Interview with the Manager on 09/19/24 at 2:25pm revealed:
-She tried to peak into the residents' rooms at least once a week.
-The facility had replaced the blinds in resident room 3 at least three different times but he always broke them.
-The resident who resided in the room would hang shirts and paper towels on the slats to the blinds and would cause them to break.

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D 083	Continued From page 17 -She had asked the resident why he hung things on the blinds, and he did not know why he did. -She did not know if he was trying to block the light or trying to keep someone from looking in. -She had not tried any other types of blinds or shade for the resident's room. Telephone interview with the Administrator on 09/19/24 at 11:48am revealed: -The facility replaced the blinds in resident room 3 but the resident kept damaging them. -The blinds had been replaced not very long ago. -He did not know why the resident damaged the blinds in his room. -The facility replaced damaged blinds throughout the facility and would replace the blinds in room 3 at that time.	D 083		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure staff who administered medications had completed the state-approved 5, 10, or 15-hour medication aide (MA) training	D 125		

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courses as required prior to administering medications for 1 of 3 sampled staff (Staff C).

The findings are:

Review of Staff C's, medication aide (MA), personnel record revealed:
-She was hired on 04/11//24.
-There was documentation Staff C completed the Medication Competency Validation Clinical Skills checklist on 09/03/22.
-There was documentation Staff C passed the written medication aide examination on 11/24/08.
-There was no certificate showing Staff C had completed the 5, 10, or 15-hour MA training.
-There was no documentation of employment verification for the required documentation of the state-approved 5, 10, or 15-hour medication aide training for Staff C.

Review of residents' July 2024 medication administration records (MARs) revealed there was documentation Staff C administered medications to residents on 21 of 31 days.

Review of residents' August 2024 MARs revealed there was documentation Staff C administered medications to residents on 17 of 31 days.

Review of residents' September 2024 MARs from 09/01/24-09/17/24 revealed there was documentation Staff C administered medications to residents on 10 of 17 days.

Interview with Staff C on 09/19/24 at 4:27pm revealed:
-She had a medication class she took "about fourteen years ago."
-She was not sure who taught the class.
-In the class, she learned to pass medications,

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D 125	Continued From page 19 check blood pressure, and check finger stick blood sugar (FSBS). -The class was an all-day class; she did not recall if the class was more than one day. Interview with the Manager on 09/19/24 at 4:29pm revealed: -She was responsible for making sure all staff had the required qualifications before the staff member administered medications. -She had audited staff records and had seen Staff C's 15-hour certificate. Telephone interview with the Administrator on 09/19/24 at 4:34pm revealed: -The Manager was responsible for ensuring staff qualifications were completed. -He was not aware Staff C did not have proof of completing the 15-hour medication aide training. -Staff C had been working at the facility for a long time. -He expected all required MA training to be completed.	D 125		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.	D 234		

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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.

The findings are:

1. Review of Resident #3's FL2 dated 11/10/23 revealed:
-Diagnoses included dementia, hyperlipidemia, hypertension, bipolar and cerebrovascular accident.
-There was an admission date of 10/06/22.

Review of Resident #3's Resident Register revealed it was signed on 10/11/22 but there was no admission date documented.

Review of Resident #3's tuberculosis (TB) form revealed:
-There was a TB consent form for documenting TB injection dates, results and result dates, but there were no dates for injections or results documented on the form.
-There was no documentation of a TB skin test for Resident #3 and the form was not dated.

Interview with Resident #3 on 09/18/24 at 8:52am revealed he did not know what a TB skin test was or if he had ever had one.

Interview with the Manager on 09/17/24 at 4:03pm revealed:
-Resident #3 was admitted to the facility

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sometime in 2022.
-Resident #3 was admitted from the local hospital.
-She thought she had seen a TB skin test result documented on a form in Resident #3's record.
-Resident #3 had to have a TB skin test before he was admitted, and a second test done once he was at the facility.
-She had reached out to Resident #3's guardian for TB results that morning, 09/17/24, but the guardian did not have the results of a TB skin test either.

Telephone interview with the Administrator on 09/19/24 at 10:20am revealed:
-Resident #3 should have had two TB skin tests administered since his admission to the facility in October of 2022.
-Resident #3 needed to be tested for TB because he could be positive and not know it.
-The Manager should have made sure Resident #3's TB skin test were completed.

Refer to the interview with the Manager on 09/19/24 at 4:00pm.

Refer to the telephone interview with the Administrator on 09/19/24 at 10:20am.

2. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included diabetes, cerebrovascular accident, coronary artery disease, and hyperlipidemia.

Review of Resident #1's Resident Register revealed an admission dated of 02/21/23.

Review of Resident #1's immunization record on 08/17/24 revealed there was no documentation of a TB skin test administered to Resident #1.

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D 234	Continued From page 22 Telephone interview with Resident #1's primary care provider (PCP) on 09/19/24 at 1:30pm revealed: -She did not administer TB skin test. -Resident #1 should have been tested for TB prior to being admitted to the facility. -If Resident #1 was positive for TB he could easily infect other residents in the facility. Interview with the Manager on 09/19/24 at 4:00pm revealed: -Resident #1 was admitted to the facility from the local hospital. -She thought the local hospital administered a TB skin test before he left the hospital. -She had not taken Resident #1 to the health department to receive a TB skin test. -She notified the local hospital this morning, 09/19/24, to request a copy of Resident #1's TB skin test. Interview with the Administrator on 09/19/24 at 9:59am revealed: -Resident #1 should have a TB on admission and a second TB with a year of living at the facility. -Resident #1 could have TB and the facility would not be aware. -If Resident #1 had TB, it could spread to other residents. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Refer to the interview with the Manager on 09/19/24 at 4:00pm. Refer to the telephone interview with the Administrator on 09/19/24 at 10:20am.	D 234		

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D 234	Continued From page 23 Interview with the Manager on 09/19/24 at 4:00pm revealed: -She was responsible for making sure the residents had a TB skin test completed before they were admitted and a second TB skin test completed after they were admitted to the facility. -She tried to do an audit of the residents' records every other month. Telephone interview with the Administrator on 09/19/24 at 10:20am revealed the Manager was responsible for ensuring all resident were tested for TB prior to being admitted to the facility.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to notify the primary care provider (PCP) for 1 of 3 sampled residents (#1) regarding elevated blood pressure (BP) readings and refusal of medications; and to ensure referrals were made for 1 of 3 sampled residents (#2) for home health management of a wound, physical therapy, the wound clinic, and a vascular surgery clinic (#2). The findings are: 1. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed:	D 273		

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-Diagnoses included sepsis and gangrene of the left 5th toe.
-Resident #2 required assistance with bathing and dressing.
-Resident #2 was semi-ambulatory.
-There was an order for wet to dry dressing daily, left foot, toe number 5.

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed:
-Resident #2 presented to the emergency department with a complaint of foot pain.
-The resident was discovered to have gangrene of the left toe.
-The resident underwent surgery for a left fifth toe amputation.
-The resident's toe was positive for acute osteomyelitis.
-The resident had sepsis.
-The resident was to have daily dressing changes with dry gauze.

a. Review of Resident #2's primary care provider's (PCP) order dated 08/09/24 revealed an order for physical therapy for generalized weakness and balance/gait instability.

Review of Resident #2's PCP's after-visit summary dated 08/27/24 revealed an order for home health PT for safety/ambulation with a walker.

Interview with Resident #2 on 09/17/24 at 1:56pm revealed:
-He had not had physical therapy and thought he was doing okay with his walker; it had gotten "easier."
-He wanted to be able to walk without a walker.

Interview with the Supervisor on 09/18/24 at

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8:05am revealed:
-She was responsible for making appointments and coordinating transportation to appointments.
-Resident #2 had not had physical therapy.
-She thought the Manager was trying to find a physical therapist who accepted Resident #2's insurance.

Interview with the Manager on 09/18/24 at 8:34am revealed:
-Resident #2 had not received physical therapy since his toe was amputated.
-When Resident #2 returned from the hospital after his toe was amputated, she thought he needed PT.
-When Resident #2's PCP saw the resident, the PCP ordered PT.
-She called a local home health agency, and the agency could not take Resident #2's insurance.
-She did not contact any other agency
-She let Resident #2's PCP know the home health agency would not accept Resident #2's insurance, and the PCP told her she would contact another agency.
-She thought the agency Resident #2's PCP contacted, also did not accept the resident's insurance.

Telephone interview with the hospital discharge planner on 09/18/24 at 9:58am revealed when Resident #2 was discharged from the hospital on 08/08/24 with an amputated toe, the resident was set up with outpatient therapy at the hospital's outpatient therapy department.

Telephone interview with a representative from the hospital's outpatient physical therapy department on 09/18/24 at 10:53am revealed:
-Resident #2 had an appointment for an evaluation at the outpatient clinic on 08/14/24.

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-Resident #2 was a "no show" for the appointment.
-Resident #2 was limited in his mobility by his wound and would stay limited until his wound was healed.
-She did not think PT would make a difference for Resident #2 until his wound was healed.
-Had the facility staff contacted her when they could not find a home health agency, she would have evaluated Resident #2.

Interview with the Manager on 09/18/24 at 3:43pm revealed:
-She did not recall the hospital discharge planner telling her anything about Resident #2's appointment with outpatient PT.
-If she had known Resident #2 had an appointment with the outpatient therapy department, she would have called the outpatient clinic to verify the appointment date and time, and let the Supervisor know.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-She ordered PT for Resident #2 because the resident had a toe amputation and was using a walker, and she wanted a professional to teach safe use of the walker.
-She would have expected the referral to have been made as soon as possible.

b. Review of Resident #2's PCP's after-visit summary dated 08/27/24 revealed an order for home health nursing for dressing changes and monitoring.

Review of Resident #2's PCP after-visit summary dated 09/03/24 revealed an order to follow up with a home health agency.

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Interview with Resident #2 on 09/17/24 at 1:56pm revealed:
-He had not had a home health nurse look at his toe.
-Somedays he wrapped the toe himself.

Interview with the Manager on 09/18/24 at 8:34am revealed:
-Resident #2 had not received a home health nurse visit since his toe was amputated.
-When Resident #2's PCP saw the resident, she ordered home health nursing.
-She called a local home health agency, and the agency could not take Resident #2's insurance.
-She did not contact any other agency
-She let Resident #2's PCP know the home health agency would not accept Resident #2's insurance and the PCP told her she would contact another agency.
-She thought the agency Resident #2's PCP contacted, also did not accept the resident's insurance.

Telephone interview with a representative from the hospital's outpatient physical therapy department on 09/18/24 at 10:53am revealed:
-When Resident #2 was seen in August 2024, home health for wound care was recommended.
-Resident #2 "one hundred percent needed wound care."
-When Resident #2 was rehospitalized in September 2024, home health was recommended again for wound care.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-She ordered home health for wound care for Resident #2 because his wound was deteriorating and needed to be monitored and dressing changes maintained by someone other than the

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facility staff.
-The facility staff did not have a clean technique when changing Resident #2's dressing.
-She observed the MA change Resident #2's dressing, and the MA put the clean dressing on the floor.
-Putting the dressing on the floor and then onto the wound was not good.
-She was concerned Resident #2 had received inconsistent wound care.
-Resident #2 had a very fragile, complex wound.
-She would have expected the referral to have been made as soon as possible.

Telephone interview with a representative from the home health agency on 09/18/24 at 9:12am revealed:
-She received an order on 08/29/24 for Resident #2.
-The order was not complete, and she reached out to the Manager to obtain other needed information to complete the referral.
-She told the Manager that at this time the agency could not accept Resident #2's insurance because the agency was only able to accept a limited number of referrals with that insurance per month.
-She suggested the Manager call other agencies.
-The Manager did not ask for suggested agencies to call.

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed he would have expected the facility staff to reach out to Resident #2's PCP and to other home health agencies to locate an agency to take the referral.

c. Review of Resident #2's general surgeon's after-visit summary dated 08/21/24 revealed:
-Resident #2 was seen in the office status post

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amputation of the fifth toe of the left foot-wound dehiscence (a surgical complication in which a wound ruptured along a surgical incision).
-Resident #2's sutures were removed.
-A sharp debridement of the wound on the left foot was performed.
-There was an order to refer the resident to a wound clinic.

Review of Resident #2's PCP order dated 08/27/24 revealed an order to please call [named] wound clinic with a telephone number to schedule an appointment; a referral had been sent.

Telephone interview with a representative from the [named] wound clinic on 09/17/24 at 1:35pm revealed:
-Resident #2 had an appointment on 09/16/24 and was a "no-show."
-There were no other appointments at the wound clinic for Resident #2.

Telephone interview with the facility's contracted podiatrist on 09/17/24 at 1:38pm revealed:
-He had not seen Resident #2 since the resident had his toe amputated.
-He had referred Resident #2 to another podiatrist, who would be able to do procedures if needed, as he mainly did toenail care in the facility.
-Resident #2 needed to keep the appointment with the wound clinic to ensure the wound was healed.

Interview with Resident #2 on 09/17/24 at 1:56pm revealed he had not been to a wound clinic.

Interview with the Supervisor on 09/17/24 at 3:15pm revealed:
-Resident #2 had an appointment at the wound

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clinic on 10/04/24 at 2:00pm.
-The appointment was made "a couple of weeks ago."
-Resident #2 had an appointment at the wound clinic on 09/16/24, but the Manager told her the appointment was canceled by hospital staff.

Interview with the Manager on 09/17/24 at 3:38pm revealed:
-Resident #2's PCP referred the resident to the wound clinic.
-The wound clinic referral was after the first hospitalization, 08/08/24, when the resident's toe was amputated.
-The Supervisor was responsible for making appointments.

Telephone interview with a medical assistant from Resident #2's general surgeon's office on 09/18/24 at 9:01am revealed:
-Resident #2 was seen by the surgeon on 08/21/24 to remove sutures and debridement of black necrotic tissue.
-Resident #2 was supposed to be seen at the wound clinic.
-Resident #2 needed to be seen by the wound clinic to start the process of wound care because it was going to take a long time for Resident #2's wound to heal.
-Resident #2's wound was debrided but other things would help, and that was the wound clinic's specialty.
-Resident #2's appointment needed to be made to see the specialist at the wound clinic.

Interview with Resident #2's general surgeon on 09/18/24 at 11:57am revealed:
-Resident #2 needed to be seen by the wound clinic to take care of the resident's wound.
-He was concerned Resident #2 had not been

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seen by the wound clinic.
-The wound was not going to heal, and the resident was going to lose his foot.

Interview with the Manager on 09/18/24 at 3:43pm revealed:
-The Supervisor was responsible for making Resident #2's appointment with the wound clinic.
-The Supervisor was not able to take Resident #2 to his wound clinic appointment and Resident #2's Licensed Counselor was supposed to take the resident to the appointment on 09/16/24.
-The Supervisor told her she had reminded the Licensed Counselor several times of the appointment.

Interview with the Supervisor on 09/18/24 at 4:20pm revealed:
-When she scheduled an appointment, she wrote the appointment on her calendar.
-She made an appointment for Resident #2 to be seen at the wound clinic.
-She did not recall when she made the appointment.
-She did not recall the date of the appointment, but the appointment for 09/16/24 was scheduled before the resident's second hospitalization (09/04/24).
-She could not take Resident #2 to the wound clinic because of another appointment and that was why Resident #2's Licensed Counselor told her she would take him.
-Resident #2's Licensed Counselor was supposed to take the resident to the appointment.
-She called Resident #2's Licensed Counselor three times on 09/16/24 and left her one voicemail, but she never got a call back.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:

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-She ordered Resident #2 to be seen at the wound care clinic because Resident #2's wound was deteriorating.
-After Resident #2's toe amputation on 08/05/24, she saw the resident on 08/13/24 and the surgical site was "beautiful."
-On her next visit, 08/27/24, the resident had an open wound.
-Resident #2's wound was going to have a hard time healing and needed experts to know how to best treat the wound.
-If Resident #2 had had an earlier intervention with his wound, the wound may have not deteriorated as much.
-She talked to the wound clinic herself because "nothing" was happening.
-She spoke to the Manager the week of 09/09/24, about changing the dressing to Resident #2's wound and making sure he went to the wound clinic appointment on Monday, 09/16/24.
-She did not know Resident #2 was a "no show" at his wound clinic appointment.

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed:
-He expected facility staff to have immediately made an appointment with the wound clinic.
-The only acceptable reason for Resident #2 to have not gone to the wound clinic appointment was if the resident refused and if the resident did refuse, the facility staff should let the PCP know as well as call the clinic to cancel the appointment.
-If the facility staff had made appointments, as ordered, maybe the resident's hospitalization could have been avoided.

d. Review of Resident #2's general surgeon's after-visit summary dated 08/21/24 revealed:
-Resident #2 was seen in the office for a

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post-surgery follow-up appointment.
-Resident #2's CT angiography (Computed tomography angiography used to look at blood vessels in the body) revealed severe peripheral artery disease of bilateral lower extremities.
-There was an order to refer the resident to vascular surgery for the management of the resident's PAD.

Review of Resident #2's PCP after-visit summary dated 08/27/24 revealed an order for vascular surgery for PAD management per the general surgeon.

Review of Resident #2's second hospital discharge summary dated 09/06/24 revealed:
-Resident #2 presented to the emergency department with a potential foot infection.
-Resident #2 had a debridement on 09/05/24.
-The resident was noted to have severe peripheral artery disease (PAD).
-There was an order for daily dressing change with dry gauze.
-The resident was to follow up with a vascular surgeon for potential stent placement.

Review of Resident #2's general surgeon's after-visit summary dated 09/06/24 revealed there was an order for the resident to follow up with [named] vascular surgeon.

Interview with Resident #2 on 09/17/24 at 1:56pm revealed he had not been to a vascular clinic.

Telephone interview with a representative from the vascular surgery department on 09/17/24 at 3:32pm revealed:
-On 09/11/24, they received a referral for Resident #2.
-An appointment was made for 10/04/24 for an

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ultrasound and 10/08/24 to see a surgeon.
-There were no appointments scheduled for Resident #2, prior to the one made on 09/11/24.

Interview with the Supervisor on 09/18/24 at 8:05am revealed:
-She took Resident #2 to a follow-up appointment with the general surgeon who amputated the resident's toe.
-She did not recall when the appointment with the surgeon was, but thought it was "about two weeks after Resident #2's hospitalization."
-Resident #2 came back from the post-op appointment with the general surgeon and had an order to see a vascular surgeon.
-She made Resident #2's appointment to see the vascular surgeon on 09/16/24.
-She did not know the wound clinic and the vascular surgeon were two different referrals.
-Before Resident #2 went to the vascular surgeon appointment, the resident went back to the hospital.
-The Manager told her the hospital had made Resident #2 an appointment with a vascular surgeon.
-She thought the appointment scheduled for 09/16/24 was canceled after the resident's second hospitalization.

Telephone interview with a medical assistant from Resident #2's general surgeon's office on 09/18/24 at 9:01am revealed:
-Resident #2 was seen by the general surgeon on 08/21/24 to remove sutures and debridement of black necrotic tissue.
-Resident #2 was supposed to be seen by a vascular surgeon.
-Resident #2 had no blood flow to his lower extremity and the resident could "possibly" end up with a below-the-knee amputation.

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-Resident #2's appointment needed to be made to see the vascular specialist.

Interview with Resident #2's general surgeon on 09/18/24 at 11:57am revealed:
-Resident #2 had poor blood supply and unless the blood flow to the foot was restored, the resident's foot would not heal.
-Resident #2 was at risk of losing his foot.
-He expected Resident #2 to see a vascular surgeon as ordered.

Telephone interview with the hospital discharge planner on 09/18/24 at 9:58am revealed:
-On 09/04/24, Resident #2 was considered to be "observation" but was then admitted to inpatient on 09/05/24 and discharged on 09/06/24.
-Resident #2's referral information had been faxed to a [named] vascular surgery clinic and the facility staff should expect a telephone call.
-If the facility staff had not received a call about the appointment by next week, 09/09/24, the facility staff should call the [named] clinic and a telephone number was provided.
-She had discussed the referral with the Manager.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-She expected Resident #2's appointment to be made with the vascular surgery clinic "right away" when the order was written.
-Resident #2 may need a stent to improve blood flow to his lower legs.

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed:
-He expected facility staff to have immediately made an appointment with the vascular surgeon.
-If the facility staff had made appointments, as

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ordered, maybe the resident's hospitalization could have been avoided.

2. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included cerebral vascular accident, coronary artery disease, and hyperlipidemia.

a. Review of Resident #1's signed physician orders dated 05/06/24 revealed there was an order for blood pressure (BP) checks twice daily.

Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm.
-Notify the Primary Care Provider (PCP) if Resident #1's BP readings were greater than 160/90.
-There was documentation Resident #1's BP was checked 60 of 62 times with 33 of the BP readings greater than 160/90, ranging from 100/85 to 181/72, from 07/01/24 to 07/31/24. Examples included:
-On 07/01/24 at 8:00pm, the BP reading was 181/102.
-On 07/02/24 at 8:00pm, the BP reading was 170/110.
-On 07/06/24 at 8:00pm, the BP reading was 174/99.
-On 07/12/24 at 8:00pm, the BP reading was 156/111.
-On 07/26/27 at 8:00am, the BP reading was 157/101.
-On 07/28/24 at 8:00am, the BP reading was 172/104.

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Review of Resident #1's August 2024 eMAR from 08/01/24 to 08/08/24 revealed:
-There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm.
-Notify the PCP if Resident #1's BP readings was greater than 160/90.
-There was documentation Resident #1's BP was checked 10 of 16 times with 5 of the BP readings greater than 160/90, ranging from 98/58 to 216/139, from 08/01/24 to 08/08/24.
Examples included:
-On 08/01/24 at 8:00am, the BP reading was 216/139.
-On 08/05/24 at 8:00am, the BP reading was 162/92.
-On 08/06/24 at 8:00pm, the BP reading was 170/105.
-On 08/07/24 at 8:00am, the BP reading was 152/94.
-On 08/08/24 at 8:00am, the BP reading was 150/92.

Review of Resident #1's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed:
-There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm.
-Notify the PCP if Resident #1's BP readings was greater than 160/90.
-There was no documentation of Resident #1's BPs obtained.

Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm.
-Notify the PCP if Resident #1's BP readings was

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greater than 160/90.
-There was no documentation of Resident #1's BPs obtained.

Review of Resident #1's PCP's progress notes from 07/01/24 to 08/08/24 revealed there was no documentation the PCP had been notified of elevated BP readings greater than 160/90.

Telephone interview with the PCP on 09/19/24 at 1:30pm revealed:
-She had not been notified of any elevated BP readings.
-She wanted to be notified if Resident #1's BP readings was greater than 160/90.
-She wrote an order to be notified for a BP reading greater than 160/90.
-Since she had not been notified, she thought Resident #1 was maintaining a BP reading below 160/90.
-Resident #1 was at risk for a stroke or a heart attack.
-BP readings that were elevated consistently over a period of time could cause organ damage to the kidneys, eyes and even the brain, and also increasing dementia.
-She expected to be notified when Resident #1 had a BP reading above 160/90 so she could adjust medications to assist with lowering his BP.

Interview with a medication aide (MA) on 09/17/24 at 1:53pm revealed:
-Resident #1's BP was checked every morning and every evening.
-She did not notify the PCP of Resident #1's BP readings.
-Resident #1's BP did not run high; his systolic pressure was between 140-160.
-She did not know what was considered a high BP reading.

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-She did not realize Resident #1's PCP was to be notified for BP readings greater than 160/90.
-She should have notified the PCP of BP readings greater than 160/90.

Interview with a second MA on 09/17/24 at 2:25pm revealed:
-She took Resident #1's BP twice daily.
-She did not call Resident #1's PCP regarding the BP readings.
-She did not realize Resident #1 had parameters for BP readings and to notify the PCP if the BP readings was greater than 160/90.
-She had taken Resident #1's BP and it had been higher than 160/90.

Interview with the Manager on 09/18/24 at 4:00pm revealed:
-The MAs should notify the PCP of BP readings greater than 160/90.
-The MAs should follow the PCP's orders.
-The MAs were able to send an electronic message to the PCPs when needed.
-If the MAs were having problems notifying the PCP, the MAs should have contacted her.

Telephone interview with the Administrator on 09/19/24 at 9:59am revealed:
-The MAs were expected to notify the PCP of elevated BP readings outside the ordered parameters.
-The MA should document when they notify the PCP of elevated BP readings.
-The PCP may want to adjust Resident #1's medication based on the BP readings.
-An elevated BP could cause harm to Resident #1, such as a stroke.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not

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D 273	Continued From page 40 interviewable. b. Review of Resident #1's signed physician orders dated 05/06/24 revealed there was an order for nicotine patches 21mg (for smoking cessation) apply one patch every 24 hours. Review of Resident #1's August 2024 MAR from 08/01/24 to 08/31/24 revealed: -There was an entry for nicotine patch 21mg apply one patch every day; remove old patch before applying the new patch, with a scheduled administration time of 8:00am. -There was documentation nicotine patch was applied every 24 hours from 08/01/24 to 08/02/24 at 8:00am and from 08/05/24 to 08/08/24 at 8:00am. -There was no documentation on 08/03/24 and 08/04/24; the eMAR was blank. -There was documentation on the MAR the nicotine patch was not applied to Resident #1 from 08/09/24 to 08/31/24. -There were no exceptions documented from 08/09/24 to 08/31/24. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry for nicotine patch 21mg apply one patch every day; remove old patch before applying the new patch, with a scheduled administration time of 8:00am. -There was documentation nicotine patch was applied every 24 hours from 09/01/24 to 09/18/24 at 8:00am. Observation of medication on hand on 09/17/24 at 2:22pm revealed there was a sealed box of 14 nicotine patches available for administration that were dispensed on 08/29/24.	D 273		

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D 273	Continued From page 41 Interview with a MA on 09/17/24 at 1:53pm revealed: -Resident #1 refused the nicotine patches. -There was a box of nicotine patches on the medication cart. -She did not offer the nicotine patches to Resident #1 because he would not allow her to apply the nicotine patch. -Resident #1 rarely smoked anymore; he may smoke 2 to 4 cigarettes a month. -Resident #1 had refused the nicotine patches for months. -She had not contacted the PCP regarding Resident #1 refusing the nicotine patches. -She told Resident #1 to tell the PCP on the next visit that he was refusing to wear the patches. -She should have circled her initials on the MAR and documented on the back of the MAR that Resident #1 refused the nicotine patch. Interview with a second MA on 09/17/24 at 2:25pm revealed: -Resident #1 refused the nicotine patches. -Resident #1 had refused the nicotine patches about 2 months. -She did not speak with the PCP about Resident #1 refusing the nicotine patches. -She did not know the PCP needed to be notified of Resident #1 refusing a medication. -She should have circled her initials on the MAR. -There was nowhere on the paper MAR to document when residents refused medications. Telephone interview with the PCP on 09/19/24 at 1:30pm revealed: -She had not been notified that Resident #1 was refusing the nicotine patches. -She thought the nicotine patches were being applied since Resident #1 smoked very little.	D 273		

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D 273	Continued From page 42 Interview with the Manager on 09/18/24 at 4:00pm revealed: -The MAs should notify the PCP when a resident refused medications for 3 days or more. -She expected the MAs to notify the PCP when a resident consistently refused medications. Telephone interview with the Administrator on 09/19/24 at 9:59am revealed: -The MAs were expected to notify the PCP when a resident continually refused a medication. -The PCP may want to change or discontinue the medication. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to ensure referral and follow up for a resident (#2), who had a toe amputation on 08/05/24 and an order for a physical therapy referral on 08/09/24 and 08/27/24 that was not arranged; an order for home health nursing for dressing changes on 08/27/24 and 09/03/24 that was not arranged; an order for a referral to the wound clinic on 08/21/24 and 08/27/24 that was eventually scheduled for 09/16/24, but the resident was a "no show" for the appointment; and an order for a referral to a vascular surgeon on 08/21/24 and 08/27/24 which was not arranged until the resident was re-hospitalized on 09/04/24 with osteomyelitis and the discharge planner initiated the referral, the failure to follow-up put the resident at further risk for deterioration in his wound due to a delay in his wound healing; and a second resident who had an order to notify the PCP of blood pressure readings greater than 160/90 which occurred 33 of 60 times in July 2024 and 5 of 10 times in August 2024 increasing the resident's risk of	D 273		

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D 273	Continued From page 43 stroke and heart attack and long-term injuries to organs (#1). This failure resulted in serious physical harm and neglect which constitutes an A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 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, record reviews, and interviews, the facility failed to implement physician's orders for 2 of 3 sampled residents (#1, #2) related to blood pressure (BP) and finger stick blood sugars (FSBS) checks (#1), and dressing changes that were not applied (#2). The findings are: 1. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed: -Diagnoses included sepsis and gangrene of the	D 276		

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left 5th toe.
-Resident #2 required assistance with bathing and dressing and was semi-ambulatory.

Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for wet-to-dry dressing daily to the left foot, toe number 5.

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed there was an order for daily dressing change with dry gauze.

Review of Resident #2's primary care provider (PCP) order dated 08/09/24 revealed:
-Apply betadine (an antiseptic used for skin disinfection) to the site of left toe amputation daily.
-Cover with dry dressing.
-Change daily and as needed (PRN) soiled/drainage.

Review of Resident #2's podiatrist's after-visit summary dated 08/20/24 revealed:
-Resident #2 did not have a dressing on his toe at the podiatry appointment.
-She cleaned the wound and applied betadine and a fabric band-aid.
-The resident was advised he must do the same daily until healed.

Review of Resident #2's general surgeon's after-visit summary dated 08/21/24 revealed an order for daily dressing changes with dry gauze to the ulcer on the left foot.

Review of Resident #2's PCP order dated 08/27/24 revealed an order for wound care: apply hydrocolloid (a bandage used for wounds) dressing every 3 days to the open wound on the left foot after gentle cleansing with saline by the

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D 276	Continued From page 45 home health nurse. Review of Resident #2's PCP after-visit summary dated 09/03/24 revealed facility staff were encouraged to apply mooncare (a dressing for wound care) to the open wound. Review of Resident #2's surgeon's after-visit summary dated 09/06/24 revealed an order for daily dressing changes to the left foot ulcer with dry gauze. Review of Resident #2's August 2024 medication administration record (MAR) from 08/09/24-08/31/24 revealed: -There was an entry for sodium chloride 0.9% gently cleanse the wound on the left foot using saline and pat dry with clean gauze before applying new hydrocolloid dressing every 3 days with a scheduled time of 8:00am. -There was no documentation that dressing changes were done from 08/09/24-08/31/24. -There was an entry for betadine applied as directed to the skin once daily. -There was no documentation that betadine had been applied from 08/09/24-08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24-09/17/24 revealed: -There was an entry for sodium chloride 0.9% gently cleanse the wound on the left foot using saline and pat dry with clean gauze before applying new hydrocolloid dressing every 3 days with a scheduled time of 8:00am. -There was documentation that the dressing had been applied from 09/01/24-09/09/24. -There was an arrow drawn and documentation that the order was discontinued 09/06/24. -There was an entry for betadine applied as directed to the skin once daily.	D 276		

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-There was documentation that betadine had been applied from 09/01/24-09/09/24.
-There was an arrow drawn and documentation that the order was discontinued 09/06/24.

Review of Resident #2's Licensed Health Professional Support (LHPS) assessment dated 09/18/24 revealed:
-Resident #2's current order was to gently cleanse the left 5th toe area with saline, pat dry, and apply hydrocolloid dressing every 3 days.
-Resident #2's dressing was saturated with a quarter-size serosanguinous fluid (blood and serum), with no odor.
-The LHPS nurse recommended a home health nurse for dressing changes.

Telephone interview with the facility's contracted LHPS nurse on 09/19/24 at 10:11am revealed:
-On 09/18/24, she saw Resident #2 at the facility.
-She asked the MA to remove the dressing on Resident #2's toe so she could see the wound.
-She did not see what type of dressing was removed from Resident #2's toe.
-The dressing had serosanguinous (combination of blood and serum that results from damage to tissue) drainage, without odor.
-The wound had areas of concern, meaning the wound bed was red.
-Resident #2's dressing was replaced with hydrocolloid dressing.
-The MA reported the hospital did not set up home health nursing care for Resident #2.
-She recommended the facility get home health nursing and follow up with the wound clinic.

Interview with the Manager on 09/17/24 at 3:38pm revealed Resident #2 returned from the hospital on 08/08/24 after having his toe amputated with no orders for wound care.

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D 276	Continued From page 47 Telephone interview with the hospital discharge planner on 09/18/24 at 9:58am revealed: -Resident #2 was admitted to the hospital on 08/05/24 and discharged on 08/08/24. -The facility staff reported the facility had a wound care person who could provide Resident #2's wound care. -She could not say for sure who the staff person was, but typically she spoke to the Manager. -Resident #2 was sent back to the facility with gauze to use until dressing supplies were obtained. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/24 at 9:45am revealed: -A bottle of betadine was dispensed on 08/27/24. -Sodium chloride for irrigation was dispensed on 08/27/24. -No dressings had been dispensed for Resident #2. Telephone interview with Resident #2's Licensed Counselor on 09/19/24 at 3:36pm revealed: -She saw Resident #2 on 08/09/24 and he did not have a dressing on his toe. -On 08/11/24, 08/12/24, 08/13/24, 08/14/24, 08/19/24, 08/20/24, 08/21/24, and 08/22/24, Resident #2 did not have a dressing on his toe. -On 08/24/24 at 3:54pm, she saw Resident #2 and the resident's toe did not have a dressing on it. -She asked the MA who was working about a dressing, and she was told the resident did not have any dressings available and the Manager had the only key to the area where the bandages were stored. -Resident #2 told her no one would help him wrap his toe.	D 276		

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-She went to a local pharmacy and purchased gauze for Resident #2.
-On 08/26/24 and 08/27/24, Resident #2 did not have dressing on his toe.
-On 08/27/24, she saw Resident #2's PCP, and the PCP was concerned Resident #2's toe was more infected than she had seen it before.
-The PCP wrapped Resident #2's toe with the gauze provided by the Licensed Counselor.
-On 08/29/24 and 08/30/24, Resident #2 had a dressing on his toe and reported he and his roommate had applied the dressing.
-On 09/04/24, Resident #2 called her and complained of pain and asked her to come to the facility.
-She could not tell if Resident #2 had a dressing on his toe on 09/04/24, but the white sock on the resident's foot was visibly soiled with a greenish-yellow drainage.
-On 09/04/24, Resident #2 was transported by emergency medical services to the local hospital.
-She had not seen Resident #2 since he returned from the hospital.

Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2's wound should be covered to prevent exposure to germs and reduce the risk of infection.

Interview with Resident #2 on 09/17/24 at 1:56pm revealed:
-He went to the hospital a couple of weeks ago because the amputated toe needed to be cleaned; he was there for 3 days.
-His toe was wrapped every day until the toe started looking bad and he went to the hospital.
-Some days he wrapped the toe himself.

Observation of Resident #2's left foot on 09/17/24

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at 1:56pm revealed the outside of the foot/toe area was covered with a dressing.

Interview with Resident #2 on 09/19/24 at 8:11am revealed:
-No one at the facility put a dressing on his toe after the hospital dressing came off.
-There were no dressings available for him to use until his Licensed Counselor purchased some dressings for him to use.
-When he asked a MA about dressings, he was told he did not have any.
-He tried to keep a sock on the foot with the amputation to protect it, but the sock hurt it.
-He had to deal with the pain until he got something to "wrap it."
-His foot was hurting this morning, 09/19/24, because the dressing had come undone during the night, but he had fixed it.
-A nurse cleaned the foot yesterday, 09/18/24, with wound cleanser and bandaged his toe.
-Staff had never used betadine on his foot.
-The staff only used wound cleanser on his foot.
-He had dressing items in his room that his Licensed Counselor purchased for him to use.

Observation of Resident #2's left foot on 09/19/24 at 8:11am revealed the outside of the foot/toe area was covered with a dressing.

Interview with a MA on 09/18/24 at 2:28pm revealed:
-Resident #2's current dressing was to spray the wound with wound cleanser and cover it with gauze.
-At one time betadine was used every day.
-She did not know why the wound care was not documented.

Interview with another MA on 09/19/24 at 8:09am

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revealed:
-Resident #1's wound dressing would not be changed again for a couple of days because a nurse changed the dressing yesterday, 09/18/24.
-Before yesterday, Resident #2's dressing was "usually" changed every day.
-She did not answer what usually meant.

Interview with the Manager on 09/19/24 at 11:07am revealed:
-Resident #2 returned from the hospital after his amputation with gauze and tape but no instructions for using.
-She reached out to Resident #2's PCP for orders.
-When Resident #2's PCP saw the resident after the amputation, the PCP stated the wound looked fine and did not need to be dressed.
-When the PCP came back again, (the PCP came every two weeks), the wound was not "looking good" and the PCP wrote an order for a dry dressing change daily.
-Resident #2's PCP ordered betadine to be used; she thought it was after the 2nd visit that the betadine was delivered and used.
-Resident #2 then went back to the hospital and when he was discharged, the new order was for dry dressing, so the bottle of betadine was returned to the pharmacy.
-Resident #2's current order for dressing changes was every three days using a duoderm dressing (hydrocolloid).

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-If Resident #2 had an open wound, it needed to be covered.
-When she saw Resident #2 after his toe had been amputated his amputation area looked fine.
-A bandage could have protected the area from

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rubbing.
-Resident #2 could have the area open to air and that was fine, but as soon as the resident had an open wound it should have been covered.
-The facility staff did not have a clean technique when changing Resident #2's dressing.
-She observed the MA change Resident #2's dressing, and the MA put the clean dressing on the floor.
-Putting the dressing on the floor and then onto the wound was not good.
-Resident #2 had an order for a dry dressing to be changed daily.
-Resident #2's wound needed to be monitored daily.
-She was concerned Resident #2 had received inconsistent wound care.
-Resident #2 had a very fragile, complex wound.
-It was very concerning Resident #2 was not getting his dressing changed as ordered.

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed:
-He knew there had been some conflicting orders from Resident #2's providers.
-One doctor said to dress the wound and another doctor said do not dress the wound.
-If Resident #2's wound should have been dressed, then the wound should have been dressed.
-Supplies to dress Resident #2's wound should have been available, even on the weekends.
2. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses of cerebral vascular accident, coronary artery disease, and hyperlipidemia.

a. Review of Resident #1's signed physician orders dated 05/06/24 revealed there was an order for blood pressure (BP) checks twice daily.

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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 276	Continued From page 52 Review of Resident #1's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm. -Notify the Primary Care Provider (PCP) if Resident #1's BP readings were greater than 160/90. -There was no documentation of BP readings to review. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry to check and record BP twice daily with a scheduled time of 8:00am and 8:00pm. -Notify the PCP if Resident #1's BP readings were greater than 160/90. -There was no documentation of BP readings to review. Telephone interview with the PCP on 09/19/24 at 1:30pm revealed: -She could not adjust Resident #1's medications without BP readings. -Resident #1 had a history of stroke and his BP needed to be monitored. -If Resident #1's BP was extremely elevated he could have a stroke or a heart attack -BP readings that were elevated consistently over a period of time could cause organ damage to the kidneys, eyes and even the brain, and also increase the risk for dementia. -She expected Resident #1's BP to be checked and recorded twice daily so she could manage Resident #1's BP. Interview with a medication aide (MA) on	D 276		

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D 276	Continued From page 53 09/17/24 at 1:53pm revealed: -Resident #1's BP was checked every morning and every evening. -She documented her initials on the MAR indicating she had checked Resident #1's BP. -She did not document the BP reading because there was nowhere to document it on the MAR. -She should have documented the BP reading on the back of the MAR. Interview with a second MA on 09/17/24 at 2:25pm revealed: -She took Resident #1's BP twice daily. -She documented Resident #1's BP on a sheet of paper, but it was thrown away at the end of the day. -She did not document Resident #1's BP on the MAR; there was nowhere to document the BP on the MAR. -She could have documented the BP on the back of the MAR, but no one had told her to. -She had not mentioned to the Manager there was nowhere to document the BP readings. Interview with the Manager on 09/19/24 at 4:00pm revealed: -The facility changed to a new pharmacy the first week of August 2024. -The facility had been on paper MARs since 08/09/24. -She reviewed the paper MARs when they arrived in the facility. -She did not notice there was nowhere to document the BP, like there had been on the electronic system. -The MAs had not asked were to document the BP, until today, 09/19/24. -She did not know the MAs were not documenting Resident #1's BP twice daily. -The BPs were important for the PCP to review to	D 276		

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D 276	Continued From page 54 adjust medications. Telephone interview with the Administrator on 09/19/24 at 9:59am revealed: -The MAs were expected to document the BP readings on the MAR. -The facility documented on paper MARs at this time but there was no reason not to document the BP readings on the back of the MAR. -The PCP would refer to the BP readings to adjust Resident #1's BP medications. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's signed physician orders dated 05/06/24 revealed: -There was an order for blood sugar checks 4 times daily before meals and at bedtime. -There was an order for Novolog sliding scale insulin (a rapid-acting insulin to lower blood sugar) for blood sugar readings of 200 or below give 0 units; 201-250 give 2 units; 251 to 300 give 4 units; 301 to 350 give 6 units; 351 to 400 give 8 units; greater than 400 call the PCP. Review of Resident #1's August 2024 MAR from 08/09/24 to 08/31/24 revealed: -There was an entry to check Resident #1's blood sugar four times daily before meals and at bedtime. -There was no documentation of blood sugar readings. -There was an entry for Novolog SSI Insulin for blood sugar readings of 200 or below give 0 units; 201-250 give 2 units; 251 to 300 give 4 units; 301 to 350 give 6 units; 351 to 400 give 8 units; greater than 400 call the PCP. -There was documentation of the MA's initials,	D 276		

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but no documentation if or how much Novolog insulin was administered.

Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry to check Resident #1's blood sugar four times daily before meals and at bedtime.
-There was no documentation of blood sugar readings.
-There was an entry for Novolog SSI Insulin for blood sugar readings of 200 or below give 0 units; 201-250 give 2 units; 251 to 300 give 4 units; 301 to 350 give 6 units; 351 to 400 give 8 units; greater than 400 call the PCP.
-There was documentation of the MA's initials, but no documentation if or how much Novolog insulin was administered.

Review of Resident #1's PCP progress note dated 09/03/24 revealed there was no blood sugar readings documented on the MAR for August 2024 or September 2024; monitor blood sugar readings closely.

Observation of Resident #1's glucometer on 09/18/24 at 10:05am revealed:
-The current date on the glucometer was 06/02/24 at 11:34am.
-There were two blood sugar readings in the glucometer.
-On 06/01/24 at 1:04pm, there was a blood sugar reading of 300.
-On 06/02/24 at 8:55am, there was a blood sugar reading of 153.

Telephone interview with Resident #1's PCP on 09/19/24 at 1:30pm revealed:
-She was unable to adjust Resident #1's insulin without blood sugar readings.

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D 276	Continued From page 56 -She was concerned that if she adjusted Resident #1's insulin he may have a hypoglycemic or hyperglycemic episode. Interview with a MA on 09/17/24 at 1:53pm revealed: -Resident #1's blood sugar was checked four times daily before meals and at bedtime. -She documented her initials on the MAR indicating she had checked Resident #1's blood sugar. -She did not document the blood sugar readings because there was nowhere to document it on the MAR. -She should have documented the blood sugar readings on the back of the MAR. -She administered Novolog insulin to Resident #1 when his blood sugar readings were greater than 200. -She looked at the prescription label on the box of Novolog insulin pens to see how many units she was to administer. -She did not document how many units she administered. -She should have documented the number of units of insulin on the MAR. -There were some blood sugar readings that were below 200 and Resident #1 did not receive Novolog insulin. -She checked Resident #1's blood sugar and administered insulin as needed when she was the MA. Interview with the same MA on 09/18/24 at 10:19am revealed: -She checked Resident #1's blood sugar this morning using his glucometer. -Resident #1 did not have a glucometer on the medication cart until 09/17/24. -This morning was the first time she had used	D 276		

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D 276	Continued From page 57 Resident #1's glucometer. Interview with a second MA on 09/17/24 at 2:25pm revealed: -Resident #1's blood sugar was checked four times daily before meals and at bedtime. -She documented Resident #1's blood sugar on a sheet of paper, which was thrown away at the end of the day. -She administered Novolog SSI to Resident #1 based on his blood sugar readings. -She referred to the insulin box to see how many units of Novolog Resident #1 was to receive. -Resident #1 was not administered Novolog insulin each time his blood sugar was checked; he did not need it because his blood sugar was below 200. -Resident #1's blood sugar was below 200 before breakfast and did not require Novolog insulin. -Resident #1's blood sugar was high before lunch and at supper, the resident "always" needed Novolog insulin. -There was nowhere to document how many units of Novolog was administered. -She had not mentioned to the Manager there was nowhere to document the blood sugar readings. Interview with the second MA on 09/18/24 at 11:00am revealed: -Resident #1 received a new glucometer yesterday, 09/17/24. -She could not locate the old glucometer, so she got a new one for Resident #1. Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -She gave the MA a new glucometer for Resident #1 before lunch on 09/17/24. -There should have been 3 blood sugar readings	D 276		

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from yesterday and one from this morning in Resident #1's glucometer when the surveyor checked the glucometer on 09/18/24.
-She did not know why there were only two readings in his glucometer.

Interview with the Manager on 09/19/24 at 4:00pm revealed:
-The facility changed to a new pharmacy the first week of August 2024.
-The facility had been on paper MARs since 08/09/24.
-She reviewed the paper MARs when they arrived in the facility.
-She did not notice there was nowhere to document the blood sugar readings, like there had been on the electronic system.
-The MAs had not asked where to document the blood sugar readings, until today, 09/19/24.
-She did not know the MAs were not documenting Resident #1's blood sugar readings.
-The blood sugar readings were important for the PCP to review to adjust Resident #1's insulin.

Interview with the Administrator on 09/19/24 at 9:59am revealed:
-The MAs were expected to document the blood sugar readings and the Novolog SSI on the MAR.
-The facility documented on paper MAR at this time but that was no reason not to document the blood sugar readings on the back of the MAR.
-The PCP would refer to the blood sugar readings and Novolog SSI documentation to adjust Resident #1's insulin.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

_____

The facility failed to implement orders for a

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D 276	Continued From page 59 resident, who had an order for wound care after his left fifth toe was amputated and the wound care was not completed as ordered and the resident was admitted to the hospital a second time with osteomyelitis to his wound (#2); and a resident, who had a history of hypertension and stroke and an order to obtain BP readings twice daily that were not obtained. This failure resulted in substantial risk of serious physical harm, which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/19/24. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2024.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all food items stored and prepared by the facility were	D 282		

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served under sanitary conditions related to dirty dining room tables and floors in the dining room, a dirty reach-in cooler and freezer, a dirty can opener, dirty stove, dirty hood vent, dirty walls and windowsills, dirty cups and mugs, dirty bowls and storage containers, rodent droppings on shelves and floors in the dry storage area, dirty floors in the kitchen, and live flies and gnats in the dining room and kitchen.

The findings are:

Review of the local health department (LHD) food establishment inspection report for the kitchen dated 03/26/24 revealed:
-The facility received a score of 94.5.
-There was documentation of observations of rodent droppings found on shelves in the [dry] storage room and the need to notify the pest control company.

Observation of the dining room on 09/17/24 at 8:00am revealed:
-There were four long tables in the resident dining room; three tables had six chairs and one table with five chairs.
-The tables had been preset with cups of orange juice, cups of milk, empty red, blue and brown coffee mugs, a disposable napkin, a fork and a spoon.
-There was rice on the floor under one of the dining room chairs and debris on the floor under tables.
-There were multiple empty packets of sugar substitute on the floor under the tables.
-There was rice on a place setting at one of the place settings.
-There was debris and pieces of dried food scattered on the tables.
-There were multiple place settings with a sticky

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residue and a white powder.
-There was a sticky substance with a long black hair stuck to it at one place setting.
-There were red coffee mugs that had cracks in the glaze that were black.
-There were blue coffee mugs that had a brown stain coating the inside of the cup and was brownish black on the outside.
-There were brown coffee cups that had a rough jagged rim that were not smooth.
-There were opaque reusable plastic cups with scuffed rough rims and chips that were not smooth and had a black buildup on the outside and inside.
-There were flies flying around the dining room and landing on the utensils and the rims of the orange juice and cups of milk.
-There were gnats flying around the dining room and landing on the utensils and the rims of the orange juice and cups of milk.
-The tables were a grayish-white plastic and had large areas that were stained a dark grayish-black.
-Staff were swatting away flies and gnats as they set the tables and served the resident meals.

Observation of the breakfast meal on 09/17/24 at 8:37am revealed multiple residents were swatting at flies while they ate their meal.

Observation of the kitchen on 09/17/24 at 8:37am revealed:
-There was no cleaning schedule posted in the kitchen.
-There were flies on the bulletin board, the menu, the book with the therapeutic diet menus, the counters, the dishwashing area, and flying around the kitchen.

Observation of the dining room on 09/17/24 at

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D 282	Continued From page 62 10:07am revealed: -There were residents eating their snack and there were flies and gnats landing on the tables. -Residents were swatting and waving away flies as they ate. Observation of the kitchen on 09/17/24 at 1:52pm revealed: -There was a reach-in cooler with double doors. -There was a buildup of a sticky substance on the handles of the reach-in cooler that could be scrapped off with a finger nail. -The inside of the cooler doors had grayish-black residue. -There was water dripping from the fans inside the cooler and collecting in a pan of water on the top shelf. -There was a case of fresh tomatoes, pitchers of lemonade and iced tea, a gallon of milk and a half of a deli turkey stored on the shelves under the pan of water. -There was a dried and wet red liquid in the bottom of the cooler that extended to both sides of the cooler; there was a pan of ground beef sitting on the liquid. -There was a dried orange splatter on the inside wall of the cooler. -There was thick build-up of food and debris and a blackish red substance on the metal shelves and the ledges where the shelves sat in the cooler. -There was a reach in freezer with double doors in the dry storage area. -There was a sticky substance and black smudges on the handles and the outside of the freezer. -There was a black film on the gaskets to the freezer doors and there was a dried liquid pooled at the bottom of the freezer. -There was thick black sticky layer of buildup	D 282		

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covering the can opener handle, blade, the support plate and extended piece that went into the support plate mounted to the table.
-There were miscellaneous pieces of equipment in the cabinets including bowls, mugs and cups with food splatters with black smudges on the inside and outside of the equipment and there were scuffed and rough areas on the surfaces including the rims of the mugs and cups.
-There were food storage containers with food in them with black smudges, the surfaces and the lids were scuffed, rough and sticky to the touch.
-There was a thick black layer of baked on grease and food on the grates on the stove.
-There was black soot on the burners on the stove top and the flames to the pilot lights were burning orange.
-There was food, grease and debris around the burners on the stove.
-There was a thick black buildup on the backsplash to the stove.
-There was a thick layer of yellow and brown grease on the sides of the stove.
-There was a black buildup on the pots and pans.
-There was a thick layer of yellow grease and a thick buildup of black dust on the hood, the hood screens and ventilation system above the stove.
-There was debris, paper items, rodent droppings and food on the floor behind and under the stove and shelving in the kitchen.
-There were rodent droppings on the floors and shelving in the dry storage area.
-There were rodent droppings on canned foods and food storage containers in the dry storage area.
-There were dead flies and gnats, cobwebs, a black debris and dust on the windowsills above the dishwashing area, food sinks, shelving and food preparation areas in the kitchen.
-There were cob webs hanging from the walls

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and ceiling with thick layers of grayish black dust hanging from them.

Review of the September 2024 cleaning schedule for the kitchen revealed:
-The floors in the dining room and kitchen were to be swept and mopped daily after every meal.
-The floors in the pantry [dry storage area] were to be mopped daily.
-The table and chairs in the dining room were to be wiped off and cleaned after every meal and snack.
-There were initials documenting the daily task were completed once daily from 09/01/24 to 09/17/24.
-The freezer shelves and the cooler shelves were to be cleaned weekly; there were initials documenting the task was completed on 09/02/24 and 09/07/24.
-The hood [vent] and exhaust fan over the stove were to be cleaned weekly; there was nothing documented on the schedule to indicate the tasks had been completed from 09/01/24 to 09/17/24.
.
-The shelves in the pantry [dry storage] were to be wiped and cleaned weekly; there were initials documenting the task was completed on 09/04/24 and 09/12/24.
-The grates on top of the stove were scheduled to be cleaned weekly; there were initials documenting the task was completed on 09/07/24.
-The windowsills were to be cleaned weekly; there was nothing documenting the task was completed from 09/01/24 to 09/17/24.

Interview with a resident on 09/17/24 at 2:42pm revealed:
-He had seen flies everywhere in the facility.
-He had swatted them away while he was in the

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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 282	Continued From page 65 dining room eating. Interview with a second resident on 09/18/24 at 9:00am revealed: -He saw flies in the dining room and would wave them away. -The staff had flyswatters they used to kill flies inside. -The staff would kill flies in the dining room after the meals. Telephone interview with the health inspector from the county's LHD on 09/18/24 at 4:48pm revealed: -The kitchen was inspected by the LHD every four months. -She had inspected the kitchen in March 204 and revisited a verification [follow-up] in April 2024 for the rodent droppings in the kitchen. -She had cited the droppings and deducted points from the score. -The pest control company was scheduled to come out and treat the facility before the verification date. -The rodent dropping were cleaned up at the verification visit. -She had deducted points for the equipment in the kitchen not being maintained and clean. -She did not note the hood in the kitchen on the inspection report, but on previous inspection reports she had noted the buildup of grease, dirt and soot on the pans and the stove. -She cited the stove in previous inspection reports but did not deduct points. -The orange flame on the pilot light indicated there was improper airflow because the burners were dirty and needed to be cleaned. -The improper flame on the stove would cause the buildup of soot on the kitchen equipment. -She had not seen gnats or flies in the kitchen on	D 282		

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D 282	Continued From page 66 her visits. Telephone interview with the facility's contracted fire suppression system inspection company on 09/18/24 at 4:33pm revealed: -They had done an inspection of the fire suppression system in the kitchen [hood] in July 2024. -They included recommendations for cleaning on the reports they prepared. -The were required to turn their reports into the local Fire Marshall. -If the flame on the pilot was burning orange and there was soot on the pots and pans it was due to the dirt and grease on the burners on the stove. -He did not have anything noted on the report he turned in for the Fire Marshall. Telephone interview with the local Fire Marshall on 09/19/24 at 1:56pm revealed: -He was new to his position and had not inspected the facility to make sure they were in compliance. -The ductwork for the hood vent should be cleaned by a private contractor at least once a year but was not required. -The hood vent should have been free of grease and dust and the stove should also have been free of grease and dirt buildup. -He would have to look at the stove and the hood when he did is inspection. -A dirty hood vent would not prevent it from working correctly. -The grease and dirt buildup on the stove could be a potential risk for a fire. Interview with the cook on 09/17/24 at 2:14pm revealed: -The stove did not work correctly and caused a black soot in the kitchen.	D 282		

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-The black soot would be transferred to the pots and pans used on the stove and when they were touched the soot would come off on the staffs' hands.
-The staff would touch items and surfaces in the kitchen and transfer the soot to them.
-The cleaning schedule was kept in the Managers office.
-She washed all the kitchen equipment in the dish machine.
-Once the soot from the stove was on something, she could not get it to come off.
-The tables and floors in the dining room were supposed to be cleaned three times a day after each meal.
-She did not work the day before, so she did not notice the floors and tables were dirty and had not been cleaned from the day before.
-The flies had been bad in the kitchen and the building for about two weeks.
-She did not know where the flies were coming from, they never left a window or a door open.

Second interview with the cook on 09/18/24 at 2:23pm revealed:
-There was a cleaning schedule.
-She was the only cook and kitchen staff.
-She had deep cleaned the grates to the stove about a month ago.
-She removed the grates and sprayed them in the sink with oven cleaner.
-She tried to deep clean the stove and the grates to the stove about once a week.
-The stove was on the cleaning schedule but not once weekly.
-She wiped the stove and knobs off every day.
-The Supervisor over saw the kitchen and helped with meals; the Supervisor did a deep cleaning of equipment in the kitchen every two weeks.
-She soaked equipment in bleach and detergent

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every other day including coffee mugs, drinking cups, bowls and food storage containers but there was so much soot from the stove she could not remove at all.
-She did not know why there was so much soot from the stove.
-She had told the Supervisor about the soot from the stove last week and the Supervisor was going to tell the maintenance worker.
-The coffee mugs and drinking cups had wear and tear on them and had been at the facility and used for a while.
-She had noticed the chips in the cups; there were no extra cups or new ones to replace the chipped cups.
-She had noticed the buildup on the cups.
-She did not know the last time the hood system was cleaned.
-She thought an outside company had to clean the hood system; she did not know the kitchen staff were responsible for the cleaning.
-She had noticed the hood was dirty and needed cleaning; she told the Supervisor to have a company come to clean it.
-She had not cleaned the floor in the kitchen or the dry storage area.
-The floors were supposed to be swept and mopped every day at the end of the day.
-The last time she had swept and mopped the floors was about a week and a half ago.
-She was the only staff in the kitchen and she just needed to get a routine going to get everything done.
-She had seen the rodent dropping and she had seen live mice when she first started working at the facility about four months ago.
-She told the pest control company representative about a month ago she saw live mice.
-The pest control company had put sticky traps down to catch the mice; she had not seen mice

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since then, but she was still seeing the droppings.
-She had noticed the dirty, smut, spider webs, and dead bugs on the windowsills but she had not had the chance to clean them off.
-The windowsills were not on the cleaning schedule.
-The doors to the reach in cooler and freezer were scheduled to be cleaned every other day.
-The reach and cooler had been dripping since she started at the facility, the pan that collected the water had to be changed every day because the water overflowed the previous week.
-She wiped the shelves the walls and the bottom of the cooler every day.
-The reach-in freezer had been defrosted and cleaned the previous week.
-The handles to the freezer door were supposed to be cleaned every day.
-The can opener was not on the cleaning schedule, but it should be cleaned with soap and water by hand every day; it had to be removed from the plate on the table and washed in the sink.
-She did not recall the last time the can opener had been cleaned.

Interview with the facility's maintenance staff on 09/18/24 at 4:21pm revealed:
-He received a list from the Manager when there were repairs needed in the facility.
-The refrigerator with the internal dripping was not on his list for repairs.
-He knew the stove would soot the pots and pans and the kitchen.
-He was notified by someone from the kitchen today that the flames on the pilot light on the stove needed to be turned down.
-He had cleaned the burners on the stove himself but two weeks later they were dirty again.
-He thought the hood system in the kitchen had

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D 282	Continued From page 70 been cleaned by a contracted company about a year ago. Interview with the Supervisor on 09/18/24 at 3:28pm revealed: -She oversaw the kitchen including the training, the cooks and the sanitation. -She did not check on the cleaning schedule for the kitchen every day; but she did walk around and look every day. -She saw some things, but she thought the sanitation in the kitchen was good. -The sanitation in the kitchen would get bad if it was not kept up with every day. -There was a daily and weekly cleaning schedule in the kitchen. -She tried to deep clean the stove once a week. -The stove was on the daily cleaning schedule and the grates and deep cleaning were on the weekly schedule. -The knobs, backsplash, shelf, and oven door were to be wiped off daily. -The grates on the stove were to be removed soaked with degreaser and food scrubbed off when they were deep cleaned weekly. -The eyes [burners] on the stove were cleaned monthly. -She had cleaned the stove before and two days later it looked the same as it had before she cleaned it. -The stove would soot up the pots and pans and hand contact and touching other equipment would transfer this soot onto the equipment. -Once soot was on the equipment it was hard to get off. -She had tried to clean the coffee mugs, cups, dishes and food storage containers to remove the soot as much as she could. -She had soaked the coffee mugs and cups once a week to try and destain them and remove as	D 282		

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much as she could, but she could not get it all off.
-The mugs and cups were supposed to be thrown away when they were damaged or cracked.
-She was not aware there were cracks in any of the coffee mugs.
-She had noticed the hood needed to be cleaned and was on the cleaning schedule either weekly or monthly.
-The last time the hood was cleaned was by a professional company in December 2023.
-These tables in the dining room were supposed to be cleared and cleaned after every meal and after every snack.
-The floors in the dining room were supposed to be swept and mopped once a day or as needed and were on the cleaning schedule.
-The cook was supposed to check the dining room before they went home in the evening.
-The floors and the kitchen and the dry storage area were on the cleaning schedule and were supposed to be swept and mopped at the end of the day; including under and behind equipment and shelves.
-She had not checked behind the equipment or under the shelves in the dry storeroom in about a week.
-The reach in cooler was supposed to be deep cleaned weakly including the inside and the outside; it was on the cleaning schedule.
-The reach in freezer was defrosted and cleaned Monday, 09/16/24 and was on the cleaning schedule for deep cleaning monthly.
-The doors to the reach in freezer were not cleaned when the freezer was recently defrosted.
-She had noticed the rodent droppings in the dry storage area before, but she had not been back there since Tuesday, 09/10/24, the week before and she did not look on the floor.
-She thought the mice were coming from the basement of the facility.

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D 282	Continued From page 72 -The facility had a contracted pest control company treating for mice, flies and gnats. -The pest control company had put sticky traps down to capture mice and she thought it had gotten better. -The shelves in the dry storage area were supposed to be cleaned by the cook once a week and were on the cleaning schedule. -She could not recall if the windowsills were on the cleaning schedule; she had noticed they were "pretty bad" because they had soot and dead flies on them. -She had noticed the cobwebs on the walls yesterday; the walls were on the weekly cleaning schedule. -She thought the gnats and flies were coming in from the doors when they were opened. -The flies and gnats had gotten bad about a week ago. -She had just not notified the pest control company yet about the increase in flies and gnats. Interview with the Manager on 09/19/24 at 8:26am revealed: -She checked on the kitchen cleaning schedule every day and looked at certain things in the kitchen at least once a day. -She checked to see if the floors were swept and mopped every morning when she came in. -The cook was supposed to sweep and mop the floors in the dining room, dry storage area and the kitchen at the end of the day and after meals as needed. -The stove was supposed to be wiped down once a day and was on the daily cleaning schedule. -The stove grates were supposed to be removed and deep cleaned as needed; when she looked at the stove on Monday, 09/16/24, she noticed the stove was not clean.	D 282		

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-She knew the hood vent in the kitchen had not been cleaned in a while; she knew it was not cleaned in July 2024 or August of 2024.
-She believed the hood vent was on the cleaning schedule to be cleaned monthly, but it had been longer than a month since it had been cleaned.
-There had been an outside hood cleaning company that would clean the hood, and she did not recall the name or the last time they were at the facility.
-She had seen the hood vent on Monday, 09/16/24, and noticed it needed to be cleaned.
-She had cleaned the hood vent herself in April 2024 or May 2024 and she believed that was the last time it had been done.
-She was concerned the debris could drip and fall from the hood into the food while it was being cooked.
-There was no reason why the hood had not been cleaned and was dirty.
-She would look at the cups and mugs to see if there were cracks trips or tuff stains.
-She would look at the cups and mugs about every day and they would be soaked in bleach as needed.
-If the cups and mugs were in bad shape, they would discard them.
-She had looked at the cups and mugs on the tables on Monday but had not inspected them to see if they were chipped, cracked or damaged.
-The equipment in the kitchen had soot because of the stove.
-The gnats and flies had been worse this year and she did not know why.
-About the last two weeks she had been seeing more flies and gnats and notice them at the windows.
-She had been spraying in the kitchen at the windowsills.
-She had not contacted the pest control company

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because she had not thought about the pest control company being able to do anything about flies and gnats.
-The pest control company was spraying monthly and putting sticky traps down for mice.
-The facility was doing all they could do about the gaps in the doors and had ordered a strip to put down at the outside doors to keep mice out.
-She called the pest control company when there was a report of even one dropping and they would return to the facility.
-She had seen a live mouse at the fireplace the night before and a live one in the hall over a month ago.
-The shelves in the dry storage area were on the weekly cleaning schedule and then as needed.
-These staff would clean the droppings off the floor in the shelves and there would be more droppings.
-The staff should have cleaned the shelving and floors when they saw droppings.
-The reach in cooler and reach in freezer were on a weekly deep cleaning schedule and a daily cleaning schedule to wipe up any spills.
-She thought the can opener was on a weekly cleaning schedule and should be wiped off after every use.
-She had used the can opener on Monday, 09/16/24, and wiped it off after she used it.
-She did not know if the windowsills were on the cleaning schedule.
-She had noticed this week the windowsills needed to be cleaned because of the soot.

Telephone interview with the Administrator on 09/19/24 at 11:40am revealed:
-The staff in the kitchen had a cleaning schedule that they were to follow.
-She reviewed the cleaning schedule every evening and had kept it in her office on the

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D 282	Continued From page 75 morning of 09/17/24. -The general cleaning on the stove was supposed to be done daily, the burners were supposed to be removed monthly and deep cleaned. -He had not had a complaint of soot from the stove, if there was a problem with soot the flame needed to be turned down. -The screens in the hood vent needed to be taken down and power washed or taken to a car wash and cleaned at least once a quarter or as needed; he expected the kitchen staff to maintain the ventilation system. -He did not have an outside company to clean the duct work in the hood vent. -The floors and the kitchen and dining room were supposed to be mopped and swept daily; he did not know if they were on the cleaning schedule. -There was a pest control company that came to the facility monthly for the issue with rodents. -He did not know if there was a visit report from the pest control company. -He was not aware of a live fly or gnat issue; the Manager had not reported it to him. -The Manager was supposed to monitor the sanitation in the kitchen let him know when there were issues. Attempted telephone interview with the facility's contracted pest control company on 09/19/24 at 3:01pm were unsuccessful.	D 282		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least	D 286		

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D 286	Continued From page 76 a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to offer table service with a place setting consisting of a non-disposable knife, fork, spoon, plate and beverage containers for each meal. The findings are: Observation of the dining room on 09/17/24 at 8:00am revealed: -The tables were preset with a disposable napkin a non-disposable fork and a non-disposable spoon. -There was a coffee cup, a cup of water and a cup of juice at each place setting. -There was no knife at any of the place settings. Observation of the breakfast meal on 09/17/24 at 8:37am revealed: -Scrambled eggs, a sausage patty, grits, buttered toast, jelly packets, water, milk, orange juice and coffee were served. -There were three residents who used their forks to spread their jelly on their toast. -There was a resident who used his fork to stab the sausage patty in the center and picked it up and ate the edges while it was on his fork. -There were two residents who used their fingers to pick up their sausage patty and ate them. -There was one resident who used her fingers and tore her sausage patty into pieces and then used her fork to pick the pieces and eat them.	D 286		

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D 286	Continued From page 77 Observation of the lunch meal on 09/17/24 at 11:49am revealed: -The tables were preset with a napkin, a fork, a spoon, water and iced tea; there were no knives on the table. -The residents were served a porkchop with onions and gravy, half of a baked potato, green bean casserole, a wheat roll, fruit cocktail, water, and iced tea. -One resident picked up his porkchop by placing his fork in the center of the porkchop and lowered his head to the plate to take bites. -A second resident requested a knife; staff brought the resident a knife. -A third resident attempted to use the side of her fork to cut her porkchop; after several attempts she picked the porkchop up with her fork and fingers and lowered her head to the plate to take bites. -A fourth resident picked his porkchop up with his fingers and took bites. -Staff offered to cut one resident's porkchop for them and used the side of the fork to cut. Observation of the kitchen on 09/17/24 at 1:52pm revealed there were four knives available for residents to use during meals. Interview with a resident on 09/17/24 at 2:42pm revealed: -He did not have a knife to eat his breakfast or lunch with. -He had not asked for a knife because he never thought to ask for one. -He would pick up his meat with his fork or his fingers to eat it if he could not cut it with his fork. Interview with a second resident on 09/18/24 at 9:00am revealed:	D 286		

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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 286	Continued From page 78 -He had never been given a knife to use while eating. -He did not know he could ask for a knife. -He would use the side of his fork to cut his food. -When he could not cut his food with the side of his fork, he would just pick it up with his fingers and chew on it like he did with the porkchop the day before. Interview with a third resident on 09/18/24 at 9:07am revealed: -The staff did not give the residents knives; he did not know why. -The staff cut up the residents' food for the residents who could not chew or had swallowing problems. -He cut his own food; he used his spoon to hold the food still and used the side of his fork to cut with. -Sometimes he would "stab" the meat with his fork and eat it off the fork. -He had never asked for a knife; he did not know if he was allowed to have a knife. Interview with the cook on 09/17/24 at 2:14pm revealed: -The residents did not use knives then they ate their meals. -The kitchen staff cut food up for the residents that needed to have their food cut. -The residents could ask staff for a knife if they wanted one. -The residents could ask the staff to cut their food for them. Second interview with the cook on 09/18/24 at 2:23pm revealed: -The Supervisor gave her a supply of knives to use in the kitchen after the lunch meal on 09/17/24.	D 286		

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D 286	Continued From page 79 -She had never asked about knives for the residents because she was scared to give them to the residents because she did not know if it was safe for the residents to have them. -She had only had a resident ask for a knife once. -She only had about 15 knives in the kitchen until yesterday afternoon. Interview with the Supervisor on 09/18/24 at 3:28pm revealed: -The facility did not give the residents knives because they did not use them. -One time a resident had threatened another resident with a knife, so they stopped putting them out for the residents to use about four to five months ago. -The residents could ask for a knife if they wanted one and the staff would cut their meat if they residents needed it cut. Interview with the Manager on 09/19/24 at 8:26am revealed: -The residents should have each had a knife at their place setting. -She had not noticed the residents did not have knives to eat their meals with. -There were knives in storage and the kitchen should have had plenty of knives for the residents. Telephone interview with the Administrator on 09/19/24 at 11:40am revealed: -Knives should always be part of the place setting. -The facility had knives for each resident and some extra. -He did not know why the staff did not put knives at the place setting for the residents.	D 286		

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D 299	Continued From page 80	D 299		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure a serving of dairy was served three times daily to residents. The findings are: Review of the facility's posted week at a glance menu for the week of 09/16/24 to 09/20/24 revealed milk was listed on the menu three times daily for breakfast, lunch and dinner. Observation of the lunch meal on 09/17/24 from 11:49am to 12:18pm revealed: -The residents were served a porkchop with onions and gravy, half of a baked potato, green bean casserole, a wheat roll, fruit cocktail, water, and iced tea. -The residents were not offered or served milk to drink.	D 299		

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D 299	Continued From page 81 Observation of the lunch meal on 09/18/24 from 11:45am to 12:12pm revealed: -The residents were served meatloaf with gravy, mashed potatoes with gravy, green beans, a wheat roll, Peach cobbler, water, and iced tea. -The residents were not offered or served milk to drink. Observation of the kitchen on 09/17/24 at 1:52pm revealed there were three and a half gallons of whole milk in the reach in cooler. Interview with a resident on 09/17/24 at 2:42pm revealed: -He had never been offered milk at lunch and dinner or at his snack. -He did not want to drink milk all day long but would drink it sometimes with certain meals. Interview with a second resident on 09/18/24 at 9:00am revealed: -He was only served milk at breakfast. -He liked to drink milk and would drink it more often if it was offered or given to him. Interview with a third resident on 09/18/24 at 9:07am revealed: -He drank milk every day at breakfast. -Milk was not served to him any other times of the day or offered to him. -He had to ask for milk at other meals; if they had milk, he would be given it when he asked. -If milk was offered to him, he would drink it more often because he liked it; he might drink it at every meal if it was offered to him. Interview with the cook on 09/18/24 at 2:23pm revealed: -Milk was only served at breakfast. -She did not know how many times a day milk	D 299		

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D 299	Continued From page 82	D 299		

was supposed to be served to the residents.
-She did not know why milk was only served once a day to the residents, it was that way when she started working at the facility about four months ago.

Interview with the Supervisor on 09/18/24 at 3:28pm revealed:
-The residents were served milk every day at breakfast and it was available if they requested it.
-The residents did not like to drink milk at other meals.
-They used to pour milk for the residents, and they would not drink it and it would get wasted.
-The staff asked the residents if they wanted milk at meals and the residents would say "no".
-Today the residents would want the milk and tomorrow they would not.

Interview with the Manager on 09/19/24 at 8:26am revealed:
-Some of the residents did not like milk, the residents that did not like milk were not served milk.
-The milk was preset at the place settings for the residents that preferred it.
-The residents could always ask for milk any time they wanted it.
-She was not aware that dairy should be on the menu three times daily.

Telephone interview with the Administrator on 09/19/24 at 11:40am revealed:
-Milk was on the menu three times a day; the staff should follow the menu.
-He did not know why the staff did not follow the menu and serve or offer milk at each meal.

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D 309	Continued From page 83	D 309		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 3 (#1) residents was accurate listed with a cardiac heart healthy diet (CHH) on the physician-ordered therapeutic diets list that was available for the guidance of the food service staff. The findings are: Observation of the dietary list in the kitchen on 09/17/24 at 8:36am revealed: -There was a diet list dated 07/17/23 hanging on a bulletin board in the kitchen. -The list included the resident's name and their physician's ordered therapeutic diet. -Resident #1 was listed to be served a low concentrated sweets diet (LCS). -The cook was plating food and not referencing the diet list. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included of coronary artery disease (CAD), cerebral vascular accident	D 309		

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D 309	Continued From page 84 (CVA), and hyperlipidemia. Review of Resident #1's hospital discharge summary dated 08/20/24 revealed there was an order for a cardiac heart healthy diet. Interview with the cook on 09/18/24 at 2:23pm revealed: -She followed the therapeutic diet list that was hanging on the bulletin board in the kitchen. -She was not sure who updated the list. -She used to reference the list, but she knew the residents and their diets now. -She did not know resident one was ordered a CHH diet. Interview with Resident #1 on 09/18/24 at 11:58am revealed: -He did not have a CHH diet. -He thought he was on a diet for "low sugar" because he was diabetic. Telephone interview with Resident #1's primary care provider (PCP) on 09/19/24 at 9:48am revealed: -Resident #1 did a lot of "snacking". -She wanted the facility to follow the CHH diet the hospital physician had ordered for Resident #1. Interview with the Supervisor on 09/18/24 at 3:28pm revealed: -She and the manager would update the therapeutic diet list when there was a new resident or a diet order change from the PCP. -She did not think the diet list that was dated July 2023 and posted in the kitchen was the most current diet list. -She did not know the last time the therapeutic diet list had been updated. -She was not aware of resident number one was	D 309		

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D 309	Continued From page 85 on a CHH diet she thought he was on a LCS diet. Interview with the Manager on 09/19/24 at 9:31am revealed: -She did the diet list for the residents' physician ordered diets. -The list was updated when there was a diet change or a new resident with a diet order. -The last time she had updated the list was three months ago. -The date was on the bottom of the diet list; the list was printed from a list generated on the computer, so the date was automatically added. -She was not aware Resident #1 had a diet order change after his recent hospital discharge. Telephone interview with the Administrator on 09/19/24 at 11:40am revealed: -The Manager was responsible for the therapeutic diet list. -The diet list was updated annually or as needed when there was a diet order change on an FL-2, physician signed diet order or care plan.	D 309		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 358		

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D 358	Continued From page 86 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#3, #4, and #5) observed during the 8:00am/9:00am medication pass including a blood thinner and a medication for blood sugars (#4); a medication for cholesterol (#3); and a blood thinner, medication for tremors, a nebulizer treatment, a medication for constipation, and a nasal spray (#5); and 2 of 3 sampled residents for record review (#1 and #2) including a blood pressure medication, an anti-viral medication and an insulin (#1); and a pain medication, multiple antibiotics, a blood pressure medication, and a medication used to treat nerve pain (#2). The findings are: 1. The medication error rate was 25% as evidenced by 8 errors out of 31 opportunities during the 8:00am and 9:00am morning medication pass on 09/18/24. a. Review of Resident #4's current FL-2 dated 03/14/24 revealed diagnoses included atrial fibrillation, hypertension, cerebrovascular accident, and diabetes mellitus. 1. Review of Resident #4's current FL-2 dated 03/14/24 revealed there was an order for Eliquis 5mg (used to prevent strokes and blood clots) twice daily. Observation during the morning medication pass on 09/18/24 at 7:37am revealed: -The medication aide (MA) opened the drawer of the medication cart and removed twelve bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup.	D 358		

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D 358	Continued From page 87 -The MA popped one Eliquis 5mg from two different bubble packs, for a total of 10mg. -She administered 12 tablets to Resident #4, returned to the medication cart and began preparing the next resident's medications. -She did not open the medication administration record (MAR) to compare the medications to ensure the medications were correct. Review of Resident #4's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry for Eliquis 5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Eliquis 5mg was administered on 09/18/24 at 8:00am. Observation during medication on hand for Resident #4 on 09/18/24 at 8:00am revealed: -There were two bubble packs of Eliquis 5mg twice daily available for administration with a handwritten entry of 8AM on the top of the bubble packs. -There was a third bubble pack of Eliquis 5mg twice daily available for administration with a handwritten entry of 8PM on the top of the bubble pack. -Each bubble pack was dispensed on 09/02/24 for 60 tablets. -One bubble pack read "card 1 of 2"; there were 20 of 30 Eliquis 5mg tablets remaining. -The second and third bubble packs read "card 2 of 2"; there were 20 of 30 Eliquis 5mg tablets remaining in each card. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -The pharmacy had an order for Eliquis 5mg twice daily.	D 358		

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-The pharmacy did not have an order for Eliquis 10mg daily.
-The pharmacy dispensed 60 Eliquis 5mg tablets on 08/06/24 and 09/02/24.
-Eliquis was a blood thinner used for vascular disease or blood clots.
-If a resident received too much Eliquis the resident could have nose bleeds, blood in their urine, and bruising.
-She did not know why there were 3 bubble packs of Eliquis 5mg dispensed on 09/02/24; there should have been only two bubble packs of 30 dispensed.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 09/18/24 at 3:25pm revealed:
-Eliquis was a blood thinner and was being administered to Resident #4 because of his diagnosis of atrial fibrillation.
-Resident #4 could have nose bleeds, blood in his urine, black tarry stools or bruising due to too much Eliquis being administered.

Interview with Resident #4 on 09/18/24 at 11:35am revealed:
-He knew he took a blood thinner but was not sure why he took it.
-He did not have any problems with nose bleeds, blood in his urine, or bruising.

Interview with the MA on 09/18/24 at 7:55am revealed:
-She did not realize she administered 2 Eliquis 5mg tablets to Resident #4.
-Resident #4 should have received 1 Eliquis 5mg tablet this morning.
-She administered medications to Resident #4 that had 8:00am handwritten on the bubble pack.
-She needed to read the directions on the bubble

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pack when administering medications.
-She should use the MAR when administering medications.

2. Review of Resident #4's current FL-2 dated 03/14/24 revealed there was an order for Jardiance 10mg (used to improve blood sugar levels) daily.

Observation during the morning medication pass on 09/18/24 at 7:37am revealed:
-The MA opened the drawer of the medication cart and removed twelve bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup.
-The MA popped one Jardiance 10mg from two different bubble packs, for a total of 20mg.
-She administered 12 tablets to Resident #4, returned to the medication cart and began preparing the next resident's medications.
-She did not open the MAR to compare the medications to ensure the medications were correct.

Review of Resident #4's September 2024 MAR from 09/01/24 to 09/18/24 revealed:
-There was an entry for Jardiance 10mg daily with a scheduled administration time of 8:00am.
-There was documentation Jardiance 10mg was administered on 09/18/24 at 8:00am.

Observation of medication on hand for Resident #4 on 09/18/24 at 8:00am revealed:
-There were two bubble packs of Jardiance 10mg daily available for administration with a handwritten entry of 8AM on the top of the bubble packs.
-Each bubble pack was dispensed on 09/02/24.
-The prescription labels on each bubble pack read 30 tablets were dispensed.

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D 358	Continued From page 90 -Each bubble pack read card 1 of 1. -One bubble pack contained 11 of 30 tablets of Jardiance and the second bubble pack contained 19 of 30 tablets Jardiance. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -The pharmacy had an order for Jardiance 10mg daily. -The pharmacy dispensed 30 Jardiance 10mg tablets on 08/06/24 and 09/02/24. -Jardiance was a long-acting medication to help control the resident's blood sugar. -She did not know why 2 bubble packs of 30 tablets of Jardiance were dispensed on 09/02/24; there should have only been one bubble pack dispensed. Telephone interview with Resident #4's PCP on 09/19/24 at 12:33pm revealed: -Resident #4 was ordered Jardiance 10mg daily to assist with blood sugar control and heart failure. -The maximum dose was 25mg daily. -She had not noticed any complications with Resident #4 receiving Jardiance 20mg daily instead of 10mg daily. -Resident #4 did not have an order for blood sugar checks. -She expected the staff to administer medications as ordered. Interview with Resident #4 on 09/18/24 at 11:35am revealed: -He was a diabetic and took medication for his blood sugar. -He did not have any problems with excessive sweating, being thirsty or hungry.	D 358		

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D 358	Continued From page 91 Interview with the MA on 09/18/24 at 7:55am revealed: -She did not realize she administered 2 Jardiance 10mg tablets to Resident #4. -Resident #4 should have received 1 Jardiance 10mg tablet this morning. -She administered medications to Resident #4 that had 8AM handwritten on the bubble pack. -She needed to read the directions on the bubble pack when administering medications. -She should have used the MAR when administering medications. _____ Interview with the same MA on 09/18/24 at 7:55am revealed: -She administered medications to the resident's 5 to 7 days a week. -She knew what medications each resident was ordered without looking at the MAR. -The Manager would handwrite the time the medication was due on the bubble pack of each medication. -If the medication was to be given in the morning she would write "8AM or 9AM". -If the medication was to be administered in the evening she would write "8PM or 9PM". -She administered medications based on what was written on the bubble pack. Interview with the Manager on 09/18/24 at 3:11pm revealed: -When the cycle-filled medications arrived, she would write the time the medications were scheduled to be administered on each bubble pack. -Most medications were administered at 8:00am/9:00am or 8:00pm/9:00pm. -This was to help the MAs identify the medications to be administered. -Medications should be administered by referring	D 358		

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D 358	Continued From page 92 to the MAR, not the time entered on the bubble packs. Refer to the interview with the Supervisor on 09/18/24 at 2:30pm. Refer to the interview with the Manager on 09/18/24 at 3:11pm. Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. b. Review of Resident #3's current FL-2 dated 11/10/23 revealed diagnosis included hyperlipidemia. Review of Resident #3's signed physician orders dated 01/25/24 revealed there was an order for atorvastatin 40mg (used to treat high cholesterol) daily. Observation during the morning medication pass on 09/18/24 at 7:49am revealed: -The medication aide (MA) opened the drawer of the medication cart removed six bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup. -She administered 6 tablets to Resident #3, returned to the medication cart and began preparing the next resident's medications. -Atorvastatin was not 1 of the 6 medications prepared for administration. -She did not open the medication administration record (MAR) to compare the medications to ensure the medications were correct. Review of Resident #3's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry for atorvastatin 40mg daily with a scheduled administration time of 8:00am.	D 358		

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D 358	Continued From page 93 -There was documentation atorvastatin 40mg was administered on 09/18/24 at 8:00am. Observation of medication on hand for Resident #3 on 09/18/24 at 8:00am revealed: -There was a bubble pack of atorvastatin 40mg on the medication cart and available for administration with a hand-written entry of "8PM" on the top of the bubble pack. -There were 30 atorvastatin 40mg tablets, dispensed on 09/02/24 and there were 20 remaining and available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -Resident #3 had an order for atorvastatin 40mg daily. -The pharmacy dispensed 30 tablets on 08/06/24 and 09/02/24. -Atorvastatin was scheduled for 8:00am because that was the time the previous pharmacy had it scheduled. Interview with the MA on 09/18/24 at 7:55am revealed: -There was a bubble pack of atorvastatin 40mg on the medication cart. -She did not administer atorvastatin 40mg to Resident #3 this morning because it had 8PM written on the bubble pack. -Resident #3 should receive his atorvastatin at night. -She did not realize atorvastatin was scheduled for 8:00am on the MAR. -She administered medications to Resident #3 based on the times that were handwritten on the bubble packs. -She administered medications to the residents 5 to 7 days a week.	D 358		

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-She knew what medications each resident was ordered without looking at the MAR.
-The Manager would handwrite the time the medication was due on the bubble pack of each medication.
-If the medication was to be given in the morning she would handwrite "8AM or 9AM".
-If the medication was to be administered in the evening she would handwrite "8PM or 9PM".
-She administered medications based on what was written on the bubble pack.

Interview with the Manager on 09/18/24 at 3:11pm revealed:
-When the cycle-filled medications arrived, she would write the time the medications were scheduled to be administered on each bubble pack.
-Most medications were administered at "8:00am/9:00am" or "8:00pm/9:00pm".
-This was to help the MAs identify the medications to be administered.
-Medications should be administered by referring to the MAR, not the time entered on the bubble pack.

Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

Refer to the interview with the Manager on 09/18/24 at 3:11pm.

Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.

c. Review of Resident #5's current FL-2 dated

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D 358	Continued From page 95 09/21/23 revealed diagnoses included schizophrenia, hypertension and chronic obstructive pulmonary disease (COPD). 1. Review of Resident #5's signed physician orders dated 01/17/24 revealed there was an order for aspirin 81mg (used as a blood thinner) daily. Observation during the morning medication pass on 09/18/24 at 8:15am revealed: -The medication aide (MA) opened the drawer of the medication cart and removed 8 bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup. -The MA administered the 9 tablets to Resident #4. -Aspirin 81 mg was not one of the 9 tablets administered to Resident #4. Review of Resident #5's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 9:00am. -There was documentation aspirin was administered from 09/01/24 to 09/17/24 at 9:00am. -There was no documentation aspirin 81mg was administered on 09/18/24 at 9:00am. Observation of medication on hand for Resident #5 on 09/18/24 at 8:30am revealed: -There was a bubble pack with 24 of 30 aspirin 81mg tablets available for administration. -The bubble pack had a handwritten entry of "9PM" at the top of the bubble pack. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed:	D 358		

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D 358	Continued From page 96 -The pharmacy had an order for aspirin 81mg daily. -The pharmacy dispensed 31 tablets on 08/06/24 and 28 tablets on 09/10/24. -The aspirin was scheduled at 9:00am to keep the time consistent with scheduling as the previous pharmacy. Telephone interview with Resident #5's Primary Care Provider (PCP) on 09/19/24 at 1:30pm revealed: -Resident #5 had been on aspirin for a long time for heart health. -She was not concerned that Resident #5 received his aspirin in the evening instead of the morning. Interview with Resident #5 on 09/19/24 at 7:55am revealed: -He thought he took and aspirin every day. -He was not sure if he took it in the morning or at night. Interview with the MA on 09/18/24 at 8:30am revealed: -There was a bubble pack of aspirin 81mg on the medication cart. -She did not administer aspirin 81mg to Resident #4 this morning because "9PM" was handwritten on the bubble pack. -Resident #5 would receive his aspirin 81mg tonight. -She did not realize aspirin was scheduled for 9:00am on the MAR. -She administered medications to Resident #5 based on the times that were handwritten on the bubble packs. Interview with the Manager on 09/18/24 at 3:11pm revealed:	D 358		

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-When the cycle-filled medications arrived, she would write the time the medications were scheduled to be administered on each bubble pack.
-Most medications were administered at 8:00am/9:00am or 8:00pm/9:00pm.
-This was to help the MAs identify the medications to be administered.
-Medications should be administered by referring to the MAR, not the time entered on the bubble pack.

2. Review of Resident #5's signed physician orders dated 01/17/24 revealed there was an order for amantadine (used to treat tremors)100mg twice daily.

Observation during the morning medication pass on 09/18/24 at 8:15am revealed:
-The MA opened the drawer of the medication cart and removed 9 bubble packs, one at a time, and popped one tablet from each bubble pack into a souffle cup.
-The MA administered 9 tablets to Resident #5.
-Amantadine 100mg was not one of the 9 tablets administered to Resident #5.

Review of Resident #5's September 2024 MAR from 09/01/24 to 09/18/24 revealed:
-There was an entry for amantadine 100mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation amantadine 100mg was administered twice daily from 09/01/24 to 09/17/24.
-There was no documentation amantadine 100mg was administered on 09/18/24 at 9:00am.

Observation of medication on hand for Resident #5 on 09/18/24 at 8:30am revealed there was no

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D 358	Continued From page 98 amantadine 100mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -The pharmacy began working with the facility the last week of July 2024. -The facility faxed the signed physician orders to the pharmacy the last week of July for all the residents in the facility. -The pharmacy began servicing the facility with medications on 08/06/24. -Resident #5 had an order for amantadine 100mg twice daily. -The order was received the last week of July 2024 with no refills. -The pharmacy had reached out 7 times to the facility and the primary care provider (PCP) for a new prescription to continue with the medication, but the pharmacy had not received a response. -The cycle-filled medications were sent on 09/02/24, but amantadine was not sent because the pharmacy did not have an order for refills. -The facility had not notified the pharmacy as to why the medication was not available for administration. Telephone interview with Resident #5's Mental Health Provider (MHP) on 09/19/24 at 2:40pm revealed: -Amantadine was ordered to help control tremors due to other medications Resident #5 was administered. -Resident #5's tremors could get worse if he was not administered the medications as ordered. -She had not been notified that a refill for amantadine 100mg was needed for Resident #5. Observation of Resident #5 on 09/18/24 at 8:15am revealed Resident #5 had fine tremors of	D 358		

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D 358	Continued From page 99 both hands. Interview with Resident #5 on 09/19/24 at 7:55am revealed: -He took a medication for his tremors in his hands. -His hands shook most of the day. -He thought his medication was administered to him each morning. Interview with the MA on 09/18/24 at 8:30am revealed: -She did not administer amantadine 100mg to Resident #5 because there was no amantadine on the medication cart. -She did not know if amantadine had been re-ordered or not. -She did not re-order amantadine. -She did not tell the Manager there was no amantadine on the medication cart for administration. 3. Review of Resident #5's signed physician orders dated 01/17/24 revealed there was an order for ipratropium bromide/albuterol 0.5-3mg/3ml (used to treat shortness of breath) by nebulizer three times daily. Observation during the morning medication pass on 09/18/24 at 8:15am revealed ipratropium bromide/albuterol 0.5mg-3mg/3ml by nebulizer was not administered. Review of Resident #5's September 2024 MAR from 09/01/24 to 09/18/24 revealed: -There was an entry for ipratropium bromide/albuterol 0.5-3mg/3ml by nebulizer three times daily with a scheduled administration times of 9:00am, 3:00pm, and 9:00pm. -There was documentation ipratropium	D 358		

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bromide/albuterol 0.5-3mg/3ml was administered three times daily from 09/01/24 to 09/17/24.
-There was no documentation ipratropium bromide/albuterol 0.5-3mg/3ml by nebulizer was administered on 09/18/24 at 9:00am.

Observation of medication on hand for Resident #5 on 09/18/24 at 8:30am revealed there was no ipratropium bromide/albuterol 0.5mg-3mg/3ml ampules available for administration through the nebulizer.

Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed:
-The pharmacy received an order for ipratropium bromide/albuterol 0.5mg-3mg/3ml by nebulizer three times daily the last week of July 2024.
-The ipratropium bromide/albuterol 0.5mg-3mg/3ml was not a cycle-filled medication.
-The facility would have to notify the pharmacy when the medication was needed.
-The facility had not notified the pharmacy that Resident #5 needed the medication.
-The pharmacy had not dispensed the medication since the pharmacy had acquired this facility the last week of July 2024.
-There was a possibility Resident #5 had ampules of medication on hand from the previous pharmacy.

Telephone interview with Resident #5's PCP on 09/19/24 at 1:30pm revealed:
-She did not realize the nebulizer treatments were still scheduled.
-She thought she had written an order to change to as needed.
-She was not concerned that Resident #5 was not receiving scheduled nebulizer treatments.
-Scheduled nebulizer treatments were not

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necessary unless Resident #5 was having an acute flare-up of symptoms related to COPD or a cold.

Interview with Resident #5 on 09/19/24 at 7:55am revealed:
-He received nebulizer treatments twice daily.
-He used to keep vials of medication in his drawer.
-He did not have any medication now and had not received a nebulizer treatment in a month.
-He did not have any problems with shortness of breath.

Interview with the MA on 09/18/24 at 8:30am revealed:
-She did not administer ipratropium bromide/albuterol 0.5mg-3mg/3ml by nebulizer to Resident #5.
-She thought Resident #5's nebulizer treatments had been discontinued.
-She did not realize the nebulizer treatment was on the MAR to be administered.
-There was no ipratropium bromide/albuterol 0.5mg-3mg/3ml ampules available on the cart to administer.
-She did not tell the Manager there was no ipratropium bromide/albuterol 0.5mg-3mg/3ml ampules on the medication cart for administration.

4. Review of Resident #5's signed physician orders dated 01/17/24 revealed there was an order for polyethylene glycol 17gms (used to treat constipation) in 8-ounces of water daily.

Observation during the morning medication pass on 09/18/24 at 8:15am revealed polyethylene glycol 17gms was not administered.

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Review of Resident #5's September 2024 MAR from 09/01/24 to 09/18/24 revealed:
-There was an entry for polyethylene glycol 17gms daily with a scheduled administration time of 9:00am.
-There was documentation polyethylene glycol 17gms was administered daily from 09/01/24 to 09/17/24 at 9:00am.
-There was no documentation polyethylene glycol was administered on 09/18/24 at 9:00am.

Observation of medication on hand for Resident #4 on 09/18/24 at 8:30am revealed there was no polyethylene glycol available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed:
-The pharmacy received an order for polyethylene glycol 17gms daily the last week of July 2024.
-The polyethylene glycol 17gms daily was not a cycle-filled medication.
-The facility would have to notify the pharmacy when the medication was needed.
-The facility had not notified the pharmacy that Resident #5 needed the medication.
-The pharmacy had not dispensed the medication since the pharmacy had acquired this facility the last week of July 2024.
-There was a possibility Resident #5 had a bottle of medication on hand from the previous pharmacy.

Telephone interview with Resident #5's PCP on 09/19/24 at 1:30pm revealed:
-Resident #1 was ordered polyethylene glycol daily for constipation.
-She was not concerned if Resident #5 missed one day during the medication pass.
-If Resident #5 had missed several doses of

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polyethylene then there was concern Resident #5 would have problems with constipation.
-She had not been contacted by the facility staff that Resident #5 was having problems with constipation.
-She expected the medication orders to be implemented as written.

Interview with Resident #5 on 09/19/24 at 7:55am revealed:
-He did not take a medication for constipation.
-He did not drink any medication; he only took his inhaler and pills.
-He denied problems with constipation.

Interview with the MA on 09/18/24 at 8:30am revealed:
-She did not administer polyethylene glycol to Resident #5 this morning because there was no polyethylene glycol on the medication cart.
-She did not know if polyethylene glycol had been re-ordered or not.
-She did not re-order polyethylene glycol today.
-She did not tell the Manager there was no polyethylene glycol on the medication cart for administration.

5. Review of Resident #5's signed physician orders dated 09/10/24 revealed there was an order for fluticasone propionate 120 metered nasal spray (used to treat symptoms of seasonal allergies) into each nostril daily.

Observation during the morning medication pass on 09/18/24 at 8:15am revealed fluticasone propionate 120 metered nasal spray was not administered on 09/18/24 at 8:00am.

Review of Resident #5's September MAR 2024 from 09/12/24 to 09/18/24 revealed:

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D 358	Continued From page 104 -There was an entry for fluticasone propionate nasal spray into each nostril daily with a scheduled administration time of 9:00am. -There was documentation fluticasone propionate nasal spray was administered daily from 09/12/24 to 09/17/24. -There was no documentation fluticasone propionate nasal spray as administered on 09/18/24 at 9:00am. Observation of medication on hand for Resident #5 on 09/18/24 at 8:30am revealed there was no fluticasone propionate nasal spray available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed: -The pharmacy received an order for fluticasone propionate nasal spray into each nostril daily the last week of July 2024. -The fluticasone propionate nasal spray was not a cycle-filled medication -The facility would have to notify the pharmacy when the medication was needed. -The facility had not notified the pharmacy that Resident #5 needed the medication. -The pharmacy had not dispensed the medication since the pharmacy had acquired this facility the last week of July 2024. -There was a possibility Resident #5 had a bottle of nasal spray on hand from the previous pharmacy. Telephone interview with Resident #5's PCP on 09/19/24 at 1:30pm revealed: -Resident #5 complained of sneezing, watery and itchy eyes, and a runny nose due to seasonal allergies. -She ordered fluticasone nasal spray for Resident	D 358		

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D 358	Continued From page 105 #5 to the symptoms of seasonal allergies he was experiencing. -She expected the nasal spray to be administered as ordered. Interview with Resident #5 on 09/19/24 at 7:55am revealed: -He was not administered a nasal spray. -He had seasonal allergies. -He had complained of a runny nose and itchy eyes to the MA. -He would like to have a medication for his allergies. Interview with the MA on 09/18/24 at 8:30am revealed: -She did not administer fluticasone propionate nasal spray to Resident #5 this morning because there was no fluticasone propionate nasal spray on the medication cart. -She did not know if fluticasone propionate nasal spray had been re-ordered or not. -She did not re-order fluticasone propionate nasal spray today. -She did not tell the Manager there was no fluticasone propionate nasal spray the medication cart for administration. _____ Interview with the Manager on 09/18/24 at 3:11pm revealed: -The MA should notify the Manager if a medication was not available for administration. -She would notify the pharmacy the medication was needed for administration. Refer to the interview with the Supervisor on 09/18/24 at 2:30pm. Refer to the interview with the Manager on 09/18/24 at 3:11pm.	D 358		

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D 358	Continued From page 106 Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. 2. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed: -Diagnoses included sepsis and gangrene of the left 5th toe. -The resident had a left fifth toe amputation. -The resident's toe was positive for acute osteomyelitis. Review of Resident #2's hospital discharge summary dated 09/06/24 revealed the resident was re-admitted to the hospital for osteomyelitis and left foot infection. a. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for levofloxacin (used to treat bacterial infections) 750mg daily (there was no end date). Review of Resident #2's hospital discharge summary dated 08/08/24 revealed an order for levofloxacin 750mg, one tablet daily, for 7 days. Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed: -There was no entry for levofloxacin 750mg daily. -There was no documentation levofloxacin was administered. Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was no levofloxacin 750mg available to be administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at	D 358		

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D 358	Continued From page 107 2:12pm revealed a 7-day supply of levofloxacin 750mg with the instructions to administer one tablet daily was dispensed on 08/08/24. Interview with a medication aide (MA) on 09/18/24 at 2:28pm revealed she did not recall if she administered Resident #2's levofloxacin or not. Interview with the Manager on 09/18/24 at 2:48pm revealed: -She did not recall seeing Resident #2's levofloxacin 750mg order. -She did not recall any MA telling her Resident #2's levofloxacin 750mg was not entered on the MAR. b. Review of Resident #2's podiatrist after-visit summary dated 08/20/24 revealed: -Resident #2 had status post amputation of the fifth toe, left foot, two weeks ago. -Mild erythema, warmth, and edema were noted surrounding the wound. -Resident #2 reported he was not taking antibiotics. -Resident #2 was ordered Cefuroxime (an antibiotic used to treat bacterial infections). -A prescription for Cefuroxime 500mg, one tablet twice daily to be taken only if the resident was not taking another antibiotic, was sent to a [named] pharmacy. Review of Resident #2's August 2024 MAR for 08/09/2024-08/31/24 revealed: -There was no entry for Cefuroxime 500mg twice daily. -There was no documentation Cefuroxime was administered twice daily. Observation of Resident #2's medications on	D 358		

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hand on 09/17/24 at 11:05am revealed no Cefuroxime 500mg available to be administered.

Telephone interview with a pharmacy technician at the [named] pharmacy on 09/18/24 at 4:30pm revealed
Resident #2's order for Cefuroxime 500mg twice daily was not received at the pharmacy and was not dispensed.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/24 at 4:45pm revealed:
-Resident #2's order for Cefuroxime 500mg twice daily was not received at the pharmacy.
-Cefuroxime was an antibiotic and if the medication was not administered as ordered the resident could have an ongoing infection.

Interview with a MA on 09/18/24 at 2:28pm revealed she did not recall if she had or had not administered Resident #2's Cefuroxime.

Interview with the Manager on 09/18/24 at 8:34am revealed:
-Resident #2 had gone to see a podiatrist after his toe was amputated and the podiatrist was not pleased with what she saw and told the resident to have a follow-up appointment with his surgeon.
-The podiatrist started Resident #2 on antibiotics for an infection.

Second interview with the Manager on 09/18/24 at 2:48pm revealed she did not recall any of the MAs telling her Resident #2's Cefuroxime was not entered on the MAR.

Interview with the Manager on 09/19/24 at 11:07am revealed:
-Resident #2's Licensed Counselor took the

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resident to the appointment with his podiatrist.
-When Resident #2 returned to the facility, the Licensed Counselor reported the antibiotic was at a [named] pharmacy.
-She called the [named] pharmacy and requested the order be transferred to the facility's contracted pharmacy.

Telephone interview with Resident #2's Licensed Counselor on 09/18/24 at 4:58pm revealed:
-She took Resident #2 to his podiatry appointment.
-The podiatrist was concerned about Resident #2's foot; the podiatrist said the resident's toe was very infected.
-The podiatrist ordered an antibiotic for Resident #2.
-She told the Manager when Resident #2 returned to the facility a prescription had been called into a local [named] pharmacy.
-The Manager told her Resident #2 did not use the [named] pharmacy and that she would handle it.

Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed:
-When Resident #2 was seen by the podiatrist on 08/20/24, the resident's incision site looked infected.
-Resident #2 reported that he had not been taking antibiotics.
-The podiatrist ordered antibiotics for Resident #2.
-If Resident #2 had been administered the antibiotics as ordered on 08/20/24, the resident's hospitalization on 09/04/24 could have possibly been avoided.

_____
Interview with a MA on 09/18/24 at 11:13am revealed:

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D 358	Continued From page 110 -When she administered medications, she matched the medication on the medication cart, with the MARs. -If a medication was in the medication cart, but was not entered on the MARs she would talk to the Manager. -She documented medications she administered on the MAR. -If a medication was not documented, the medication may have not been given but may have just missed documenting the medication. -She may have matched the MAR and the medication in the cart, administered the medication, and then forgot to document it. -If Resident #2 had any antibiotics the resident took "every last dose of them." -If Resident #2's antibiotics were on the medication cart, she administered the antibiotic. -She did not remember what medications Resident #2 "had and did not have" but she could look at the MAR to know what was administered. Interview with a second MA on 09/18/24 at 2:28pm revealed: -The MAs were told verbally if there were any changes in a resident's medications by the Manager. -The Manager changed the MARs when there were new medications or discontinued medications. -She administered medications based on the MAR and medication available. -If the medication was in the medication cart, but not listed on the MAR, she would let the Manager know. -If a medication was listed on the MAR but not in the medication cart, she would let the Manager know. -If medication was not documented, the medication would be considered not given.	D 358		

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-She did not recall any antibiotics being in the medication cart but not on the MAR for Resident #2.

Interview with the Manager on 09/18/24 at 2:48pm revealed:
-When a resident was discharged from the hospital, she wrote the medication on the MAR and when the medication was delivered, she drew arrows on the MAR to indicate the start of the medication.
-If Resident #2 had had any other antibiotics, the antibiotic would have been written on the MAR.
-She must have missed entering the other antibiotics on Resident #2's MAR.

Telephone interview with Resident #2's hospitalist on 09/18/24 at 11:30am revealed:
-Resident #2 had an infection and antibiotics were ordered.
-He had consulted with Resident #2's surgeon on what antibiotics were needed.
-If Resident #2 did not take the antibiotics as ordered, he could potentially have a worsening of the infection.

Interview with Resident #2's surgeon on 09/18/24 at 11:57am revealed:
-Resident #2's infection would not resolve if the antibiotics were not administered as ordered.
-Resident #2 could lose his left foot if the infection was not resolved and the wound healed.

Telephone interview with Resident #2's primary care provider (PCP) on 09/19/24 at 9:22am revealed:
-She did not know if Resident #2 had been administered his antibiotics or not.
-If the antibiotics were not documented as administered it was the same as the medication

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not being administered.
-She had questioned the staff at the facility if Resident #2 was being administered his antibiotics and was told he was, but the resident ended up getting an infection and was hospitalized (09/04/24).

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed:
-He expected Resident #2 to have been administered his antibiotics as ordered.
-If Resident #2 had received the antibiotics as ordered, the infection could have cleared up and kept the infection from reoccurring.

c. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for Oxycodone (used to treat severe pain) 5mg every six hours as needed (PRN) for pain.

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed an order for Oxycodone Immediate Release 5mg every 6 hours as needed for pain, for a quantity of 7 tablets.

Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed:
-There was no entry for Oxycodone 5mg every six hours as needed for pain.
-There was no documentation that Oxycodone 5mg was administered.

Review of Resident #2's controlled substance count sheets (CSCS) revealed there was no CSCS for the Oxycodone Immediate Release 5mg every 6 hours as needed for pain, quantity 7 tablets.

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D 358	Continued From page 113 Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was no punch card for Oxycodone 5mg with the directions to administer every 6 hours as needed. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed that 7 tablets of Oxycodone 5mg were dispensed on 08/08/24 with the directions to administer one tablet every 6 hours as needed. Review of Resident #2's electronic prescription dated 09/10/24, revealed an order for Oxycodone 5mg, take one-half tablet every 8 hours for fourteen days. Review of Resident #2's September 2024 medication administration record (MAR) for 09/10/2024-09/17/24 revealed: -There was no entry for Oxycodone 5mg take one-half tablet every 8 hours. -There was no documentation that Oxycodone 2.5mg was administered. Review of Resident #2's controlled substance count sheets (CSCS) revealed there was no CSCS for the Oxycodone 5mg take one-half tablet every eight hours for 14 days. Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was no punch card for Oxycodone 5mg with the directions to take one-half tablet every eight hours for 14 days. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed 21 whole tablets of Oxycodone 5mg were split to equal 42 one-half tablets were	D 358		

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D 358	Continued From page 114 dispensed on 09/10/24 with the directions to take one-half tablet every eight hours for 14 days. _____ Interview with a MA on 09/18/24 at 2:28pm revealed: -Resident #2 complained of his foot hurting "all day, every day." -Resident #2 complained of his foot hurting, today, 09/18/24. -She had not administered Resident #2's Oxycodone today, 09/18/24, because the medication was PRN and the resident did not ask for the pain medication. -Resident #2 did not have any scheduled Oxycodone, just PRN. Interview with the Manager on 09/18/24 at 2:48pm and 3:43pm revealed: -Based on the order, Resident #2 should be administered Oxycodone every 8 hours, 7:00am, 3:00pm, and 11:00pm. -She did not know why she had not entered the order on Resident #2's MAR. -She was not aware Resident #2 had complained of pain in his toe; he had not complained to her. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/24 at 4:45pm revealed Resident #2 did not have any controlled medication that had been returned to the pharmacy. Telephone interview with the Administrator on 09/19/24 at 11:24am revealed Resident #2's Oxycodone should have been administered as ordered. Interview with Resident #2 on 09/17/24 at 1:56pm revealed: -His toe was hurting right now.	D 358		

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D 358	Continued From page 115 -He did not have a pain pill today, 09/17/24. -His toe hurt every day. Interview with Resident #2 on 09/18/24 at 5:25pm revealed his toe had been painful all day. Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2 reported he had not been taking pain medication during his office visit on 08/20/24. Telephone interview with Resident #2's Licensed Counselor on 09/18/24 at 4:58pm revealed every time she completed an assessment on Resident #2 the resident complained of pain, "every single time." Telephone interview with Resident #2's Licensed Counselor on 09/19/24 at 3:36pm revealed: -She saw Resident #2 on 08/09/24 and he complained of excruciating pain; he had tears in his eyes. -Her co-worker saw Resident #2 on 08/11/24 and documented the resident complained of foot pain. -On 08/12/24, 08/13/24, and 08/14/24, Resident #2 complained of pain. -On 08/19/24, 08/20/24, 08/21/24, and 08/22/24, Resident #2 complained of pain. -On 08/26/24, Resident #2 complained of pain. -On 08/27/24, she saw Resident #2's PCP, and the PCP was concerned Resident #2's toe was more infected than she had seen it before. -Resident #2 complained of pain to the PCP and the PCP ordered pain medication. -Every time she asked the MAs about pain medication for Resident #2, she was told the resident had been administered pain medication. -Resident #2 told her he was not getting pain medication. -Resident #2 gave the same answers every time	D 358		

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she asked him about his pain, "he was hurting and was not administered pain medication."

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-She ordered Resident #2's Oxycodone to be administered as a scheduled medication instead of PRN on 09/10/24 because she wanted to make sure the resident received the medication.
-Every time she saw Resident #2, he complained of a lot of pain.
-She was angry that Resident #2 had not received the pain medication as ordered.
-Her fear when she wrote the order for a narcotic was the resident may not get the medication.
-When she would ask the MA if Resident #2 had received his pain medication, the MA always told her Resident #2 had not complained of pain.
-Resident #2 did not deserve to be in pain; he had a terrible wound.
-"Human suffering from pain would prevent the healing of wounds."

d. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed there was no order for Amlodipine (used to treat high blood pressure) 10mg once daily.

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed an order to stop Resident #2's Amlodipine 10mg.

Review of Resident #2's primary care provider's (PCP) order dated 08/13/24 revealed an order to stop Amlodipine.

Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed:
-There was an entry for Amlodipine 5mg once

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daily with a scheduled administration time of 9:00am.
-There was documentation that Amlodipine 5mg was administered daily from 08/09/24-08/27/24.
-There was documentation that Amlodipine 5mg was discontinued on 08/27/24.

Review of Resident #2's September 2024 MAR for 09/01/2024-09/17/24 revealed:
-There was an entry for Amlodipine 5mg once daily with a scheduled administration time of 9:00am.
-There was documentation that Amlodipine 5mg was administered daily from 09/01/24-09/17/24.

Review of Resident #2's BP readings revealed:
-Resident #2's BP reading was documented as 125/92 on 07/01/24 and 129/86 on 07/15/24.
-Resident #2's BP reading was documented as 128/85 on 08/01/2; there were no other BPs documented in August 2024.
-There was a BP reading of 118/88 documented on a piece of notebook paper with Resident #2's name, the paper was not dated.
-There were no other BP readings documented for Resident #2 for September 2024.

Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed a punch card for Amlodipine 5mg dispensed on 09/02/24 for 30 tablets; 10 tablets had been punched from the card.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/24 at 4:45pm revealed:
-Resident #2's current order for Amlodipine was received on 07/30/24 to stop the Amlodipine 10mg once daily and start Amlodipine 5mg once daily.

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-A thirty-day supply of Amlodipine 5mg was dispensed on 07/30/24 and on 09/02/24.
-The pharmacy had not received an order to discontinue Resident #2's Amlodipine.
-Amlodipine was used to lower blood pressure.
-If Resident #2 did not need the medication and it was administered, the resident could experience low blood pressure, which could lead to falls.

Interview with Resident #2 on 09/17/24 at 1:56pm revealed:
-Staff checked his blood pressure today, 09/17/24, and the reading was 118/88.
-He had times he felt dizzy.
-He could be standing or even sitting down and get dizzy.
-He had a dizzy spell, "not too long ago."
-Staff usually checked his BP once a month.

Interview with the Manager on 09/18/24 at 2:48pm revealed:
-When Resident #2's order to discontinue the Amlodipine was received, she pulled the medication from the medication cart and returned the medication to the pharmacy.
-She did not send the pharmacy a copy of the order to stop Resident #2's Amlodipine.
-She did not know how she missed marking out Amlodipine on the September 2024 MAR since the medication had been discontinued.
-If Resident #2's Amlodipine was still on the medication cart, it was her oversight.
-She was concerned Resident #2 had been administered Amlodipine after the medication had been discontinued because the resident was administered other BP medications, and his BP could have "bottomed out."

Telephone interview with the hospitalist on 09/18/24 at 11:30am revealed:

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-He had discontinued Resident #2's Amlodipine because the resident's BP was adequate, and the resident was on three additional BP medications.
-If Resident #2 continued to be administered the Amlodipine, the resident could pass out from his BP dropping, experience dizziness, and be tired.
-He would have expected Resident #2's Amlodipine to not be administered until the resident had a follow-up appointment with the PCP.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-Resident #2 had some low BP readings and did not need the Amlodipine.
-Resident #2 was symptomatic and had orthostatic hypotension as evidenced by complaints of lightheadedness.
-Her concern was the medication could be making the resident's BP too low and he could have a fall.

e. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for Gabapentin (used to treat seizures or nerve pain) 400mg three times daily (TID).

Review of Resident #2's hospital discharge summary dated 09/06/24 revealed Gabapentin 400mg was changed to Gabapentin 100mg, dose 300mg, TID.

Review of Resident #2's September 2024 medication administration record (MAR) for 09/01/2024-09/17/24 revealed:
-There was an entry for Gabapentin 100 mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation that Gabapentin 100mg was administered at 8:00am from

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09/01/24-09/17/24.
-There was documentation that Gabapentin 100mg was administered at 2:00pm from 09/01/24-09/12/24 and on 09/16/24.
-There was documentation that Gabapentin 100mg was administered at 8:00pm from 09/01/24-09/16/24.

Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed no Gabapentin 100mg or Gabapentin 300mg was available to be administered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed:
-Resident #2 had an order for Gabapentin 400mg three times daily dated 08/28/24, but the order was only for a three-day supply.
-Nine capsules of Gabapentin 400mg were dispensed on 08/08/24.
-There was no order for Gabapentin 300mg for Resident #2.
-Gabapentin 300mg nor Gabapentin 100mg had been dispensed for Resident #2.

Interview with Resident #2 on 09/19/24 at 8:11am revealed:
-He was supposed to get Gabapentin three times a day for pain.
-He thought staff had administered Gabapentin on 09/18/24, but he did not know what tablets he was administered.

Interview with a MA on 09/18/24 at 2:28pm revealed:
-She documented she gave Resident #2's Gabapentin 100mg because she thought she had administered the medication.
-She did not administer the Gabapentin 100mg

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today, 09/18/24, at 2:00pm, because the medication was not in the medication cart.
-She was not paying attention close enough when she documented administering medication.

Interview with the Manager on 09/18/24 at 2:48pm revealed:
-Resident #2's Gabapentin was changed on his last hospital admission.
-The order was sent to the facility when Resident #2 returned from the hospital.
-She wrote the Gabapentin on Resident #2's MAR.
-She thought the order was for Gabapentin 100mg.
-She thought Resident #2's Gabapentin was delivered.
-She was concerned Resident #2's Gabapentin was not administered as ordered.
-If a medication was not in the facility, the MAs should have called the pharmacy and let her know.
-She did not recall the MAs telling her Resident #2's Gabapentin was not delivered.

Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed:
-She did not know why Resident #2 was ordered Gabapentin; the resident was taking the medication when she began seeing the resident.
-She agreed with the hospitalist on a gradual reduction of the dose of Gabapentin.
-Gabapentin needed to be tapered so the resident could be monitored for any changes such as mild seizure or resurgence of pain.

Telephone interview with the Administrator on 09/19/24 at 10:21am revealed:
-Resident #2's Gabapentin had been ordered for a reason.

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D 358	Continued From page 122 -He was concerned Resident #2's Gabapentin had not been administered as ordered. Refer to the interview with the Supervisor on 09/18/24 at 2:30pm. Refer to the interview with the Manager on 09/18/24 at 3:11pm. Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. 3. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included diabetes, cerebrovascular accident, coronary artery disease, and hyperlipidemia. a. Review of Resident #1's discharge summary dated 08/20/24 revealed there was an order to increase amlodipine to 10mg (used to treat elevated blood pressure) daily. Review of Resident #1's August 2024 medication administration record (MAR) from 08/23/24 to 08/31/24 revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was no documentation amlodipine was administered daily from 08/03/24 to 08/31/24 at 8:00am. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am. -There was documentation amlodipine was administered from 09/01/24 to 09/17/24 at 8:00am. Observation of medication on hand for Resident	D 358		

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D 358	Continued From page 123 #1 on 09/17/24 at 12:02pm revealed there was no amlodipine 10mg available for administration. Observation of Resident #1's blood pressure (BP) check on 09/17/24 at 1:55pm revealed Resident #1's BP reading was 157/97. Review of Resident #1's progress notes dated from 08/13/24 to 09/03/24 revealed: -On 08/01/24, there was a blood pressure reading of 188/108. -On 08/06/24, there was a blood pressure reading of 150/92. -On 08/08/24, there was a blood pressure reading of 150/92. -On 08/13/24, there was a blood pressure reading of 123/74. -On 09/03/24, there was a blood pressure reading of 132/78. Telephone interview with a representative from the facility's contracted pharmacy on 09/17/24 at 3:24pm revealed: -Resident #1 had an order to increase amlodipine from 7.5mg to 10mg dated 08/21/24. -The amlodipine order was received from the physician who discharged Resident #1 from the hospital, with no refills. -The pharmacy dispensed 17 amlodipine 10mg tablets on 08/22/24 which was enough tablets for daily administration until the cycle-fill was due. -The pharmacy had not dispensed anymore amlodipine 10mg because there was no refill on the original prescription. -No one from the facility had contacted the pharmacy regarding amlodipine 10mg. -The pharmacy faxed the prescribing physician regarding refill orders and the pharmacy did not receive a response from the physician. -The pharmacy notified the facility that a new	D 358		

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prescription was needed for amlodipine 10mg, and the pharmacy did not receive a response from the facility.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 09/19/24 at 12:33pm revealed:
-Resident #1 was ordered amlodipine for his blood pressure.
-She knew Resident #1 was in the hospital from 08/19/24 to 08/20/24; she requested the hospital discharge summary on 08/27/24.
-She did not receive the hospital discharge summary, and she did not know Resident #1's amlodipine had been increased to 10mg daily.
-She expected the MAs to administer medications as ordered until she was able to review the hospital discharge summary.
-Resident #1 could have a stroke or heart attack if his medication was not administered as ordered.

Interview with a medication aide (MA) on 09/17/24 at 1:53pm revealed:
-She administered amlodipine 10mg to Resident #1 each morning and documented on the MAR when she administered the medication.
-She compared the medications to the MAR when she was administering medications.
-She administered amlodipine 10mg to Resident #1 this am, 09/17/24.
-She did not realize there was no amlodipine 10mg on the medication cart.
-She thought she administered amlodipine 10mg this morning.
-She needed to be careful when administering medications and notify the Manager if a medication was not on the medication cart.

Interview with a second MA on 09/17/24 at

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D 358	Continued From page 125 2:25pm revealed: -She did not pass medications today, but she administered amlodipine 10mg to Resident #1 when she did pass medications. -She signed the MAR because she administered the medication. -She did not realize the pharmacy had not dispensed enough medication for Resident #1 to have amlodipine available to administer. -If the amlodipine was not on the medication cart, she did not administer the medication. -She did not compare medications to the MAR; she administered medications based on the handwritten times placed on the bubble packs by the Manager. Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -If a medication was not on the medication cart, the MAs should let the Director know. -The Manager was the only one who could contact the pharmacy. Interview with the Manager on 09/18/24 at 3:11pm revealed: -The MA should notify the Manager if the medication was not available for administration. -She would notify the pharmacy the medication was needed for administration. Telephone interview with the Administrator on 09/19/24 at 9:59am revealed: -The MAs should notify the Manager when a medication was not available for administration. -The Manager should audit the medication cart to ensure the medications were available for administration. -He was concerned that Resident #1's blood pressure may increase.	D 358		

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D 358	Continued From page 126 Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. b. Review of Resident #1's hospital discharge summary dated 08/20/24 revealed there was an order for Paxlovid 3mg (used to treat a virus) twice daily. Review of Resident #1' August 2024 MAR from 08/23/24 to 08/31/24 revealed: -There was an entry for Paxlovid 3mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was no documentation Paxlovid was administered twice daily from 08/23/24 to 08/31/24. Observation of medication on hand on 09/17/24 at 12:05pm revealed there were no Paxlovid 3mg available for administration. Telephone interview with a representative for the facility's contracted pharmacy on 09/17/24 at 3:24pm revealed: -The pharmacy received an order for Paxlovid 3mg 3 tablets twice daily for 5 days on 08/22/24. -The pharmacy dispensed 30 Paxlovid tablets on 08/22/24. Interview with the MA on 09/17/24 at 1:53pm revealed: -Resident #1 was ordered Paxlovid when he was discharged from the hospital on 08/20/24. -The pharmacy dispensed Paxlovid and she administered the medication to Resident #1 when she worked as the MA. -She did not realize she failed to document on the MAR that she administered Paxlovid to Resident #1. -It was an oversight that she did not document	D 358		

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D 358	Continued From page 127 the administration of Paxlovid. Interview with a second MA on 09/17/24 at 2:25pm revealed: -She was sure she administered Paxlovid to Resident #1. -If the medication was on the medication cart, then she administered the medication to Resident #1. -She did not pay attention to the documentation. -She thought she documented the administration of the Paxlovid. -She needed to look closely at the MAR to ensure she documented correctly. Interview with the Director on 09/19/24 at 4:00pm revealed: -The MAs should document on the MAR when a medication was administered. -The MARs should be accurate when the PCP wants to review the resident's medication. Interview with the Administrator on 09/19/24 at 9:59am revealed: The MA should administer medication as ordered and document correctly on the MAR for each medication so the MARs would be accurate for the PCP to review. c. Review of Resident #1's signed physician's order dated 02/21/24 revealed there was an order for Lantus 5 units (a long-acting insulin used to treat high blood sugars) every morning. Review of Resident #1's signed physician's order dated 06/04/24 revealed there was an order to increase Lantus to 7 units in the morning. Review of Resident #1's signed physician's order dated 07/02/24 revealed there was a second	D 358		

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order to increase Lantus to 7 units in the morning (the order was written last month, and it had not been added to the MAR).

Review of Resident #1's fingerstick blood sugar (FSBS) readings for July 2024 from 07/01/24 to 07/31/24 revealed Resident #1's FSBS readings ranged from 145 to 578.

Review of Resident #1's July 2024 electronic medication administration record (eMAR) from 07/01/24 to 07/31/24 revealed:
-There was an entry for Lantus 5 units every morning with a scheduled administration time of 8:00am.
-There was documentation Lantus 5 units was administered at 8:00am from 07/01/24 to 07/03/24.
-There was an entry for Lantus 7 units every morning with a scheduled administration time of 8:00am.
-There was documentation 7 units was administered at 8:00am from 07/04/24 to 07/31/24.

Review of Resident #1's signed physician's order dated 08/13/24 revealed there was an order to increase Lantus to 9 units in the morning.

Review of Resident #1's FSBS readings for August 2024 MAR revealed:
-Resident #1's FSBS readings ranged from 126 to 400 from 08/01/24 to 08/08/24.
-There were no FSBS readings documented from 08/09/24 to 08/31/24.

Review of Resident #1 August 2024 MAR from 08/01/24 to 08/31/24 revealed:
-There was an entry for Lantus 7 units every morning with a scheduled administration time of

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8:00am.
-There was documentation Lantus 7 units was administered at 8:00am on 08/01/24 to 08/02/24 and from 08/05/24 to 08/31/24.
-There was no documentation on 08/03/24 and 08/04/24 at 8:00am; the MAR was blank.
-There was no entry for Lantus 9 units every morning as ordered on 08/13/24
-There was no documentation Lantus 9 units was administered.

Review of Resident #1's signed physician order dated 09/03/23 revealed there was an order to increase Lantus to 10 units every morning and 43 units every evening.

Review of Resident #1's FSBS readings for September 2024 from 09/01/24 to 09/17/24 revealed there were no FSBS readings documented for review.

Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry for Lantus 9 units every morning with a scheduled administration time of 8:00am.
-There was documentation Lantus 9 units was administered from 09/01/24 to 09/17/24 at 8:00am
-There was no entry for Lantus 10 units every morning.
-There was no documentation Lantus 10 units was administered every morning.
-There was an entry for Lantus 40 units every evening with a scheduled administration time of 8:00pm.
-There was no documentation Lantus 40 units was administered from 09/01/24 to 09/17/24 at 8:00pm.
-There was no entry for Lantus 43 units at

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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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bedtime.
-There was no documentation Lantus 43 units were administered at bedtime.

Review of Resident #1's laboratory values dated 05/27/24 revealed a hemoglobin A1C (HgbA1C) value of 9.3. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%).

Review of Resident #1's Primary Care Provider's (PCP) visit note dated 06/04/24 revealed:
-Resident #1's HgbA1C was 9.3 on 05/27/24.
-She increased Lantus to 7 units every morning.

Review or Resident #1's triage note dated 07/30/24 revealed:
-Resident #1's blood sugar on 07/24/24 was 578.
-Resident #1 was given Novolog 9 units (a rapid-acting insulin to lower blood sugar)
-Continue to monitor HgbA1C monthly and increase insulin until HgbA1C is down to 8.0.

Review of Resident #1's laboratory values dated 08/05/24 revealed a HgbA1C value of 10.1.

Review of Resident #1's triage note dated 09/01/24 revealed:
-The on-call provider was notified of a blood sugar reading of 542.
-The facility received an order to administer Novolog insulin 12 units and re-check blood sugar in 30 minutes.

Review of Resident #1's record revealed there was no recheck blood sugar reading to review.

Telephone interview with a representative from the facility's contracted pharmacy on 09/18/24 at 9:19am revealed:

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D 358	Continued From page 131 -The pharmacy did not receive the order dated 06/04/24 to increase Lantus from 5 units to 7 units. -The pharmacy received the order dated 07/02/24 to increase Lantus from 5 units to 7 units. -The order dated 07/02/24 for Lantus 7 units was entered on the July 2024 eMAR. -The pharmacy did receive an order dated 08/13/24 to increase Lantus from 7 units to 9 units. -The staff was responsible for handwriting the order dated 08/13/24 to increase Lantus to 9 units on the MAR since they were using paper MARS as of 08/09/24. -The pharmacy entered the order to increase Lantus to 9 units and it would be printed on the September MARs. -The pharmacy received the order dated 09/03/24 to increase Lantus to 10 units in the morning and 43 units in the evening. -The staff were responsible for handwriting the order to increase Lantus to 10 units in the morning and 43 units in the evening on the September MAR since they had been printed and were being used by the facility. -The pharmacy entered the order for Lantus 10 units in the morning and Lantus 43 units in the evening and it would print on the October 2024 MARs. Review of Resident #1's PCP progress note dated 09/03/24 revealed: -Resident #1's type 2 diabetes was managed currently with Lantus 9 units in the morning and 40 units in the evening. -Resident #1 also used a sliding scale insulin. -Resident #1's HgbA1C dated 08/04/24 was 10.1 indicating poor glycemic control. -The order to increase Lantus from 7 units to 9 units was not entered on the MAR for August	D 358		

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2024 or September 2024.
-There was no blood sugar readings documented on the MAR for August 2024 or September 2024; monitor blood sugar readings closely.
-She would increase Lantus to 10 units every morning and 43 units every evening

Telephone interview with Resident #1's PCP on 09/19/24 at 12:33pm revealed:
-Resident #1 was a "brittle" diabetic and required frequent changes to his insulin orders.
-She ordered an increase of Lantus from 5 to 7 units in May of 2024 that was not entered on the MAR.
-She re-wrote the order again in July 2024.
-Resident #1's blood sugar readings and HgbA1C were high which was why she increased the insulin.
-On 08/13/24, she increased Lantus insulin to 9 units every morning because Resident #1's blood sugar readings remained elevated.
-This order was not added to the MAR until September 2024.
-On 09/03/24, Resident #1's Lantus was increased to 10 units in the morning and 43 units in the evening.
-She did not know the most recent order for Lantus had not been added to the September MAR for administration.
-She had a very difficult time adjusting Resident #1's insulin because she never knew if he was getting the ordered dose or not.
-She ordered the increase in insulin in small increments so the resident would not crash and have an extreme low blood sugar.

Interview with the Supervisor on 09/18/24 at 2:30pm revealed:
-The Manager was responsible for reviewing new orders and entering the new orders on the paper

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MARs.
-The Manager was responsible for faxing the new orders to the pharmacy.

Interview with the Manager on 09/18/24 at 3:11pm revealed:
-The PCP would call new medications orders into the pharmacy.
-She would document the new order on the MAR when the medication was in the facility.
-She was the only one who documented new orders on the MAR.
-She did not recall receiving the new orders to increase Lantus; if she had, she would have added them to the MAR.
-She reviewed the progress notes and triage report completed by the PCP.
-She did not notice the new orders to increase the Lantus insulin.
-It was an oversight; she needed to pay more attention to the reports and orders.

Telephone interview with the Administrator on 09/19/24 at 9:59am revealed:
-The Manager was responsible for entering new orders on the MARs.
-He expected new orders to be entered, and medication administered as ordered.
-The resident could have problems with elevated blood sugar levels.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

Refer to the interview with the Manager on 09/18/24 at 3:11pm.

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D 358	Continued From page 134 Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. _____ Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -The MAs should compare the medication to the MAR three times before administering the medication to ensure the medication was correct. -She assisted the Manager in auditing the medication carts. -She and the Manager would alternate completing the medication cart audits every other month. -The medication cart audits were completed monthly when the cycle-fill medications arrived and were placed on the medication cart. -She would compare the medications placed on the medication cart with the medications entered on the MAR. -She did not find problems with the medication cart audit but if she did, she would notify the Manager. Interview with the Manager on 09/18/24 at 3:11pm revealed: -The MAs were expected to administer medications as entered on the MARs. -The MAs should notify the Manager if a medication was not available for administration. -She did not know medications were not available for administration if she was not notified. -She did not observe the MAs administering medications. -When the cycle-filled medications arrived, she would place the time the medications were scheduled to be administered on each bubble pack. -Most medications were administered at 8:00am/9:00am or 8:00pm/9:00pm.	D 358		

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D 358	Continued From page 135 -This was to help the MAs identify the medications to be administered. -It was not to be used to administer the medications; the MAR was to be referenced to administer the medications. Telephone interview with the Administrator on 09/19/24 at 9:59am revealed: -He expected the MAs to administer medications as ordered. -He expected the Manager to oversee the medication administration by ensuring medications were available for administration. _____ The facility failed to administer medications as ordered to a resident who did not receive his an antibiotic as ordered, was seen by the podiatrist who was concerned the resident's toe was infected and ordered another antibiotic which was not administered and subsequently the resident was hospitalized for an infection. The resident was in pain daily because of the wound and was not administered scheduled pain medication (#2); a resident who had a diagnosis of diabetes and whose blood sugar readings were as high as 584 with a HgbA1C of 10.1. The insulin order had been changed monthly for 4 months without the order being placed on the medication administration record to be administered, a blood pressure medication had not been dispensed and the resident had a history of high blood pressure which could lead to a stroke or heart attack (#1); a resident was administered a double dose of a blood thinner who was at an increased risk of bleeding (#4); a resident who had seasonal allergies and was not receiving his medication and continued to suffer with a runny nose and itchy eyes (#5); This failure resulted in serious harm and neglect which constitutes a Type A1 Violation.	D 358		

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D 358	Continued From page 136 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/24. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 19, 2024.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff documented on the medication administration records (MAR) immediately following administration of medication for 2 of 3 sampled residents (# 3 and #4) and did not pre-chart administration of medications prior to the administration of the medication for 1 of 3 sampled residents (#5) during the 8:00am/9:00am medication pass. The findings are: 1. Observation during the 8:00am morning medication pass on 09/18/24 at 7:37am revealed: -The medication aide (MA) administered diltiazem	D 366		

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240mg (used to treat high blood pressure), Jardiance 10mg (used to improve blood sugar levels), vitamin D 25mcg (used as a supplement), Eliquis 5mg (used to thin blood), atorvastatin 40mg (used to lower cholesterol), metoprolol 100mg (used to lower blood pressure), tamsulosin 0.4mg (used to treat symptoms of and enlarged prostate), and gabapentin 100mg (used to treat nerve pain).
-The MA did not initial the medication administration record (MAR) immediately following the administration of medications to Resident #4.

2. Observation during the 8:00am morning medication pass on 09/18/24 at 7:49am revealed:
-The medication aide (MA) administered vitamin B1 100mg (used as a supplement), vitamin B6 50mg (used as a supplement), aspirin 81mg (used to thin blood), folic acid 1mg (used as a supplement), medroxyprogesterone (a hormone replacement), and levetiracetam (used to prevent seizures) to Resident #3.
-The MA did not initial the medication administration record (MAR) immediately following the administration of medications to Resident #3.

_____
Interview with the MA on 09/18/24 at 8:00am revealed:
-She administered medication to all the residents before she documented the administration of the medications.
-When she completed the morning medication pass, she would sign the resident's MARs.
-She would sign the medications she administered.
-If the medication was not on the medication cart and was not administered, she would not sign the resident's MAR for the missing medication.

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-She had administered medications to the resident 5 to 7 days a week and she knew the medications that each resident was ordered.
Interview with the Manager on 09/18/24 at 3:00pm revealed:
-Medications administered to the residents should be initialed on the MAR immediately after the medications were administered.
-When medications were signed off immediately after the medications were administered the MARs would be accurate.
-If the MA documented administration of medications after all the residents were administered their medications, there was the possibility the documentation would not be correct.
-The MA may sign the MAR as a medication was administered when the resident may have refused the medication, or the medication was not on-hand to administer.
-She expected the MAs to initial each MAR immediately after the administration of medications to a resident.

Interview with the Administrator on 09/19/24 at 9:59am revealed he expected the MA to document on the MARs immediately after the administration of medications.

3. Observation during the 9:00am morning medication pass on 09/18/24 at 8:15am revealed:
-The medication aide (MA) prepared acetaminophen 500mg (used to treat pain), magnesium oxide 400mg (used to treat heartburn), potassium chloride 10mg (used as a supplement), gabapentin 300mg (used to treat nerve pain), risperidone 1mg (used for mood), vitamin D3 25mg (used as a supplement), and a docusate sodium 100mg (a stool softener).
-The MA initialed the medication administration

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D 366	Continued From page 139 (MAR) record after popping each medication in the souffle cup, before administering the medication to Resident #5. Interview with the MA on 09/18/24 at 8:30am revealed: -She documented her initials on the MAR when she popped the pill into the souffle cup. -When she documented her initials on the MAR, she knew the medication was ready to be administered. -She documented on the MAR before she administered the medications. -If the resident refused a medication, she would circle her initials that she had documented. Interview with the Manager on 09/18/24 at 3:00pm revealed: -The MA should document the administration of the medication immediately after the medication was administered. -The MA should not document on the MAR before the medication was administered, in case the resident refused to take the medication. -If the resident refused to take the medication, the MAR would not be accurate. Interview with the Administrator on 09/19/24 at 9:59am revealed he expected the MA to document on the MARs immediately after the administration of medications.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	D 367		

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D 367	Continued From page 140 (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 3 of 5 sampled residents (#1, #2, and #5) including the administration of an anti-anxiety medication (#1), two antibiotics (#2), and a supplement (#5). The findings are: 1. Review of Resident #1's current FL-2 dated 02/21/24 revealed diagnoses included diabetes, cerebrovascular accident, coronary artery disease, and hyperlipidemia. Review of Resident #1's signed physician orders dated 07/31/24 revealed there was an order for trazodone 50mg (used to treat anxiety) at bedtime.	D 367		

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D 367	Continued From page 141 Review of Resident #1's hospital discharge summary dated 08/20/24 revealed there was an order to discontinue trazodone 50mg. Review of Resident #1's signed physician order dated 08/28/24 revealed there was an order for trazodone 50mg at bedtime. Review of Resident #1' August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry for trazodone 50mg at bedtime with a scheduled administration time of 8:00pm. -There was a handwritten entry to discontinue trazodone 50mg on 08/21/24. -There was no documentation trazodone was administered from 08/22/24 to 08/31/24. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed: -There was an entry for trazodone 50mg at bedtime with a schedule administration time of 8:00pm. -There was a handwritten entry to discontinue trazodone 50mg on 08/21/24. -There was no documentation trazodone was administered from 09/01/24 to 09/17/24. Observation of medications on hand on 09/17/24 at 12:05pm revealed there were 21 of 30 trazodone 50mg dispensed on 09/05/24. Telephone interview with a representative from the facility's contracted pharmacy on 0917/24 at 3:24pm revealed: -The pharmacy received an order on 08/28/24 for trazodone 50mg at bedtime. -The pharmacy dispensed 30 trazodone tablets on 09/02/24.	D 367		

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-Resident #1 had an order for trazodone 50mg but it was discontinued on 08/20/24 and was restarted on 08/28/24.

Interview with the medication aide (MA) on 09/17/24 at 1:53pm revealed:
-Resident #1's trazodone was discontinued when he returned from the hospital on 08/20/24.
-The pharmacy dispensed trazodone 50mg again in September 2024.
-When a medication was on the medication cart, she administered the medication.
-She had administered trazodone 50mg to Resident #1 since 09/05/24, since the medication was dispensed.
-She did not realize she did not sign the MAR that trazodone 50mg was administered to Resident #1.
-It was an oversight that she did not sign the MAR.

Interview with a second MA on 09/17/24 at 2:25pm revealed:
-She was sure she administered trazodone 50mg to Resident #1.
-If the medication was on the medication cart, then she administered the medication to Resident #1.
-She did not pay attention to the documentation.
-She thought she documented the administration of the trazodone.
-She needed to look closely at the MAR to ensure she documented correctly.

2. Review of Resident #5's current FL-2 dated 09/21/23 revealed diagnoses of schizophrenia, hypertension and chronic obstructive pulmonary disease (COPD).

Review of Resident #5's signed physician orders

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dated 01/17/24 revealed there was an order for vitamin D3 1000 units (used as a supplement) daily.

Review of Resident #5's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed:
-There was an entry for vitamin D3 1000 units (25mcg) daily with a scheduled administration time of 9:00am.
-There was documentation vitamin D3 was administered daily from 08/09/24 to 08/31/24.
-There was a second entry for vitamin D3 25mcg daily with a scheduled administration time of 9:00am.
-There was documentation vitamin D3 was administered daily from 08/09/24 to 08/31/24.

Review of Resident #5's September 2024 MAR from 09/01/24 to 09/18/24 revealed:
-There was an entry for vitamin D3 1000 units (25mcg) daily with a scheduled administration time of 9:00am.
-There was documentation vitamin D3 was administered daily from 09/01/24 to 09/18/24.
-There was a second entry for vitamin D3 25mcg daily with a scheduled administration time of 9:00am.
-There was documentation vitamin D3 was administered daily from 09/01/24 to 09/18/24.

Observation of medication on hand on 09/18/24 at 8:15am revealed there was a bubble pack of vitamin D3 25mcg dispensed on 09/02/24 with 19 of 30 tablets remaining.

Interview with the medication aide (MA) on 09/18/24 at 8:30am revealed:
-She administered one vitamin D3 to Resident #5.
-She did not realize there were two entries on the

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MAR for vitamin D3.
-She should not have documented on both entries for vitamin D3.
-It appeared she administered two vitamin D3 when she only administered one.
-One of the vitamin D3 entries needed to be removed from the MAR.

Interview with the Manager on 09/19/24 at 4:00pm revealed:
-She was responsible for reviewing the paper MARs at the end of each month.
-She did not notice vitamin D3 was entered on the MAR twice.
-She would have marked one of the entries out and called the pharmacy to remove the duplicate entry.
-The MAs had not mentioned to her there were two entries on the MAR for the same medication.
-The MARs should be accurate when the primary care provider (PCP) reviewed them.

Refer to the interview with the Manager on 09/19/24 at 4:00pm.

Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am and 11:24am.

3. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed diagnoses included sepsis and gangrene of the left 5th toe.

a. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for Metronidazole (used to treat infections) 500mg three times daily (there was no end date).

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed an order for

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D 367	Continued From page 145 Metronidazole 500mg three times daily, for 7 days. Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed: -There was a handwritten entry for Metronidazole 500mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There were arrows on the MAR indicating the date to start the medication as 08/09/24 and the date the medication was to be completed was 08/15/24. -There was documentation beside the arrow indicating the stop date, which read, completed 08/15/24. -There were no initials documented on the MAR from 08/09/24-08/15/24 to indicate the medication had been administered. -There was no other entry for the Metronidazole on the August 2024 MAR. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed twenty-one tablets of Metronidazole 500mg were dispensed on 08/08/24 for a 7-day supply. Interview with a medication aide (MA) on 09/18/24 at 2:28pm revealed she did not recall if she administered Resident #2's Metronidazole or not. Interview with the Manager on 09/18/24 at 2:48pm revealed: -Resident #2's Metronidazole was administered as ordered. -She recalled seeing the empty punch card for Resident #2's Metronidazole.	D 367		

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-If Resident #2's Metronidazole was not documented as administered on the MAR, it "did not happen."

b. Review of Resident #2's hospital discharge summary dated 09/06/24 revealed an order for Clindamycin (antibiotic) 300mg three times daily, for 7 days.

Review of Resident #2's September 2024 MAR for 09/01/2024-09/17/24 revealed:
-There was a handwritten entry for Clindamycin three times daily with a scheduled administration time of 7:00am, 3:00pm, and 11:00pm.
-There were arrows on the MAR indicating the date to start the medication as 09/06/24 for the 11:00pm dose.
-There was documentation Clindamycin was administered at 7:00am from 09/07/24-09/17/24; 11 doses were documented.
-There was documentation Clindamycin was administered at 3:00pm from 09/07/24-09/12/24 and on 09/16/24; 7 doses were documented.
-There was documentation Clindamycin was administered at 11:00pm from 09/06/24-09/16/24; 11 doses were documented.

Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed no Clindamycin was available to be administered.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed twenty-one tablets of Clindamycin 300mg were dispensed on 09/06/24 for a 7-day supply.

Interview with a MA on 09/18/24 at 2:28pm revealed she was not paying attention close enough when she documented administering

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D 367	Continued From page 147 medication. Refer to the interview with the Manager on 09/19/24 at 4:00pm. Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am and 11:24am. _____ Interview with the Manager on 09/19/24 at 4:00pm revealed: -The MAs should document on the MAR when a medication was administered. -The MARs should be accurate when the primary care provider (PCP) wants to review the resident's medication. Interview with the Administrator on 09/19/24 at 9:59am and 11:24am revealed: -The MAs should administer medications as ordered and document the administration. -The MA should document correctly on the MAR for each medication so the MARs would be accurate for the PCP to review.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: TYPE B VIOLATION	D 392		

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Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 2 of 2 sampled residents (#2, #6) related to a narcotic pain reliever (#2) and an anti-anxiety medication (#2, #6).

The findings are:

1. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed diagnoses included sepsis and gangrene of the left 5th toe.

a. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for Oxycodone (used to treat severe pain) 5mg every six hours as needed for pain.

Review of Resident #2's hospital discharge summary dated 08/08/24 revealed an order for Oxycodone Immediate Release 5mg every 6 hours as needed for pain, quantity 7 tablets.

Review of Resident #2's August 2024 medication administration record (MAR) for 08/09/2024-08/31/24 revealed:
-There was no entry for Oxycodone 5mg every six hours as needed for pain.
-There was no documentation that Oxycodone 5mg was administered from 08/09/2024-08/31/24.

Review of Resident #2's controlled substance count sheets (CSCS) revealed there was no CSCS for Oxycodone immediate release 5mg every 6 hours as needed for pain, for a quantity of 7 tablets.

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D 392	Continued From page 149 Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was no Oxycodone 5mg with the directions to administer every 6 hours as needed available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed: -Seven tablets of Oxycodone 5mg were dispensed on 08/08/24 with the directions to administer one tablet every 6 hours as needed. -When the pharmacy dispensed controlled drug medication, they sent the CSCS with the medication to be used for documentation by the MAs. Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation, 7 tablets of Oxycodone were unaccounted for. b. Review of Resident #2's electronic prescription dated 09/10/24 revealed an order for Oxycodone 5mg, take one-half tablet every 8 hours for fourteen days. Review of Resident #2's September 2024 MAR for 09/10/24-09/17/24 revealed: -There was no entry for Oxycodone 5mg take one-half tablet every 8 hours. -There was no documentation that Oxycodone 2.5mg was administered from 09/10/24-09/17/24. Review of Resident #2's CSCS revealed no CSCS for Oxycodone 5mg one-half tablet every eight hours for 14 days. Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed there was	D 392		

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D 392	Continued From page 150 no Oxycodone 5mg with the directions to take one-half tablet every eight hours for 14 days available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed 21 whole tablets of Oxycodone 5mg were split to equal 42 one-half tablets and were dispensed on 09/10/24 with the directions to take one-half tablet every eight hours for 14 days. Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation, 21 tablets of Oxycodone were unaccounted for. Interview with the Manager on 09/18/24 at 2:48pm revealed: -Based on the order, Resident #2 should be administered Oxycodone every 8 hours, 7:00am, 3:00pm, and 11:00pm. -She did not know why she had not entered the order on Resident #2's MAR. _____ Interview with a MA on 09/17/24 at 11:14am revealed there were no other CSCS for Resident #2. Interview with a second MA on 09/18/24 at 2:28pm revealed: -Resident #2 complained of his foot hurting "all day, every day." -Resident #2 complained of his foot hurting, today, 09/18/24. -She had not administered Resident #2 's Oxycodone today, 09/18/24, because the medication was PRN and the resident did not ask for the pain medication. -Resident #2 did not have any scheduled Oxycodone, just PRN.	D 392		

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D 392	Continued From page 151 Interview with the Manager on 09/18/24 at 2:48pm revealed: -The MAs should look at the MAR and the medication on hand and make sure the order matched. -Once the controlled medication was administered, the MAs should document the administration on the MAR and the CSCS. -She randomly audited the CSCS. -She could not recall the last time she audited the CSCS. -There were no other CSCS for Resident #2. -The MAs were supposed to count off before giving the key to the next shift MA. -"It was not good" Resident #2's Oxycodone was missing because controlled medication could be abused. Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/18/24 at 4:45pm revealed: -The major concern for controlled medication that was unaccounted for was drug diversion. -Any controlled medication that was unaccounted for should be reported to the pharmacy so the pharmacy staff could ensure the medication had not been returned accidentally. -The facility should follow its internal process for an investigation, such as notifying law enforcement. -Resident #2 did not have any controlled medication that had been returned to the pharmacy. Interview with Resident #2 on 09/17/24 at 1:56pm revealed: -His toe was hurting right now. -He did not have a pain pill today, 09/17/24. -His toe hurt every day.	D 392		

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D 392	Continued From page 152 Interview with Resident #2 on 09/18/24 at 5:25pm revealed his toe had been painful all day. Interview with Resident #2's podiatrist's medical assistant on 09/19/24 at 2:05pm revealed Resident #2 reported he had not been taking pain medication during his office visit on 08/20/24. Telephone interview with Resident #2's Licensed Counselor on 09/18/24 at 4:58pm revealed every time she completed an assessment on Resident #2 the resident complained of pain, "every single time." Telephone interview with Resident #2's Licensed Counselor on 09/19/24 at 3:36pm revealed: -She saw Resident #2 on 08/09/24 and he complained of excruciating pain; he had tears in his eyes. -On 08/12/24, 08/13/24, and 08/14/24, Resident #2 complained of pain. -On 08/19/24, 08/20/24, and 08/21/24, and 08/22/24 Resident #2 complained of pain. -On 08/26/24, Resident #2 complained of pain. -Resident #2 complained of pain to the PCP and the PCP ordered pain medication. -Every time she asked the MAs about pain medication for Resident #2, she was told the resident had been administered pain medication. -Resident #2 told her he was not getting pain medication. -Resident #2 gave the same answers every time she asked him about his pain, he was hurting and was not administered pain medication. Telephone interview with Resident #2's PCP on 09/19/24 at 9:22am revealed: -She ordered Resident #2's Oxycodone to be administered as a scheduled medication instead	D 392		

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of PRN on 09/10/24 because she wanted to make sure the resident received the medication.
-Every time she saw Resident #2, he complained of a lot of pain.
-She was angry that Resident #2 had not received the pain medication as ordered.
-Her fear when she wrote the order for a narcotic was the resident may not get the medication.
-When she would ask the MA if Resident #2 had received his pain medication, the MA always told her Resident #2 had not complained of pain.
-Resident #2 did not deserve to be in pain.

Telephone interview with the Administrator on 09/19/24 at 11:24am revealed
-Resident #2's controlled medication should be administered as ordered.
-If Resident #2's Oxycodone was not documented as administered on the MAR, and was not on the medication cart, and it was verified the pharmacy sent the medication, then he had a problem with missing medication.
-The Manager needed to start an investigation to include notifying law enforcement.

c. Review of Resident #2's hospital discharge FL-2 dated 08/08/24 revealed an order for Lorazepam (used to treat anxiety) 0.5mg twice daily.

Review of Resident #2's August 2024 MAR for 08/09/2024-08/31/24 revealed:
-There was an entry for Lorazepam 0.5mg twice daily with a scheduled administration time of 9:00am and 9:00pm.
-There was documentation that Lorazepam 0.5mg was administered at 9:00am from 08/09/24-08/31/24.
-There was no documentation that Lorazepam 0.5mg was administered at 9:00pm from

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D 392	Continued From page 154 08/09/24-08/31/24. Review of Resident #2's September 2024 MAR for 09/01/24-09/17/24 revealed: -There was an entry for Lorazepam 0.5mg twice daily with a scheduled administration time of 9:00am and 9:00pm. -There was documentation that Lorazepam 0.5mg was administered at 9:00am and 9:00pm from 09/01/24-09/16/24 and at 9:00am on 09/17/24. Review of Resident #2's CSCS on 09/17/24 at 11:15am revealed: -There were two CSCS for 60 tablets of Lorazepam 0.5mg dispensed on 08/08/24. -One of the CSCS had a start date of 08/14/24 and at 8:00am Lorazepam 0.5mg was signed out and a balance of 29 was documented. -The 8:00am CSCS had Lorazepam signed out from 08/14/24-08/31/24 with a balance of 12. -The amount on hand from 08/14/24-08/23/24 had been initialed as checked by a [named] staff member. -The date and times were completed for 09/01/24-09/03/24 but there was no documentation the medication had been signed out. -On 09/04/24 there was documentation one tablet of Lorazepam was signed out at 8:00am, and a balance of 8 was documented. -On 09/05/24, there was documentation that no Lorazepam was signed out, and the balance remaining was 8. -The date and times were completed for 09/06/24-09/12/24 but there was no documentation the medication had been signed out. -On the second CSCS, the start date was 08/13/24, and at 8:00pm Lorazepam 0.5mg was	D 392		

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signed out and a balance of 29 was documented.
-The CSCS for 8:00pm had Lorazepam documented as signed out from 08/13/24-09/12/24 and a balance of 0 was documented.
-The amount on hand for 08/13/24-08/22/24 had been initialed as checked by a [named] staff member.
-There were 10 tablets not accounted for on the CSCS sheet dated from 08/14/24 to 09/12/24.

Interview with two MAs on 09/17/24 at 11:14am revealed there were no other CSCS for Resident #2.

Review of Resident #2's CSCS on 09/18/24 at 2:28pm revealed:
-These two CSCS were not in the CSCS book on the medication cart om 9/17/24.
-There were two CSCS for 60 tablets of Lorazepam 0.5mg dispensed on 09/11/24.
-One of the CSCS had a start date of 08/11/24 and the dates were documented from 08/11/24-08/16/24.
-There was no documentation for time, dose given, or signature of the MA who signed out the medication.
-The beginning amount started with 29 tablets and counted down to 24 tablets.
-There was no documentation of medication being wasted or if the count was verified.
-The second CSCS had a start date of 09/13/24, with a time of 8:00pm, signed by a [named] MA with a remaining amount of 29 tablets.
-There was no documentation on 09/14/24.
-The next entry was on 09/15/24 with a time of 8:00pm, signed by a [named] MA with a remaining amount of 27 tablets.
-The next entry was on 09/16/24 with a time of 8:00pm, signed by a [named] MA with a

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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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remaining amount of 26 tablets.
-On 09/17/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 25 tablets.
-On 09/18/24 there was no documentation for time, dose given, or signature of the MA who signed out the medication; the amount remaining was documented as 24 tablets.

Observation of Resident #2's medications on hand on 09/17/24 at 11:05am revealed:
-There was a punch card of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00am.
-There were 27 of 30 tablets of Lorazepam remaining on the card.
-There was a punch card of Lorazepam 0.5mg dispensed on 09/11/24 labeled as 8:00pm.
-There were 25 of 30 tablets of Lorazepam remaining on the card.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 09/17/24 at 2:12pm revealed:
-Sixty tablets of Lorazepam 0.5mg were dispensed on 08/08/24.
-Sixty tablets of Lorazepam 0.5mg were dispensed on 09/11/24.

Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation revealed 10 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 08/08/24 and 5 tablets of Lorazepam were unaccounted for from the 60 tablets dispensed on 09/11/24.

Interview with the Supervisor on 09/18/24 at 4:20pm revealed:

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D 392	Continued From page 157 -She had signed Resident #2's CSCS when she counted and verified the count was correct. -If her initials were not on the CSCS, she did not verify the count and would not have signed the CSCS. -She had not verified Resident #2's CSCS counts since 08/23/24. Refer to the interview with a MA on 09/19/24 at 2:51am, Refer to the interview with the Manager on 09/18/24 at 2:48pm. Refer to the interview with the Manager on 09/19/24 at 2:34pm. Refer to the telephone interview with the Administrator on 09/19/24 at 11:24am. 2. Review of Resident #6's current FL-2 dated 07/01/24 revealed: -Diagnoses included traumatic brain injury. -There was an order for lorazepam (used to treat agitation) 1mg twice daily. Review of Resident #6's physician orders dated 08/07/24 revealed there was an order for lorazepam 1mg twice daily. Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg twice daily scheduled at 8:00am and 8:00pm. -Lorazepam was documented as administered 60 of 62 opportunities from 07/01/24 to 07/31/24. -There were no exceptions documented on the MAR.	D 392		

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Review of Resident #6's August 2024 eMAR from 08/01/24 to 08/08/24 revealed:
-There was an entry for lorazepam 1mg twice daily scheduled at 8:00am and 8:00pm.
-Lorazepam was documented as administered 10 of 16 opportunities from 08/01/24 to 08/08/24.
-There were no exceptions for lorazepam documented on the MAR.

Review of Resident #6's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed:
-The facility changed pharmacies and the new pharmacy did not have an eMAR system set up for the facility.
-The MAR was an electronic print out and the medication administration documentation was handwritten.
-There was an entry for lorazepam 1mg twice daily scheduled at 8:00am and 8:00pm.
-Lorazepam was documented as administered 42 of 42 opportunities from 08/09/24 to 08/31/24.

Review of Resident #6's September 2024 MAR from 09/01/24 to 09/19/24 revealed:
-There was an entry for lorazepam 1mg twice daily scheduled at 8:00am and 8:00pm.
-Lorazepam was documented as administered 37 of 37 opportunities from 09/01/24 to 09/19/24.

Observation of Resident #6's medication on hand on 09/18/24 at 6:21pm revealed:
-There were two punch cards dispensed on 09/11/24 with lorazepam 1mg
-Thirty tablets were dispensed in each card for a total of 60 tablets; the cards were labeled "1 of 2" and "2 of 2" by the pharmacy.
-On the card labeled "1 of 2", 8:00am was handwritten on the top left corner; there were 24 tablets available for administration

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D 392	Continued From page 159 -On the card labeled "2 of 2", 8:00pm was handwritten on the top left corner; there were 24 tablets available for administration. Review of Resident #6's control substance count sheet (CSCS) from 08/12/24 to 09/09/24 revealed: -There were two CSCS for the lorazepam 1mg dispensed on 08/08/24; one CSCS was labeled "1 of 2" and the other was labeled "2 of 2". -The first CSCS labeled "2 of 2" was for the 8:00am administration. -There was documentation lorazepam 1mg was signed out from 08/12/24 to 09/06/24. -From 08/24/24 to 08/28/24, there was nothing documented on the CSCS except a count from 17 to 13 tablets; there were no signatures, no times, no tablets were signed out, nothing documented for waste and no checked off initials. -From 09/01/24 to 09/03/24, there was nothing documented on the CSCS; there were no counts, no signatures, no times, no tablets signed out, nothing documented for waste and no checked off initials. -The second CSCS labeled "1 of 2" was for the 8:00pm administration. -There was documentation lorazepam 1mg was signed out from 08/12/24 to 09/09/24. -There was nothing documented on 08/23/24, 08/28/24, 09/06/24 and 09/08/24; there were no spenddown counts, no signatures, no times, no tablets signed out, nothing documented for waste and no checked off initials. -There were 12 tablets unaccounted for on the CSCS sheet dated from 08/12/24 to 09/06/24 labeled "2 of 2" and 3 tablets unaccounted for on the CSCS sheet dated from 08/12/24 to 09/09/24 labeled "1 of 2". Review of Resident #6's CSCS from 09/12/24 to	D 392		

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D 392	Continued From page 160 09/18/24 revealed: -There were two CSCS for the lorazepam 1mg dispensed on 09/11/24; one CSCS was labeled "1 of 2" and the other was labeled "2 of 2". -The first CSCS labeled "2 of 2" was for the 8:00am administration. -There was documentation lorazepam 1mg was signed out on 09/13/24, 09/15/24, 09/16/24, and 09/18/24.. -There was nothing documented on the CSCS except a count on 09/14/24 and 09/17/24; there were no signatures, no times, no tablets signed out, nothing documented for waste and no checked off initials. -There was a count of 24 tables remaining on the CSCS sheet labeled "2 of 2". -The second CSCS labeled "1 of 2" was for the 8:00pm administration. -There was documentation lorazepam 1mg was signed out on 09/12/24, 09/13/24, 09/15/24, and 09/16/24. -There was nothing documented on the CSCS except a spenddown count for 09/14/24 and 09/17/24; there were no signatures, no times, no tablets signed out, nothing documented for waste and no checked off initials. -There was a count of 24 tables remaining on the CSCS sheet labeled "1 of 2". -There were two tablets unaccounted for on the CSCS sheet dated from 09/13/24 to 09/18/4 labeled "2 of 2" and two tablets unaccounted for on the CSCS sheet dated from 09/12/24 to 09/17/24 labeled "1 of 2". Telephone interview with the pharmacist from the facility's contracted pharmacy on 09/19/24 at 12:05pm revealed: -Resident #6 had a current order for lorazepam 1mg twice daily dated 08/07/24. -Sixty tablets of lorazepam were dispensed on	D 392		

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08/08/24 and 09/11/24; there were 30 tablets per punch card and the cards were labeled "1 of 2" and "2 of 2".
-CSCS sheets were provided for each card dispensed.
-The lorazepam was signed off as received by staff at the facility.
-The lorazepam was signed off on 08/08/24 at 6:01pm and on 09/12/24 at 12:11am.
-Lorazepam had not been returned from the facility.

Interview with Resident #6 on 09/19/24 at 1:44pm revealed:
-He did not know what lorazepam was and he did not know if he took lorazepam.
-The medication aide (MA) gave him his medication every day.

Interview with a MA on 09/19/24 at 2:51am revealed:
-She did not verify Resident #6's lorazepam with another staff this morning; she did not know why the control count was not verified.
-She would forget to sign the CSCS and do a tablet count when she administered Resident #6's lorazepam.

Interview with the Manager on 09/19/24 at 2:34pm revealed:
-The MAs should have always counted Resident #6's lorazepam before the beginning of the next shift and documented the verified count on the CSCS.
-The MAs knew they had to document lorazepam administration on the CSCS as well as the MAR.

Based on observation of medications on hand, interview with the contracted pharmacy, and review of MARs and CSCS documentation

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D 392	Continued From page 162 revealed 19 tablets of Lorazepam were unaccounted for. Refer to the interview with a MA on 09/19/24 at 2:51am, Refer to the interview with the Director on 09/18/24 at 2:48pm. Refer to the interview with the Director on 09/19/24 at 2:34pm. Refer to the telephone interview with the Administrator on 09/19/24 at 11:24am. _____ Interview with a MA on 09/19/24 at 2:51am revealed: -She matched the punch card to the MAR for medications, then popped the tablet out of the punch card, administered it and documented on the MAR and the CSCS for each controlled medication. -The controlled medication was counted, and the remaining balance verified between shifts and documented on the CSCS. -There were supposed to be two MAs verifying the remaining count for each controlled medication on the CSCS. -The staff had not been verifying the remaining balance of controlled medication for a while; they just were not doing it. -She forgot to sign the CSCS because of the paper MARs the facility was using. -The facility had eMARs with a different pharmacy until 08/01/24, and the eMARs had a reminder to document on the CSCS before she could see the next medication to be administered. -She did not realize she had not documented on the CSCS so frequently.	D 392		

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D 392	Continued From page 163 Interview with the Director on 09/18/24 at 2:48pm revealed: -The MAs should look at the MAR and the medication on hand and make sure the order matched. -Once the controlled medication was administered, the MAs should document the administration on the MAR and signed out on the CSCS. -She randomly audited the CSCS. -She could not recall the last time she audited the CSCS. -The MAs were supposed to count off controlled substances before giving the key to the next shift's MA. Interview with the Director on 09/19/24 at 2:34pm revealed she did not know why they had not been documenting on the CSCS. Telephone interview with the Administrator on 09/19/24 at 11:24am revealed -The MAs should administer controlled medication as ordered. -Controlled medication should be documented as administered on the MAR and signed out on the CSCS. -At shift change the controlled medication should be counted to ensure the medication on hand was correct with the CSCS. _____ The facility failed to ensure there was an accurate record of controlled substances being maintained for a resident with physician orders for oxycodone and 28 tablets were unaccounted for and the resident had experienced pain daily since his toe was amputated on 08/005/24 (#2), and two residents with orders for lorazepam and multiple tablets were not signed out on the CSCS; 15 tablets were unaccounted for (#2) and 19 tablets	D 392		

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D 392	Continued From page 164 were unaccounted for (#6). This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/24. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 4, 2024.	D 392		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease	D 611		

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D 611	Continued From page 165 outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to follow the Federal Centers for Disease Control and Prevention (CDC) guidelines to ensure proper infection control procedures for the use of glucometers for 4 of 4 sampled diabetic residents (#1, #7, #8, and #9) with orders for blood sugar monitoring resulting in the sharing of glucometers between residents. The findings are:	D 611		

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Review of the CDC guidelines for infection control revealed:
-The CDC recommends blood glucose monitoring devices (glucometers) should not be shared between residents.
-If the glucometer was to be used for more than one resident, it should be cleaned and disinfected per the manufacturer's instructions.
-If the manufacturer did not list disinfection information, the glucometer should not be shared between residents.

Review of the manufacturer's manual for Brand A glucometers revealed:
-Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) during the delivery of healthcare services have been increasingly reported by persons using glucose monitoring systems as a risk group due to sharing of blood glucose meters.
-The Food and Drug Administration's (FDA) Public Health notification revealed the use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.
-CDC Clinical Reminder: Use of a finger-stick device on more than one person posed a risk for transmitting blood-borne pathogens.

Observation of the facility's south-hall medication cart on 09/18/24 at 10:05am revealed there were four black zippered bags labeled with residents' names in the top drawer of the medication cart.

1. Review of Resident #1's current FL-2 dated 02/21/24 revealed:
-Diagnosis included diabetes.
-There was an order to check blood sugar before meals and at bedtime.

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D 611	Continued From page 167 Observation of a medication aide (MA) during the 8:00am medication pass on 09/18/24 at 7:37am revealed: -The MA retrieved a black zipped bag from the top drawer of the medication cart. -The black zipped bag had Resident #1's name on it. -The glucometer in the black zipped bag did not have a name on it. -The MA checked Resident #1's blood sugar reading; the reading was 153. -The MA sanitized her hands before and after donning and doffing gloves Review of Resident #1's Brand A glucometer on 09/18/24 at 10:05am revealed: -The current date on the glucometer was 06/02/24 at 11:34am. -There were two blood sugar readings in the glucometer. -On 06/01/24 at 1:04pm, there was a blood sugar reading of 300. -On 06/02/24 at 8:55am, there was a blood sugar reading of 153. -There were no other blood sugar readings in Resident #1's glucometer. Review of Resident #1's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry to check Resident #1's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was no documentation of blood sugar readings from 08/09/24 to 08/31/24. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/17/24 revealed:	D 611		

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D 611	Continued From page 168 -There was an entry to check Resident #1's blood sugar before meals and at bedtime with a scheduled time of 7:30am, 11:30am, 4:30pm, and 8:00pm. -There was no documentation of blood sugar readings from 09/01/24 to 09/17/24. Interview with the MA on 09/18/24 at 10:19am revealed: -She checked Resident #1's blood sugar reading this morning using his glucometer. -Resident #1 did not have a glucometer until yesterday, 09/17/24. -Resident #1's glucometer was in the facility but had not been placed on the medication cart until yesterday, 09/17/24. -This morning was the first time she had used Resident #1's glucometer. -She had used Resident #8's glucometer to check Resident #1's blood sugar readings. -She did not know why the glucometer was not placed on the medication cart before yesterday. -She did not know who placed the glucometer on the medication cart. Interview with a second MA on 09/18/24 at 11:00am revealed: -Resident #1's blood sugar reading was checked four times daily. -She checked Resident #1's blood sugar reading four times on 09/17/24. -Resident #1 received a new meter yesterday, 09/17/24. -She could not locate the previous meter, so she got a new one for Resident #1. Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -She gave the MA a new glucometer for Resident #1 before lunch on 09/17/24.	D 611		

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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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-Resident #1's blood sugar checks were before meals and at lunch.
-There should have been three blood sugar readings from yesterday and one blood sugar reading this morning in Resident #1's glucometer when the surveyor checked the glucometer this morning, 09/18/24.
-She did not know why there were only two blood sugar readings on Resident #1's glucometer.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to the interview with a second MA on 09/18/24 at 11:00am.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

Refer to the interview with the Manager on 09/18/24 at 3:11pm.

Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.

2. Review of Resident 7's current FL-2 dated 05/17/24 revealed:
-Diagnosis included diabetes mellitus.
-There was an order to check blood sugars three times a day before meals and at bedtime.

Observation of Resident #7's Brand A glucometer on 09/18/24 at 10:05am revealed:
-The glucometer was in a black zippered bag labeled with Resident #7's name.
-The glucometer was not labeled with Resident #7's name.

Review of Resident #7's Brand A glucometer

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history revealed:
-The current date on the glucometer was 06/02/24 at 10:34am.
-There were 40 blood sugar readings on Resident #7's Brand A glucometer from 07/05/24 to 07/09/24.

Review of Resident #7's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed:
-There was an entry to check Resident #7's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.

Review of Resident #7's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry to check Resident #7's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 09/01/24 to 09/17/24.

Interview with Resident #7 on 09/18/24 at 11:02am revealed:
-Staff checked his blood sugar four times daily.
-He had his blood sugar checked sitting in the hallway in his wheelchair.
-He did not see the pouch that contained the glucometer.
-He did not know if the staff used the same glucometer or not.

Interview with a medication aide (MA) on 09/18/24 at 11:00am revealed:
-She did not recall using Resident #7's glucometer on other residents.

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	HAL073010	A. BUILDING: _____ B. WING _____	R 09/19/2024

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-She did not know why there were multiple readings on the same day and within 15-20 minutes of each reading.

Refer to the interview with a second MA on 09/18/24 at 11:00am.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

Refer to the interview with the Manager on 09/18/24 at 3:11pm.

Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am.

3. Review of Resident #8's current FL-2 dated 11/06/23 revealed diagnosis included diabetes mellitus type 2.

Review of Resident #8's signed physician orders dated 03/06/24 revealed there was an order for blood sugar checks before meals and at bedtime.

Observation of Resident #8's Brand A glucometer on 09/18/24 at 10:05am revealed:
-The glucometer was in a black zippered bag labeled with Resident #8's name.
-The glucometer was not labeled with Resident #8's name.

Review of Resident #8's Brand A glucometer history revealed:
-The current date on the glucometer was 07/03/24 at 2:37pm.
-There were 14 blood sugar readings on Resident #8's Brand A glucometer from 06/04/24 to 07/03/24.

Review of Resident #8's August 2024 medication

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administration record (MAR) from 08/09/24 to 08/31/24 revealed:
-There was an entry to check Resident #8's blood sugar three times daily before meals and at bedtime scheduled at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.

Review of Resident #8's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry to check Resident #8's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 09/01/24 to 09/17/24.

Interview with Resident #8 on 09/18/24 at 11:12am revealed:
-Her blood sugar was checked four times a day.
-Her blood sugar was checked in her room or standing by the medication cart in the hallway.
-She did not know which glucometer was used to check her blood sugar.

Interview with a medication aide (MA) on 09/18/24 at 11:00am revealed:
-She did not recall using Resident #8's glucometer on other residents.
-She did not know why there were multiple readings on the same day and within 15-20 minutes of each reading.

Refer to the interview with a second MA on 09/18/24 at 11:00am.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 611	Continued From page 173 Refer to the interview with the Manager on 09/18/24 at 3:11pm. Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. 4. Review of Resident #9's current FL-2 dated 09/21/23 revealed diagnosis included diabetes mellitus. Review of Resident #9's signed physician orders dated 11/06/23 revealed there was an order to check blood sugar readings before meals and at bedtime. Observation of Resident #9's Brand A glucometer on 09/18/24 at 10:05am revealed: -The glucometer was in a black zippered bag labeled with Resident #9's name. -The glucometer was not labeled with Resident #9's name. Review of Resident #9's Brand A glucometer history revealed: -The current date in the glucometer was 06/02/24 at 11:50am. -There were two blood sugar readings in Resident #9's glucometer. -On 06/01/24 at 1:14pm, there was a blood sugar reading of 105. -On 06/02/24 at 8:56am, there was a blood sugar reading of 99. -There were no other blood sugar readings in Resident #9's glucometer. Review of Resident #9's August 2024 medication administration record (MAR) from 08/09/24 to 08/31/24 revealed: -There was an entry to check Resident #9's blood sugar three times daily before meals and at	D 611		

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bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 08/09/24 to 08/31/24.

Review of Resident #9's September 2024 MAR from 09/01/24 to 09/17/24 revealed:
-There was an entry to check Resident #9's blood sugar three times daily before meals and at bedtime with a scheduled administration time of 7:30am, 11:30am, 4:30pm, and 8:00pm.
-There was no documentation of blood sugar readings from 09/01/24 to 09/17/24.

Interview with Resident #9 on 09/18/24 at 11:19am revealed:
-His blood sugar was checked four times a day.
-He did not recall a day where the staff forgot to check his blood sugar.
-He did not know which glucometer the staff used to check his blood sugar.

Interview with a medication aide (MA) on 09/18/24 at 11:00am revealed:
-She checked Resident #9's blood sugar 4 times daily when she worked as a MA.
-She worked as a MA on 09/17/24 and checked Resident #9's blood sugar reading 4 times.
-She used Resident #9's glucometer on 09/17/24 to check his blood sugar readings.
-She did not know why there were only two blood sugar readings in Resident #9's glucometer.
-Resident #9 did not receive a new meter yesterday, 09/17/24.

Refer to the interview with a second MA on 09/18/24 at 11:00am.

Refer to the interview with the Supervisor on 09/18/24 at 2:30pm.

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D 611	Continued From page 175 Refer to the interview with the Manager on 09/18/24 at 3:11pm. Refer to the telephone interview with the Administrator on 09/19/24 at 9:59am. _____ Interview with a second medication aide (MA) on 09/18/24 at 11:00am revealed: -There were four residents on the south-hall who received blood sugar checks. -Each resident had their own glucometer. -It may be possible that a glucometer was used for multiple residents. -Glucometers were not to be shared because of blood-borne diseases and cross contamination. Interview with the Supervisor on 09/18/24 at 2:30pm revealed: -It appeared the MAs were using the same glucometer to check multiple resident's blood sugars because there were 3 to 5 readings in one glucometer with a 10 to 15 minute time frame. -The residents could be a risk of cross-contamination with blood. Interview with the Manager on 09/18/24 at 3:11pm revealed: -Glucometers were not to be shared among residents. -Each resident should have their own glucometer with their name placed on the glucometer and the black zippered bag. -She was not aware the MAs were sharing glucometers among multiple residents. -Residents could become sick due to blood-borne pathogens. -There were no residents in the facilty with a blood-borne pathogen diagnosis. -She could not locate the infection control policy.	D 611		

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D 611	Continued From page 176 Telephone interview with the Administrator on 09/19/24 at 9:59am revealed: -The MAs should not share glucometers between multiple residents. -Each resident who had their blood sugar checked should have their own glucometer, labeled with their name. -If staff shared glucometers between residents, there was a risk of transmission of infection or disease. _____ The facility failed to implement infection control measures consistent with the Centers for Disease Control and Prevention (CDC) guidelines resulting in staff sharing glucometers between residents for 4 of 4 diabetic residents, placing the residents at risk for blood borne pathogen diseases. This failure was detrimental to the health, safety, and welfare of the residents, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/18/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 3, 2024.	D 611		