STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034116	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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 completed an annual survey and complaint investigation from August 20, 2024 to August 23, 2024. The complaint investigations were initiated by the Forsyth County Departmrnt of Social Services on August 1, 2024 and August 13, 2024.	D 000		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure immediate response and intervention by staff for 1 of 1 sampled residents (#1) who was found unresponsive in the dining room. The findings are: Review of the facility's policy titled Accidents/Incidents dated December 2007 revealed: -An employee who witnessed an accident/incident	D 271	The RCC, MCC, SIC, or designee will be in the dining rooms during meal times for increased supervision of residents. The community has updated the code statuses for the residents. The community has updated all diet orders for residents in the charts and for dietary. The RCC, MCC or designee will be responsbile for updating diet orders for all residents including updating the DSD. In which the DSD will ensure the resident is receiving the correct diet. The RCC, MCC or designee will review daily for diet order changes and make the updates as needed. Audits will be conducted weekly by the RCC, MCC or designee. Date of compliance is 9/22/24.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristain Walker	Executive Director	10/3/2024

Reviewed and acknowledged 10/07/24
H Ray Peedin

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involving a resident should report the accident/incident to his/her immediate supervisor as soon as practicable; however, an employee should not leave an accident victim unattended unless it was absolutely necessary to summon assistance.
-Staff who witnessed an accident or found it necessary to aid an accident victim should follow first-aid procedures and summon help as needed to evaluate and manage the situation.
-A Report of Incident/Accident form should be submitted to the Director of Nursing Services no later than 24 hours after the occurrence of the accident/incident.

Review of Resident #1's current FL2 dated 04/10/24 revealed diagnoses included dysphagia (difficulty swallowing), history of cerebrovascular accident (CVA/stroke) with right-sided hemiplegia and hemiparesis, and muscle weakness.

Review of Resident #1's care plan dated 04/24/24 revealed:
-There were no restrictions documented for the resident's diet or nutrition.
-He required limited assistance with eating, but there were no specific tasks documented that he required assistance with.

Review of Resident #1's diet order dated 05/21/24 revealed an order for a regular diet with a mechanical soft texture modification.

Review of Resident #1's Report of Incident/Accident form dated 07/31/24 revealed:
-At 5:00pm, Resident #1 was found with his eyes closed and was unresponsive with his arms down at his sides seated at the dining room table.
-Staff alerted the facility's Health and Wellness Director (HWD) that Resident #1 "didn't look

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good."
-The HWD went to the dining area to assess Resident #1 and found he had cyanosis (a blue color to the skin due to lack of oxygen in the blood) to his face and hands along with a thready, weak pulse.
-Resident #1 was not responsive to painful stimuli.
-Resident #1 was removed from the dining area and taken into the hallway where the Heimlich maneuver was performed.
-Emergency Medical Services (EMS) was called and Resident #1's power of attorney (POA) was contacted.
-Cardiopulmonary Resuscitation (CPR) was initiated.
-Vital signs were documented as being unable to obtain with a weak thready pulse and respirations at 4-5 breaths per minute.
-The staff completing the incident/accident report was the HWD.

Review of a medication aide's (MA) written statement dated 08/01/24 revealed:
-She was at her medication cart and one of the personal care aides (PCA) stepped out of the dining room and said she thought something was wrong with Resident #1.
-The MA stepped in the dining room to find Resident #1 sitting at the dining room table with his head over to the side; his face looked pale and clammy with bluish coloring around his mouth.
-She called out Resident #1's name a couple of times and rubbed his chest and back with no response.
-She then ran into the hallway to notify the HWD, and went back into the dining room.
-The HWD came into the dining room and called out Resident #1's name to him with no response,

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so she checked his pulse and called out for someone to call 911.
-The MA pulled Resident #1's chair out into the hallway and she started the Heimlich maneuver because she could see food in the back of Resident #1's throat.
-As she did the third upward thrust, sausage came out of Resident #1's mouth.
-The HWD attempted to get vital signs on Resident #1.
-The emergency services operator was on the phone and told her to get Resident #1 in a laying down position for CPR, so Resident #1 was placed onto his bed in his room.
-CPR was started and she, the HWD, and the Resident Care Coordinator (RCC) took turns doing rounds of CPR until EMS arrived and took over.

Review of a second MA's written statement dated 08/01/24 revealed:
-A PCA came out of the dining room and told her and the other MA that Resident #1 was not looking well.
-When she went into the dining room, Resident #1 was slumped over, and she observed his bottom lip looking blue-purple in color.
-The HWD and the other MA pulled Resident #1 out of the dining room to the hallway so they could try to do a mouth sweep.
-She called 911 and told them what was happening and where EMS could find them.
-The operator prompted her to put Resident #1 on the floor and start CPR.
-She kept the operator on the phone until the local fire department arrived.

Review of the facility's former RCC's written statement dated 08/02/24 revealed:
-Resident #1 was sitting in a regular dining room

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chair when she came into the dining room from throwing a bag of trash into the dumpster.
-She went to the bathroom to wash her hands and assist with Resident #1.
-Resident #1 was sitting upright outside the dining room and the MA had put on gloves to clear Resident #1's airway because he seemed to be struggling to breathe.
-Resident #1 was given the Heimlich maneuver.
-One MA was calling 911 while the other MA was sitting with Resident #1.
-The 911 operator instructed them to lay Resident #1 on his left side and have someone do a sweep of his mouth in case he was choking.
-Resident #1 was laid on the floor in his room and the MA began chest compressions, alternating with the HWD, while the 911 operator was still on the phone.
-She took over chest compressions to give the HWD a break, and the HWD went outside to meet with the first responders.
-First responders took over performing CPR on Resident #1 until they called his time of death at 5:22pm.
-Resident #1's POA came, and the crematory was called.

Review of the EMS report dated 07/31/24 revealed:
-EMS received a call at 4:56pm and was dispatched to the facility for an unconscious resident which was upgraded to a cardiac arrest.
-EMS arrived at the facility at 5:09pm.
-Upon arrival to the facility, the local fire department was present and performing CPR.
-When the local fire department arrived at the facility, Resident #1 had been unconscious and unresponsive, and was not breathing.
-Resident #1 was lying on the floor, and personnel from the local fire department reported

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performing one round of compressions and no shock from the automated external defibrillator (AED) was advised; CPR continued.
-Staff reported to EMS that Resident #1 had choked on a hot dog and staff had performed abdominal thrusts and cleared some of the airway obstruction.
-Staff reported that Resident #1 had a "Do Not Resuscitate" (DNR) order, but they could not produce the document.
-Family arrived on the scene and wished to honor Resident #1's DNR order and cease CPR efforts.
-Resident #1 was pronounced deceased at 5:29pm and remained at the facility, as the resident's family wanted to make arrangements for the funeral.

Review of Resident #1's record on 08/20/24 revealed there was no DNR order for review.

Interview with Resident #1's tablemate on 08/20/24 at 3:35pm revealed:
-He sat at the same table as Resident #1.
-On 07/31/24, Resident #1 had been eating supper fine, but then he stopped eating and started drooling.
-A couple of staff were in the dining room but someone had to flag down a staff member to check on Resident #1.
-He thought it took 2-3 minutes to get a staff member's attention to check on Resident #1.
-The staff (he could not remember who) pulled Resident #1 out of the dining room as he remained seated on his dining room chair.
-The staff did not perform the Heimlich maneuver in the dining room.

Interview with a MA on 08/20/24 at 4:00pm revealed:
-The facility's policy for mealtimes was that there

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should always be at least one PCA in the dining room at all times when food was being served.
-When the MAs were finished passing medications they were supposed to join the PCA to help in the dining room.
-On 07/31/24, there was one PCA in the dining room at dinner along with two dietary staff.
-The PCAs and dietary staff were the ones who passed out meal trays.
-She was not aware of Resident #1 having any trouble chewing or swallowing prior to 07/31/24.
-She was working on 07/31/24 when Resident #1 passed away and wrote a statement about what happened that evening.
-She and the other MA had their medication carts parked outside of the dining room.
-One of the PCAs stepped out of the dining room and said something was wrong with Resident #1.
-Both she and the other MA went into the dining room and saw that Resident #1 was sitting slumped over and his lips looked blue.
-She stepped out of the dining room and yelled for the HWD to come to the dining room, then went back to Resident #1.
-She thought the other MA stayed with Resident #1 while she was yelling for the HWD.
-When the HWD got to the dining room and saw that Resident #1 was unresponsive, one of the residents helped them to pull Resident #1 out of the dining room on his chair into the hallway.
-She performed the Heimlich maneuver on Resident #1 in the hallway and some sausage came out of his mouth, so she put on a glove and did a mouth sweep to see if she could remove more of the sausage, and was able to get a little more food out.
-When asked why she did not perform the Heimlich maneuver in the dining room, she said she did not want to disrupt the other residents and she was not sure whether or not he was

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unresponsive due to choking.
-The other MA called 911.
-The 911 operator told them to lay Resident #1 flat for CPR.
-The HWD initiated CPR and after a while she took over to give the HWD a break.
-They did a couple rounds of CPR, counting compressions out loud with the 911 operator who was still on the phone, until the first responders arrived (she did not know what time the first responders arrived).
-The first responders from the fire department moved Resident #1 from his bed to the floor and took over performing CPR until EMS arrived.
-The HWD contacted Resident #1's POA and she came to the facility.
-After a while, EMS called out Resident #1's time of death.
-EMS left Resident #1 at the facility and he was picked up by a person she thought was from the funeral home.

Telephone interview with Resident #1's POA on 08/21/24 at 10:43am revealed:
-On 07/31/24, she received a phone call from the facility's HWD saying Resident #1 had been eating and staff observed him in distress and were currently "working on him."
-By the time she arrived at the facility, Resident #1 had been dead for about 15 minutes.
-The HWD told her that Resident #1 had been in a wheelchair going down the hallway in distress, and she saw that he was turning blue in color, so she wheeled him into his room to perform the Heimlich maneuver.
-She was told that no food had come out of Resident #1's mouth as a result of the Heimlich maneuver.
-She did not know why the staff in the dining room did not perform a Heimlich maneuver if he began

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choking during the meal service.
-Resident #1 did not have or use a wheelchair, so it did not make sense that she was told he was in a wheelchair in the hallway.
-Resident #1 had a DNR order, so she did not know why the facility did not have a copy of his DNR order on file or why they initiated CPR on him to begin with.
-None of the staff could tell her what Resident #1 had been eating at the time of his distress, where his table was, or who had been eating with him at the time of the incident.

Interview with a kitchen staff on 08/21/24 at 11:40am revealed:
-She was a cook at the facility.
-She had not witnessed Resident #1 choking, but one of the residents in the dining room had yelled out for staff saying that Resident #1 was not moving.
-When she looked in the dining room, Resident #1 was sitting in a dining room chair and his head was down.
-One of the other staff (she could not remember who) had already gone to get the PCA.
-The HWD came into the dining room and dragged Resident #1 out of the dining room on his chair.
-She had not witnessed the entire event because she had also been prepping the other residents' meal plates.
-There was not a PCA in the dining room at the time the resident yelled out for help for Resident #1 because they were still getting residents and bringing them into the dining room.
-There was always supposed to be 1 to 2 PCAs or MAs in the dining room during meals.

Interview with a resident on 08/21/24 at 3:17pm revealed:

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D 271	Continued From page 9 -She sat at a table across from Resident #1's table in the dining room. -She was about 5 to 10 feet away from Resident #1 when she noticed that he was sitting in his chair not moving. -One of the kitchen staff was passing out meal plates so she told him to look at Resident #1. -The kitchen staff shook Resident #1's shoulder and Resident #1 did not respond, so he went and got the PCA. -Some staff went into the dining room and checked on Resident #1, and had one of the other residents help them drag Resident #1 out of the dining room on his dining chair into the hallway. -She did not remember seeing any nursing staff in the dining room at the time that she had noticed Resident #1 not moving. -The nursing staff must have moved Resident #1 to his room, because when she left the dining room and went to check on Resident #1, he was laying on his bedroom floor and a man was performing CPR on him. -Staff had not attempted a Heimlich maneuver on Resident #1 in the dining room. Interview with a second resident on 08/21/24 at 3:33pm revealed: -During dinner on 07/31/24, one of the female residents told him that Resident #1 was not moving. -He looked at Resident #1 and his arms and face looked blue in color, and his head was tucked towards his chest. -There were no PCAs in the dining room, so he called out for a PCA who had been in the hallway with the MAs. -The PCA and MAs came into the dining room, and someone said Resident #1 was not breathing.	D 271		

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-He helped slide Resident #1 out of the dining room and into the hallway on his dining room chair.
-He saw the MA try the Heimlich maneuver on Resident #1 in the hallway and some rice came out of his mouth.
-He thought Resident #1 was already dead while he was sitting at the dining room table, but one of the staff called 911 and EMS showed up.
-Resident #1 was taken into his room.

Interview with a PCA on 08/22/24 at 10:38am revealed:
-She was the PCA on duty in the dining room during the supper meal on 07/31/24.
-She had been setting up drinks for the residents, and left the dining room to go get a couple of residents who needed assistance getting from their room to the dining room.
-She had not heard Resident #1 coughing or struggling when she was in the room nearby getting the other resident.
-She had been out of the dining room for less than 5 minutes.
-When she got back into the dining room, one of the residents told her that something looked wrong with Resident #1, so she took the resident she was helping to their table and went to check on Resident #1.
-Resident #1 was sitting in the chair with his head down and to the side, not responding to her so she went into the hall and got the MA.
-The MA ran into the dining room and after seeing that Resident #1 was unresponsive, she went out of the dining room and yelled for the HWD to come help.
-The HWD came into the dining room and checked Resident #1's pulse and yelled for the other MA to call 911.
-One of the residents and one of the MAs

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dragged Resident #1 out of the dining room and into the hallway on his chair.
-No Heimlich maneuver had been performed until after Resident #1 was out of the dining room.

Interview with the HWD on 08/22/24 at 2:00pm revealed:
-She was working the evening Resident #1 passed away.
-She interviewed some residents afterward and none of them said Resident #1 had coughed or made any sound prior to staff arriving to assess him.
-She had been standing outside of the dining room doors with the two MAs, and started walking up the hall towards the copy machine when she heard one of the MAs yell for her that Resident #1 did not look right.
-She ran back to the dining room and checked on Resident #1 who was sitting in a dining room chair at his table with his arms down at his side and a blue tint to his face.
-She checked Resident #1's pulse and it was weak and thready.
-One of the MAs called 911, and the other MA stayed with Resident #1 while she went to get equipment to check Resident #1's vital signs.
-When she got back to the dining room, she saw the MA and one of the residents dragging Resident #1 out of the dining room and into the hallway.
-The MA should have attempted a Heimlich maneuver in the dining room but she had not advised her to do so because at that time they did not realize he was choking versus having a different type of medical emergency.
-The MA on the phone with 911 told her the operator told them to start CPR, so they took Resident #1 to his room which was a few doors down from the dining room and put him on his

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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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bed and started CPR.
-One of the MAs had attempted the Heimlich maneuver between the calling of 911 and when she left to get the equipment to check vital signs.
-Resident #1's mouth had mushy, chewed up food in it that they were not able to swipe out.
-She got an error message on the blood pressure machine, so she never obtained a set of vital signs.
-The fire department showed up first after about 7 minutes, and moved Resident #1 from his bed to the floor and continued performing CPR that she and the MA had started.
-When EMS arrived, they applied the AED machine and took over chest compressions.
-She called Resident #1's POA, and the POA said she would come to the facility.
-Resident #1 was documented as a full code in their computer system, but when his POA arrived at the facility and said he was a DNR, EMS stopped CPR and pronounced Resident #1 deceased.
-The MAs had been in and out of the dining room passing medications, and the PCA had been in and out of the dining room bringing residents, so staff had been around at the time of the incident but she did not know if any nursing staff were in the dining room at the moment Resident #1 became unresponsive.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-She received a call from the HWD on the evening of 07/31/24 telling her that EMS was performing CPR on Resident #1, then she received a second call letting her know the CPR was unsuccessful.
-There was supposed to be either a PCA or a MA in the dining room at all times once food was served to the first resident.

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 271	Continued From page 13 -The PCA that was assigned to be in the dining room should not have left the dining room once the first resident was served their meal. -She expected the staff to intervene in medical emergencies immediately. -The staff who found Resident #1 unresponsive in the dining room should have attempted an intervention such as the Heimlich maneuver there in the dining room prior to moving him into the hallway. Telephone interview with Resident #1's primary care provider (PCP) on 08/21/24 at 3:50pm revealed: -If Resident #1 had a pulse while staff checked him in the dining room, they should have acted immediately and started a Heimlich maneuver right there in the dining room. -Dragging Resident #1 on his chair out of the dining room and into the hallway before intervening may have taken too long, and contributed to the negative outcome of his death. Attempted telephone interview with the second MA on duty the evening Resident #1 passed away on 08/22/24 at 2:26pm was unsuccessful. _____ The facility failed to intervene immediately for Resident #1, who was found cyanotic and slumped over with a weak pulse in the dining room during supper. Staff was not available in the dining room to immediately perform the Heimlich maneuver and the Heimlich maneuver was not attempted until the resident was dragged in a chair to the hallway. Afterwards, he was placed in his bed instead of on the floor, prior to the initiation of CPR. The failure of the facility to respond immediately to this incident resulted in the death of Resident #1 and constitutes a Type A1 Violation.	D 271		

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D 271	Continued From page 14 _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2024	D 271		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute healthcare needs for 4 of 7 sampled residents (#3, #4, #6, and #7) related to a resident who had insulin and fingerstick blood sugar (FSBS) refusals along with FSBS values over 400 (#6), a resident who had a referral to a vascular clinic and an order for an ultrasound (#3), a resident who had a referral for a psychiatric evaluation (#4), and a resident who had FSBS values over 400 (#7). The findings are: 1. Review of the facility's undated policy titled Procedure for Documenting Medication Refusals revealed: -If a medication was refused, it must be documented that the medication aide (MA) made	D 273	The RCC, MCC, or designee will be responsible for revewing the med exception report daily and communicating with the PCP on any med refusals. Any PCP recommendations will be followed up with and corrected in the residents charts. Education was provided to the clinical staff on med refusals and sliding scale insulin and FSBS and the process for following up. The RCC, MCC or designee will be responsible for making rounds with the PCP and get clarifications on orders if needed. The RCC, MCC, or designee will audit daily for all med refusals and referrals for appointments to ensure they have been completed. If there are any changes, documentation will be made in the residents chart and PCP notified. Date of compliance 9/22/24.	

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at least three attempts.
-Under no circumstance should any resident go without receiving their medication.
-The primary care provider (PCP) must be notified and an order should be given during the same shift.
-If a medication was refused more than 5 days in a row, it should be reported to the supervisor immediately.
-Every medication refusal required a chart note documenting the PCP had been notified; the documentation should include that the PCP was made aware, along with the time, or if a message was left.

Review of Resident #6's current FL2 dated 04/22/24 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, and hypertension.

a. Review of Resident #6's physician's order dated 05/20/24 revealed an order for FSBS checks four times daily.

Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm, and 9:00pm.
-There was documentation Resident #6 refused his FSBS check 15 times from 06/01/24 through 06/30/24.
-Resident #6's FSBS values from 06/01/24 through 06/30/24 ranged from 96 to 587.

Review of Resident #6's July 2024 eMAR revealed:
-There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm,

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and 9:00pm.
-There was documentation Resident #6 refused his FSBS check 28 times from 07/01/24 through 07/31/24; all except for two of the refusals were at the 9:00pm FSBS check.
-Resident #6's FSBS values from 07/01/24 through 07/31/24 ranged from 120 to 499.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm, and 9:00pm.
-There was documentation Resident #6 refused his FSBS check 22 times from 08/01/24 through 08/21/24.
-Resident #6 refused his 9:00pm FSBS check every night from 08/01/24 through 08/20/24.
-Resident #6's FSBS values from 08/01/24 through 08/21/24 ranged from 144 to 583.

Review of Resident #6's charting notes from June, July, and August 2024 revealed there was no documentation that Resident #6's PCP had been notified about his FSBS refusals.

b. Review of Resident #6's current FL2 dated 04/22/24 revealed an order for lispro (a fast-acting insulin used to lower blood sugar spikes associated with meal intake) inject 9 units three times daily with meals.

Review of Resident #6's June 2024 eMAR revealed:
-There was an entry for lispro, inject 9 units three times daily with meals scheduled at 6:30am, 11:30am, and 4:30pm.
-There was documentation Resident #6 refused lispro 28 times from 06/01/24 through 06/30/24.
-Resident #6's FSBS values from 06/01/24

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through 06/30/24 ranged from 96 to 587.

Review of Resident #6's July 2024 eMAR revealed:
-There was an entry for lispro, inject 9 units three times daily with meals scheduled at 6:30am, 11:30am, and 4:30pm.
-There was documentation Resident #6 refused lispro 33 times from 07/01/24 through 07/31/24.
-Resident #6's FSBS values from 07/01/24 through 07/31/24 ranged from 120 to 499.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for lispro, inject 9 units three times daily with meals scheduled at 6:30am, 11:30am, and 4:30pm.
-There was documentation Resident #6 refused lispro 2 times from 08/01/24 through 08/21/24.
-Resident #6's FSBS values from 08/01/24 through 08/21/24 ranged from 144 to 583.

Review of Resident #6's charting notes from June, July, and August 2024 revealed there was no documentation that Resident #6's PCP had been notified about his lispro refusals.

c. Review of Resident #6's current FL2 dated 04/22/24 revealed an order for insulin glargine (glargine is also known as Lantus, which is a long-acting insulin used to control blood sugar levels) 15 units twice daily.

Review of Resident #6's June 2024 eMAR revealed:
-There was an entry for Lantus, inject 15 units twice daily scheduled at 6:30am and 4:30pm.
-There was documentation Resident #6 refused Lantus 16 times from 06/01/24 through 06/30/24.
-Resident #6's FSBS values from 06/01/24

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D 273	Continued From page 18 through 06/30/24 ranged from 96 to 587. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for Lantus, inject 15 units twice daily scheduled at 6:30am and 4:30pm, with an order discontinue date of 07/24/24. -There was an entry for Lantus, inject 20 units once daily scheduled at 6:30am, with an order start date of 07/25/24. -There was documentation Resident #6 refused Lantus 10 times from 07/01/24 through 07/31/24. -Resident #6's FSBS values from 07/01/24 through 07/31/24 ranged from 120 to 499. Review of Resident #6's physician's orders dated 07/25/24 revealed there was no order to change Lantus to 20 units once daily. A copy of the physician's order dated 07/25/24 was requested from the Health and Wellness Director (HWD) on 08/21/24 at 1:04pm and was not provided. Review of Resident #6's charting notes from June and July 2024 revealed there was no documentation that Resident #6's PCP had been notified about his Lantus refusals. _____ Review of Resident #6's PCP's visit note dated 06/20/24 revealed: -Resident #6's most recent Hemoglobin A1c (a blood laboratory test indicating an average blood sugar level over the previous three months) was checked on 05/24/24 and was 7.5% (normal level was 5.7% or lower; pre-diabetes range was 5.7% to 6.4%; 6.5% or higher indicated diabetes). -There was no documentation regarding Resident #6's lispro, Lantus, or FSBS refusals or FSBS values.	D 273		

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D 273	Continued From page 19 Interview with Resident #6 on 08/21/24 at 3:33pm revealed: -He refused his lispro "often." -The reason he refused to take his lispro was because if the medication aide (MA) checked his FSBS and it was less than 200, he did not want to take the insulin and have his blood sugar drop too low. -He refused to take his Lantus insulin at times. -He refused the Lantus insulin if he thought taking it would drop his blood sugar too low. -He refused his 9:00pm FSBS check because there was no insulin ordered before bedtime. -He did not want a FSBS check for no reason. -He had never discussed his concerns or insulin or FSBS refusals with his PCP. -His blood sugar often ran high, in the 400 and 500's, but he never had symptoms of high blood sugar or did not feel well because of it. -He was more comfortable having high blood sugars than low blood sugars. Interview with a MA on 08/21/24 at 4:40pm revealed: -The MAs were supposed to let the HWD know if a resident refused a medication three times, then follow the HWD's guidance for whether or not to contact the PCP. -She had not notified the HWD about Resident #6's lispro or Lantus refusals. -She did not know if the facility had a policy regarding who was responsible for contacting the PCP about medication refusals and when. -Resident #6 had never reported symptoms of high blood sugar to her. Interview with a second MA on 08/22/24 at 10:50am revealed: -Resident #6 refused lispro for her a lot in the	D 273		

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mornings, and had refused Lantus for her several times.
-She thought she had notified Resident #6's PCP about lispro and Lantus refusals but could not remember when.
-She talked to Resident #6's PCP in person during one of the days the PCP was at the facility to see Resident #6, and the PCP told her she would talk to Resident #6 about it and go from there.
-She did not document notifying Resident #6's PCP about his lispro or Lantus refusals or what the PCP's response was.
-Resident #6 never reported symptoms of high blood sugar to her.

Interview with a third MA on 08/22/24 at 11:20am revealed:
-The MAs were supposed to notify the PCP about medication refusals after three consecutive refusals.
-Resident #6 refused his lispro and Lantus because he told her he was worried his blood sugar would drop too low if he took the insulin.
-She let Resident #6's PCP know in-person while she was at the facility doing rounds that he was refusing lispro and Lantus, but she could not remember when and she did not document the conversation.
-Resident #6 refused his bedtime FSBS check because he said there was no point in checking his FSBS if there was no insulin ordered.
-She had never notified Resident #6's PCP about his FSBS check refusals.
-She thought the PCP said she was going to discontinue Resident #6's insulin order but did not end up discontinuing the order because his FSBS values were high.

Interview with a fourth MA on 08/23/24 at 2:10pm

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revealed:
-Resident #6 refused his bedtime FSBS values almost every night because he did not have insulin scheduled at that time.
-She had never followed up with Resident #6's PCP about the FSBS check refusals because she thought one of the day shift MAs had notified the PCP during one of the PCP's visits to the facility.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-The MAs had been educated that after three refusals in a row or within a 30-day period, they needed to address the refusals with the PCP.
-If the MA could not contact the PCP for some reason, they were responsible for notifying her about the refusals so she could follow up.
-Any time a MA notified the PCP about a medication refusal, the MA was responsible for documenting the notification in a charting note along with any new orders received.
-She knew that Resident #6 sometimes refused lispro, because he refused for her before when she was working on the medication cart, but since there were so many refusals she expected one of the MAs to notify her.
-She was not aware that Resident #6 refused Lantus as often as was documented.
-She was not aware that Resident #6 refused his FSBS check every night in August 2024 and as often as was documented in June and July 2024.
-She had never discussed Resident #6's lispro or Lantus refusals or his FSBS refusals with the PCP because she had not been aware of how frequently he had been refusing to take the insulin.
-She had not been completing any routine audits of the eMARs to check for medication refusals.
-The facility's former Resident Care Coordinator (RCC) had been responsible for auditing the

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eMARs but the facility had been without an RCC for a couple of weeks, and she did not think the former RCC had been auditing the eMARs like she was supposed to.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-She was not aware that Resident #6 had been refusing lispro, Lantus, or his FSBS checks.
-The MAs were expected to notify the PCP after each medication or order refusal.
-The MAs could notify the PCP about medication refusals via filling out a communication sheet and faxing it to the PCP's office.
-The MAs had probably notified Resident #6's PCP about his lispro and Lantus refusals via text or phone call, but they were supposed to document any communication they had with the PCP.
-The HWD was ultimately responsible for ensuring notifications for frequent medication refusals had been completed.
-The HWD was also responsible for completing eMAR audits to look for medication refusals once a week.
-She did not know if eMAR audits had been completed as expected.

Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed:
-She was not aware that Resident #6 had been refusing lispro or Lantus.
-She had not received any notification from the facility's staff regarding Resident #6's lispro or Lantus refusals for June, July, or August 2024.
-She was not aware that Resident #6 had been refusing FSBS checks.
-She had not received any notification from the facility's staff regarding Resident #6's FSBS refusals for June, July, or August 2024.

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-If she had known that Resident #6 was refusing the evening FSBS checks on a regular basis, she would have discontinued the 9:00pm FSBS check.
-She expected to be notified of insulin refusals right away.
-If she had known how often Resident #6 was refusing lispro and Lantus, she would have either adjusted his order, or re-educated him on the importance of insulin compliance to his health.
-Adverse effects for refusing lispro and Lantus included high blood sugar levels which, when prolonged, could lead to diabetic retinopathy, kidney and heart damage.
-Resident #6's Hemoglobin A1c was 7.7% in July 2024 which was an okay value considering how often he was refusing insulin.

2. Review of Resident #3's current FL2 dated 08/08/24 revealed diagnoses included Alzheimer's disease, hypertension, and lower extremity lymphedema.

a. Review of Resident #3's physician's order dated 06/06/24 revealed a referral for a vascular clinic for venous insufficiency and edema.

Review of Resident #3's primary care provider's (PCP) after visit summaries dated 06/06/24, 06/20/24, 06/27/24 and 07/02/24 revealed:
-There was documentation Resident #3's exam revealed venous stasis, lymphedema, venous insufficiency and concern for necrosis of the toes.
-Resident #3 had previous visits to the hospital due to concerns for weeping of the legs and poor circulation.
-There was an order for Resident #3 to be seen at a vascular clinic.

Review of a hospital discharge summary dated

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D 273	Continued From page 24 01/28/24 revealed: -Resident #3 was evaluated for redness and swelling in both lower legs for 3 days. -A venous ultrasound was performed on both lower legs that revealed she had pulses in both feet and no blood clots were present at the time. -Resident #3 was prescribed an antibiotic and returned to the facility. Review of Resident #3's record revealed no recent documentation that she was seen in a vascular clinic after 08/22/23. b. Review of Resident #3's physician's order dated 06/06/24 revealed an order for a bilateral lower extremity ultrasound related to deep vein thrombosis (blood clot). Review of Resident #3's PCP's after visit summaries dated 06/06/24 revealed: -There was documentation Resident #3's exam revealed venous stasis, lymphedema and venous insufficiency. -Resident #3 had been sent to the hospital due to concerns for weeping of the legs and poor circulation. -Resident #3 was ordered to have a bilateral lower extremity venous ultrasound to rule out deep vein thrombosis. Review of Resident #3's record revealed no documentation she had undergone a bilateral lower venous ultrasound. _____ Observation of Resident #3 on 08/21/24 at 9:20am revealed: -She was sitting in her wheel chair in the Special Care Unit (SCU) television room. -Both of her lower legs were dry with a foam	D 273		

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dressing intact on her inner left middle shin.
-Both legs were discolored pink and blotched without swelling.

Observation of Resident #3 on 08/22/24 at 1:55pm reveled:
-She propelled herself through the SCU hallway.
-Both of there lower legs were dry with a foam dressing intact on her inner left middle shin.
-Her toes on both feet were discolored gray, but her skin was dry and intact.

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

Telephone interview with Resident #3's power of attorney (POA) on 08/22/24 at 2:05pm revealed:
-Resident #3 had visited a vascular doctor last year in 2023.
-He had discussed Resident #3 revisiting a vascular clinic with the facility's PCP, but he was unsure if that was ordered and the POA had not accompanied her to a vascular clinic since August in 2023.
-Resident #3 had discolored legs and swelling for a few years now, but he was not aware the PCP was concerned about her toes.
-He had discussed Resident #3 having an ultrasound on her legs with the facility's PCP, but he was unsure if that was ordered or completed.
-Resident had discolored legs and swelling for a few years now, but he wasn't aware the PCP was concerned about her toes.

Interview with the facility's scheduler on 08/22/24 at 2:20pm revealed:
-The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) or Special Care Unit Coordinator (SCUC) would give her

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orders or PCP notes to schedule residents' appointments.
-She had not scheduled Resident #3 for a vascular clinic appointment ordered on 06/06/24 or after.
-She had not scheduled Resident #3 for an ultrasound ordered on 06/06/24 or after.

Interview with Resident #3's visiting home health nurse on 08/22/24 at 11:50am revealed:
-Resident #3 had discolored skin on her lower legs and occasionally had edema and weeping as well as 2 venous stasis ulcers that she felt were not healing well.
-She saw a visit note in her record that indicated she had went to a vascular clinic last year 2023.
-She did not remember a recent visit to a vascular clinic or an ultrasound of her legs.

Telephone interview with Resident #3's PCP on 08/23/24 at 1:55pm revealed:
-In June 2024, she ordered Resident #3 a venous ultrasound of both her legs and to be seen by a vascular clinic to reevaluate her legs for circulation even though she was evaluated in August 2023.
-She was concerned about Resident #3 developing blood clots and necrosis because her toes were beginning to turn black.
-Her legs were discolored and she had weeping and edema and was seen by home health nurses to treat venous stasis ulcers on her lower legs.
-She had noticed that many of her referrals and orders were not implemented and she had to repeatedly ask the RCC, SCUC and HWD for them to be completed.
-She expected all her orders to be followed and referrals made.

Interview with the Health and Wellness Director

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(HWD) on 08/23/21 at 3:40pm revealed:
-She was responsible to review the physician's order and visit notes from the PCP since the RCC and SCUC positions had been vacant.
-She was not aware Resident #3 had an order for an ultrasound of her legs and a referral to a vascular clinic on 06/06/24.
-The PCP notes were accumulated in the RCC and SCUC emails that she did not have access to the emails until the Administrator gave her the passwords on 08/20/24.

Interview with the Administrator on 08/23/24 at 5:50pm revealed:
-The HWD was responsible to ensure that orders by the resident's PCP were implemented.
-The HWD supervised the previous RCC and SCUC.
-The PCP visit notes were delivered to emails the previous RCC and SCUC used and she provided the HWD with the passwords to access those emails this week.
-She expected the HWD to ensure that orders by the PCP were implemented for all the residents.

3. Review of Resident #4's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, aggression and convulsions.
-There was an order for valproic acid sprinkles (used to treat seizures and behaviors) 125mg 1 capsule 2 times a day.

Review of Resident #4's Primary Care Provider's (PCP) after visit summary dated 04/16/24 revealed there was a referral for a psychiatric evaluation and treatment for concerns of appropriate Special Care Unit (SCU) admission or behavior health (BH) placement.

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Review of Resident #4's provider visit notes revealed no documentation he had a psychological evaluation.

Telephone interview with Resident #4's family member on 08/22/24 at 12:10pm revealed:
-Resident #4 had multiple previous evaluations for behaviors in the emergency departments.
-Resident #4 was combative, hitting staff and other residents when he was admitted in April 2024, but he had been calmer after the PCP started medications.
-Staff had told her that he did not sleep well at night and wandered most of the night.
-She would have liked the PCP to try something to help him sleep and not wander at night.
-She had not been contacted by staff or the PCP regarding a psychiatric evaluation for Resident #4.

Telephone interview with Resident #4's PCP on 08/23/24 at 1:55pm revealed:
-Resident #4 was admitted to the SCU in April 2024 and was hitting staff and other residents and displaying elopement behavior.
-She ordered antianxiety medications for short term use and ordered a psychological evaluation and treatment referral to have BH determine better long term use medications for residents with dementia.
-His recent behavior had been calm and he had not been exit seeking.
-She also gave the Health and Wellness Director (HWD) a list of residents she wanted seen by BH, including Resident #4.
-She expected all her orders for referrals to be implemented.

Interview with the HWD on 08/23/21 at 3:40pm revealed:

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-She was responsible to review the physician's order and visit notes from the PCP since the Special Care Unit Coordinator (SCUC) position was vacant.
-She was not aware Resident #4 had a referral for a psychiatric evaluation on 04/16/24.
-The PCP notes were accumulated in the Resident Care Coordinator (RCC) and SCUC emails that she did not have access to until the Administrator gave her the passwords on 08/20/24.

Interview with the Administrator on 08/23/24 at 5:50pm revealed:
-The HWD was responsible to ensure that orders by the resident's PCP were implemented.
-The HWD supervised the previous RCC and SCUC, but both those positions were vacant.
-The PCP visit notes were delivered to emails the previous RCC and SCUC used and she provided the HWD with the passwords to access those emails this week.
-She expected the HWD to ensure that orders and referrals by the PCP were implemented for all the residents.

Based on observations, record reviews and interviews it was determined that Resident #4 was not interviewable.
4. Review of the facility's undated policy form regarding physician notification that was posted on the medication cart revealed the PCP should be notified of any FSBS over 400; the MA should administer any scheduled or sliding scale insulin (SSI) and recheck FSBS every hour until FSBS was down to 300, then resume FSBS checks as scheduled.

a. Review of Resident #7's current FL2 dated 4/10/24 revealed diagnoses included chronic

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anemia, diabetes mellitus type II with chronic kidney disease.

1. Review of Resident #7's physician's orders revealed:
-There was an order dated 07/02/24 to check fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime and to inject Humalog (a rapid acting insulin) as per sliding scale (SS): 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units. Greater (FSBS) than 400 notify MD or on-call provider after hours. Inject before meals and at bedtime.
-There was an order dated 08/14/24 to discontinue Humalog SS insulin.

Review of Resident #7's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for check FSBS before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 9:00pm.
-There was documentation Resident #7's FSBS was over 400 on 30 of 104 opportunities from 07/03/24 through 07/31/24 with examples as follows:
-On 07/03/24 at 4:30am, FSBS was documented as 500; there was no documented PCP notification or FSBS recheck.
-On 07/13/24 at 4:30pm, FSBS was documented as 465; there was no documented PCP notification or FSBS recheck.
-On 07/19/24 at 11:30am, FSBS was documented as 431; there was no documented PCP notification or FSBS recheck.
-On 07/24/24 at 11:30am, FSBS was documented as 459; there was no documented PCP notification or FSBS recheck.
-On 07/25/24 at 11:30am, FSBS was documented as 595; there was no documented PCP

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notification or FSBS recheck.
-Resident #7's FSBS values from 07/03/24 through 07/31/24 ranged from 150 to 595.

Review of Resident #7's August 2024 eMAR from 08/01/24 to 08/20/24 revealed:
-There was an entry for check FSBS before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 9:00pm.
-There was documentation Resident #7's FSBS was over 400 on 3 of 80 opportunities from 08/01/24 through 08/20/24 as follows:
-On 08/12/24 at 11:30am, FSBS was documented as 415; there was no documented PCP notification or FSBS recheck.
-On 08/13/24 at 9:00pm, FSBS was documented as 512; there was no documented PCP notification or FSBS recheck.
-On 08/14/24 at 11:30am, FSBS was documented as 430; there was no documented PCP notification or FSBS recheck.
-Resident #7's FSBS values from 08/01/24 through 08/21/24 ranged from 97 to 512.

Review of Resident #7's charting notes for July 2024 and August 2024 revealed there was no documentation that Resident #7's PCP had been notified about FSBS values over 400.

Interview with a medication aide (MA) on 08/23/24 at 2:10pm revealed:
-Resident #7's FSBS was sometimes over 400 when she checked it.
-The MAs were supposed to call the PCP or the on-call doctor any time a resident had a FSBS value in the 400's or 500's.
-She followed up with Resident #7's PCP or the on-call doctor about the FSBS checks being over 400 because she needed to know how much sliding scale insulin to administer.

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D 273	Continued From page 32 -She did not document her PCP notification because she was not sure where to document notes in the computer eMAR system. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 3:45pm revealed: -The MAs were expected to notify the PCP of any FSBS check result over 400. -If the MA could not contact the PCP for some reason, they were responsible for notifying her about the refusals so she could follow up. -Any time a MA notified the PCP about a high FSBS value, the MA was responsible for documenting the notification in a charting note along with any new orders received. -She did not know Resident #7's blood sugars were over 400 so often. -She had never discussed Resident #7's FSBS values with the PCP. -She had not been completing any routine audits of the eMARs to check for FSBS over 400 and completion of the proper notifications. -The facility had been without a Resident Care Coordinator (RCC) for a couple of weeks. -The facility's former RCC had been responsible for auditing the eMARs for health care, including referrals to the PCP. -She did not think the former RCC had been auditing the eMARs. -She did not know if MAs had been rechecking FSBS since there was no documentation available for review. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -It was the facility's policy to notify the PCP or on-call provider of any FSBS over 400. -She was not aware that residents with FSBS had been having frequent FSBS values over 400 without documented provider notification.	D 273		

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-The HWD was ultimately responsible for ensuring notifications for FSBS over 400 had been completed.
-The MAs were expected to document in a chart note any communication they had with the PCP or on-call provider regarding FSBS values along with any subsequent orders received.

Telephone interview with Resident #7's primary care provider (PCP) on 08/21/24 at 3:45pm revealed:
-Resident #7 had "hard to control" diabetes.
-She was trying different medication regimens to help control Resident #7's blood sugar.
-She expected to be notified for FSBS values over 400 per the FSBS order's parameters.
-She was available by phone texting, fax, or phone messaging daily Monday through Friday.
-There was an on-call provider available nights and weekends.
-The on-call providers routinely documented facility notifications in the residents' notes maintained by the PCP's clinic.
-She did not know Resident #7 had multiple FSBS values over 400.
-Elevated FSBS values placed the resident at increased risk for damage to the kidneys, eyes, and possibly heart.

b. Review of Resident #6's current FL2 dated 04/22/24 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, and hypertension.

Review of Resident #6's physician's order dated 05/20/24 revealed an order for fingerstick blood sugar (FSBS) checks four times daily.

Review of Resident #6's June 2024 eMAR revealed:

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D 273	Continued From page 34 -There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm, and 9:00pm. -There was documentation Resident #6's FSBS was over 400 eighteen times from 06/01/24 through 06/30/24 with examples as follows: -On 06/07/24 at 11:30am, FSBS was documented as 456; there was no documented PCP notification or FSBS recheck. -On 06/12/24 at 11:30am, FSBS was documented as 527; there was no documented PCP notification or FSBS recheck. -On 06/18/24 at 11:30am, FSBS was documented as 461; there was no documented PCP notification or FSBS recheck. -On 06/21/24 at 4:30pm, FSBS was documented as 587; there was no documented PCP notification or FSBS recheck. -On 06/29/24 at 9:00pm, FSBS was documented as 480; there was no documented PCP notification or FSBS recheck. -Resident #6's FSBS values from 06/01/24 through 06/30/24 ranged from 96 to 587. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm, and 9:00pm. -There was documentation Resident #6's FSBS was over 400 eight times from 07/01/24 through 07/31/24 with examples as follows: -On 07/01/24 at 11:30am, FSBS was documented as 497; there was no documented PCP notification or FSBS recheck. -On 07/13/24 at 4:30pm, FSBS was documented as 405; there was no documented PCP notification or FSBS recheck. -On 07/15/24 at 11:30am, FSBS was documented as 499; there was no documented PCP	D 273		

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notification or FSBS recheck.
-On 07/27/24 at 11:30am, FSBS was documented as 497; there was no documented PCP notification or FSBS recheck.
-On 07/31/24 at 11:30am, FSBS was documented as 498; there was no documented PCP notification or FSBS recheck.
-Resident #6's FSBS values from 07/01/24 through 07/31/24 ranged from 120 to 499.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for FSBS checks four times daily scheduled at 7:00am, 11:30am, 4:30pm, and 9:00pm.
-There was documentation Resident #6's FSBS was over 400 five times from 08/01/24 through 08/21/24 with examples as follows:
-On 08/01/24 at 11:30am, FSBS was documented as 436; there was no documented PCP notification or FSBS recheck.
-On 08/04/24 at 4:30pm, FSBS was documented as 583; there was no documented PCP notification or FSBS recheck.
-On 08/10/24 at 4:30pm, FSBS was documented as 564; there was no documented PCP notification or FSBS recheck.
-On 08/17/24 at 11:30am, FSBS was documented as 567; there was no documented PCP notification or FSBS recheck.
-Resident #6's FSBS values from 08/01/24 through 08/21/24 ranged from 144 to 583.

Review of Resident #6's charting notes from June, July, and August 2024 revealed there was no documentation that Resident #6's primary care provider (PCP) had been notified about his FSBS values over 400.

Review of Resident #6's PCP's visit note dated

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D 273	Continued From page 36 06/20/24 revealed: -Resident #6's most recent Hemoglobin A1c (a blood laboratory test indicating an average blood sugar level over the previous three months) was checked on 05/24/24 and was 7.5% (normal level was 5.7% or lower; the pre-diabetes range was 5.7% to 6.4%, and 6.5% or higher indicates diabetes). -There was no documentation regarding Resident #6's FSBS values. Interview with Resident #6 on 08/21/24 at 3:33pm revealed: -He could not remember his PCP discussing his high FSBS values with him before. -His blood sugar often ran high, in the 400 and 500's, but he never had symptoms of high blood sugar or did not feel well because of it. -He was more comfortable having high blood sugars than low blood sugars. Interview with a medication aide (MA) on 08/22/24 at 10:50am revealed: -She had checked Resident #6's FSBS values and the values were over 400 before. -She was not aware of any facility policy to contact the PCP for FSBS values over 400. -She had never contacted Resident #6's PCP about his FSBS values being over 400 because he never had symptoms. -She could not remember if she ever went back and rechecked Resident #6's FSBS to see if the value came down to 300 or lower. -She was not aware she was supposed to recheck a resident's FSBS if the initial value was over 400. -Resident #6 was alert, oriented, and able to report if he was not feeling well due to high FSBS values.	D 273		

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	HAL034116	A. BUILDING: _____ B. WING _____	C 08/23/2024

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D 273	Continued From page 37 Interview with a second MA on 08/22/24 at 11:20am revealed: -Resident #6 sometimes had FSBS values over 400. -She had mentioned Resident #6's high FSBS values to his PCP but she could not remember when and she had not documented the conversation. -Resident #6's PCP had access to the eMARs so she could see what his FSBS values were each month. -Resident #6 had never reported symptoms of high blood sugar to her when his FSBS was in the 400's or 500's. -She had never received any new orders from Resident #6's PCP regarding his FSBS over 400; the PCP always said to administer his scheduled insulin and recheck the FSBS. -She never documented her FSBS rechecks because the value always went down and Resident #6 never had symptoms. Interview with a third MA on 08/23/24 at 2:10pm revealed: -Resident #6's FSBS was sometimes over 400 when she checked it. -The MAs were supposed to call the PCP or the on-call doctor any time a resident had a FSBS value in the 400's or 500's. -She had never followed up with Resident #6's PCP or the on-call doctor about the FSBS checks being over 400 because Resident #6 was never symptomatic. -She could not remember if she ever went back and rechecked Resident #6's FSBS to see if the value came down. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 3:45pm revealed: -The MAs were expected to notify the PCP of any	D 273		

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D 273	Continued From page 38 FSBS check result over 400. -If the MA could not contact the PCP for some reason, they were responsible for notifying her about the refusals so she could follow up. -Any time a MA notified the PCP about a high FSBS value, the MA was responsible for documenting the notification in a charting note along with any new orders received. -She knew that Resident #6's blood sugars ran high, but was not aware how often it was over 400. -She had never discussed Resident #6's FSBS values with the PCP. -Resident #6 had never reported symptoms of high blood sugar to her. -She had not been completing any routine audits of the eMARs to check for FSBS over 400 and completion of the proper notifications. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -It was the facility's policy to notify the PCP or on-call provider of any FSBS over 400. -She was not aware that Resident #6 had been having frequent FSBS values over 400. -The MAs should have been rechecking Resident #6's FSBS per the policy instructions. -The HWD was ultimately responsible for ensuring notifications for FSBS over 400 had been completed. -The MAs were expected to document in a chart note any communication they had with the PCP or on-call provider regarding FSBS values and any subsequent orders received or follow-up FSBS checks. Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed: -She expected to be notified about any FSBS value over 400.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 39 -She had not received any notification from the facility's staff regarding Resident #6's FSBS values being over 400 in June, July, or August 2024. -Adverse effects of frequent high FSBS levels included diabetic retinopathy, kidney and heart damage. -She was not aware of Resident #6 experiencing any symptoms or adverse effects from having FSBS values in the 400's and 500's. _____ The facility failed to ensure referral and follow-up to meet the acute health care needs for 4 residents whose primary care provider was not notified including Resident #6, who had multiple refusals of mealtime insulin injections and long-acting insulin injections, and multiple refusals of FSBS checks placing the resident at risk for adverse effects of frequent high FSBS levels including diabetic retinopathy and kidney and heart damage; Resident #3, who had discoloration of her lower extremities and was at risk for blood clots, and did not have a lower extremity ultrasound performed and was not referred to the vascular clinic; Resident #4, who had aggressive behaviors in the SCU and was not referred for a psychiatric evaluation; and Resident #7, who had multiple FSBS values over 400 and parameters to notify the PCP for FSBS over 400 placing the resident at risk for adverse effects of frequent high FSBS levels including diabetic retinopathy, kidney and heart damage. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation.. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/24 for this violation.	D 273		

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D 273	Continued From page 40 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 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: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#5) related to an order for a bed transfer handle and trapeze bar. The findings are: Review of Resident #5's current FL2 dated 4/10/24 revealed: -Diagnoses included stiff man syndrome (a neurological disorder that causes muscle stiffness and spasms), Parkinson's disease and adult failure to thrive. -Resident #5 was semi-ambulatory. Review of Resident #5's current Care Plan dated 10/17/23 revealed: -Resident #5 needed limited assistance with eating, toileting, dressing, and grooming. -Resident #5 needed extensive assistance with bathing.	D 276	The RCC, MCC or designee will be responsible for monitoring all referral and follow ups that comes from the PCP and ensuring the referral has been completed. The RCC, MCC has completed audits of the charts for any missing orders. The community will use a QI tracker to monitor all required documents. The RCC, MCC or deisgnee will audit daily for all orders. Date of compliance October 7, 2024.	

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D 276	Continued From page 41 Review of Resident #5's physician's order dated 02/29/24 revealed there was an order for a trapeze bar and bed transfer handle. Review of Resident #5's Licensed Health Professional Support (LHPS) revealed: -There was an LHPS evaluation dated 03/28/24. -There was documentation for a LHPS task of transferring semi-annual or non-ambulatory residents. -The LHPS review had documentation for the resident needing meal set-up and bathing assist. -There was no documentation related to Resident #5 needing or using bed transfer assisting devices. -There was no LHPS review after 03/28/24 available for review. Review of Resident #5's primary care provider (PCP) facility visit encounter notes requested from the PCP on 08/21/24 revealed: -On 04/18/24, the PCP noted a side rail attached to the bed would provide a safe, sturdy place to grab to assist in and out of bed. The plan for care was noted for durable medical equipment (DME) side rail and bed trapeze. -On 05/14/24, the PCP noted in the plan of care DME: Resident #5's side rail was "ordered but insurance will not pay. Awaiting response from medical supplier" for an alternative for side rail bar. Observation of Resident #5 on 08/23/25 at 1:40pm revealed: -Resident #5 was ambulating around his room using a wheelchair. -Resident #5 had a hospital bed with the head of the bed elevated 15 to 20 degrees. -There was no bed transfer handle for the bed.	D 276		

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D 276	Continued From page 42 Interview with Resident #5 on 08/23/24 at 1:43pm revealed: -He had a degenerative neurological disorder that made his muscles stiff. -He had difficulty sometimes transferring from his bed to the wheelchair. -His PCP told him several months ago he might benefit from a trapeze bar or bed siderail/handle to assist him transferring to and from the bed. -The PCP mentioned a handle or rail in one of his previous visits but he was not sure of the date. -He did not want the trapeze bar as he did not think his muscles would allow him to reach up and use the trapeze bar for transfers. -He would like to have some type of rail or handle to grab when he was getting in and out of the bed. -The rail or handle would make it easier and probably safer transferring. -The facility had a lot of staff turnover in the last 6 months, and the current facility Nurse had not asked him if had or needed a side rail or handle. -No facility staff had asked him about a side rail or handle. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 3:40pm revealed: -She had been the facility Nurse for more than one year. -She had been most actively involved in LHPS reviews and assisted the former Resident Care Coordinator (RCC) and Special Care Unit Coordinator (SCUC) as needed. -The previous RCC and SCUC were responsible to review the PCP's encounter visits summaries and process the medication and treatment orders. -Both the RCC and SCUC no longer worked at the facility with the SCUC leaving in April 2024	D 276		

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D 276	Continued From page 43	D 276		

and the RCC about 2 weeks prior to 08/20/24.
-She assumed duties of the SCUC in April 2024 while the facility was hiring a replacement.
-She assumed the RCC duties when the RCC left until a replacement was hired.
-She did not know realize the PCP emailed the residents' visit encounters to the RCC and the SCUC and had not been reviewing PCP visit encounters.
-She was not aware the PCP ordered Resident #5 a bed rail or handle on 02/29/24 because she did not have a system in place to routinely review or audits residents' orders for treatments or medications. She assumed the former RCC and former SCUC were doing the audits.
-On 08/20/24, the Administrator gave her the passwords to the emails used by the previous RCC and SCUC.
-She was not aware the PCP noted on 05/14/24 Resident #5's side rail was "ordered but insurance will not pay. Awaiting response from medical supplier" for an alternative for side rail bar because she had not reviewed Resident #5's PCP visits notes.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-PCP encounter summaries were emailed to the corporate email that the previous RCC and SCUC used.
-The previous RCC and SCUC were responsible for ensuring the PCP encounter notes were reviewed and any clinical orders implemented.
-The HWD was responsible for overseeing the RCC and SCUC and was now responsible for their duties until a new RCC and SCUC were hired and trained.
-She expected the HWD to have the PCP's resident encounter notes reviewed and ensure that new orders or changes were followed.

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D 276	Continued From page 44 Telephone interview with Resident #5's PCP on 08/23/24 at 1:50pm revealed: -The facility should have ordered Resident #5's side rail in February 2024 when she requested the rail. -She became aware in May 2024 that Resident #5 had not received a side rail. -She thought the resident would benefit from having a handle or rail to grip while transferring from wheelchair to bed. -No facility staff had corresponded with her regarding the status of obtaining a side rail/handle for Resident #5.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the	D 280	The RCC, MCC or designee will be responsible for keeping track of all LHPS reviews to be completed quarterly. The communiuty will use a QI tracker to track all dates of LHPS's needed and other required documents. An audit completed of all outstanding LHPS reviews needed. The RCC, MCC or designee will be responsible to coordinate with the RN consultant nurse, PCP or Therapist on LHPS reviews. Date of compliance 10/7/24.	

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D 280	Continued From page 45	D 280		

resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly on 2 of 6 sampled residents (#5 and #7) to include the identified task of ambulation with staff assistance with an assistive device and transferring with staff assistance (#5) and fingerstick blood sugar (FSBS) checks with insulin administration (#7).

The findings are:

1. Review of Resident #5's current FL2 dated 04/10/24 revealed:
-Diagnoses included stiff man syndrome (a neurological disorder that causes muscle stiffness and spasms), Parkinson's disease and adult failure to thrive.
-Resident #5 was semi-ambulatory.

Review of Resident #5's current Care Plan dated 10/17/23 revealed:
-Resident #5 needed limited assistance with eating, toileting, dressing, and grooming.
-Resident #5 needed extensive assistance with bathing

Review of Resident #5's Licensed Health Professional Support (LHPS) evaluations revealed:
-There were LHPS evaluations dated 09/28/23, 12/28/23, and 03/28/24.
-The LHPS tasks included transferring semi-annual or non-ambulatory residents as a marked task.

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D 280	Continued From page 46 -The LHPS evaluations included documentation Resident #5 needed meal set-up and bathing assistance. -There was no LHPS evaluation after 03/28/24 available for review. Observation of Resident #5 on 08/23/25 at 1:40pm revealed Resident #5 was ambulating around his room using a wheelchair. Interview with Resident #5 on 08/23/24 at 1:50pm revealed: -He had a neurological disorder that caused his muscles to be stiff. -Some days his symptoms of weakness or shaking were worse than other days. -He was able to transfer to his wheelchair most days. -He needed some assistance with bathing hard to reach areas. Interview with a medication aide (MA) on 08/23/24 at 2:00pm revealed: -Resident #5 used a wheelchair to ambulate around the facility. -Resident #5 was mostly independent with his transfers from his wheelchair. -Some days, he was weaker than others and needed assistance getting from the wheelchair to bed or bed to wheelchair. Interview with a personal care aide (PCA) on 08/23/24 at 2:30pm revealed: -Resident #5 did not require much assistance with care. -Some days, he needed assistance transferring to the wheelchair if he was weaker. Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:15pm.	D 280		

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D 280	Continued From page 47 Refer to the interview with the Administrator on 08/23/24 at 6:15pm. 2. Review of Resident #7's current FL2 dated 4/10/24 revealed: -Diagnoses included chronic anemia, diabetes mellitus type II with chronic kidney disease, -Resident #7 was semi-ambulatory. Review of Resident #7's current Care Plan dated 02/06/24 revealed: -Resident #7 needed limited assistance with eating, toileting, and dressing. -Resident #7 needed extensive assistance with bathing and grooming. Review of Resident #7's physician's orders revealed: -There was an order dated 04/30/24 for Novolog Mix (a combination of long acting and fast acting insulin) 70/30 insulin inject 30 units once daily before breakfast, hold for fingerstick blood sugar (FSBS) less than 130. -There was an order dated 04/30/24 for Novolog Mix 70/30 insulin inject 12 units once daily with dinner, hold for FSBS less than 100. -There was an order dated 07/02/24 to check FSBS 4 times a day before meals and at bedtime and to inject Humalog (a rapid acting insulin) as per sliding scale (SS): 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units. Greater (FSBS) than 400 notify MD or on-call provider after hours. Review of Resident #7's June 2024 electronic medication record (eMAR) revealed: -The was an entry to check FSBS every morning at 7:30am with FSBS values and inject 30 units of Novolog Mix before breakfast (hold for FSBS less	D 280		

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than 130) documented from 06/01/24 to 06/30/24.
-The was an entry to check FSBS at 4:30am before meal with FSBS values and inject 12 units of Novolog Mix with dinner (hold for FSBS less than 100) documented from 06/01/24 to 06/30/24.

Review of Resident #7's July 2024 eMAR revealed:
-There was an entry to check FSBS before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 9:00pm and to inject Humalog (a rapid acting insulin) as per sliding scale (SS): 200-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units. Greater (FSBS) than 400 notify MD.
-FSBS values were documented 4 times a day from 07/02/24 to 07/31/24.

Review of Resident #7's physician's orders dated 08/14/24 revealed there was an order to discontinue FSBS and Humalog SS insulin.

Review of Resident #7's August 2024 eMAR from 08/01/24 to 08/14/24 revealed:
-There was an entry to check FSBS before meals and at bedtime scheduled for 7:30am, 11:30am, 4:30pm, and 9:00pm.
-FSBS values were documented from 08/01/24 to 08/14/24.

Review of Resident #7's Licensed Health Professional Support (LHPS) evaluations revealed:
-There was an LHPS evaluation dated 09/28/23 and 03/28/24.
-The LHPS included medication through injections and collecting and testing FSBS samples as marked tasks.
-The LHPS evaluation included documentation Resident #7 needed stand-by assistance with

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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D 280	Continued From page 49 bathing. -There was no LHPS review after 03/28/24 available for review. Interview with Resident #7 on 08/23/24 at 2:00pm revealed: -She had been a diabetic and taken insulin for many years. -The medication aides (MAs) did FSBS checks 2 to 4 times a day. -The staff assisted her with bathing. Interview with a MA on 08/23/24 at 2:20pm revealed: -Resident #7 had FSBS and insulin injections ordered for a long time. -She checked Resident #7's FSBS and injected insulin per the instruction on the resident's eMAR. . Interview with a personal care aide (PCA) on 08/23/24 at 2:30pm revealed Resident #7 received assistance with bathing, dressing, and personal grooming. Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:15pm. Refer to the interview with the Administrator on 08/23/24 at 6:15pm. _____ Interview with the HWD on 08/23/24 at 4:15pm revealed: -She completed LHPS assessments and quarterly evaluations of residents' LHPS tasks. -She was primarily responsible for completing LHPS evaluations until April 2024 when there was a staff turnover. -She assumed the duties of the Special Care Unit Coordinator (SCUC) in April 2024 while the facility was recruiting a new SCUC.	D 280		

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D 280	Continued From page 50 -There was additional staff turnover when the Resident Care Coordinator (RCC) position became vacant since early August 2024. -She assumed the duties of the RCC in addition to the SCUC for the past few weeks. -The facility had hired a RCC and SCUC to begin working the last week of August 2024. -She had not completed an LHPS quarterly evaluations for residents since 03/28/24. -She had fallen behind with completing quarterly LHPS evaluations for some of the residents due to the increased responsibilities of RCC and SCUC duties. Interview with the Administrator on 08/24/24 at 6:15pm revealed: -She was aware the residents' LHPS were to be reviewed quarterly. -The HWD was responsible for completing quarterly LHPS evaluations for the facility's residents with LHPS tasks. -She did not know the HWD was behind on completing quarterly LHPS evaluations.	D 280		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296	The community completed an audit of all therapuetic diet menus and diet orders for residents. The community has updated therapuetic diet menus that they dietary staff have been trained to use. The therapuetic diet menus are readily available and used during the preparation of resident meals. The DSD or designee will be responsible to ensure all therapuetic diet menus are used daily by the cooks. Date of compliance 10/7/24.	

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D 296	Continued From page 51 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 5 sampled residents (#2) who had an order for a no concentrated sweets (NCS) and mechanical soft (MS) diet. The findings are: Review of Resident #2's current FL2 dated 08/08/24 revealed diagnoses included diabetes mellitus type 2, dementia, and gastroesophageal reflux disease (GERD). Review of Resident #2's diet order dated 09/21/23 revealed an order for a NCS/MS diet. Review of the facility's menus revealed there was no therapeutic diet menu for a NCS/MS diet. Observation of the kitchen on 08/20/24 at 10:35am revealed: -There were week-at-a-glance menus hanging on the wall and therapeutic diet menus at the serving table. -There was a therapeutic menu for MS diet, but no therapeutic menu for a NCS/MS diet. -The facility's therapeutic diet list, dated 08/20/24, posted in the kitchen revealed Resident #2 was to be served a regular no concentrated sweets (NCS) diet. Review of the facility's week-at-a-glance menu for the lunch meal service on Monday, 08/20/24, for regular diets revealed chicken Alfredo, salad with dressing, a baked roll, vanilla pudding, milk, and a choice of coffee or tea were to be served. Observation of the lunch meal service on	D 296		

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D 296	Continued From page 52 08/20/24 between 12:00pm and 1:00pm revealed: -Resident #2 was served ground chicken Alfredo, chopped salad with dressing, dinner roll, water, unsweetened iced tea, and sweetened chocolate pudding. -Resident #2 consumed 90% of her meal including all the sweetened chocolate pudding and salad without difficulty. Based on observation of the lunch meal service on 08/20/24, it could not be determined if Resident #2 was served the correct therapeutic diet due to no NCS/MS diet menu being available for staff guidance. Review of the facility's week-at-a-glance menu for the breakfast meal service on Tuesday, 08/21/24, for regular diets revealed a choice of cereal, scrambled eggs, bacon, milk, a choice of juice, and a choice of coffee or tea were to be served. Observation of the lunch meal service on 08/21/24 between 8:00am and 8:45am revealed: -Resident #2 was served lumpy scrambled eggs, ground bacon, oatmeal, sweetened iced tea, water, sweetened orange juice, and coffee. -Resident #2 consumed 100% of her meal and consumed both the sweetened tea and the orange juice. Based on observation of the lunch meal service on 08/21/24, it could not be determined if Resident #2 was served the correct therapeutic diet due to no NCS/MS diet menu being available for staff guidance. Interview with a cook on 08/20/24 at 12:45pm revealed: -He prepared meals for residents including NCS meal food items and he prepared Resident #2's	D 296		

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lunch meal on 08/20/24.
-He prepared Resident #2's NCS meal according to the therapeutic diet listed located at the serving table in the kitchen.
-The Dietary Manager (DM) was responsible for updating the kitchen staff with therapeutic menus and updating the residents' meal cards.
-He was aware the kitchen was supposed to have therapeutic diet menus to match each therapeutic diet offered by the facility.
-He was not aware there was not a therapeutic menu for NCS/MS to be used to prepare meals for the residents.
-Resident #2's meal card was for a NCS/MS diet.
-He was not aware Resident #2 was served chocolate pudding for the lunch meal on 08/20/24.

Interview with a personal care aide (PCA) on 08/21/24 at 8:45am revealed:
-The PCA used the therapeutic diet list provided by the kitchen staff to serve residents according to their meals.
-She was aware she served Resident #2 sweetened chocolate pudding for the lunch meal on 08/20/24 and sweetened orange juice and sweet tea for the breakfast meal on 08/21/24.
-She was not aware Resident #2 was on a NCS/MS diet.

Interview with a second PCA on 08/21/24 at 8:50am revealed:
-The PCAs used the therapeutic diet list provided by the kitchen staff to serve residents according to their meals.
-He relied on the kitchen staff to provide the meals according to the therapeutic diet list to serve residents according to their diet orders.
-He was aware Resident #2 was ordered a NCS/MS diet, but was not present for the lunch

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D 296	Continued From page 54 meal on 08/20/24 and did not serve Resident #2's meal for the breakfast meal on 08/21/24 Interview with a second cook on 08/21/24 at 9:10am revealed: -She was responsible for preparing, cooking and helping to serve the meals to residents. -The only guidance she had to prepare NCS/MS meals was the week-at-a-glance menu, and the therapeutic diet list located at the serving table. -There was no therapeutic diet menu available for guidance while preparing meals for residents ordered NCS/MS therapeutic diets. -She was not aware Resident #2 was ordered a NCS/MS diet. -She was not aware Resident #2 was served chocolate pudding for the lunch meal on 08/20/24 and was served regular orange juice and sweetened tea for the breakfast meal on 08/21/24. Interview with the DM on 08/21/24 at 9:15am revealed: -There was a therapeutic diet list posted in the kitchen listing which residents had a diet order for NCS and for MS. -The kitchen did not have a therapeutic diet menu for a NCS/MS diet. -She was aware the kitchen was supposed to have therapeutic diet menus to match each therapeutic diet offered by the facility. -She was responsible for ensuring the kitchen had therapeutic diet menus to match each therapeutic diet offered by the facility, but she must have overlooked not having a NCS/MS therapeutic diet menu for Resident #2. -Resident #2's diet order in her book was dated 01/16/23 and was for a NCS/MS diet. Interview with the Health and Wellness Director	D 296		

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(HWD) on 08/21/24 at 10:50am revealed:
-She or the medication aides (MA) were responsible for taking new diet orders and giving a copy of the order to the kitchen staff.
-The DM was responsible for ensuring that the kitchen was supposed to have therapeutic diet menus to match each therapeutic diet offered by the facility.
-She was not aware the kitchen did not have a therapeutic menu to match a NCS/MS diet.
-She was not aware Resident #2 was ordered a NCS/MS diet.
-She expected the kitchen to have a therapeutic menu to match each therapeutic diet offered at the facility.

Interview with the Administrator on 08/21/24 at 11:05am revealed:
-She was aware the kitchen needed therapeutic diet menus in addition to the week-at-a-glance menu.
-The previous evening on 08/20/24, she found the therapeutic diet menus on her computer and printed them for the kitchen.
-She was aware Resident #2 was on a NCS/MS diet.
-She was not aware the kitchen did not have a therapeutic menu to match a NCS/MS diet.
-She thought the kitchen staff were aware of the residents who were ordered therapeutic diets and serving them appropriately.
-She expected the kitchen to have a therapeutic menu to match each therapeutic diet offered at the facility.

Telephone interview with Resident #2's PCP on 08/21/24 at 4:45pm revealed:
-She had ordered Resident #2 a NCS/MS diet and expected the kitchen to have a matching therapeutic menu to match Resident #2's diet

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D 296	Continued From page 56 order. -Resident #2 was ordered a NCS/MS diet due to her diabetes mellitus type 2 and her diagnosis of dementia. Based on observations, record reviews and interviews, it was determined Resident #2 was not interviewable. Attempted telephone interview on 08/21/24 at 3:00pm with Resident #2's power of attorney (POA) was unsuccessful.	D 296		
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 that 8 ounces of milk or other equivalent dairy products were served three times daily to 33 of 34 residents in the Special Care Unit (SCU).	D 299	The community provided education to the staff on the importance and the requirement of serving milk to all residents in the SCU. The DSD will ensure that the community has enough milk at all times to provide to the residents. The DSD, the MCC or designee will be responsible to ensure that milk is being served along with the correct diet daily during meal service times. Date of compliace 10/7/24.	

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D 299	Continued From page 57 The findings are: Review of the facility's census revealed a census of 34 residents residing in the SCU. Review of the facility's daily menu for 08/20/24 and 08/21/24 revealed: -Milk was listed to be served for breakfast, lunch, and dinner meal service. -There were no equivalent dairy products listed on the menu to be served on 08/20/24 or 08/21/24. Observation of the kitchen's reach-in refrigerators on 08/20/24 revealed there were 4 unopened gallons of milk and 1 gallon of milk that had been opened with 1/4 gallon of the milk remaining in the container. Observation of the lunch meal service in the SCU on 08/20/24 between 12:00pm and 1:00pm revealed: -There were 33 residents present in the dining room. -There were 33 place settings prepared for the residents with 1 empty cup at each place setting. -The beverages were served from a dining cart by the personal care aides (PCAs). -Beverages included juice, tea, and water, but there was no milk available on the dining cart. -All residents were served water and tea. -There were 33 residents who were not served milk, and there were no other dairy products offered or served to the 33 residents. -No staff retrieved milk from the kitchen. Observation of the breakfast meal service in the SCU on 08/21/24 between 8:00am and 8:45am revealed: -There were 27 residents present in the dining	D 299		

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room.
-There were 27 place settings prepared for the residents with 1 empty cup at each place setting.
-The beverages were served from a dining cart by the PCAs.
-Beverages included juice, coffee, tea, a gallon of milk, and water.
-All residents were served water and juice.
-There were 27 residents who were not served milk, and there were no other dairy products offered or served to the 27 residents.

Interview with a kitchen staff on 08/20/24 at 12:45pm revealed:
-He was not aware milk should have been served with each meal to the residents in the SCU.
-The dietary staff were responsible to send all beverage, including milk, on the dining carts for the SCU residents.
-He was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU.

Interview with a PCA on 08/21/24 at 8:45am revealed:
-The dietary staff prepared the dining cart and the PCAs served the beverages.
-The PCAs were responsible for serving meals and beverages in the SCU.
-Residents were not served milk, but she did not know why.
-She was aware milk was not served or offered with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU.
-She was told to serve the residents a beverage and water, but she had not been told to serve the residents milk.

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D 299	Continued From page 59 Interview with a second PCA on 08/21/24 at 8:50am revealed: -She was not aware milk should have been served with each meal to the residents in the SCU. -Milk was not regularly served to the residents in the SCU. -The dietary staff prepared the dining cart and the PCAs served the beverages. -Milk was not always provided on the dining cart for all the residents in the SCU for every meal, and she did not know why. -She served beverages to the residents in the SCU during the lunch meal service on 08/20/24 and the breakfast meal service on 08/21/24. -She was aware milk was not served or offered with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU. -She had not offered milk to the residents residing in the SCU for the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24. -She thought staff only had to offer milk to the residents and there were residents who usually refused milk during their meals. Interview with a third PCA on 08/21/24 at 8:55am revealed: -She was aware milk should have been served with each meal to the residents in the SCU. -Milk was not regularly served to the residents in the SCU due to the SCU residents refusing the milk. -The dietary staff prepared the dining cart and the PCAs served the beverages. -Milk was not always provided on the dining cart for all the residents in the SCU for every meal because there was a shortage of milk. -She served beverages to the residents in the	D 299		

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D 299	Continued From page 60 SCU during the lunch meal service on 08/20/24 and the breakfast meal service on 08/21/24. -She was aware milk was not served or offered with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 for the residents residing in the SCU. -She had not offered milk to the residents residing in the SCU for the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24. -She was told to serve the residents a beverage and water, but she had been told to offer milk only if it was available. Interview with a second kitchen staff on 08/21/24 at 9:05am revealed: -The dietary staff were responsible to send all beverages, including milk, on the dining carts for the SCU residents. -She was not aware milk was not sent on the dining cart for the lunch meal service on 08/20/24. -She was not aware all the residents in the SCU were supposed to receive milk with all meals. -She was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU. Interview with a third kitchen staff on 08/21/24 at 9:10am revealed: -The dietary staff were responsible to send all beverages, including milk, on the dining carts for the SCU residents. -She was not aware all the residents in SCU were supposed to receive milk with all meals. -She was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU.	D 299		

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D 299	Continued From page 61 Interview with the Dietary Manager (DM) on 08/21/24 at 9:15am revealed: -She did not know milk products should be served to the residents in the SCU three times daily. -The dietary staff should have taken milk to the SCU from the assisted living (AL) kitchen when they took meals to the SCU. -She did not know why milk had not been taken to the SCU to be served with the lunch meal on 08/20/24. -She was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU. -She expected a gallon of milk to be placed always on the dining carts for all the SCU residents. Interview with the Health and Wellness Director (HWD) on 08/21/24 at 10:50am revealed: -She was aware milk should have been served with each meal to the residents in the SCU. -She was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU. -She expected milk to be served, and not just offered to the residents by the PCAs in the SCU during each meal. Interview with the Administrator on 08/21/24 at 11:05am revealed: -She was aware milk should have been served with each meal to the residents in the SCU. -She was not aware milk was not served with the lunch meal service on 08/20/24 or with the breakfast meal service on 08/21/24 to the residents residing in the SCU.	D 299		

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D 299	Continued From page 62 -She expected PCAs to serve milk to the SCU residents at every meal according to the menu and regulations.	D 299		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 7 sampled residents (#1 and #12) including a resident who was ordered a mechanical soft diet and received a regular diet (#1) and a resident, who was ordered a pureed diet and received a regular diet (#12). The findings are: 1. Review of Resident #1's current FL2 dated 04/10/24 revealed diagnoses included dysphagia (difficulty swallowing), history of cerebrovascular accident (CVA/stroke) with right-sided hemiplegia and hemiparesis, and muscle weakness. Review of Resident #1's diet order dated 05/21/24 revealed an order for a regular diet with a mechanical soft texture. Review of Resident #1's record on 08/20/24 revealed there was no DNR order available for	D 310	The community immediately held an inservice on diet orders and completed an audit of all diet orders and received updated signatures from the pcp for the orders. Any clarifications was sent over to the PCP for review and entered into the residents charts. Additional education was given by the RN consultant nurse for the staff. The RCC, MCC or designee is responsible for supervision during meal times to ensure the residents receive the right diet orders at all meals. The RCC, MCC or designee will be responsible for following up with the pcp for any diet order clarifications. Date of compliance 9/22/24.	

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review.

Review of Resident #1's Incident/Accident Report dated 07/31/24 revealed:
-At 5:00pm, Resident #1 was found with his eyes closed and was unresponsive with his arms down at his sides seated at the dining room table.
-Staff alerted the facility's Health and Wellness Director (HWD) that Resident #1 "didn't look good."
-The HWD went to the dining area to assess Resident #1 and found he had cyanosis (a blue color to the skin due to lack of oxygen in the blood) to his face and hands along with a thready, weak pulse.
-Resident #1 was not responsive to painful stimuli.
-Resident #1 was removed from the dining area and taken into the hallway where the Heimlich maneuver was performed.
-Emergency Medical Services (EMS) was called and Resident #1's power of attorney (POA) was contacted, time was not specified.
-Cardiopulmonary Resuscitation (CPR) was initiated by staff, names were not specified.
-Vital signs were documented as being unable to obtain with a weak thready pulse and respirations at 4-5 breaths per minute.
-The staff completing the incident/accident report was the HWD.

Review of the EMS report dated 07/31/24 revealed:
-EMS received a call at 4:56pm and was dispatched to the facility for an unconscious resident which was upgraded to a cardiac arrest.
-EMS arrived at the facility at 5:09pm.
-Upon arrival to the facility, the local fire department was present and performing CPR.
-When the local fire department arrived at the

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facility, Resident #1 had been unconscious and unresponsive, and was not breathing.
-Resident #1 was lying on the floor, and personnel from the local fire department reported performing one round of compressions and no shock from the automated external defibrillator (AED) was advised; CPR continued.
-Staff reported to EMS that Resident #1 had choked on a hot dog and staff had performed abdominal thrusts and cleared some of the airway obstruction.
-Family arrived on the scene and wished to honor Resident #1's DNR order and cease CPR efforts at 5:29pm.
-Resident #1 was pronounced deceased at 5:29pm.

Observation of Resident #1's meal card in the kitchen on 08/20/24 at 3:25pm revealed his diet was listed as a regular diet.

Interview with a cook on 08/20/24 at 3:26pm revealed:
-Resident #1 had been ordered and served a regular diet, not mechanical soft.
-Resident #1 never had trouble chewing or swallowing the regular textured foods the kitchen served him.
-Either the Dietary Manager (DM) or the HWD were responsible for updating the kitchen staff if a resident's diet order had changed, and updating that resident's meal card.
-Resident #1's meal card was for a regular texture diet.

Interview with a dietary aide on 08/20/24 at 3:30pm revealed:
-His responsibilities included serving meal trays to the residents.
-Each meal tray had a card on it with the

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resident's name and diet order.
-Resident #1 was ordered a regular textured diet and always received a regular meal tray.
-He was not working the night Resident #1 passed away.

Interview with a second cook on 08/21/24 at 11:40am revealed:
-She had not witnessed Resident #1 choking, but one of the residents in the dining room had yelled out for staff saying that Resident #1 wasn't moving.
-When she looked in the dining room, Resident #1 was sitting in a dining room chair and his head was down.
-One of the other staff, she could not remember who, had already gone to get the PCA.
-The HWD came into the dining room and dragged Resident #1 out of the dining room in his chair.
-Resident #1 always got to the dining room early and was one of the first to eat his meal and leave the dining room.
-She had never observed Resident #1 having trouble chewing the regular textured foods.
-Resident #1 was on a regular textured diet, and that was what he had been served for supper on 07/31/24.
-She had never observed anyone from nursing staff in the dining room to audit a meal service and ensure each resident was served meals according to their diet order.

Interview with the DM on 08/21/24 at 11:28am revealed:
-If a resident's diet order changed, she usually found out during the daily morning meeting.
-The HWD was responsible for giving her a copy of each new diet order.
-She had a diet order book where she kept each

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resident's diet order.
-Resident #1's diet order in her book was dated 05/21/24 and was for a mechanical soft textured diet.
-She had not seen Resident #1's order for a mechanical soft diet.
-She thought someone from the nursing staff put the new order in her diet book and forgot to tell her Resident #1's diet order had changed.
-She thought Resident #1 was still supposed to receive a regular textured diet, and that was what the kitchen had served to him.
-She was not at the facility during the evening meal on 07/31/24, but staff had texted her a photo of the meal that was served that night which included sausage cut into "coin" slices, peppers, onions, rice, and cornbread.

Interview with Resident #1's tablemate on 08/20/24 at 3:35pm revealed:
-He sat at the same table as Resident #1.
-On 07/31/24, Resident #1 had been eating supper fine, then he stopped eating and started drooling.
-A couple of staff were in the dining room but someone had to flag down a staff member to check on Resident #1.
-The staff (he could not remember who) pulled Resident #1 on his chair out of the dining room.

Interview with a MA on 08/20/24 at 4:00pm revealed:
-The facility's policy for mealtimes was that there should always be at least one PCA in the dining room at all times when food was being served, then when the MAs were finished passing medications they were supposed to join the PCA to help in the dining room.
-At the dinner meal service on 07/31/24, there was one PCA in the dining room along with two

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dietary staff.
-The PCAs and dietary staff were the ones who served meal trays to the residents.
-She was not aware of Resident #1 having any trouble chewing or swallowing prior to 07/31/24.
-She was working on 07/31/24 when Resident #1 passed away.
-She and the other MA had their medication carts parked outside of the dining room.
-One of the PCAs stepped out of the dining room and said something was wrong with Resident #1.
-Both she and the other MA went into the dining room and saw that Resident #1 was sitting slumped over and his lips looked blue.
-She stepped out of the dining room and yelled for the HWD to come to the dining room.
-When the HWD got to the dining room and saw that Resident #1 was unresponsive, one of the residents helped them to pull Resident #1 out of the dining room in his chair into the hallway.
-She performed the Heimlich maneuver on Resident #1 and some sausage came out of his mouth, so she put on a glove and did a mouth sweep to see if she could remove more of the sausage, and was able to get a little more food out.
-The other MA called 911.
-The 911 operator advised them to lay Resident #1 flat for CPR.
-The HWD initiated CPR.
-The first responders from the local fire department moved Resident #1 from his bed to the floor and took over performing CPR until EMS arrived.
-The HWD contacted Resident #1's POA and she came to the facility.
-After a while, EMS called out Resident #1's time of death.

Telephone interview with Resident #1's POA on

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D 310	Continued From page 68 08/21/24 at 10:43am revealed: -She had not been at the facility with Resident #1 during meals so she did not know if the kitchen served him a regular textured meal or mechanical soft. -Resident #1 had a stroke 30 years prior which impaired his ability to read, write, and speak. -Resident #1 did not have any teeth but she had never observed him having trouble eating regular textured food when she took him out to eat. -On 07/31/24, she received a phone call from the facility's HWD saying Resident #1 had been eating and staff observed him in distress and were currently "working on him." Interview with the HWD on 08/22/24 at 2:00pm revealed: -If a resident's diet order changed, either she or the RCC was supposed to give a copy of the diet order to the kitchen staff. -She did not know if the facility had an RCC on staff on 05/21/24 when Resident #1's diet order changed from regular texture to mechanical soft texture. -She was not aware that Resident #1's diet order was for a mechanical soft diet. -The RCC who was working on 07/31/24 no longer worked for the facility. -The RCC was responsible for being in the dining room at meal times to observe, but she did not know if the RCC checked that each resident was served their diet as ordered by the primary care provider (PCP). -The RCC had not been in the dining room when Resident #1 was found unresponsive at his table on 07/31/24. -She was working the evening Resident #1 passed away. -She had interviewed some residents afterward and none of them said Resident #1 had coughed	D 310		

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or made any sound prior to staff arriving to assess him.
-Resident #1's mouth had mushy, chewed up food in it that they were not able to swipe out.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-She received a call from the HWD on the evening of 07/31/24 telling her that EMS was performing CPR on Resident #1, then she received a second call letting her know the CPR was unsuccessful.
-The HWD was responsible for notifying the kitchen of any changes in a resident's diet order.
-The kitchen staff were responsible for updating the diet book and notifying the rest of the kitchen staff.
-The staff who were working in the kitchen during the supper meal on 07/31/24 told her they had served Resident #1 a regular diet.
-She expected the kitchen staff to serve each resident the diet that was ordered by the PCP.

Interview with Resident #1's PCP on 08/20/24 at 11:55am revealed:
-She had ordered Resident #1 a mechanical soft diet and expected the kitchen to serve Resident #1 a mechanical soft diet as ordered.
-Resident #1 had expressive aphasia but could understand and answer simple questions.
-She had not received any reports of Resident #1 having trouble chewing or swallowing from the staff or Resident #1.
-She had last seen Resident #1 on 07/25/24 for an acute complaint of leg pain and had sent him to the Emergency Department (ED) for imaging and evaluation.
-She had received a text message, she was unsure what day, letting her know that Resident #1 had passed away.

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D 310	Continued From page 70 2. Review of Resident #12's current FL2 dated 04/11/24 revealed: -Diagnoses included dementia unspecified, atrial fibrillation, aphasia, mental retardation, and anxiety. -There was an order for a regular diet. Review of Resident #12's physician's order dated 08/20/24 revealed a diet order for a pureed diet. Review of the therapeutic diet list posted in the kitchen dated 08/20/24 revealed Resident #12 was to be served a pureed diet. Review of the facility's therapeutic diet menu for a pureed diet for the lunch meal service on 08/20/24 revealed Resident #12 was to be served pureed chicken Alfredo, pureed green beans, a pureed baked roll, vanilla pudding, milk, and a choice of coffee or tea. Observation of Resident #12's lunch meal service on 08/20/24 between 12:00pm and 1:00pm revealed: -Resident #12 was served ground chicken Alfredo, a regular salad with large chunks of lettuce and raw carrots, chocolate pudding, water, and tea. -Resident #12 ate about 90% of the meal without difficulty and did not eat the regular salad after staff were prompted by the surveyor. Interview with a personal care aide (PCA) on 08/20/24 at 12:26pm revealed: -The PCAs used the therapeutic diet list provided by the kitchen staff to serve residents according to their diet orders. -She was not aware Resident #12 should not be served regular salad for the lunch meal on	D 310		

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08/20/24.
-She was not aware Resident #12 was ordered a pureed diet and thought Resident #12's diet had been changed to a mechanical soft diet.

Interview with a cook on 08/20/24 at 12:45pm revealed:
-He prepared meals for residents including pureed food items and he prepared Resident #12's lunch meal on 08/20/24.
-He was not aware Resident #12 should have been served pureed green beans in place of the regular salad because he did not reference the pureed diet therapeutic menu.
-Either the Dietary Manager (DM) or the Health and Wellness Director (HWD) were responsible for updating the kitchen staff if a resident's diet order had changed, and updating that resident's meal card.
-Resident #12's meal card was for a pureed diet.
-Residents were served incorrect meals previously due to PCAs mixing up the residents meal cards.
-He was not aware Resident #12 was served a regular salad for the lunch meal on 08/20/24.

Review of the facility's therapeutic diet menu for a pureed diet for the breakfast meal service on 08/21/24 revealed Resident #12 was to be served pureed scrambled eggs, pureed bacon, pureed hot cereal, milk, a choice of juice, and a choice of coffee or tea.

Observation of Resident #12's breakfast meal service on 08/21/24 between 8:00am and 8:45am revealed:
-Resident #12 was served lumpy scrambled eggs, regular oatmeal, water, juice, and tea.
-The oatmeal had visible chunks and looked the same as the oatmeal served to the residents

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served a regular diet.
-Resident #12's plate was taken to the kitchen and the kitchen staff pureed the oatmeal and the scrambled eggs after staff were prompted by the surveyor.
-Resident #12's plate was returned to her with oatmeal pureed along with pureed scrambled eggs.
-Resident #12 consumed 95% of the meal without difficulty.

Interview with another cook on 08/21/24 at 9:05am revealed:
-She prepared meals for residents including pureed food items and she prepared Resident #12's breakfast meal on 08/21/24 with pureed bacon and pureed scrambled eggs.
-She was not aware Resident #12 was served regular oatmeal or mechanical soft scrambled eggs for the breakfast meal on 08/21/24.
-The PCAs were supposed to use the diet order list or the meal cards to serve residents meals but she did not know why the meals were served incorrectly.
-She expected the PCAs to serve Resident #12 a pureed meal according to the therapeutic diet list.

Interview with a third cook/dietary aide on 08/21/24 at 9:10am revealed:
-She was not aware Resident #12 was served regular lettuce for the lunch meal on 08/20/24.
-She was not aware Resident #12 was served regular oatmeal or mechanical soft scrambled eggs for the breakfast meal on 08/21/24.
-The PCAs were supposed to use the therapeutic diet list or the meal cards to serve residents meals.
-She did not know why the meals were served incorrectly.
-She expected the PCAs to serve Resident #12 a

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D 310	Continued From page 73 pureed meal according to the therapeutic diet list. Interview with a second PCA on 08/21/24 at 8:45am revealed: -She was not aware that Resident #12 should not be served regular salad for the lunch meal on 08/20/24 and regular oatmeal or mechanical soft scrambled eggs for the breakfast meal on 08/21/24. -She was not aware Resident #12 was on a pureed diet and was told Resident #12's diet order was changed to a mechanical soft diet. Interview with a third PCA on 08/21/24 at 8:50am revealed: -The PCAs used the therapeutic diet list provided by the kitchen staff to serve residents according to their diet orders. -He relied on the kitchen staff to provide the meals according to the therapeutic diet list to serve residents according to their diets. -He was aware Resident #12 was on a pureed diet but was not present for the lunch meal on 08/20/24 and did not serve Resident #12's meal for the breakfast meal on 08/21/24. -He was not aware Resident #12 was served regular lettuce for the lunch meal on 08/20/24 and was served regular oatmeal or mechanical soft scrambled eggs for the breakfast meal on 08/21/24. Interview with the Dietary Manager (DM) on 08/21/24 at 9:15am revealed: -The HWD was responsible for giving her a copy of each new diet order. -She had a diet order book where she kept each resident's diet order. -Resident #12's diet order in her book was dated 02/21/23 and was for a mechanical soft textured diet.	D 310		

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D 310	Continued From page 74 -She had not seen Resident #12's order for a pureed diet. -She was provided with Resident #12's pureed diet order on the morning of 08/21/24, dated 08/20/24 which matched the therapeutic diet list. -She was not aware Resident #12's diet was listed as a pureed diet on the therapeutic diet list. -She thought Resident #1 was supposed to receive a mechanical soft diet, and that was what the kitchen had served to her. Interview with the HWD on 08/21/24 at 10:50am revealed: -Either she or the RCC were responsible to clarify diet orders with each resident's primary care provider (PCP). -If a resident's diet order changed, either she or the RCC was supposed to give a copy of the diet order to the kitchen staff. -She was not aware that Resident #12's diet order was for a pureed diet. -She was not aware Resident #12 was served regular lettuce for the lunch meal on 08/20/24 and was served regular oatmeal and lumpy scrambled eggs for the breakfast meal on 08/21/24. -She expected the PCAs to serve Resident #12 a pureed meal according to the therapeutic diet list. -She expected the kitchen staff to prepare Resident #12's pureed meals according to the PCP's diet orders. Interview with the Administrator on 08/21/24 at 2:22pm revealed: -She was not aware Resident #12 was served regular lettuce for the lunch meal on 08/20/24 and was served regular oatmeal and lumpy scrambled eggs for the breakfast meal on 08/21/24. -She expected staff to follow the therapeutic menus for ordered diets. -She expected the dietary staff to make	D 310		

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D 310	Continued From page 75 substitutions for food items according to the therapeutic menus. -She expected the kitchen to serve each resident the diet that was ordered by the PCP. Interview with Resident #12's PCP on 08/21/24 at 4:45pm revealed: -She had ordered Resident #12 a pureed diet and expected the kitchen to serve Resident #12 a pureed soft diet as ordered. -Resident #12 was ordered a pureed diet related to her aphasia, history of strokes, and her diagnosis of dementia. -Resident #12 could aspirate or choke as a possible outcome with the facility not following orders for a pureed diet. Based on record reviews and interviews, it was determined Resident #12 was not interviewable. Attempted telephone interview with Resident #12's power of attorney (POA) was unsuccessful. _____ The facility failed to serve the diet as ordered to Resident #1 who was found cyanotic and with a weak pulse in the dining room during supper. The kitchen staff served Resident #1 a regular textured diet when his physician's order was for a mechanical soft textured diet resulting in the resident choking. The failure of the facility to serve Resident #1 the diet ordered by the physician resulted in the death of Resident #1 and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/20/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER	D 310		

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D 310	Continued From page 76 22, 2024	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure contact with the residents' primary care provider (PCP) for verification or clarification of medication orders for 4 of 7 sampled residents (#2, #3, #4, and #6) related to a resident whose current FL2 did not match the previous medication orders (#2); two residents, who had missing orders on the electronic medication administration record (eMAR) (#3 and #4); and a resident who had a dose change on the eMAR without an order, and a medication that was ordered but never started (#6). The findings are:	D 344	The community completed a review of all medication orders. The PCP reviewed all physician orders and signed them and sent to pharmacy for updates. The updated physician orders have been filed in the residents charts and clarifications made by the PCP. The RCC, MCC or designee is responsible for reviewing the medication exceptions report daily and completing follow ups as needed. The Pharmacy review was completed, sent to the PCP and follow ups were completed. The RCC, MCC or designee is responsible for reviewing the Medication orders daily. Date of compliance 10/7/24.	

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D 344	Continued From page 77 1. Review of Resident #3's current FL2 dated 08/08/24 revealed diagnoses included Alzheimer's disease, hypertension, and lower extremity lymphedema. Review of Resident #3's physician's order date 05/07/24 revealed: -There was an order for bumetanide 1mg (used to treat edema) take 1 tablet daily. -There was no discontinue order for bumetanide 1mg. Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for bumetanide 1mg 1 tablet daily at 8:00am and documented as administered 3 of 6 opportunities, with a discontinue date of 06/06/24. -There was a second entry for bumetanide 1mg 1 tablet daily at 8:00am and documented as administered 9 of 11, with a discontinue date of 06/17/24. -There was a third entry for bumetanide 1mg 1 tablet daily at 8:00am and documented as administered 4 of 4 opportunities, with a discontinue date of 06/21/24. -There was a fourth entry for bumetanide 1mg 1 tablet daily at 8:00am with no opportunities documented as administered, with a discontinue date of 06/24/24. Review of Resident #3's July 2024 eMAR revealed there was no entry for bumetanide 1mg. Review of Resident #3's August 2024 eMAR from 08/01/24-08/20/24 revealed there was no entry for bumetanide 1mg. Observation of Resident #3's medications on	D 344		

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hand on 08/21/24 at 9:10am revealed there was no bumetanide 1mg on hand for administration.

Observation of Resident #3 on 08/21/24 at 9:20am revealed:
-She was sitting in her wheel chair in the Special Care Unit (SCU) television room.
-Both of her lower legs were dry with a foam dressing intact on her inner left middle shin.
-Both legs were discolored pink and without swelling or weeping.

Observation of Resident #3 on 08/22/24 at 1:55pm reveled:
-She propelled herself through the SCU hallway.
-Both of he lower legs were dry with foam dressing intact on her inner left middle shin.
-Her toes on both feet were discolored gray, but her skin was dry and intact.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 10:00am revealed:
-Resident #3 had a current order for bumetanide 1mg take 1 tablet daily with an original order date of 05/07/24.
-Bumetanide 1mg was dispensed to the facility on 06/05/24, 21 tablets for a 21-day supply to last until the facility's cycle fill on 06/21/24.
-Bumetanide 1mg was dispensed 06/21/24, 07/16/24 and 08/13/24, all 30 tablets to cover a 30 day supply.
-If any new orders or changes were signed by the PCP, the pharmacy would process the order by entering it into the eMAR system and the eMAR would reflect the change.
-Facility staff could review, change or discontinue orders in the eMAR system.
-The pharmacy staff exchanged the facility's medications on the medication carts during each

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cycle fill.
-The pharmacy staff compared the eMAR to the medications and any medications that were not on the eMAR were returned to the pharmacy.
-There was no record of medications returned by pharmacy staff after the medications were delivered to the facility.
-There was no documentation of communication from the facility requesting Resident #3's bumetanide 1mg.

Telephone interview with Resident #3's power of attorney (POA) on 08/21/24 at 3:09pm revealed:
-Resident #3 had a fluid pill ordered but he did not remember the name or dose.
-She had swelling and weeping in her legs for years and the fluid pill helped reduce both.
-Her swelling and weeping were about the same, not worse than previous months.

Interview with a medication aide (MA) on 08/22/24 at 3:50pm revealed:
-The previous Special Care Unit Coordinator (SCUC) reviewed eMARs and orders; and she thought the Health and Wellness Director (HWD) would have that responsibility since the SCUC position was vacant.
-The MAs were to continuously note any missing medication or discrepancies throughout their shift.
-The MAs could call the PCP and pharmacy to resolve any missing medication issues and reported them to the HWD if they could not resolve the problem.
-She did not realize Resident #3's bumetanide was no longer on the eMAR and she did not contact the pharmacy or PCP to verify if Resident #3 should still be administered bumetanide.
-The edema and weeping in Resident #3's legs were no worse than 2-3 months before.

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D 344	Continued From page 80 Interview with a second MA on 08/22/24 at 3:55pm revealed: -The MAs "constantly" conducted medication cart audits during their shift and reported any medication problem they could not fix to the HWD. -She had not noticed Resident #3 did not have bumetanide on the eMAR after June 2024. -She had not called the facility's contracted pharmacy or asked the PCP or HWD if Resident #3 was to be administered bumetanide. Interview with the HWD on 08/23/24 at 3:40pm revealed: -She was not aware Resident #3 was not administered bumetanide 1mg for 2 months. -She was not sure if the previous SCUC addressed the Resident #3's bumetanide order falling off the eMAR. -The MAs should audit medication carts for missing medications compared to the eMAR and follow up with the pharmacy and PCP to correct the issue and have the medication delivered. -No MA had informed her that Resident #3 had not received her bumetanide. -After the facility changed contracted pharmacies in May 2024, the SCUC was to stand with the pharmacy staff during the medication cycle fill exchange and compare medications delivered to the eMAR to see that all medications were correct and delivered. -If the order for Resident #3's bumetanide was not on the eMAR, facility staff would not have known to verify the order to continue the medication. -She was responsible to ensure clarification of all resident orders with the PCP. Telephone interview with Resident #3's PCP on	D 344		

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D 344	Continued From page 81 08/22/24 at 1:55pm revealed: -Resident #3 was ordered bumetanide 1mg daily to treat lower extremity edema and weeping in her legs. -She was not aware Resident #3 had not received her bumetanide 1mg daily and had not been contacted by the facility to verify to continue the order or if there was a discontinue order. -Resident #3 was at risk for increased edema and weeping due to lymphedema if she did not receive her bumetanide as ordered. -She expected facility staff to contact her to clarify any discrepancy in medication orders. Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable. Refer to the interview with the Administrator on 08/23/24 at 5:30pm. 2. Review of Resident #4's current FL-2 dated 08/08/24 revealed: -Diagnoses included Alzheimer's disease, aggression and convulsions. -There was an order for valproic acid sprinkles 125mg (used to treat seizures and behaviors) 1 capsule 2 times a day. Review of Resident #4's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for valproic acid 125mg 1 capsule twice daily at 8:00am and 8:00pm and documented as administered 9 of 13 opportunities, with a discontinue date of 06/14/24. -There was a second entry for valproic acid 125mg 4 capsules daily at bedtime at 8:00pm and	D 344		

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documented as administered 19 of 27 opportunities, with a discontinue date of 06/14/24.
-There was a third entry for valproic acid 125mg 2 capsules twice daily at 8:00am and 8:00pm and documented as administered 9 of 11 opportunities, with a discontinue date of 06/20/24.
-There was a fourth entry for valproic acid 125mg 2 capsules twice daily at 8:00am and 8:00pm with no opportunities documented as administered, with a discontinue date of 06/21/24.

Review of Resident #4's July 2024 eMAR revealed there was no entry for valproic acid 125mg.

Review of Resident #4's August 2024 eMAR from 08/01/24-08/20/24 revealed there was no entry for valproic acid 125mg.

Observation of Resident #4's medications on hand on 08/21/24 at 10:30am revealed there was no valproic acid on hand for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 10:05am revealed:
-Resident #4 had a current order for valproic acid 125mg one capsule 2 times a day dispensed on 06/14/24, a quantity of 48 tablets for a 12 day supply until cycle fill on 06/21/24.
-Resident #4's valproic acid 125mg was also dispensed on 06/19/24, 07/16/24 and 08/13/24, a quantity of 120 tablets with each dispensing for each monthly supply.
-If any new orders or changes were signed by the PCP, the pharmacy would process the order by entering it into the eMAR system and the eMAR would reflect the change.
-Facility staff could review, change or discontinue orders in the eMAR system.

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-The pharmacy staff exchanged the facility's medications on the medication carts during each cycle fill.
-The pharmacy staff compared the eMAR to the medications and any medications that were not on the eMAR were returned to the pharmacy.
-There was no record of medications returned by pharmacy staff after the facility medications were delivered.

Telephone interview with Resident #4's family member on 08/22/24 at 12:10pm revealed:
-Resident #4 was combative and hit staff and other residents when he was admitted in April 2024, but he had been calmer after the PCP started his medications.
-Staff told her that he did not sleep well at night and wandered most of the night.
-She would have liked the PCP to try something to help him sleep and not wander at night.

Interview with a medication aide (MA) on 08/22/24 at 3:50pm revealed:
-She tried to review eMARs compared to medications on hand during her shift.
-She did not remove any of Resident #4's medications from the eMAR and did not notice that the order for valproic acid was no longer on the eMAR.
-The pharmacy staff exchanged the medication in the medication carts each month during cycle fills.
-If the pharmacy staff did not leave a medication, that meant there was no longer an order for that medication.
-Resident #4's behavior had been better for the past 3 months.

Interview with a second MA on 08/22/24 at 3:55pm revealed:
-The MAs were to "constantly" conduct

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medication cart audits during their shift and report any medication problem they could not fix to the HWD.
-She had not noticed Resident #4 did not have valproic acid and the entry was no longer on the eMAR.
-She had not called the facility's contracted pharmacy or reported to the Health and Wellness Director (HWD) about Resident #4's missing valproic acid.

Interview with the HWD on 08/23/24 at 3:40pm revealed:
-The previous Special Care Unit Coordinator (SCUC) was responsible to verify any orders or discrepancies with a resident's PCP.
-The SCUC no longer worked at the facility since about 2 weeks prior to 08/20/24 so she was now responsible to verify orders with the PCP.
-The MAs should audit medication carts for missing medications compared to the eMAR but if a medication fell off the eMAR, the MAs would not be alerted to a problem.
-No MA had informed her that Resident #4's valproic acid had fallen off the eMAR.
-After the facility changed contracted pharmacies in May 2024, the SCUC was to stand with the pharmacy staff during the medication cycle fill exchange and compare medications delivered to the eMAR to see that all medications were correct and delivered.
-The SCUC was to contact the pharmacy office, PCP or responsible party/POA to resolve any issue preventing medication from being delivered.
-It was her responsibility to ensure verification of orders with the PCP.

Interview with Resident #4's PCP on 08/22/24 at 1:55pm revealed:
-Resident #4 was ordered valproic acid for

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behaviors due to his dementia.
-She was not aware that the order for Resident #4's valproic acid 125mg 1 capsule 2 times a day was no longer on the eMAR.
-He could revert to having aggressive behaviors if he was not administered the valproic acid.
-The facility staff had not contacted her to inquire if Resident #4 was to continue valproic acid.
-She expected facility staff to contact her to clarify any discrepancies in medication orders.

Based on observations, record reviews and interviews, it was determined Resident #4 was not interviewable.

Refer to the interview with the Administrator on 08/23/24 at 5:30pm.

3. Review of Resident #6's current FL2 dated 04/22/24 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, and hypertension.

a. Review of Resident #6's current FL2 dated 04/22/24 revealed an order for insulin glargine (also known as Lantus and is a long-acting insulin used to control blood sugar levels) 15 units twice daily.

Review of Resident #6's physician's orders revealed there was no order to discontinue Lantus 15 units twice daily and begin Lantus 20 units once daily.

Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus insulin, inject 15 units twice daily scheduled at 6:30am and

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

(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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4:30pm, with an order discontinue date of 07/24/24.
-There was a second entry for Lantus insulin, inject 20 units once daily scheduled at 6:30am, with an order start date of 07/25/24.

A copy of Resident #6's physician's order to discontinue Lantus 15 units twice daily and start Lantus 20 units once daily dated 07/25/24 was requested from the Health and Wellness Director (HWD) on 08/21/24 at 1:04pm and was not provided.

Review of Resident #6's charting notes for April 2024 through July 2024 revealed there was no documentation about Resident #6's Lantus order changing from 15 units twice daily to 20 units once daily.

Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was one full insulin pen of Lantus insulin 20 units daily, with a dispensed date of 08/16/24 and an opened date of 08/21/24.

Interview with Resident #6 on 08/21/24 at 3:33pm revealed:
-His Lantus insulin order had changed from twice daily to once daily in the morning a month or two ago.
-He did not remember discussing a change in the Lantus dose with his primary care provider (PCP).

Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed:
-Resident #6 had a Lantus order for 15 units twice daily dated 04/24/24 written by the facility's PCP.
-Resident #6 had an order transferred to the

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pharmacy on 05/08/24 from a pharmacy out of the state for Lantus 20 units daily and written by a different prescriber.
-Since the order for Lantus 20 units daily had a more current order date and had refills available on the prescription, the order for Lantus 15 units twice daily had been discontinued.
-The pharmacy entered orders on the facility's eMAR, but someone at the facility had to review and approve the order entry before it became an active entry on the eMAR.

Interview with a medication aide (MA) on 08/22/24 at 10:50am revealed:
-When Resident #6's PCP wrote a new medication order, she would let the MA know about the order change and either give the MA a handwritten order for the medication or would electronically send the prescription to the pharmacy.
-She had not been given an order to change Resident #6's Lantus.
-The MAs administered medications however they showed up on the eMAR, because the order had to be reviewed and approved by either a supervisor or the HWD.

Interview with a second MA on 08/22/24 at 11:20am revealed she did medication cart audits once or twice a week where she checked the medications in the cart and compared them to the orders on the eMAR, and she did not remember any discrepancies in Resident #6's medications.

Interview with a third MA on 08/23/24 at 2:10pm revealed:
-She administered Lantus to Resident #6 however it was ordered on the eMAR.
-She did not know who, if anyone, audited the eMARs, but if anyone was responsible for audits

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it would be the HWD.
-Only the HWD or a couple of the supervisors had access to approve order entries in the eMAR, and they were supposed to ensure the entry matched a physician's order.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-She had noticed Resident #6's new order for Lantus on the eMAR, but had assumed Resident #6's PCP had changed the dose and one of the MAs approved the entry in the eMAR.
-She did not have an order for Lantus 20 units daily for Resident #6.
-Whoever approved the order change for Lantus in the eMAR should have looked for a matching physician's order, and if there was not an order, to either notify her or clarify the order with the PCP.

Telephone interview with Resident #6's PCP on 08/23/24 at 1:40pm revealed:
-None of the facility staff had contacted her to clarify Resident #6's Lantus order.
-She expected the facility's staff to clarify any new orders with her, especially if they came from a different prescriber.
-The Health and Wellness Director (HWD) should be the primary staff responsible for verifying new medication orders in the eMAR since she was a Registered Nurse (RN).
-Resident #6's current Lantus order was scheduled at 6:30am, and if the facility would have clarified the order with her, she would have scheduled it at bedtime instead.

Refer to the interview with the Administrator on 08/23/24 at 5:30pm.

b. Review of Resident #6's PCP visit note dated

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D 344	Continued From page 89 05/23/24 revealed: -Resident #6's laboratory result dated 05/24/24 showed he had a vitamin D level of 22.2 (normal reference range was 20-40ng/mL). -There was an order to start vitamin D (a dietary supplement) 400 iu daily for vitamin D deficiency. Review of Resident #6's June and July 2024 eMARs and August 2024 eMAR from 08/01/24 through 08/21/24 revealed there were no entries for vitamin D 400 iu daily. Review of Resident #6's charting notes for June, July and August 2024 revealed there was no documentation about Resident #6 having a new order for vitamin D or that it had been discontinued. Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was no vitamin D available for administration. Interview with Resident #6 on 08/21/24 at 3:33pm revealed he did not know if he was prescribed a vitamin D supplement or not. Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed the pharmacy did not have a current or previous order for vitamin D for Resident #6. Interview with a MA on 08/22/24 at 10:50am revealed: -When Resident #6's PCP wrote a new medication order, she would let the MA know about the order change and either give the MA a handwritten order for the medication or would electronically send the prescription to the pharmacy.	D 344		

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D 344	Continued From page 90 -The MAs administered medications however they showed up on the eMAR, because the order had to be reviewed and approved by either a supervisor or the HWD. Interview with a second MA on 08/22/24 at 11:20am revealed: -She did medication cart audits once or twice a week where she checked the medications in the cart and compared them to the orders on the eMAR, and she did not remember any discrepancies in Resident #6's medications. -Either the Resident Care Coordinator (RCC) when the facility had one, or the HWD were responsible for reading the PCP's visit notes for new orders and following up with the PCP if she said she was going to start a medication but it was never received from the pharmacy. Interview with the HWD on 08/23/24 at 3:45pm revealed: -The PCP's visit notes had been sent directly to the RCC's email address. -The facility had been without an RCC for a couple of weeks. -She could not remember if there was an RCC at the facility on 05/23/24 when Resident #6's PCP wrote the order to start him on a vitamin D supplement. -The RCC would have been responsible for reviewing the visit note, and following up with PCP when the vitamin D supplement never arrived from the pharmacy for Resident #6. -She had just been given access to the RCC's email account a day prior and had not been aware the PCP was sending all of her visit notes to the RCC. Telephone interview with Resident #6's PCP on 08/23/24 at 1:40pm revealed:	D 344		

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D 344	Continued From page 91 -None of the facility staff had contacted her to clarify Resident #6's vitamin D order. -She had written Resident #6's visit notes and forgot to send the prescription to the pharmacy. -Either the RCC or HWD should have reviewed her visit note and contacted her to clarify if she wanted Resident #6 to start vitamin D or not. -Resident #6's vitamin D level was 22, and the normal range was 30 or higher. -There was no harm for Resident #6 not starting the vitamin D supplement, but she had intended for him to begin supplementation as ordered. Refer to the interview with the Administrator on 08/23/24 at 5:30pm. 4. Review of Resident #2's current FL2 dated 08/08/24 revealed: -Diagnoses included dementia, schizophrenia, seizures, hypertension, hyperlipidemia, cystitis, and gastro-esophageal reflux disease (GERD). -The FL2 was filled out and completed for Resident #2 but the medications listed on the FL2 belonged to another resident. -There was an order for acetaminophen (used to treat mild pain) 325mg 1 tablet (no frequency). -There was an order for amlodipine besylate (used to treat elevated blood pressure) 10mg 1 tablet (no frequency). -There was an order for aspirin (used to thin blood) 81mg, 1 tablet (no frequency). -There was an order for atorvastatin (used to treat elevated cholesterol) 40mg 1 tablet (no frequency). -There was an order for capsaicin (a topical cream for pain relief) 0.1% cream, topical both feet (no frequency). -There was an order for carvedilol (used to treat high blood pressure) 6.25mg 1 tablet (no	D 344		

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frequency).
-There was an order for PEG (used to treat constipation) 3350 powder 17g (no frequency).
-There was an order for reguloid (used to treat constipation and diarrhea) 1 capsule (no frequency).
-There was an order for Tradjenta (used treat elevated blood sugar) 5mg 1 tablet (no frequency).
-There was an order for trazadone (used to treat depression) 150mg 1 tablet (no frequency).
-There was an order for venlafaxine (used to treat depression) hcl er 150mg 1 tablet (no frequency).
-There was an order for vitamin D3 (a vitamin supplement) 25mcg 1 tablet (no frequency).
-There was an order for glipizide (used to treat elevated blood sugar) 5mg 1 tablet (no frequency).
-There was an order for melatonin (used to treat insomnia) 5mg 1 tablet (no frequency).
-There was an order for metformin (used to treat elevated blood sugar) hcl 500mg 1/2 tablet twice daily.
-There was an order for olanzapine (used to treat mental disorders) 10mg 1 tablet (no frequency).
-There was an order for oxycodone-apap (used to treat pain) 5-325 1 tablet three times daily.
-There was an order for pantoprazole (used to treat GERD) sod dr 40mg 1 tablet (no frequency).

Review of Resident #2's primary care provider (PCP) progress note dated 07/11/24 revealed current medications included:
-Amlodipine 10mg 1 tablet daily.
-Atorvastatin 20mg 1 tablet at bedtime.
-Keppra (used to treat seizures) 500mg 1 tablet twice daily.
-Lisinopril (used to treat elevated blood pressure) 20mg 1 tablet daily.
-Omeprazole (used to treat GERD) 40mg 1

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capsule twice daily.
-Acetaminophen (used to treat mild pain) 325mg 1 tablet every 6 hours as needed (PRN).
-Seroquel (used to treat mental disorders) 75mg 1 tablet in the morning.
-Seroquel 100mg 1 tablet at bedtime.
-Senna (used to treat constipation) 8.6mg 1 tablet twice daily.
-Sertraline (used to treat depression) 100mg 1 tablet daily.

Telephone interview with Resident #2's PCP on 08/21/24 at 4:45pm revealed:
-The medications listed on the FL2 dated 08/08/24 were not the medications ordered for Resident #2.
-Resident #2's medication orders on the PCP's progress notes from a 07/11/24 should reflect the resident's current medications.
-She also changed Resident #2's quetiapine to 25mg every morning and 3 tablets of 25mg at bedtime in place of the previous order on 07/11/24.
-She was not aware there were different medications on the FL2 dated 08/08/24 that she had signed previously compared to her progress notes dated 07/11/24.
-She expected the facility staff to contact her for clarification if an FL2 had different medications compared to medication orders from her previous PCP progress notes.

Interview with the Health and Wellness Director (HWD) on 08/23/24 at 3:45pm revealed when shown the FL2 dated 08/08/24 for Resident #2 the HWD said, that was not Resident #2's FL2 and it must belong to another resident, but she did not know which resident the FL2 belonged to.

Review of the medications ordered for Resident

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D 344	Continued From page 94 #2 on the FL2 dated 08/08/24 compared to medications listed on the resident's PCP progress note dated 07/11/24 revealed the medications on the FL2 did not match the medication orders dated 07/11/24.. Review of Resident #2's June 2024 and July 2024 electronic medication administration record (eMAR) revealed medications orders matched the medication orders dated 07/11/24 as follows: -There was an entry for amlodipine 10mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for atorvastatin 20mg 1 tablet every night at bedtime scheduled for administration at 8:00pm. -There was an entry for levetiracetam (Keppra) 500mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for lisinopril 20 mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for omeprazole 40mg 1 capsule twice daily scheduled for administration at 6:00am and 4:00pm. -There was an entry for quetiapine (Seroquel) 25mg 1 tablet every morning scheduled for administration at 8:00am. -There was an entry for quetiapine (Seroquel) 25mg 3 tablets at bedtime scheduled for administration at 8:00pm. -There was an entry for senna-plus 8.6mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for sertraline 100mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for acetaminophen (Tylenol) 325mg 1 tablet every 6 hours PRN.	D 344		

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D 344	Continued From page 95 Review of Resident #2's August 2024 eMAR from 08/01/24 to 08/20/24 revealed medication orders matched the medication orders dated 07/11/24 as follows: -There was an entry for amlodipine 10mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for atorvastatin 20mg 1 tablet every night at bedtime scheduled for administration at 8:00pm. -There was an entry for levetiracetam (Keppra) 500mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for lisinopril 20 mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for omeprazole 40mg 1 capsule twice daily scheduled for administration at 6:00am and 4:00pm. -There was an entry for quetiapine (Seroquel) 25mg 1 tablet every morning scheduled for administration at 8:00am. -There was an entry for quetiapine (Seroquel) 25mg 3 tablets at bedtime scheduled for administration at 8:00pm. -There was an entry for senna-plus 8.6mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -There was an entry for sertraline 100mg 1 tablet once daily scheduled for administration at 8:00am. -There was an entry for acetaminophen (Tylenol) 325mg 1 tablet every 6 hours PRN. Telephone interview with the pharmacist from the facility's contracted pharmacy on 08/22/24 at 10:15am revealed: -The pharmacy had not received Resident #2's new FL2 dated 08/08/24. -The pharmacy expected the facility to fax all	D 344		

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FL2's and PCP progress notes to the pharmacy.
-Resident #2's medication orders matched the PCP's progress notes dated 07/11/24 and the eMAR.
-The pharmacy expected the facility to clarify any new medication or treatment orders listed on residents' FL2s that were signed by the PCP if the orders were inconsistent with previous orders.

Interview with a medication aide (MA) on 08/22/24 at 9:10am revealed:
-She was responsible to send new orders to the pharmacy and she never reviewed FL2s.
-The HWD was responsible to review FL2s, PCP progress notes, local hospital after-visit summaries, and physician orders and to report any discrepancies to a resident's PCP.
-She was not aware of new orders for Resident #2 and the information from the previous FL2 dated 08/08/24 had not been communicated to the MA.
-She was not aware the medication orders on Resident #2's FL2 dated 08/08/24 were not the medication orders for Resident #2.

Interview with a second MA on 08/21/24 at 10:55am revealed:
-The MAs were responsible for sending new orders to the pharmacy; she never reviewed FL2s or PCP progress notes.
-The HWD was responsible to review FL2s, PCP progress notes, local hospital after-visit summaries, and physician orders and to report any discrepancies to a resident's PCP.
-She was not aware of new orders for Resident #2 and the information from the FL2 dated 08/08/24 had not been communicated to the MAs.
-She was not aware the medication orders on Resident #2's FL2 dated 08/08/24 were not the

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D 344	Continued From page 97 medication orders for Resident #2. Second interview with the HWD on 08/23/24 at 4:00pm revealed: -She was responsible for preparing residents FL2s for annual renewal. -The medication list was generated from the resident's current eMAR, including the medication name, dosage, and scheduled time. -The MAs and the HWD were responsible for scanning and faxing FL2s to the PCP along with the list of medications and new orders. -The FL2s were scanned to the pharmacy after they were signed by the resident's PCP. -It was her responsibility to ensure the FL2s were completed, including the medication orders. -It was her responsibility to review the FL2 for accuracy and contact the PCP if information was needed compared to the PCP's progress notes. -The MAs and the HWD were responsible for scanning and faxing FL2s to the PCP along with the list of medications and new orders. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -The HWD filled out the FL2 based on the most recent care plan, physicians' orders, previous FL2 and any order changes. -The HWD faxed the FL2 to the physician to sign and the physician would send the FL2 back to the facility. -The HWD was supposed to review the FL2 for accuracy and contact the PCP if information was needed. -She expected the HWD to review the FL2 for accuracy and contact the PCP if information was needed. -She did not know why the medication orders on the FL2 dated 08/08/24 for Resident #2 did not match the medication orders list dated 07/11/24	D 344		

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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 344	Continued From page 98 and why the FL2 dated 08/08/24 may have belonged to another resident. Refer to the interview with the Administrator on 08/23/24 at 5:30pm. _____ Interview with the Administrator on 08/23/24 at 5:30pm revealed: -The HWD was responsible for approving new medication orders in the eMAR system after verifying the eMAR entry against the physician's order. -The HWD was responsible for ensuring all medication orders on the eMAR were correct, and for clarifying any eMAR entry changes that did not have a matching order from the PCP. _____ The facility failed to ensure medication orders were clarified with the PCP for 4 residents; a resident who had an order for a diuretic to treat lymphedema that was removed from the eMAR increasing the risk of hospitalization and delayed wound healing (#3), a resident who had an order for a mood stabilizer that was removed from the eMAR increasing the risk for aggressive behaviors toward other residents (#4), a resident who had an insulin dosage and frequency change and had elevated FSBS values along with an order for a vitamin supplement that was never started resulting in delayed treatment of a deficiency (#6), and a resident who had medications that did not match the resident's current medication order list (#2). 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 09/11/24 for this violation.	D 344		

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D 344	Continued From page 99 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 2024.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to 1 of 3 residents (#13) observed during the morning medication pass including errors with a medication used to treat fluid retention and a topical cream for irritation and rash; and 3 of 7 sampled residents for record review (#3, #5, and #6) related to a blood thinner medication (#3), multiple missed doses of a medication used to treat a neurological disorder (#5), and a long-acting insulin for elevated blood sugar, a nerve pain medication , a cholesterol medication, an antidepressant medication and a medication to help urination (#6). The findings are: 1. The medication error rate was 5% as	D 358	The community has sent over a review of all medication exceptions for the PCP to review. Education was provided immediately to the clinical staff and additional education was held by the RN nurse consultant. The RCC, MCC or designee is responsible for reviewing the medication exception report daily and following up with the PCP with documentation made in the file. The Report is all reviewed during the directors stand up meeting and the ED or deisgnee ensures the follow ups have been reviewed. Education will be ongoing with the clinical staff as the report is reviewed daily . Date of compliance 9/22/24.	

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evidenced by the observation of 2 errors out of 34 opportunities during the morning medication passes on 08/21/24.

a. Review of Resident #13's current FL2 dated 07/11/24 revealed diagnoses included dementia, atrial fibrillation, congestive heart failure, and anxiety.

1. Review of Resident #13's current FL2 dated 07/11/24 revealed:
-There was an order for furosemide (used to treat swelling and fluid retention) 20mg one tablet in the morning as needed for weight increase of 2 pounds.
-There was an order for weight checks daily, record for doctor appointments and call office if weight goes up 2 pounds and give furosemide 20mg.

Review of Resident #13's new prescription summary revealed an order dated 07/12/24 for furosemide 20mg one tablet every morning if weight increases by 2 pounds.

Review of a physician's order dated 07/12/24 for Resident #13 revealed finding included legs and abdomen swelling with orders to weight and blood pressure daily.

Observation of the 8:00am morning medication pass on 08/21/24 at 7:45am revealed:
-The morning medication aide (MA) for the 200 Hall cart was preparing and administering medications outside the assisted living dining room.
-The MA was consulting the electronic medication administration record (eMAR) and pulling medications scheduled on the eMAR for administration at 8:00am.

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D 358	Continued From page 101 -The MA prepared 6 oral medications and administered to Resident #13. -The MA documented medication administration on the eMAR. -Furosemide 20mg was not included in the medications administered. Interview with the MA on 08/21/24 at 7:55am revealed: -She administered all Resident #13's medications scheduled on the eMAR. -Resident #13 often requested to use the facility's scales for obtaining weight but did not today. -She was not sure why Resident #13 wanted to weigh himself daily because the eMAR had no orders to weight the resident daily. -The MA pointed to a stand on scale across the hallway that was propped against the wall. Review of Resident #13's August 2024 eMAR from 08/01/24 to 08/21/24 revealed: -There was an entry for furosemide 20mg one tablet every morning as needed if weight increase by 2 pounds. -There were no documented administrations from 08/01/24 to 08/21/24. -There was no entry for daily weights for Resident #13. Review of Resident #13's charting notes for August 2024 revealed: -On 08/15/24 at 2:47pm, a MA documented Resident #13's weight was 215.4 pounds. -On 08/16/24 at 2:42pm, a MA documented Resident #13's weight was 216.6 pounds. -On 08/21/24 at 1:15pm, a MA documented Resident #13's weight was 214.4 pounds. -There were other August 2024 weights available for review.	D 358		

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D 358	Continued From page 102 Based on observations, record reviews, and interviews it could not be determined if Resident #13 had a daily weight gain of 2 pounds and if furosemide 20 mg should have been administered. Observation of mediations on hand for administration to Resident #13 on 08/21/24 at 11:00am revealed there was no furosemide 20mg available for administration. Interview with a second morning MA on 08/21/24 at 10:55am revealed: -She documented Resident #13's weight when the resident requested to be weighed and she was working. -She did not realize Resident #13 had an order to administer furosemide 20mg every morning for weight gain more than 2 pounds. Interview with a pharmacist at the contracted pharmacy on 08/21/24 at 2:55pm revealed: -The pharmacy staff entered residents' medications on the eMARs. -Resident #13's order for furosemide 20mg one tablet every morning for weight gains greater than 2 pounds was entered in the as needed (prn) section of the eMAR because it was not scheduled every day, only if the resident had a weight gain of 2 pounds. -The pharmacy staff did not routinely enter clinical tasks, like weighing daily. The facility staff was responsible for entering clinical tasks or treatments on the eMAR. -The eMAR system displayed scheduled medications due for administration but did not display prn medication orders unless the MA clicked on the PRN orders tab. -On 07/12/24, the pharmacy filled furosemide 20mg labeled one tablet every morning for weight	D 358		

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gain greater than 2 pounds.
-The facility's cycle-filled medications were exchanged on the medication carts by pharmacy staff.
-The pharmacy staff used the current eMAR for ensuring medications on the eMAR were included on the cycle-filled medications exchanged on the medication cart.
-The pharmacy staff may have pulled furosemide 20mg when they did the medication exchange since it was not on the current scheduled medications.

Interview with the HWD on 08/21/24 at 4:00pm revealed:
-It was her responsibility to ensure the FL2s were complete, including the medication orders; she did not know about the additional and missed medication orders for Resident # 13, so it fell through the cracks.
-It was her responsibility to review the FL2 compared to the eMAR but she had not completed eMAR compared to medication orders audits.

Interview with Resident #13 on 08/22/24 at 10:40am revealed:
-Staff did not weigh him daily.
-He weighed himself most days because he had a heart condition and in the past had swelling in his legs.
-He did not have swelling in legs or ankle at the present time.
-He weighed himself and told staff the reading on the days he weighed.

Telephone interview with a nurse at Resident #13's primary care provider (PCP) office on 08/22/24 at 10:25am revealed:
-Resident #13 was seen at the clinic on 07/12/24

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for a follow-up after a hospital discharge for treatment of atrial fibrillation.
-Resident #13 was ordered furosemide 20mg in the morning for a weight gain of more than 2 pounds daily.
-The PCP would expect the facility to administer furosemide 20mg as ordered.
-There was no information documented for contact from the facility.

2. Review of Resident #13's current FL2 dated 07/11/24 revealed an order for Lotrisone (a topical steroid and antifungal combination used to treat rash) cream apply topically twice a day.

Observation of the 8:00am morning medication pass on 08/21/24 at 7:45am revealed:
-The MA for the 200 Hall cart was preparing and administering medications outside the assisted living dining room.
-The MA was consulting the eMAR)and pulling medications scheduled on the eMAR for administration at 8:00am.
-The MAs were responsible for sending new orders to the pharmacy if the orders came to the facility when the Resident Care Coordinator (RCC) was not working.
-She never reviewed FL2s or PCP progress visit notes.
-The Health and Wellness Director (HWD) was responsible to review FL2s, PCP progress visit notes, local hospital after-visit summaries, and physician orders to ensure medications orders were on the eMAR and available for administration.
-The MA prepared 6 oral medications and administered to Resident #13.
-The MA documented medication administration on the eMAR.
-Lotrisone cream was not administered.

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D 358	Continued From page 105 Interview with the MA for the 200 Hall cart on 08/21/24 at 7:55am revealed: -She administered all Resident #13's medications scheduled on the electronic medication administration record (eMAR). -There were no other medications scheduled for administration for Resident #13. Review of Resident #13's August 2024 electronic medication administration record (eMAR) from 08/01/24 to 08/21/24 revealed there was no listing for Lotrisone cream apply topically twice a day. Observation of medications on hand for administration to Resident #13 on 08/21/24 at 11:00am revealed there was no Lotrisone cream available for administration. Interview with the same MA on 08/21/24 at 10:55am revealed there was no Lotrisone cream listed on Resident #13's eMAR for administration scheduled or as needed (prn). Interview with a pharmacist at the contracted pharmacy on 08/21/24 at 2:55pm revealed: -The pharmacy staff entered residents' medications on the eMARs. -The pharmacy had a copy of Resident #13's FL2 dated 07/11/24 received from the facility on 07/12/24. -On 07/12/24, the facility received faxed medications orders from Resident #13's PCP dated 07/12/24. -Oral medications were faxed from the PCP but not an order from the PCP for Lotrisone Cream. -The pharmacy routinely entered medication orders from FL2s and medication orders. -The pharmacy staff entered medication orders faxed from Resident #13's PCP in the eMAR	D 358		

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D 358	Continued From page 106 system and dispensed the medications for Resident #13. -The facility was responsible for verifying medication orders and releasing orders that were pending approval in the eMAR system. -The facility was responsible to contact the pharmacy for medication entered incorrectly or omitted. -The pharmacy staff failed to enter the order for Lotrisone Cream apply topically twice a day on Resident #13's eMAR and did not dispense the cream for Resident #13 on 07/12/24 or subsequently. Interview with the HWD on 08/21/24 at 4:00pm revealed: -It was her responsibility to ensure the FL2s were complete, including the medication orders; she did not know about the missed Lotrisone cream medication order, so it fell through the cracks. -It was her responsibility to review the FL2 compared to the eMAR but she had not completed eMAR compared to medication orders audits. Interview with Resident #13 on 08/22/24 at 10:40am revealed: -He had a spot on his buttock, near the top of his butt cheeks, that was irritated and itched. -He mentioned the spot to the PCP on 07/12/24 when he visited the PCP. -The PCP said she would give him a cream to use. -He had not been administered a cream for his itching spot. -The spot was not bad, just itched occasionally. -He applied some body lotion when it itched. -He had not mentioned the cream to the MAs because they managed his medications.	D 358		

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D 358	Continued From page 107 Interview with the MA for the 200 Hall cart on 08/21/24 at 10:55am revealed: -The MAs were responsible for sending new orders to the pharmacy if the orders came to the facility when the Resident Care Coordinator (RCC) was not working. -She never reviewed FL2s or PCP progress visit notes. -The Health and Wellness Director (HWD) was responsible to review FL2s, PCP progress visit notes, local hospital after-visit summaries, and physician orders to ensure medications orders were on the eMAR and available for administration. Interview with a MA on 08/21/24 at 10:55am revealed: -The MAs were responsible for sending new orders to the pharmacy if the orders came to the facility when the Resident Care Coordinator (RCC) was not working. -She never reviewed FL2s or PCP progress visit notes. -The Health and Wellness Director (HWD) was responsible to review FL2s, PCP progress visit notes, local hospital after-visit summaries, and physician orders to ensure medications orders were on the eMAR and available for administration. Interview with the HWD on 08/23/24 at 3:40pm revealed: -The previous Resident Care Coordinator (RCC) and Special Care Unit Coordinator (SCUC) were responsible to review the PCP's encounter visits summaries and process the medication and treatment orders. -Both the RCC and SCUC no longer work at the facility with the SCUC leaving in April 2024 and the RCC about 2 weeks prior to 08/20/24.	D 358		

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-She assumed the RCC duties when the RCC left until a replacement was hired.
-She did not have a system in place to routinely review or audits residents' orders for treatments or medications. She assumed the former RCC was doing the audits.
-She had fallen behind with completing audits due to the increased responsibilities of RCC and SCUC duties.

Telephone interview with a nurse at Resident #13's primary care provider (PCP) office on 08/22/24 at 10:25am revealed:
-Resident #13 was seen at the clinic on 07/12/24 for a follow-up after a hospital discharge for treatment of atrial fibrillation.
-Resident #13 was given new medications orders including a new FL2.
-The PCP would expect the facility to administer medications as ordered.
-There was no information documented for contact from the facility.

2. Review of Resident #5's current FL2 dated 4/10/24 revealed diagnoses included stiff-man syndrome (a neurological disorder that causes muscle stiffness and spasms), Parkinson's disease and adult failure to thrive.

Review of Resident #5's signed physician's orders dated 04/30/24 revealed an order for diazepam (a controlled substance used to treat muscle spasms or twitches) 5mg three (3) times a day.

Review of Resident #5's July 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for diazepam 5mg one tablet 3 times a day for stiff-man syndrome scheduled

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for administration at 8:00am, 2:00pm, and 8:00pm daily.
-Diazepam 5mg was documented as administered 3 times a day except 4 of 124 opportunities as follows:
-On 07/04/24 at 8:00pm, staff documented diazepam 5mg not administered with "other- see note" but there was no information noted.
-On 07/05/24 at 8:00am, staff documented diazepam 5mg not administered with "other- see note" awaiting pharmacy.
-On 07/05/24 at 2:00pm, staff documented diazepam 5mg not administered with "other- see note" but there was no information noted.
-On 07/05/24 at 8:00pm, staff documented diazepam 5mg not administered with "other- see note" but there was no information noted.

Review of Resident #5's August 2024 eMAR from 08/01/24 to 08/20/24 revealed:
-There was an entry for diazepam 5mg one tablet 3 times a day for stiff-man syndrome scheduled for administration at 8:00am, 2:00pm, and 8:00pm daily.
-Diazepam 5mg was documented as administered 3 times a day except 5 of 60 opportunities as follows:
-On 08/04/24 at 2:00pm, staff documented diazepam 5mg not administered with "other- see note" but there was no information noted.
-On 08/04/24 at 8:00pm, staff documented diazepam 5mg not administered with "other- see note" awaiting pharmacy.
-On 08/05/24 at 8:00am, staff documented diazepam 5mg not administered with "other- see note" called Doctor awaiting in the computer notes.
-On 08/05/24 at 2:00pm, staff documented diazepam 5mg not administered with "other- see note" awaiting was noted in the computer notes.

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D 358	Continued From page 110 -On 08/05/24 at 8:00pm, staff documented diazepam 5mg not administered with "other- see note" but there was no information noted. Interview with Resident #5 on 08/22/24 at 3:00pm revealed: -He had missed 4 or 5 scheduled doses of diazepam 5mg for the last 2 months. -He was administered diazepam routinely 3 times a day for long stretches, then he would be out of the medication for a few doses and start the routine dosing again for a while. -He had routine visits with the facility's contracted PCP. -The PCP told him he should take diazepam regularly and should not miss doses. -When he did not receive diazepam 5mg his muscles stiffened up and he generally laid in the bed until he started receiving the diazepam again. Interview with a first shift medication aide (MA) on 08/22/24 at 10:55am revealed: -Resident #5 received most of his medications on cycle fill from the contracted pharmacy. -Diazepam 5mg was not a cycle fill medication. -The medication aides were supposed to reorder non-cycle filled medication when the prepacked medications had a 4- or 5-days' supply of medication remaining. -If a medication was not available to be administered, she documented the missed dose on the eMAR. -MAs could put notes explaining why a medication was not administered and note any PCP contact in the computer note field. -She had contacted Resident #5's PCP in the past for being out of diazepam 5mg but did not see documentation for having notified the PCP. Telephone interview with a pharmacist at the	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 111 facility's contract pharmacy on 08/22/24 at 10:30am revealed: -The pharmacy did not provide cycle-filled controlled medication like diazepam. -The facility would be responsible for requesting a refill. -If Resident #5's diazepam 5mg needed a new physician's order, the pharmacy would advise the facility's staff when the refill was requested. -The pharmacy refilled Resident 5's diazepam 5mg on 06/05/24 for 90 tablets, on 07/05/24 for 90 tablets, and on 08/05/24 for 90 tablets. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:30pm revealed: -The MAs were responsible to ensure providers were notified of missed medications after 3 consecutive doses. -The Resident Care Coordinator (RCC) for the assisted living unit and the Special Care Unit Coordinator (SCUC) were responsible to audit residents' eMARs and progress notes to ensure medications were administered as ordered. -The RCC and SCUC positions were vacant due to recent staff turnover. -She was currently staffing those positions and was responsible to ensure the MAs notified providers and documented notification in the residents' records. -She had not done recent resident record audits and did not know Resident #5 was not administered diazepam 5mg as ordered. Interview with the Administrator on 08/23/24 at 6:00pm revealed: -The facility did not have a RCC or SCUC at present. -A RCC and MCC had been hired and were scheduled to begin work during the week of 8/26/24.	D 358		

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GRAND VILLA ASSISTED LIVING AT WINSTON	2609 OLD SALISBURY ROAD WINSTON SALEM, NC 27127

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-The HWD could print a summary report through the facility's eMAR system for missed medications.
-The HWD was responsible for managing the clinical operation of the facility which included ensuring residents received medications and treatments as ordered during the vacancy of the RCC and SCUC.
-She did not know Resident #5's had multiple missed doses of diazepam 5mg.

Telephone interview with Resident #5's primary care provider (PCP) on 08/21/24 at 4:25pm revealed:
-Resident #5 had a neurological disorder that caused his muscles to become stiff.
-Resident #5 was ordered diazepam 5mg routinely 3 times a day to relax stiff muscles.
-Resident #5 should not run out of diazepam 5mg.
-Resident #5 could experience muscle stiffness, cramping, and loss of mobility if he did not receive routine doses of diazepam.
-She expected the facility to let her know if Resident #5 needed a new order for diazepam prior to running out of the medication.
-She was available by phone texting, fax, or phone messaging daily Monday through Friday.

3. Review of Resident #3's current FL2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, hypertension, and lower extremity lymphedema.
-There was an order for apixaban 5mg (a blood thinner) take 1 tablet, no frequency noted.

Review of Resident #3's physician's order dated 04/30/24 revealed an order for apixaban 5mg take 1 tablet twice daily for anticoagulation.

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D 358	Continued From page 113 Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for apixaban 5mg 1 capsule twice daily at 9:00am and 9:00pm with a discontinue date of 06/24/24. -There were 9 opportunities apixaban was documented as not administered with reasons documented including "on order/awaiting pharmacy", "resident resting" and "other-see note" with no note why it was not administered. -There was a second entry for apixaban 5mg 1 capsule twice daily at 9:00am and 9:00pm documented as administered twice daily beginning 06/27/24 at 9:00pm to 06/30/24 at 9:00pm. -There was no documentation apixaban 5mg was administered on 5 opportunities from 06/25/24 at 8:00am through 06/27/24 at 8:00am with no reason documented why it was not administered. Review of Resident #3's July 2024 eMAR revealed: -There was an entry for apixaban 5mg 1 capsule twice daily at 9:00am and 9:00pm. -There were 11 opportunities apixaban was documented as not administered with reasons documented including "on order/awaiting pharmacy", "resident resting", "out of facility" and "other-see note" with no note why it was not administered. -There was no documentation apixaban was administered on 3 opportunities with no reason documented why it was not administered. Review of Resident #3's August 2024 eMAR from 08/01/24-08/20/24 revealed: -There was an entry for apixaban 5mg 1 capsule twice daily at 9:00am and 9:00pm. -There were 19 opportunities apixaban was	D 358		

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documented as not administered with reasons documented including "on order/awaiting pharmacy", "resident resting", "out of facility".
-There was no documentation apixaban 5mg was administered on 2 opportunities and had no reason documented why it was not administered.

Observation of Resident #3's medications on hand on 08/21/24 at 9:10am revealed there was no apixaban 5mg on hand for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 10:00am revealed:
-Resident #3 had a current order for apixaban 5mg take 1 tablet 2 times a day that required a copay from the resident.
-Apixaban 5mg was dispensed to the facility on 05/10/24 and 6/01/24 for 28 tablets to cover a 14 day supply and on 06/18/24 for 60 tablets to cover a 30 day supply.
-A request for payer information for the apixaban 5mg was faxed to the facility on 05/10/24, 06/19/24 and 08/20/24.
-The pharmacy filled partial doses on 05/10/24 and 06/01/24 to allow time for the facility/resident to provide the payer information for copays.
-When copay payer information was not received after several notices, the pharmacy could not send Resident #3's apixaban.
-No payer information was provided from the facility or the resident/POA until 08/22/24.

Telephone interview with Resident #3's power of attorney (POA) on 08/21/24 at 3:09pm revealed:
-Resident #3 had a blood thinner ordered but he did not remember the name or dose.
-He had received a bill for a copay for the blood thinner from the previous pharmacy.
-He had not received a bill for 2 or 3 months and

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he just thought that Resident #'s pharmacy account was paid up for the copay.
-He did not realize the facility changed contracted pharmacies and the new pharmacy did not have his payment and contact information for the copay of the blood thinner.
-The facility staff nor the new contracted pharmacy had not contacted him for information or payment.

Interview with a medication aide (MA) on 08/22/24 at 3:50pm revealed:
-The previous Special Care Unit Coordinator (SCUC) reviewed requests from the pharmacy; now she thought the Health and Wellness Director (HWD) would have that responsibility since the SCUC position was vacant.
-The MAs were to continuously note any missing medication throughout their shift.
-The MAs could call the Primary Care Provider (PCP) and pharmacy to resolve any missing medication issues and report to the HWD if they could not resolve the problem.
-She called the facility's contracted pharmacy that morning, 08/22/24, to ask why Resident #3's apixaban was not delivered.
-The staff at the facility's contracted pharmacy needed payer authorization and she gave them Resident #3's POA's information.
-Before 08/22/24, she thought Resident #3 had her apixaban on the days she worked.
-She did not contact the pharmacy before 08/22/24 regarding Resident #3's apixaban.

Interview with a second MA on 08/22/24 at 3:55pm revealed:
-The MAs "continually" conducted medication cart audits during their shift and report any medication problem they could not fix to the HWD.
-She had not noticed Resident #3 did not have

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apixaban on several occasions.
-She had not called the facility's contracted pharmacy or reported to the HWD about Resident #3's missing apixaban.

Interview with the HWD on 08/23/24 at 3:40pm revealed:
-She was not aware the facility's contracted pharmacy had requested copay and payer information for Resident #3's apixaban.
-Faxed requests were placed in the incoming boxes in the SCUC's office who would have been responsible to provide the facility's contracted pharmacy with payer information.
-The previous SCUC no longer worked at the facility and she was not sure if the previous SCUC addressed the requests for payer information for Resident #3's apixaban.
-The facility also had trouble with their fax machine not sending or receiving faxes even though it appeared to be working.
-The MAs should audit medication carts for missing medications compared to the eMAR and follow up with the pharmacy and PCP to correct the issue and have the medication delivered.
-No MA had informed her that Resident #3 had not received her apixaban or that the facility's contracted pharmacy needed additional information.
-After the facility changed contracted pharmacies in May 2024, the SCUC was to stand with the pharmacy staff during the medication cycle fill exchange and compare the eMAR to medications to see that all medications were correct and delivered.
-The SCUC was responsible to contact the pharmacy office, PCP or responsible party/POA to resolve any issue preventing medication from being delivered.
-She was currently responsible to ensure

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requests for payer information from the facility's contracted pharmacy were answered.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-The previous SCUC was responsible to audit medication carts for missing medications and to contact the pharmacy, the PCP, or responsible party to have the medications delivered.
-The HWD was responsible for overseeing the SCUC and was responsible for conducting SCUC duties until a new SCUC was hired and trained.
-She expected the HWD to ensure all medications were delivered and to follow up on any requests from the facility's contracted pharmacy for payer information.
-She expected staff to administer all medications as ordered by the PCP.

Interview with Resident #3's PCP on 08/22/24 at 1:55pm revealed:
-Resident #3 was ordered apixaban 5mg 2 times a day to prevent blood clots due to vascular inefficiency.
-She was not aware Resident #3 had not received her apixaban 2 times a day because her copay was not paid to pharmacy.
-Resident #3 was at risk for blood clots if she did not receive her apixaban as ordered.
-She expected Resident #3 to be administered apixaban 5mg 2 times a day as ordered.

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

4. Review of Resident #6's current FL2 dated 04/22/24 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, and hypertension.

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D 358	Continued From page 118 a. Review of Resident #6's current FL2 dated 04/22/24 revealed an order for glargine (also known as Lantus, a long-acting insulin used to control blood sugar levels) 15 units twice daily. Review of Resident #6's physician's orders revealed there was no order to discontinue Lantus 15 units twice daily and begin Lantus 20 units once daily. Review of Resident #6's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus insulin, inject 15 units twice daily scheduled at 6:30am and 4:30pm, with an order discontinue date of 07/24/24. -There was documentation Lantus 15 units twice daily was not administered 8 times from 07/01/24 through 07/24/24 due to either awaiting pharmacy or "other - see note" without a note to reference. -There was a second entry for Lantus insulin, inject 20 units once daily scheduled at 6:30am, with an order start date of 07/25/24. -There was documentation Lantus 20 units once daily was not administered daily from 07/25/24 through 07/31/24 due to awaiting pharmacy. -Resident #6's fingerstick blood sugar (FSBS) values from 07/01/24 through 07/31/24 ranged from 120 to 499. A copy of the physician's order dated 07/25/24 was requested from the HWD on 08/21/24 at 1:04pm and was not provided. Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed: -There was an entry for Lantus insulin, inject 20 units once daily scheduled at 6:30am.	D 358		

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D 358	Continued From page 119 -There was documentation Lantus 20 units once daily was not administered daily from 08/02/24 through 08/20/24 due to awaiting pharmacy. -Resident #6's FSBS values from 08/01/24 through 08/21/24 ranged from 144 to 583. Review of Resident #6's charting notes for July and August 2024 revealed: -On 07/12/24, a medication aide (MA) documented that she contacted the pharmacy regarding Resident #6's Lantus prescription and was told there was a billing issue and the pharmacy was trying to resolve the issue as soon as possible so Resident #6 could receive a refill of Lantus insulin in the next delivery. -On 07/29/24, a MA documented calling the pharmacy regarding Resident #6's Lantus insulin refill and was told the Lantus could not be delivered until the following month's insurance copay amount was paid. Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was one full Lantus insulin pen for 20 units daily with a dispensed date of 08/16/24 and an opened date of 08/21/24. Interview with Resident #6 on 08/21/24 at 3:33pm revealed: -He had been without his Lantus for a month or two, but he started receiving it again that morning. -The MAs had told him that the pharmacy delivered his Lantus to the wrong address and his insurance would not pay for the pharmacy to resend it to the facility. -His former pharmacy was in another state and would mail his medications to an acquaintance's house since at the time he did not have a permanent address.	D 358		

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D 358	Continued From page 120 -He had contacted the acquaintance about his Lantus and she said she had received his Lantus, but could not afford to deliver his medications to him. -He had not noticed any change in his FSBS values or how he felt over the last month without his Lantus because he was also taking a short-acting insulin. -His blood sugars were sometimes high but he did not have symptoms or feel sick when his FSBS values were over 400. Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed: -Resident #6's current order for Lantus was for 20 units every morning, with an order date of 05/08/24 by a provider other than Resident #6's primary care provider (PCP). -Resident #6's previous Lantus order was for 15 units twice daily, with an order date of 04/24/24 by Resident #6's PCP. -The pharmacy dispensed 1 Lantus insulin pen, to administer 15 units twice daily, which was a 10-day supply on 05/06/24, 06/14/24, and 07/12/24. -The pharmacy dispensed 1 Lantus insulin pen, to administer 20 units once daily, on 08/16/24, which was a 15-day supply. -The facility called to request a refill of Resident #6's Lantus insulin on 07/11/24, but the facility staff requested the pharmacy dispense a box of Lantus insulin pens and Resident #6's insurance denied the request because the prescription had already been filled at a different pharmacy. -She could not tell where the other pharmacy had dispensed Resident #6's Lantus insulin to. -The facility would be responsible for either tracking down Resident #6's Lantus or paying for him to receive a refill.	D 358		

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D 358	Continued From page 121 Interview with a MA on 08/22/24 at 10:50am revealed: -Resident #6 ran out of his Lantus insulin because the facility's new pharmacy would only dispense one insulin pen at a time, where the previous pharmacy would send a box of 4 or 5 insulin pens. -She had attempted to reorder Resident #6's Lantus by hitting the "reorder" button on the eMAR, but she thought the request had been denied. -She had talked with the facility's former Resident Care Coordinator (RCC) about Resident #6 running out of Lantus and she said she would contact the pharmacy about it. -She figured the RCC would also talk to Resident #6's PCP about him not having Lantus for administration as ordered. -Resident #6 had not reported any symptoms of high blood sugar while he was out of his Lantus insulin even though his blood sugars were sometimes in the 400's and 500's. Interview with a second MA on 08/22/24 at 11:20am revealed: -She called the pharmacy on 07/29/24 regarding Resident #6 being out of Lantus, and she was told that the pharmacy Resident #6 used prior to his admission to the facility was still billing and dispensing his medications to his former address. -She forwarded the information from the pharmacy on to the HWD at the end of July 2024, and the HWD told her she would look into it. -Resident #6 told her he was waiting for the person who lived at his former address to bring the Lantus to the facility for him, but they never did. -Resident #6 had high blood sugar levels, but he had high blood sugars even when he was taking	D 358		

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the Lantus.
-Resident #6 never reported symptoms of high blood sugar or feeling unwell because of it.

Interview with a third MA on 08/23/24 at 2:10pm revealed:
-She had requested a refill of Resident #6's Lantus from the pharmacy but the request was denied due to "quantity exceeded."
-She let the HWD know (she did not remember when) that the pharmacy was not refilling Resident #6's Lantus.
-The HWD told her she would contact the pharmacy, but she did not know if the HWD ever called the pharmacy.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-She was aware that Resident #6 was not administered Lantus as ordered due to it not being in the facility.
-Resident #6's former pharmacy had delivered it to his former address and billed his insurance, so the facility's contracted pharmacy could not dispense it.
-She had spoken with staff at Resident #6's former pharmacy some time in July 2024 and they said they would transfer all of their prescriptions for Resident #6 to the facility's contracted pharmacy, and she had not followed up on Resident #6's medications after that.
-She had not discussed the issue with the Administrator to see whether the facility could pay for a short-term refill for Resident #6 so that he would not go without his Lantus insulin.
-Resident #6 asked her about his Lantus prescription, but he reported feeling okay without it because he still was using his short-acting insulin.
-She thought she had discussed with Resident

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D 358	Continued From page 123 #6's PCP that he was without Lantus insulin but she could not remember receiving any new orders or documenting the conversation. Interview with the Administrator on 08/23/25 at 5:30pm revealed: -She was not aware Resident #6 went without Lantus insulin for the previous month. -If she had been aware of the situation with Resident #6's Lantus insulin, the facility would have either paid for the Lantus or arranged for the transportation staff to go pick up his Lantus from where it had been delivered. -All medications were supposed to be reordered and in the facility prior to a resident running out. -She expected medications to be administered as ordered by the PCP. Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed: -She could not remember if she changed Resident #6's Lantus insulin order from 15 units twice daily to 20 units once daily. -If Resident #6's Lantus insulin order was for 20 units once daily, that was the dose she expected the staff to administer. -She was aware Resident #6 had missed some doses of his Lantus insulin because the Health and Wellness Director (HWD) told her the Lantus had been delivered to Resident #6's former address and insurance would not pay for the pharmacy to dispense another insulin pen. -Without taking his insulin as ordered, Resident #6 was at risk for prolonged high blood sugar levels which placed him at increased risk of developing diabetic retinopathy or kidney or heart damage. -She was not aware Resident #6 did not receive any Lantus insulin until that morning (08/21/24) since 07/25/24.	D 358		

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D 358	Continued From page 124 -The facility was responsible for administering medications as ordered. b. Review of Resident #6's physician's order dated 05/16/24 revealed an order for gabapentin (a medication used to relieve nerve pain) 400mg twice daily to treat neuropathy. Review of Resident #6's June 2024 eMAR revealed: -There was an entry for gabapentin 400mg twice daily scheduled at 8:00am and 8:00pm. -There was documentation gabapentin was not administered for 15 doses from 06/17/24 through 06/25/24 due to medication on order and awaiting delivery from the pharmacy. Review of Resident #6's charting notes from June 2024 revealed there was no documentation about Resident #6 running out of gabapentin. Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there were two medication cards containing gabapentin 400mg capsules to administer one capsule twice daily with a dispensed date of 08/13/24 and with 29 out of 30 dispensed capsules remaining in each card. Interview with Resident #6 on 08/21/24 at 3:33pm revealed: -He had ran out of his gabapentin medication a couple of months prior. -He took gabapentin because his legs and feet hurt without it. -When he took gabapentin he did not have pain, but without gabapentin he felt his pain was severe. -He remembered his legs and feet hurting in June 2024 when he was without gabapentin.	D 358		

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D 358	Continued From page 125 Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed: -Resident #6 had a current order for gabapentin 400mg twice daily. -The pharmacy dispensed gabapentin 400mg capsules for Resident #6 on 05/16/24 for a quantity of 60 capsules, and prepared his next refill of 60 capsules on 06/16/24 but due to a billing issue or some other delay, it was not delivered to the facility until 06/24/24. -The facility had not contacted the pharmacy requesting a refill of Resident #6's gabapentin in June 2024. Interview with a MA on 08/22/24 at 10:50am revealed: -She had documented Resident #6's gabapentin as administered at 8:00am on 06/24/24 but it was in error because Resident #6 did not receive his gabapentin from the pharmacy until that night or the following day. -She had attempted to reorder Resident #6's gabapentin by hitting the "reorder" button on the eMAR, but she thought it had already been requested. -The MAs were supposed to request refills of medications when the quantity remaining was down to the last column on the medication card. -Resident #6 had not complained of nerve pain to her when he was out of gabapentin. Interview with a second MA on 08/22/24 at 11:20am revealed: -She and the other MAs had been requesting medication refills by clicking the "reorder" button on the eMAR but they just found out that the pharmacy did not receive those requests and all refill requests needed to be faxed to the	D 358		

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pharmacy instead.
-She thought Resident #6 ran out of gabapentin because the pharmacy had not received their refill request.
-She requested a refill of Resident #6's gabapentin when he was down to his last 8-10 doses.
-Resident #6 had no reports of increased pain when he was out of gabapentin and he told her he did not think the gabapentin was helpful for his leg pain.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-She remembered Resident #6 mentioning to her that he was out of gabapentin in June 2024.
-She had contacted Resident #6's previous pharmacy about his gabapentin prescription because the facility's contracted pharmacy could not dispense gabapentin for him while it was still on file at the other pharmacy.
-The pharmacy told her they would transfer Resident #6's prescriptions to the facility's contracted pharmacy so that they could dispense gabapentin for Resident #6.
-Resident #6 had a history of foot pain but she could not remember if his complaints of foot pain were at the same time that he had been without gabapentin.

Interview with the Administrator on 08/23/25 at 5:30pm revealed:
-She was not aware Resident #6 went without gabapentin for a week in June 2024.
-All medications were supposed to be reordered and in the facility prior to a resident running out.
-She expected medications to be administered as ordered by the PCP.

Telephone interview with Resident #6's PCP on

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D 358	Continued From page 127 08/21/24 at 3:50pm revealed: -Resident #6 was ordered gabapentin due to a diagnosis of diabetic neuropathy. -She had not been aware of his missed doses of gabapentin in June 2024. -Adverse effects for missing 15 doses of gabapentin included an increase in nerve pain which Resident #6 had experienced in the past. -If a new prescription for a medication was needed, the MAs just needed to let her know before the weekend and she would be able to send an electronic prescription to the pharmacy with additional refills. -She expected the facility's staff to reorder medications prior to the medications running out so that no doses were missed. c. Review of Resident #6's current FL2 dated 04/22/24 revealed an order for atorvastatin (used to treat elevated cholesterol) 40mg nightly. Review of Resident #6's June 2024 eMAR revealed: -There was an entry for atorvastatin 40mg every night at bedtime scheduled at 8:00pm. -There was documentation Resident #6 was not administered atorvastatin 5 times from 06/01/24 through 06/30/24. -The documented reason Resident #6 was not administered atorvastatin from 06/01/24 through 06/04/24 was due to "other - see note" with no note reference, and it was not administered on 06/16/24 due to order rejected by pharmacy. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for atorvastatin 40mg every night at bedtime scheduled at 8:00pm. -There was documentation Resident #6 was not administered atorvastatin 16 times between the	D 358		

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dates of 07/07/24 and 07/25/24 with a documented reason of "other - see note" with no note reference, or that the medication had not come from the pharmacy yet.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for atorvastatin 40mg every night at bedtime scheduled at 8:00pm.
-There was documentation Resident #6 was not administered atorvastatin 5 times between the dates of 08/01/24 and 08/06/24 with a documented reason of "other - see note" with no note reference, or awaiting pharmacy.

Review of Resident #6's charting notes from June, July, and August 2024 revealed there was no documentation regarding Resident #6 being out of atorvastatin.

Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was one medication card for atorvastatin 40mg daily with a dispensed date of 08/18/24 and a quantity of 29 out of 30 tablets remaining.

Interview with Resident #6 on 08/21/24 at 3:33pm revealed he had ran out of atorvastatin a couple of times and was told by the MAs that the pharmacy did not send it.

Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed:
-Resident #6 had a current order for atorvastatin 40mg nightly.
-The pharmacy dispensed atorvastatin 40mg tablets for Resident #6 on 05/15/24 for a quantity of 5 tablets to get him to the next cycle fill, then dispensed 21 tablets on 06/05/24, then 15 tablets

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on 08/06/24, and 30 tablets on 08/17/24.
-The facility had not contacted the pharmacy requesting a refill of Resident #6's atorvastatin until 08/06/24.

Interview with a MA on 08/22/24 at 11:20am revealed:
-She and the other MAs had been requesting medication refills by clicking the "reorder" button on the eMAR but they just found out that the pharmacy did not receive those requests and all refill requests needed to be faxed to the pharmacy instead.
-She thought Resident #6 ran out of atorvastatin because the pharmacy had not received their refill request.
-She requested a refill of Resident #6's atorvastatin when he was down to his last 8-10 doses like she did for his other medications.

Interview with second MA on 08/23/24 at 2:10pm revealed:
-Resident #6 had ran out of atorvastatin a couple of times.
-She had requested a refill for Resident #6's atorvastatin by clicking the "reorder" button on the eMAR but she could not remember when she had made the request or if the pharmacy sent the refill.
-She had found out a day or two prior that the pharmacy did not receive the refill requests sent via the eMAR, and requests needed to be faxed to the pharmacy, so she thought that was why Resident #6 had ran out of atorvastatin each month.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-She was not aware that Resident #6 had ran out of atorvastatin in June, July, and August 2024.

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D 358	Continued From page 130 -The facility had been having issues with the pharmacy, especially in June 2024 when they were trying to establish a cycle-fill program for all of the residents. -If a MA sent a refill request to the pharmacy but did not receive the medication or if the request was denied, the MA was responsible for notifying her so that she could follow up on the request. Interview with the Administrator on 08/23/25 at 5:30pm revealed: -She was not aware that Resident #6 went without atorvastatin for 5 doses in June and August, and 16 doses in July 2024. -All medications were supposed to be reordered and in the facility prior to a resident running out. -She expected medications to be administered as ordered by the PCP. Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed: -She was not aware that Resident #6 had missed 5 doses of atorvastatin in June and August, and 16 doses in July 2024. -She expected medications to be refilled and in the facility prior to them running out and causing missed doses. -Not taking cholesterol medications as ordered could lead to an increase in cholesterol levels which placed Resident #6 at risk for cardiovascular events like a heart attack. d. Review of Resident #6's physician's orders revealed there was no order for amitriptyline (a medication used to treat depression) 25mg nightly. Review of Resident #6's July 2024 eMAR revealed: -There was an entry for amitriptyline 25mg every	D 358		

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night at bedtime scheduled at 8:00pm with an order written date of 07/12/24.
-There was documentation amitriptyline 25mg was administered 07/30/24 and 07/31/24.
-There was documentation amitriptyline 25mg was not administered on 07/25/24 and 07/26/24 due to "other-see note" with no note to reference, and there was documentation amitriptyline 25mg was not administered on 07/27/24 or 07/28/24 due to awaiting medication from pharmacy.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for amitriptyline 25mg every night at bedtime scheduled at 8:00pm.
-There was documentation amitriptyline 25mg was administered on 08/03/24, and from 08/05/24 through 08/20/24.
-There was documentation amitriptyline 25mg was not administered on 08/01/24, 08/02/24 or 08/04/24 due to either "other-see note" or awaiting medication from the pharmacy.

Review of Resident #6's charting notes for July and August 2024 revealed there was no documentation about Resident #6 having a new order for amitriptyline.

Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was one medication card for amitriptyline 25mg tablets with a dispensed date of 08/19/24 and 29 out of 30 dispensed tablets remained.

Interview with Resident #6 on 08/21/24 at 3:33pm revealed he was not familiar with an order for amitriptyline or if his PCP had mentioned starting him on it.

Telephone interview with a representative from

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the facility's contracted pharmacy on 08/22/24 at 9:15am revealed:
-Resident #6 had an order for amitriptyline 25mg daily dated 07/12/24 by a prescriber other than Resident #6's PCP.
-The order for amitriptyline had transferred to the pharmacy directly from Resident #6's former pharmacy on 07/24/24, and since it was a current order with available refills, the pharmacy dispensed the medication.
-The pharmacy added the order for amitriptyline to Resident #6's eMAR, but someone at the facility would have needed to approve the entry to make it active in the eMAR.

Interview with a MA on 08/22/24 at 10:50am revealed:
-When Resident #6's PCP wrote a new medication order, she would let the MA know about the order change and either give the MA a hand written order for the medication or would electronically send the prescription to the pharmacy.
-She had not been given an order for amitriptyline for Resident #6.
-The MAs administered medications however they showed up on the eMAR, because the order had to be reviewed and approved by either a supervisor or the HWD.

Interview with a second MA on 08/22/24 at 11:20am revealed she did medication cart audits once or twice a week where she checked the medications in the cart and compared them to the orders on the eMAR, and she did not remember any discrepancies in Resident #6's medications.

Interview with a third MA on 08/23/24 at 2:10pm revealed:
-She administered new medications such as

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Resident #6's amitriptyline however it showed as being due on the eMAR.
-She did not know who, if anyone, audited the eMARs, but if anyone was responsible for audits it would be the HWD.
-Only the HWD or a couple of the MA supervisors had access to approve order entries in the eMAR but they were supposed to ensure the entry matched a physician's order.

Interview with the HWD on 08/23/24 at 3:45pm revealed:
-She had noticed Resident #6's new order for amitriptyline on the eMAR, but had assumed Resident #6's PCP had written the order and one of the MAs approved the entry in the eMAR.
-She did not have an order for amitriptyline 25mg daily for Resident #6.
-Whoever approved the order for amitriptyline in the eMAR should have looked for a matching physician's order, and if there was not an order, to let her know so she could ensure they were administering the medication as ordered.

Interview with the Administrator on 08/23/24 at 5:30pm revealed:
-She was not aware that Resident #6 had been administered amitriptyline without an order from his PCP.
-She expected only medications with an order from the resident's PCP to be administered to each resident.

Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed:
-Amitriptyline was ordered as an antidepressant.
-She had not prescribed amitriptyline for Resident #6.
-There was no harm for Resident #6 taking amitriptyline, but the facility should have noticed

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that it was added to the eMAR without an order and not administered it to the resident until they received an order from her.
-The HWD should be the primary staff responsible for verifying new medication orders in the eMAR since she was a RN.

e. Review of Resident #6's physician's order dated 06/21/24 revealed an order for tamsulosin (used to treat an enlarged prostate gland and help with urination) 0.4 mg every night.

Review of Resident #6's order clarification form dated 06/21/24 revealed an order to discontinue tamsulosin and not to dispense it.

Review of Resident #6's July 2024 eMAR revealed:
-There was an entry for tamsulosin 0.4mg daily scheduled at 8:00am with an order written date of 08/17/23.
-There was documentation tamsulosin 0.4mg was administered daily from 07/27/24 through 07/31/24.
-There was documentation tamsulosin 0.4mg was not administered on 07/25/24 or 07/26/24 due to awaiting medication from the pharmacy.

Review of Resident #6's August 2024 eMAR from 08/01/24 through 08/21/24 revealed:
-There was an entry for tamsulosin 0.4mg daily scheduled at 8:00am.
-There was documentation tamsulosin 0.4mg was administered daily from 08/01/24 through 08/21/24.

Review of Resident #6's charting notes for July and August 2024 revealed there was no documentation about Resident #6 having an order for tamsulosin.

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D 358	Continued From page 135 Observation of medications on hand for Resident #6 on 08/21/24 at 4:33pm revealed there was no tamsulosin available for administration. Interview with Resident #6 on 08/21/24 at 3:33pm revealed: -He had been taking tamsulosin since before moving into the facility. -He did not remember his PCP mentioning changing or discontinuing his order for tamsulosin. Telephone interview with a representative from the facility's contracted pharmacy on 08/22/24 at 9:15am revealed: -The pharmacy had received the prescription for tamsulosin 0.4mg daily on 06/21/24 from Resident #6's PCP, but they also received the note to cancel the order so the pharmacy never processed or dispensed tamsulosin for Resident #6 in June 2024. -The pharmacy received an order on 07/25/24 from Resident #6's former pharmacy dated 07/13/24 for tamsulosin 0.4mg daily. -Since the order received from Resident #6's former pharmacy was a current order with one refill remaining on it, the pharmacy dispensed tamsulosin to the facility for Resident #6. -The pharmacy did not have any refills remaining on the tamsulosin prescription for Resident #6, so a new order was needed. Interview with a MA on 08/22/24 at 10:50am revealed: -When Resident #6's PCP wrote a new medication order, she would let the MA know about the order change and either give the MA a handwritten order for the medication or would electronically send the prescription to the	D 358		

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pharmacy.
-She had not received an order for tamsulosin for Resident #6.
-The MAs administered medications however they showed up on the eMAR, because the order had to be reviewed and approved by either a MA supervisor or the HWD.

Interview with a second MA on 08/22/24 at 11:20am revealed:
-She did medication cart audits once or twice a week where she checked the medications in the cart and compared them to the orders on the eMAR, and she did not remember any discrepancies in Resident #6's medications.
-Resident #6 had tamsulosin on the medication cart a day ago before the pharmacy went through the medication cart and switched out all the medication cards for cycle fill.
-Resident #6 had some tamsulosin remaining in his medication card, so she did not know why the pharmacy removed that medication card from the cart if they did not have a new medication card to replace it with.
-She was planning to call the pharmacy that afternoon to request a refill of Resident #6's tamsulosin since they did not include a refill in his cycle fill batch.

Interview with a third MA on 08/23/24 at 2:10pm revealed:
-She administered new medications such as Resident #6's tamsulosin however it was ordered on the eMAR.
-She did not know who, if anyone, audited the eMARs, but if anyone was responsible for audits it would be the HWD.
-Only the HWD or a couple of the MA supervisors had access to approve order entries in the eMAR but they were supposed to ensure the entry

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D 358	Continued From page 137 matched a physician's order. Interview with the HWD on 08/23/24 at 3:45pm revealed: -She had noticed Resident #6's order for tamsulosin on the eMAR, but had assumed Resident #6's PCP had written the order and one of the MAs approved the entry in the eMAR. -She did not have a current order for tamsulosin 0.4mg daily for Resident #6. -Whoever approved the order for tamsulosin in the eMAR should have looked for a matching physician's order, and if there was not an order, to notify her so she could ensure the medication was being administered as ordered. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -She was not aware that Resident #6 had been administered tamsulosin without an order from his PCP. -She expected only medications with an order from the resident's PCP to be administered to each resident. Telephone interview with Resident #6's PCP on 08/21/24 at 3:50pm revealed: -She wanted to start Resident #6 on tamsulosin when she wrote the prescription on 06/21/24 because he had some symptoms of an enlarged prostate, but then changed her mind and wanted to run some tests prior to starting a medication. -She had discontinued the tamsulosin prescription that she wrote on 06/21/24. -She was not aware that tamsulosin had been added to Resident #6's eMAR in July 2024 or that there was documentation he had been receiving tamsulosin. -There was no harm for Resident #6 receiving tamsulosin, but she would have expected the	D 358		

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D 358	Continued From page 138 facility's staff to clarify the order with her since she had discontinued the prescription that she wrote. _____ The facility failed to administer medications as ordered to a resident, who had a diagnosis of congestive heart failure with an order for a medication for fluid retention in the morning for 2 pound daily weight gain but was not weighed so it was unable to be determined if the resident required the medication (#13), a resident not receiving a medication for muscle spasms causing the resident pain and immobility (#5); a resident not receiving a blood thinner placing the resident at risk for blood clots or stroke (#3); and a resident, who went one month without his long-acting insulin which resulted in elevated blood sugar levels placing him at risk for developing diabetic retinopathy or kidney or heart damage, the resident also missed a week of his nerve pain medication which caused an increase in pain and discomfort to his feet, and he received two medications without having an order for them from his PCP (#6). This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation.. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/22/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 22, 2024.	D 358		
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	D 392		

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D 392	Continued From page 139 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: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 1 of 7 sampled residents (#5) related to a controlled substance for muscle stiffness or spasms. The findings are: Review of Resident #5's current FL2 dated 4/10/24 revealed diagnoses included stiff man syndrome (a neurological disorder that causes muscle stiffness and spasms), Parkinson's disease and adult failure to thrive. Review of Resident #5's signed physician's orders dated 04/30/24 revealed an order for diazepam (a controlled substance used to treat muscle spasms or twitches) 5mg three (3) times a day. Telephone interview with a pharmacist at the facility's contract pharmacy on 08/22/24 at 10:30am revealed: -The pharmacy did not provide cycle-filled controlled medication like diazepam meaning the facility staff had to request the medication. -The pharmacy dispensed Resident #5's diazepam 5 mg tablets on 05/10/24 for 60 tablets with instructions for one tablet twice a day.	D 392	The community completed education with the staff on how to properly store control substance sheets for residents. The RCC, MCC or designee is responsible for keep file of all control sheets for residents. In the event one goes missing the RCC, MCC or designee will immediately notify then PCP and the pharmacy with documentation made in the residents chart. Date of compliance 10/7/24.	

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D 392	Continued From page 140 -The pharmacy dispensed Resident 5's diazepam 5mg tablets on 05/20/24 for 90 tablets with instructions to administer one tablet 3 times a day. -The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to document administration of controlled medications. -The purpose of the CSCS was to keep track of the doses administered to deter theft of controlled medications. Review Resident #5's May 2024, June 2024 and July 2024 electronic medication administration records (eMARs) from 05/15/24 to 07/04/24 revealed: -There was an entry for diazepam 5mg tablet 3 times a day, scheduled for administration at 8:00am, 2:00pm, and 8:00pm daily on each monthly eMAR. -Diazepam 5mg was documented on the May 2024, June 2024, and July 2024 eMARs as administered for 150 doses from 05/15/24 to 07/04/24. Review of Resident #5's CSCS for diazepam 5mg tablets revealed: -There were 30 of 60 doses of diazepam 5mg dispensed on 05/10/24 signed out on the CSCS from 05/15/24 to 05/24/24 with no CSCS sheet available for review for 30 doses. -There were 30 of 90 doses of diazepam 5mg dispensed on 05/20/24 signed out on the CSCS from 06/24/24 to 07/04/24 with no CSCS sheet available for review for 60 doses. -There were no CSCS available for review for 90 of 150 doses of diazepam 5mg documented as administered on the May 2024, June 2024 and July 2024 eMARs.	D 392		

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D 392	Continued From page 141 Observation of Resident #5's medication on hand for administration on 08/22/25 at 9:35am revealed there were 40 tablets reaming of 90 tablets dispensed on 08/05/24 which matched the quantity documented on the current CSCS for diazepam 5mg. Interview with a medication aide (MA) on 08/22/24 at 9:35am revealed: -The MAs documented administration of controlled medications on the eMAR and signed each dose out on the corresponding CSCS provided by the contracted pharmacy for each controlled medication. -The completed CSCS were either placed in a hanger file in the copy room for the Resident Care Coordinator (RCC) or Special Care Unit Coordinator (SCUC) to review. -Sometimes the MAs slid the CSCS under the RCC's office door. -She was not sure what happened to the CSCS after they were reviewed. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 2:30pm revealed: -The RCC and the SCUC were responsible for reviewing and filing CSCS. -The RCC and SCUC positions were vacant due to recent staff turnover. -She was currently staffing those positions and was responsible for ensuring the CSCS were complete and accounted for. -She was unable to locate additional CSCS missing for Resident #5's diazepam 5mg. -There was no system currently in place to audit the CSCS to ensure there were matching CSCS compared to the controlled medication sent by the pharmacy and documented as administered on the residents' eMARs.	D 392		

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D 392	Continued From page 142 Interview with the Administrator on 08/23/24 at 6:00pm revealed: -The facility did not have a RCC or SCUC at present. -A RCC and SCUC had been hired and were scheduled to begin work during the week of 8/26/24. -The HWD was responsible for ensuring there was an accurate accounting for the receipt, administration and /or disposition of controlled medications until the newly hired RCC and SCUC were oriented and filling the corresponding positions. -The HWD should have been running a missed medication report on a regular basis to review medications for missed medications, and ensuring the provider was notified for missed medications if more than 2 doses were missed or refused in a row. Telephone interview with Resident #5's primary care provider (PCP) on 08/21/24 at 4:25pm revealed: -Resident #5 had a neurological disorder that caused his muscle to become stiff. -Resident #5 was ordered diazepam 5mg routinely 3 times a day to relax stiff muscle. -She had ordered diazepam 5mg 3 times a day for a one month supply routinely.	D 392		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.	D 406	The community has audited the pharmacy review and have sent over to the PCP for review. Any recommendations or clarifications was completed in the residents chart and updated on the MAR. The RCC, MCC or designee is responsible for sending over all pharmacy reviews to the PCP and ensuring the follow ups are completed. Date of compliance 10/7/24.	

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This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to follow-up on pharmacy medication review recommendations for 1 of 7 sampled residents (#4) who had recommendations for missing medication orders.

The findings are:

Review of Resident #4's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, aggression and convulsions.
-There was an order for valproic acid sprinkles 125mg 1 capsule 2 times a day (used to treat seizures and behaviors).

Review of Resident #4's physician's order dated 04/30/24 revealed there was no order for valproic acid 125mg.

Review of a pharmacy review for Resident #4 dated 05/12/24 revealed:
-Orders for valproic acid DR 125mg take 1 capsule 2 times a day was missing from Resident #4's record.
-Resident #4's primary care provider (PCP) did not sign the pharmacist's recommendation.

Review of Resident #4's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for valproic acid 125mg 1 capsule twice daily at 8:00am and 8:00pm with a discontinue date of 06/14/24.
-There was an entry for valproic acid 125mg 4 capsules daily at bedtime at 8:00pm with a

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discontinue date of 06/14/24.
-There was an entry for valproic acid 125mg 2 capsules twice daily at 8:00am and 8:00pm with a discontinue date of 06/20/24.
-There was an entry for valproic acid 125mg 2 capsules twice daily at 8:00am and 8:00pm with a discontinue date of 06/21/24.

Review of Resident #4's July 2024 eMAR revealed there was no entry for valproic acid 125mg.

Review of Resident #4's eMAR for 08/01/24-08/20/24 revealed there was no entry for valproic acid 125mg.

Observation of Resident #4's medications on hand on 08/21/24 at 10:30am revealed there was no valproic acid on hand for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 10:05am revealed:
-The consulting pharmacist emailed the pharmacy recommendations to an email provided by the facility after all reviews were completed on 05/12/24.
-If any new orders or changes were signed by the Primary Care Provider (PCP), the pharmacy would then process the order by entering it into the eMAR system and the eMAR would reflect the change.
-Resident #4 had a current order dated 04/23/24 for valproic acid 125mg one capsule 2 times a day which was dispensed on 06/14/24, a quantity of 48 tablets for a 12 day supply until cycle fill.
-Resident #4's valproic acid 125mg was also dispensed on 06/19/24, 07/16/24 and 08/13/24 each for a quantity of 120 tablets for a month supply.

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D 406	Continued From page 145 -Facility staff could review, change or discontinue orders in the eMAR system. -The pharmacy staff exchanged the facility's medications on the medication carts during each cycle fill. -The pharmacy staff compared the eMAR to the medications and any medications that were not on the eMAR were returned to the pharmacy. -There was no record of valproic acid returned by pharmacy staff after cycle fill returns. Interview with a medication aide (MA) on 08/22/24 at 3:50pm revealed: -She did not review residents' pharmacy medication reviews or submit them to the PCP. -The pharmacy staff exchanged the medication in the medication carts each month during cycle fill. -If the pharmacy staff did not leave a medication, that meant there was no longer an order for that medication. -She did not remove any of Resident #4's medications from the eMAR and did not notice that the order for his valproic acid was no longer on the eMAR. -His behavior has been better for the past 3 months. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 3:40pm revealed: -She was not aware there were pharmacy medication reviews that the PCP had not reviewed. -The previous Resident Care Coordinator (RCC) and Special Care Unit Coordinator (SCUC) were responsible to have the PCP review pharmacy medication reviews. -Both the RCC and SCUC no longer worked at the facility since about 2 weeks prior to 08/20/24. -On 08/20/24, the Administrator gave her the passwords to the emails used by the previous	D 406		

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D 406	Continued From page 146 RCC and SCUC. -She printed the pharmacy medication reviews for all residents that were completed on 05/12/24. -She was not aware the PCP had not reviewed recommendations from the pharmacy that included Resident #4's missing valproic acid order. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -Pharmacy recommendations were emailed to the corporate email the previous RCC and SCUC used. -The RCC/SCUC were responsible to ensure the PCP saw and signed off on pharmacy recommendations. -The HWD was responsible for overseeing the RCC and SCUC and was now responsible for their duties until a new RCC and SCUC were hired and trained. -She expected the HWD to have the PCP review all residents' quarterly pharmacy medication reviews and ensure that new orders or changes were followed. Telephone interview with Resident #4's previous PCP on 08/22/24 at 1:55pm revealed: -She did not review the pharmacist's recommendation dated 05/12/24 for Resident #4. -She was not aware that the order for Resident #4's valproic acid 125mg 1 capsule 2 times a day was no longer on the eMAR. -He was ordered valproic acid for behaviors and she would have reordered the medication if she was given the pharmacy recommendation noted that it was missing.	D 406		
D 420	10A NCAC 13F .1104 (b) Accounting For Resident's Personal Funds	D 420		

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D 420	Continued From page 147 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (b) No employee of a facility shall handle the personal funds for a resident, except for the facility administrator or the administrator's designee after having received prior written authorization from the resident or the resident's authorized representative. The facility administrator or their designee shall maintain an accurate account balance and accounting of all funds received, disbursements, and the balance on hand which shall be available upon request to the resident or their authorized representative during the facility's regular business office hours. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide an accurate accounting of the handling of personal funds for 1 of 5 sampled residents (#6). The findings are: Review of Resident #6's current FL2 dated 04/22/24 revealed diagnoses included type 2 diabetes mellitus, hyperlipidemia, and hypertension. Review of resident personal fund ledgers from May 2024 to August 2024 revealed there was no personal fund ledger for Resident #6 available for review.	D 420	The community has posted the resident bank hours for all residents. During that time the residents or RP can access their funds. The residents can also review their accounts if requested. The BOM, ED or deisgnee will be available during those times to access the funds for the residents. Date of compliance 10/7/24.	

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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 420	Continued From page 148 Interview with Resident #6 on 08/23/24 at 9:07am revealed: -He had not received any money since he was admitted to the facility in April 2024. -He spoke with his guardian and verified his guardian was not receiving his money instead of him. -He talked with the Administrator each month about his money and she always told him she did not know when he would start receiving money. -He was never given an explanation for why he had not received any money like the other residents did. -The facility received a check each month for him totaling $1,204.00. -The facility took $1,200.00 of the check and kept it, and the remaining $4.00 went on a card for him. -He thought he was supposed to receive $90.00 per month. Telephone interview with Resident #6's guardian on 08/22/24 at 10:32am revealed: -She did not know anything about Resident #6's funds. -She did not receive any money for Resident #6. -Nobody at the facility had contacted her regarding funds for Resident #6. -She had to pay for things for Resident #6 out of her own money because Resident #6 did not have any money to buy extra things like clothes. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -She and the Business Office Manager (BOM) were responsible for the accounting and administration of residents funds. -Resident Funds and the Resident Trust Fund Ledger was kept in the Administrator's office and only the Administrator and the BOM had access	D 420		

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D 420	Continued From page 149 to the office. -The BOM should be available in the event the Administrator was out of the office for the designated office hours. -Resident #6 moved to the facility from a different county. -Resident #6 had been working with a social worker to help him complete paperwork to get financial assistance, but it had not been processed or approved yet. -Resident #6 did not receive any money each month like the other residents, and there was no money for the facility to give to him until his financial assistance was approved, so that was why he did not have a personal funds ledger. Attempted telephone interview with the BOM on 08/23/24 at 4:45pm was unsuccessful.	D 420		
D 423	10A NCAC 13F .1104 (e) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (e) All or any portion of a resident's personal funds shall be available to the resident or their authorized representative upon request during the facility's established business days and hours except as provided in Rule .1105 of this Section. This Rule is not met as evidenced by: TYPE B VIOLATION	D 423	The community has posted the resident bank hours for all residents. During that time the residents or RP can access their funds. The residents can also review their accounts if requested. The BOM, ED or deisgnee will be available during those times to access the funds for the residents. Date of compliance 10/7/24.	

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D 423	Continued From page 150 Based on interviews and record reviews, the facility failed to ensure residents' personal funds were available during regular established business office hours for 4 of 5 sampled residents (Resident #5, #15, #16 and #17). The findings are: 1. Review of Resident #5's current FL2 dated 4/10/24 revealed diagnoses included stiff man syndrome (a neurological disorder that cause muscle stiffness and spasms), Parkinson's disease and adult failure to thrive. Review of Resident #5's personal funds ledger from May 2024 to August 2024 revealed: -In May 2024, there was a beginning balance of $119.89 and an ending balance of $103.89 with a 05/13/24 deposit of $64.00 for Special Assistance (SA) and 05/13/24 withdrawal of $80.00. -In June 2024, there was a beginning balance of $103.89 and an ending balance of $93.89 with a 06/14/24 deposit of $90.00 for SA and a withdrawal on 06/14/24 of $100.00. -In July 2024, there was a beginning balance of $93.89 and an ending balance of $77.00 with a 07/11/24 deposit of $64.00 for SA and a withdrawal on 07/17/24 of $80.00. -In August 2024, there was a beginning balance of $77.00 and an ending balance of $51.00 with a 08/15/24 deposit of $64.00 for SA and withdrawals on 08/15/24 of $80.00 and $20.00 (for pharmacy bill). -There was an ending balance of $51.00 on 08/23/24. Interview with Resident #5 on 08/23/24 at 1:30pm revealed: -Resident #5 sometimes had to ask several times before receiving his personal funds.	D 423		

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D 423	Continued From page 151 -The last time Resident #5 asked for personal funds was about one week ago. -There were no established business office hours for the last 3 months. -There was nobody in the business office to ask about funds. -He used to receive his personal funds around the 10th of each month. -For the past few months, it was later and later in the month. -He starting asking the front desk receptionist about getting his monthly funds around the 10th each month. -He was told the Administrator was the only person who had access to funds and she was not there. -He used his personal funds to obtain tooth paste, snacks or food items he liked, and some clothing. -He had family members that provided limited funds, otherwise he would have to do without personal items until he could access his funds. -He was told on 2 occasions the funds would be available on a Friday, but he did not receive them until the following Monday. -There were no set business hours for him to count on receiving his funds. Attempted telephone interview with the Business Office Manager (BOM) on 08/23/24 at 4:45pm was unsuccessful. Refer to the interview with the Activity Director on 08/23/24 at 1:45pm. Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:00pm. Refer to the interview with the Administrator on 08/23/24 at 5:30pm.	D 423		

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D 423	Continued From page 152 2. Review of Resident #15's current FL2 dated 08/08/24 revealed diagnoses included asthma, hypertension and schizophrenia. Review of Resident #15's personal funds ledger from May 2024 to August 2024 revealed: -In May 2024, there was a beginning balance of $492.77 and an ending balance of $522.77 with a 05/13/24 deposit of $90.00 for Special Assistance (SA) and a 05/13/24 withdrawal of $60.00. -In June 2024, there was a beginning balance of $522.17 and an ending balance of $552.77 with a 06/14/24 deposit of $90.00 for SA and a withdrawal on 06/14/24 of $60.00. -In July 2024, there was a beginning balance of $552.77 and an ending balance of $582.77 with a 07/11/24 deposit of $90.00 for SA and a withdrawal of $60.00 with no date listed after the 07/11/24 deposit. -In August 2024, there was a beginning balance of $582.77 with an 08/15/24 deposit of $90.00 for SA and 2 withdrawals on 08/15/24 of $60.00 and $20.00 (for pharmacy bill). -There was an ending balance of $592.77.00 on 08/15/24. Interview with Resident #15 on 08/20/24 at 9:45am revealed: -Her money had always been in the bank by the 3rd of each month. -The previous Business Office Manager (BOM) was always in the office during weekday hours and she could get her resident funds any weekday before 3:00pm. -She was able to withdraw her funds in the business office on the 10th of each month. -There was no BOM now and the Administrator dispersed resident funds. -The Administrator was only in the facility for 1 or 2 days a week.	D 423		

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-Even then, the Administrator would delay dispersing resident funds for a week.
-She received her last 2 withdrawals on 07/17/24 and 08/19/24, because she marked the dates on her personal calendar.
-When she did not get her resident funds on the 10th, she could not have the Activity Director shop for her snacks, drinks and personal items like shampoo.

Attempted telephone interview with the Business Office Manager (BOM) on 08/23/24 at 4:45pm was unsuccessful.

Refer to the interview with the Activity Director on 08/23/24 at 1:45pm.

Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:00pm.

Refer to the interview with the Administrator on 08/23/24 at 5:30pm.

3. Review of Resident #16's current FL2 dated 04/10/24 revealed diagnoses included anxiety, hypertension and diabetes type 2.

Review of Resident #16's personal funds ledger from May 2024 to August 2024 revealed:
-In May 2024, there was a beginning balance of $8.00 and an ending balance of $88.00 with a 05/11/24 deposit of $88.00 for Special Assistance (SA) and a deposit 05/24/24 of $8.00 and 05/24/24 withdrawal of $80.00.
-In June 2024, there was a beginning balance of $88.00 and an ending balance of $8.00 with no recorded deposit or withdrawals.
-In July 2024, there was a beginning balance of $8.00 and an ending balance of $0.00 with no deposit recorded and a 07/03/23 withdrawal of

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$88.00 and a 07/04/24 withdrawal of $8.00.
-In August 2024, there was a beginning balance of $0.00 with no deposits or withdrawals recorded.
-There was an ending balance of $0.00 on 08/15/24.

Interview with Resident #16 on 08/23/24 at 9:00am revealed:
-Her money had always been in the bank by the 3rd of each month.
-Recently the facility changed banks and the routing number was incorrect on her deposit information.
-This had been addressed and she should start receiving regular deposits again.
-The previous BOM always had her funds available by the 10th of each month in the office during weekday hours.
-The Administrator gave residents their money by making an announcement and having residents line up in the hall at the front reception desk.
-The Administrator was in the facility on a random weekday for about 3 hours and did not give residents money until the 14th or 15th of each month.
-When she did not get her resident funds by the 10th of each month, she could not have the Activity Director shop for her personal items and snacks.

Attempted telephone interview with the Business Office Manager (BOM) on 08/23/24 at 4:45pm was unsuccessful.

Refer to the interview with the Activity Director on 08/23/24 at 1:45pm.

Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:00pm.

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D 423	Continued From page 155 Refer to the interview with the Administrator on 08/23/24 at 5:30pm. 4. Review of Resident #17's current FL2 dated 08/20/24 revealed diagnoses bipolar disorder, chronic obstructive pulmonary disease, and type II diabetes. Review of Resident #17's personal funds ledger from May 2024 to August 2024 revealed: -In May 2024, there was a beginning balance of $20.00 and an ending balance of $20.00 with a 05/13/24 deposit of $90.00 Special Assistance (SA) and 05/13/24 withdrawal of $90.00. -In June 2024, there was a beginning balance of $20.00 and an ending balance of $110.00 with a 06/14/24 deposit of $90.00 for SA and no withdrawal for June 2024. -In July 2024, there was a beginning balance of $110.00 and an ending balance of $110.00 with a 07/11/24 deposit of $90.00 for SA and a withdrawal on 07/14/24 of $90.00. -In August 2024, there was a beginning balance of $90.00 and an ending balance of $90.00 with a 08/15/24 deposit of $90.00 for SA and withdrawals on 08/15/24 of $90.00. -There was an ending balance of $90.00 on 08/23/24. Interview with Resident #17 on 08/23/24 at 1:30pm revealed: -Resident #17 sometimes had to ask several times before receiving his personal funds. -The last time Resident #17 asked for personal funds was about one and a half weeks ago. -There were no established business office hours for the last 3 months. -There was nobody in the business office to ask about funds.	D 423		

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-He used to receive his personal funds around the 10th of each month.
-For the past few months, it was later and later in the month.
-He started asking the front desk receptionist about getting his monthly funds around the 10th each month.
-He was told the Administrator was the only person who had access to funds, and she was not there.
-He was told on 2 occasions the funds would be available on a Friday but he did not receive funds until the following Wednesday.
-He addressed the Activity Director after the resident council meetings in June 2024 and July 2024 with concerns from the residents related to resident funds.
-The Activity Director was supposed to address the residents concerns about resident funds with the Administrator.
-Resident #17 never heard any information from the Administrator and was his concerns were not addressed after his conversation with the Activity Director.

Attempted telephone interview with the Business Office Manager (BOM) on 08/23/24 at 4:45pm was unsuccessful.

Refer to the interview with the Activity Director on 08/23/24 at 1:45pm.

Refer to the interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:00pm.

Refer to the interview with the Administrator on 08/23/24 at 5:30pm.

_____

Interview with the Activity Director on 08/23/24 at 1:45pm revealed:

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D 423	Continued From page 157 -The Administrator and the BOM were responsible for the resident funds. -The Administrator and the BOM were available in the facility 2-3 days a week. -She was aware of residents concerns related to accessing their funds. -She received concerns from the residents related to accessing their funds and had discussed the concerns with the Administrator. -The Administrator told the Activity Director she would talk with the residents and would handle the situation. -Resident funds used to be accessible on the 10th of every month, but the availability of funds had progressed later in every month for the last 3 months. -She was not aware if the facility had designated office hours for the residents to access their funds. Interview with the Health and Wellness Director (HWD) on 08/23/24 at 4:00pm revealed: -The Administrator and the BOM were responsible for the resident funds. -She was not aware if the facility had designated office hours for the residents to access their funds. -She was unsure if residents were able to access their funds every day of the month, but thought the funds were available on the 3rd and the 15th on every month. -She received concerns from the residents related to accessing their funds and had discussed the concerns with the Administrator. -The Administrator told the HWD she would talk with the residents and handle the situation. Interview with the Administrator on 08/23/24 at 5:30pm revealed: -She and the BOM were responsible for the	D 423		

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accounting and administration of residents funds.
-Resident Funds and the Resident Trust Fund Ledger were kept in the Administrator's office and only the Administrator and the BOM had access to the office.
-The BOM should be available in the event the Administrator was out of the office for the designated office hours.
-The Administrator had previously helped at a sister facility which caused her absence several times a week until 08/19/24.
-Residents had access to funds Monday through Friday from 8:00am to 4:30pm but these hours were not posted in the facility.
-Funds were previously deposited into the bank on the 10th of every month and residents received their funds within 24 hours from the deposit.
-The facility's accountant had advised the Administrator funds were deposited on the 1st, 5th, 10th, and 15th of every month due to the process of switching banks.
-She was aware residents had concerns about accessing their funds but had told them about the situation with the issue of bank transfers.

_____

The facility failed to ensure all or any portion of residents' personal funds were available during regular established business office hours for 4 sampled residents, including a resident who used his funds for purchasing tooth paste, snacks or food items, and some clothing which he would not be able to purchase until he could access his personal funds (#5); two residents who did not receive personal funds and could not have the Activity Director shop for snacks, drinks and personal items (#15 and #16); and a resident who had requested his personal funds and was not able to get his funds in a timely manner (#17). This failure was detrimental to the welfare of the

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D 423	Continued From page 159 residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 7, 2024.	D 423		