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	HAL016018	A. BUILDING: _____ B. WING _____	R 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

(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 and the Carteret County Department of Social Services conducted an annual and follow-up survey, and complaint investigation on October 22, 2024 and October 23, 2024. The Carteret County Department of Social Services initiated the complaint investigation on October 04, 2024.	D 000		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents. (B) 20 hours of aide duty for facilities with a census of 41 to 50 residents. (C) 24 hours of aide duty for facilities with a census of 51 to 60 residents. (D) 28 hours of aide duty for facilities with a census of 61 to 70 residents. (E) 32 hours of aide duty for facilities with a census of 71 to 80 residents. (F) 36 hours of aide duty for facilities with a census of 81 to 90 residents. (G) 40 hours of aide duty for facilities with a census of 91 to 100 residents. (H) 44 hours of aide duty for facilities with a census of 101 to 110 residents.	D 194		

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D 194	Continued From page 1 (I) 48 hours of aide duty for facilities with a census of 111 to 120 residents. (J) 52 hours of aide duty for facilities with a census of 121 to 130 residents. (K) 56 hours of aide duty for facilities with a census of 131 to 140 residents. (L) 60 hours of aide duty for facilities with a census of 141 to 150 residents. (M) 64 hours of aide duty for facilities with a census of 151 to 160 residents. (N) 68 hours of aide duty for facilities with a census of 161 to 170 residents. (O) 72 hours of aide duty for facilities with a census of 171 to 180 residents. (P) 76 hours of aide duty for facilities with a census of 181 to 190 residents. (Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents. (R) 84 hours of aide duty for facilities with a census of 201 to 210 residents. (S) 88 hours of aide duty for facilities with a census of 211 to 220 residents. (T) 92 hours of aide duty for facilities with a census of 221 to 230 residents. (U) 96 hours of aide duty for facilities with a census of 231 to 240 residents. (2) On third shift, the total aide duty hours shall be at least: (A) 8 hours of aide duty for facilities with a census of 21 to 30 residents. (B) 16 hours of aide duty for facilities with a census of 31 to 60 residents. (C) 24 hours of aide duty for facilities with a census of 61 to 90 residents. (D) 32 hours of aide duty for facilities with a census of 91 to 120 residents. (E) 40 hours of aide duty for facilities with a census of 121 to 150 residents. (F) 48 hours of aide duty for facilities with a	D 194		

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census of 151 to 180 residents.
(G) 56 hours of aide duty for facilities with a census of 181 to 210 residents.
(H) 64 hours of aide duty for facilities with a census of 211 to 240 residents.
(3) If the Department determines the needs of the residents at a facility are not being met by staffing requirements of Paragraph (b) of this Rule, the Department shall require the facility to employ staff to meet the needs of the residents.

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

Based on observations, interviews and record reviews, the facility failed to ensure the required staffing hours for the Assisted Living (AL) with a census of 38 residents for 8 of 21 sampled shifts.

The findings are:

Review of the facility's license effective January 01, 2024 revealed the facility was licensed for a capacity of 64 beds.

Observations of the facility on 10/04/24 revealed:
-The facility was a one level facility.
-The facility's current census on 10/04/24 was 38 residents.

Review of the facility's census report from 10/01/24 through 10/07/24 revealed there were

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D 194	Continued From page 3 38 residents in the facility. Review of the facility's daily employee timecards dated 10/01/24 revealed: -Staff time cards had two staff members on the second shift from 3:00pm to 11:00pm. -The second shift staff time card had one medication aide (MA) and one personal care aide (PCA) assigned. -The staff time cards had a total of 3.23 PCA hours plus 4 MA hours provided for a total of 7 hours and 23 minutes of PCA hours for a shortage of 8 hours and 37 minutes of PCA hours. Review of the facility's daily employee timecards dated 10/02/24 revealed: -Staff time cards had 2 staff members on first shift from 7:00am to 3:00pm. -The first shift staff time card had one MA assigned and one PCA assigned. -The staff time cards had a total of 7 hours and 29 minutes of PCA hours plus 4 MA hours for a total 11 hours and 49 minutes of PCA hours provided for the first shift for a shortage 4 hours and 11 minutes of PCA hours. -Staff times card had 2 staff members on third shift from 11:00pm to 7:00am. -The third shift staff time card had one MA assigned and the Administrator assigned. -The staff time cards had a total of 15 hours and 20 minutes of staff hours provided for the third shift for a shortage of 40 minutes of PCA hours. Review of the facility's daily employee time cards dated 10/04/24 revealed: -Staff time cards had 2 staff members on the first shift from 7am to 3pm. -The first shift time card had one MA assigned and one PCA assigned.	D 194		

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-The staff time cards had a total of 7 hours and 26 minutes of PCA plus 4 MA hours provided for a total of 11 hours and 26 minutes of PCA hours for a shortage of the first shift for a shortage of 4 hours and 34 minutes of PCA hours.
-Staff time cards had one staff member on the third shift from 11:00pm to 7:00am.
-The third shift time card had one MA assigned.
-The staff times cards had a total of 42 minutes of PCA hours and 8 hours of MA hours for the third shift for a shortage of 7 hours and 18 minutes of PCA hours.

Review of the facility's daily employee time cards dated 10/06/24 revealed:
-Staff time cards had 2 staff members on third shift from 11pm to 7:00am.
-The third shift staff time card had one MA assigned and one PCA assigned.
-The staff time cards had a total of 7 hours and 19 minutes of PCA hours and 7 hours and 29 minutes of MA hours for a total of 14 hours and 48 minutes of PCA hours for the third shift for a shortage of 1 hour and 12 minutes of PCA hours.

Review of the facility's daily staff assignment sheet and employee time cards dated 10/07/2024 revealed:
-Staff time cards had 2 staff members on first shift from 11pm-7am.
-The third shift staff time card had one MA assigned and one PCA assigned.
-The staff time cards had a total of 7 hours and 36 minutes of PCA hours and 7 hours and 30 minutes of MA hours for a total of 15 hours and 15 hours and 6 minutes of PCA hours provided for the third shift for a shortage of 54 minutes of PCA hours.

Interview with the MA on 10/04/24 at 12:15 pm

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revealed:
-The MAs usually worked an 8-hour shift from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am.
-The PCAs work 8 hours shift from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am.
-The facility had not had enough staff for coverage for the month of October 2024 due to the COVID-19 Outbreak.
-The facility assigned one MA and two PCAs to cover all three shifts.
-On 10/04/24, there was one MA and one PCA on the floor, due to not having enough staff to provide coverage.
-She informed the Administrator that there were only one MA and one PCA on the floor today (10/04/24).
-The Administrator informed the MA that she had no other staff member to help provide coverage.
-Medications had been late due to passing out medications to the whole facility and assisting with other personal care needs.
-She reported there was an altercation between two residents today in the courtyard.
-The altercation was unwitnessed by staff due to assisting other residents and medication pass.
-She was the only MA and was unable to assist with any other care needs of the residents due to medication rounds.
-She had addressed staffing with management (unknown date) and was told they were hiring staff.

Telephone interview with a second MA on 10/07/24 at 9:30am revealed:
-The MAs and PCAs worked 8-hour shifts
-She worked the 11pm-7am shift.
-She reported working by herself on the floor 11pm-7am (unknown dates)

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D 194	Continued From page 6 -She notified the Administrator when staffing had been short and the Administrator informed her that there was no other coverage. -The MA on the 11pm-7am shift were responsible for passing out medications and assisting the personal care aides (PCAs). -She was unable to complete the early morning medications rounds due to providing personal care for the residents when working by herself. -Staffing call outs happened frequently and no coverage was provided. -Management stated they would assist if needed, but they never came in or worked the floor. -Staffing shortages happened periodically (unknown dates). -Staff had been told not to tell anyone about the shortage of staffing. Interview with a PCA on 10/04/24 at 1:15pm revealed: -The MAs usually worked 8-hour shifts from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am. -The PCAs worked 8 hours shift from 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am. -The facility assigned one MA and two PCAs to cover all three shifts. - She notified the Administrator that she was the only PCA in the facility for 7:00am-3:00pm on 10/04/24. -She was responsible for showering, assisting with dressing/grooming, transferring and other personal care needs. -She was unable to complete her task or give the additional care need today due to an altercation that occurred in the smoking area on 100 hall. -There needed to be an increase in staffing because one PCA could not take care of all the residents.	D 194		

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D 194	Continued From page 7 -The staffing shortage began this month (unknown date) due to COVID-19 Outbreak. Observation in the Facility on 10/04/24 from 1:30pm to 2:30pm revealed: -The AL had a total of 38 residents. -There was one MA and one PCA on duty from 7:00am-3:00pm. -There was a resident, sitting in the door way of their room, waiting for assistance to use the bathroom. -There was a second resident asking when they would get their shower today. -There was a third resident asking to be changed due to incontinence. -The PCA was attending to another resident in a resident's room. -The MA was in another resident's room giving medications. -No additional staff member members were on the floor during the time from 1:30pm to 2:30pm. -The Resident Care Coordinator (RCC), Administrator, and the Business Office Coordinator (BOC) were in their offices during observations from 1:30pm to 2:30pm. Interview with Administrator on 10/04/24 at 2:45 pm revealed: -The MAs worked 8 hour shifts 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am both weekdays and weekends. -The PCAs worked 8 hours shifts 7:00am-3:00pm, 3:00pm-11:00pm and 11:00pm-7:00am both weekdays and weekends. -She made the schedule and the daily assignment sheets. -She was not aware that the facility was short staffed on any dates. -She was unaware that there was only one PCA on the floor today (10/04/24), no one reported	D 194		

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they were short on the floor.
-She was staffing to the aide hours of needs per state regulations of sixteen hours each shift.
-They had been hiring new staff; it had been difficult due to staff turnover and individuals not showing up for interviews.
-Her expectation was for staff to let her know they need additional assistance with providing care to the residents or if there was a call out.
-She would call other staff members to see if they were able to come in or she would work the floor.
-The RCC and BOC were helping assist with coverage when there was a need.
-On 10/04/24, she was unaware there was 1 MA and 1 PCA on the floor.

Interview with a resident on 10/04/24 at 3:30 pm revealed:
-All three shifts were usually short staffed.
-She had to find the MA to receive her morning medications at times because the MA was helping to assist another resident with their personal needs.
-The meals were always late due to short staff.
-She had to use the call bell today (10/04/24) and waited over 30 minutes for assistance.
-There needs to be more staff in the building at all times.

Interview with a second PCA on 10/08/24 at 10:00 am revealed:
-The facility assigned one MA and two PCAs to cover all three shifts.
-There were days when there was only one MA and one PCA.
-He notified the Administrator when there was only one PCA on the floor on 3:00pm-11pm when working that shift.
-The Administrator stated that she would help and never showed up on the floor to assist.

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D 194	Continued From page 9 -He was responsible for showering, assisting with dressing/grooming, transferring, helping to assist getting up or back to bed and other personal care needs. -He was unable to complete all tasks when working by himself on the floor with meeting all the residents needs. -Staffing needed to be increased, because one PCA could not take care of all these residents and meet their needs. -He believed that staffing issues happened around the first of October, 2024 due to the COVID-19 Outbreak and everyone getting sick. Interview with a MA on 10/14/24 at 4:00pm revealed: -The facility assigned one MA and two PCAs to cover all three shifts. -There were days when there would be only one MA and one PCA. -He notified the Administrator at night (3:00pm-11:00pm/11:00pm-7:00am) to inform of a PCA callouts or staffing shortage. -PCAs on the evening and night shift were responsible for showers, assisting with preparing for bed or getting dressed in the mornings, transferring, personal hygiene and other personal care needs for 38 residents. -He was unable to complete evening medications pass on time due to the staff shortage. -The shortage began around the first of October 2024 when the COVID-19 hit the facility. -Management tried to cover some of the days, but there were days that left shifts with only 1 MA and 1 PCA. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision] _____	D 194		

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D 194	Continued From page 10 The failure of the facility to ensure the required staffing hours for the Assisted Living (AL) unit, which included one shift with only one staff, who was alone in the facility from 11:00pm to 7:00am to care for 38 residents, 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 10/14/24 and on 10/23/24. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 07, 2024	D 194		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#3, #6), which resulted in an altercation with a resident with a known history of behaviors (#3) and another resident with a diagnosis of dementia (#6) who was not assessed to smoke independently.	D 270		

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D 270	Continued From page 11 The findings are: 1. Review of Resident #3's current FL-2 dated 01/23/24 revealed: -Diagnoses included vascular dementia, diabetes mellitus type 2, insomnia, anxiety, mixed hyperlipidemia, atherosclerotic heart disease, hypertension, benign prostatic hypertrophy, and gastroesophageal reflux disease. -He was intermittently disoriented. Review of Resident #3's Care Plan dated 03/29/24 revealed: -It was documented under the mental health/social history section the Resident had a history of being verbally abusive, disruptive and socially inappropriate. -He was sometimes disoriented. -He was forgetful and needed reminders. Review of Resident #3's Smoking Risk Assessment dated 10/09/24 revealed he was deemed a safe smoker. Review of Resident #3's Incident/Accident (I/A) report dated 10/04/24 revealed: -The date and time of the report was 10/04/24 at 9:45am. -The location of the I/A was the 100-hall smoking area. -The type of incident was listed as Behavior-Physical Assault. -The incident was not witnessed by staff. -The incident was witnessed by two residents. -Resident #3 was documented as saying he was playing around with the female resident like he normally does. -Resident #3 was not sent to the emergency department (ED) but the female resident was sent to the ED.	D 270		

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D 270	Continued From page 12 Review of Resident #3's progress note dated 10/04/24 at 9:45am revealed: -The resident grabbed a female resident around the neck and pulled her. -The provider and the Resident #3's responsible party were notified. -Supervision of Resident #3 was increased to every 30 minutes for 24 hours. Review of the local City Police Department Incident/Investigation Report dated 10/04/24 revealed: -The Crime/Incident was documented as assault on a female. -The incident was reported at 10:49am. -How attacked or committed was documented as "by assaulting victim". -Weapon/Tools were documented as personal weapons (hands fists, feet, teeth, etc.) -The number of victims was one person. -Injury was documented as minor. -A female resident was named as the victim. -The previous Administrator was the reporting person. -Resident #3 was identified as the offender. -Another resident was identified as a witness. -In the narrative area, police were dispatched to the facility in reference to an assault that took place. -After arriving, the police officer spoke with the previous Administrator, who stated one of the residents had choked another resident and placed the victim's hand on his crotch. -A short time later, the victim who was identified as the female resident was placed in the ambulance. -The police officer attempted to speak with the female resident, but due to her being hard of hearing and having dementia, he was not	D 270		

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receiving any answers.
-The only areas of redness on the female resident the police officer observed was her left ear, there were no signs of bruising or discoloration on her neck area.
-The female resident was then transported to the emergency department (ED) by emergency medical services (EMS) as requested by her guardian.
-The previous Administrator stated the resident that assaulted the female resident was Resident #3, and she stated both residents suffered from dementia.
-The police officer spoke with two other residents, the resident said the female resident and Resident #3 were both sitting beside each other in the courtyard.
-The resident stated that he saw Resident #3's hand go between the female resident's leg as well as the female resident's hand go between Resident #3's legs.
-The resident stated Resident #3 was smacking the female resident's shoulder as well.
-The resident also stated the female resident was hollering at Resident #3 to stop.
-The resident said this was a normal occurrence and that it wasn't the first time it had happened.
-The police officer was approached by another resident who witnessed the incident and said she observed Resident #3 put his hands around the female resident's neck and at that point, she went over and began to yell at Resident #3 to stop and he did, she then notified staff and both parties were separated.
-A short time later, the police officer spoke with Resident #3, while accompanied by the previous Administrator.
-The police officer asked Resident #3 what happened, and he stated that he kissed the female resident, and she kissed him.

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D 270	Continued From page 14 -Resident #3 said he then grabbed the female resident and brought her closer, he then used both hands and placed them on her neck. -Resident #3 said he then placed his right hand on the female resident's forehead and his left on the back of her head. -Resident #3 showed the police officer how he grabbed the female resident by doing it to himself. -The police officer asked Resident #3 if at any time, did the female resident say stop, and he stated he doesn't remember that. -After speaking with Resident #3, the police officer asked the previous Administrator if they planned to get Resident #3 out of the facility, and she said she had already set up a meeting with Resident #3's family about possibly moving facilities. -The previous Administrator also stated she had contacted the female resident's guardian about the incident. -Due to Resident #3 being diagnosed with dementia, the police officer was unable to pursue any charges at the time. -The police officer advised the previous Administrator that they would need to ensure that both Resident #3 and the female resident would be separated at all times. -The case status was closed. -Prosecution was declined. Interview with Resident #3 on 10/04/24 at 1:50pm: -He just put his hand around the female resident's neck and let it go for a kiss. -The female resident wanted a smoke, and he wanted a kiss, and she said no. -He and the female resident always kiss each other when they saw each other. -He never touched the female resident's private	D 270		

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D 270	Continued From page 15 parts, he would never do that to a lady. Interview with the medication aide (MA) on 10/04/24 at 12:15 pm revealed: -There was an incident this morning between two residents. -The female resident and Resident #3 were in the smoking area on 100 hall. -The incident was unwitnessed by staff; only one resident witnessed the incident and took the female resident in for assistance from the Administrator. -The female resident and Resident #3 were not supervised and they could smoke anytime they want. -The female resident required us to give her the cigarette and light it for her as she was not allowed to have a lighter. -It was reported to her from the Administrator that Resident #3 was trying to get a kiss from the female resident and when she would not agree, he put her in a choke hold. -The female resident was yelling and that was when another resident went over to help and took her to the Administrator for assistance. -The Administrator called the police and emergency medical services (EMS) for the female resident to go to the hospital. -Resident #3 had a foul mouth at times but she had never seen him aggressive towards any resident or staff. -Resident #3 got agitated at times when things did not go his way. Interview with a second MA on 10/23/24 at 9:54am revealed: -Resident #3 used rough language. -Sometimes Resident #3 would bump other residents with his walker if they were in his way. -Resident #3 and the female resident often	D 270		

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smoked together.
-Resident #3 would try to kiss the female resident and staff intervened and Resident #3 would say "some choice words".
-The female resident got upset if she could not sit with Resident #3 in the smoking area.
-He had never seen Resident #3 be violent or physically aggressive towards the female resident or any other residents.
-No residents required smoking supervision that he was aware of.

Second interview with the MA on 10/23/24 at 2:01pm revealed:
-He was not working on the day of the 10/04/24 incident with Resident #3 and the female resident.
-Resident #3 and the female resident considered themselves boyfriend and girlfriend.
-Resident #3 often asked the female resident for a kiss and sometimes she would kiss him and sometimes she would not but he never saw Resident #3 put his hands on the female resident.
-The previous Administrator had countless times told staff to keep an eye on Resident #3 and the female resident because the female resident had dementia.

Interview with a resident on 10/23/24 at 1:49pm revealed:
-He was sitting outside in the courtyard directly across from the 100 hall smoking area.
-Resident #3 and the female resident often smoked together.
-He saw Resident #3 occasionally kiss the female resident in the smoking area and saw Resident #3 put the female resident's hand between his legs.
-He had heard Resident #3 say "vulgar things' to the female resident, but he never reported this to

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anyone but he was pretty certain staff knew about it.
-On the 10/04/24, he saw Resident #3 grab the female resident around the neck, and the female resident kept yelling "quit", another resident that was outside, went and got the female resident and took her inside.
-He never witnessed Resident #3 acting inappropriately with anyone else except the female resident.

Interview with a second resident on 10/23/24 at 8:55am revealed:
-She had witnessed Resident #3 "groping" the female resident in the past.
-The female resident often asked Resident #3 for cigarettes and he would say she "had to give him some" for a cigarette.
-Resident #3 tried to kiss her and grab her chest before but she did not let him bother her and could fend for herself.
-Resident #3 often spoke to female residents in a mean way.
-She was not sure if she had told any staff about Resident #3.
-She was outside in the smoking area on 10/04/24 and saw Resident #3 pulling the female resident in a headlock, the female resident was telling him to stop and Resident #3 kept telling Resident #6 to shut up.
-There were no staff present in the smoking area on 10/04/24 when Resident #3 assaulted the female resident, so she went over and got the female resident away from Resident #3 by rolling her inside the facility and took her to the previous Administrator's office.
-She said the female resident was shaking and said she was afraid of Resident #3,
-She explained what happened to the female resident and the previous Administrator called

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D 270	Continued From page 18 EMS and the police. Interview with the previous Administrator on 10/04/24 at 2:45pm revealed: -She was sitting at her desk when another resident pushed the female resident into her office and stated that Resident #3 had attacked the female resident in the courtyard. -The resident stated that a female resident was put in a choke hold by Resident #3 and was hitting her on the side of the head. -The female resident's ear was red, so, she called the female resident's guardian to get approval to call EMS to be sent to the ED for further evaluation. -She also called the local city Police Department to come out to speak with Resident #3. -The female resident was sent via ambulance to the hospital (unknown time, maybe 45 minutes after the incident occurred). -Resident #3 was interviewed by herself and the local city Police Department. -Resident #3 stated he wanted a kiss, and when the female resident would not kiss him, he grabbed her neck and started hitting her. -Resident #3 was placed on every 30-minute checks for 72 hours and was to be supervised when out on the patio smoking during the 72 hours. -The female resident will be on every 30-minute checks for 72 hours and be supervised when out on the patio smoking during the 72 hours. Interview with a PCA on 10/23/24 at 2:21pm revealed: -She had been employed at the facility since July 2024. -She was hired as a shower aide and moved into the PCA position about a month ago. -Resident #3 could get agitated depending on	D 270		

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how you approached him.
-Resident #3 was known to be verbally aggressive at times, argumentative, and promiscuous.
-Resident #3 and the female resident had an on again off again relationship.
-Resident #3 and the female resident had to be separated on multiple occasions for inappropriate behavior.
-Previously, the female resident and Resident #3 were not to be in the smoking area at the same time, but she could not remember when this was put into place or the when the plan was lifted.
-Both Resident #3 and the female resident, liked to smoke after meals.
-The facility had been short staffed and frequently, it was just herself and one MA for the shift for the entire facility.
-On the morning of 10/04/24, there was one MA on duty, and she was notified that she was the only PCA for the shift and would be training a new PCA starting her first day on the job.
-She and the new PCA were trying to get the residents up, cleaned and dressed and to the dining room for breakfast.
-She got all the residents to the dining room and was helping to pass meal trays while the MA passed medications.
-She had to escort another resident back to her room and then she took the female resident to the smoking area on the 100 hall and another resident lit her cigarette for her.
-She was then called to the 200 hall to help another resident and could not stay with the female resident.
-When she finished on the 200 hall, she headed back to the 100 hall smoking area to bring the female resident back in and another resident told her she had removed the female resident from the smoking area away from Resident #3 and

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took her to the Administrator.
-The female resident was flushed and red in the face and complained of her head and neck hurting.
-She had notified the RCC that she needed help but was not given any assistance.

Interview with the RCC on 10/23/24 at 3:40pm revealed:
-The residents were checked every 2 hours for incontinence, need for assistance and to make sure they were still breathing.
-If a resident had a fall or returned from the hospital or ED, they were checked every 30 minutes for 72 hours by the PCAs and the MAs.
-It was reported to her on 10/04/24 that Resident #3 and the female resident were in the smoking area and Resident #3 grabbed the female resident around the neck.
-Another resident reported the incident between Resident #3 and the female resident to the previous Administrator.
-Resident #3 was interviewed but did not recall the incident but said he was being "a little frisky" with the female resident.
-She was told Resident #3 could be a little vulgar but nothing else had ever been reported.
-She reached out to Resident #3's behavioral health provider after the 10/04/24 incident and she did not have any new orders for Resident #3.
-She reached out to Resident 3's primary care provider (PCP) after the 10/04/24 incident and she ordered a urinalysis.
-Resident #3 had previously not had any major behaviors aside from cursing and being argumentative.
-There were days when the facility was short staffed, and a shift may have only one MA and one PCA on the floor to care for the residents and management tried to help when they could.

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D 270	Continued From page 21 Interview with the Interim Administrator on 10/23/24 at 5:19pm revealed: -The previous Administrator resigned without notice about a week ago. -The residents were to be checked hourly for incontinence, for any assistance needed, and to make sure they were not in distress. -The residents may require more frequent monitoring if they exhibited abnormal behaviors such as aggressiveness, increased agitation or if they appeared ill. -The frequency of monitoring for the residents depended on the situation and circumstances. -He expected the residents to be monitored and supervised to keep them from harm and injury. Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed: -Resident #3 took several medications including a behavioral health medication for vascular dementia, anxiety and agitation. -She was notified of the incident with Resident #3 on 10/04/24. -Being without the behavioral health medication could have an effect on Resident #3's behavior, resulting in increased anxiety and/or agitation. -It was possible being without the behavioral medication could have triggered the 10/04/24 incident with Resident #3. Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed: -Resident #3 had been on a behavioral health medication for quite a long time for anxiety and agitation. -Without the behavioral health medication, Resident #3 could become very aggressive and sexually focused. -She was not made aware that Resident #3 was	D 270		

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without his behavioral medication until the 10/04/24 incident.
-It was possible that being without the behavioral health medication contributed to the incident with Resident #3 on 10/04/24.

2. Review of the facility's undated Tobacco Policy revealed:
-Each resident at admission is assessed for ability to smoke safely by means of interview with the resident and responsible party and through staff observation.
-Assessments are repeated at least on admission, readmission from hospital visits and quarterly or as needed to ensure safe smoking practices.
-Staff are in-serviced to provide ongoing assessment of resident smoking habits and to report to their supervisor any change in ability to smoke safely.
-Residents assessed to need supervision will be placed on a smoking schedule and will be supervised while smoking by staff, smoking materials will be secured by Community staff who will supervise materials during use.
-Residents who smoke safely outside of the building may be allowed to access smoking materials during the times they are outside of the building.
-Residents who smoke may do so only in designated smoking areas outside of the building.

Review of Resident #6's current FL2 dated 08/06/24 revealed:
-Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), bi-polar disorder, major depressive disorder, hypertension, and headaches.
-She was intermittently disoriented.
-She was on oxygen as needed at 2 liters per

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minute.

Review of Resident #6's Care Plan dated 03/27/24 revealed:
-Under Social/Mental Health History, bi-polar depression and adjustment disorder were documented.
-She had limited range of motion of both upper extremities.
-She was sometimes disoriented.
-She was forgetful and needed reminders.

Review of Resident #6's record on 10/23/24 revealed there was no smoking assessment completed upon admission.

Review of Resident #6's Incident/Accident (I/A) Report dated 10/04/24 at 9:45am revealed:
-The incident was documented as "Other"-left ear redness.
-The location of the incident was documented as 100 Hall smoking area.
-The incident was not witnessed by staff.
-The incident was reported by a resident.
-The resident was not alone.
-Resident #6 was observed sitting in her wheelchair, visibly shaking and left ear redness noted.
-Her level of care was assisted living.
-Resident #6 stated that a male resident would not leave her alone.
-She complained of left ear pain.
-She was alert and oriented.
-The resident was sent to the emergency department (ED) on 10/04/24 at 10:40am via emergency medical services (EMS).
-The resident was not hospitalized.
-The status of the resident after the ED visit was no acute fracture, no soft tissue swelling, follow-up with primary care provider (PCP) in 2-4

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days.
-Resident #6's guardian was notified on 10/04/24 at 10:00am.
-Resident #6's PCP was notified on 10/04/24 at 10:20am.

Review of Resident #6's progress notes dated 10/04/24 revealed:
-There was an entry at 10:00am, by the previous Administrator, who spoke with the resident's guardian regarding the incident that occurred this morning, he requested the resident be sent out to the ED for evaluation.
-There was an entry at 10:20am, by the previous Administrator informed Resident #6's PCP of the incident that occurred with the resident this morning.
-There was an entry at 11:00am, by the Resident Care Coordinator (RCC), the resident was transported to the hospital via EMS, complaining of neck and left ear discomfort, the PCP, guardian and hospice were notified.

Review of Resident #6's hospital after visit summary dated 10/04/24 revealed:
-She was seen for neck complaint,
-After care instructions were given for neck sprain/strain.
-The resident had a cervical spine x-ray done in the ED today.
-There was no acute fracture.
-There was no soft tissue swelling and she had no obvious injury to her neck.
-She is resting comfortably in the exam bed and is appropriate for discharge from the hospital back to the facility.
-If she has any pain, she may have one acetaminophen 500mg tablet every 6 hours as needed.
-She is to follow up with her PCP in 2-4 days.

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D 270	Continued From page 25 Review of Resident #6's Smoking Risk Assessment dated 10/09/24 revealed: -The resident smoked cigarettes. -The resident borrowed cigarettes from others. -The resident smoked every few hours. -The resident did not smoke in unauthorized areas. -Under the heading, resident was careless with smoking materials, drops cigarettes butts or matches on the floor, furniture, self or others, burns fingertips, smoke near oxygen, "severe problem" was documented. -The resident did not smoke cigarette butts from ashtrays. -The resident did not inappropriately provide cigarettes to others. -Under the heading, resident begs or steals cigarettes from others, "severe problem" was documented. -Under the heading, general awareness and Orientation, including ability to understand facility safe smoking policy, "severe problem" was documented. -Under the heading, mobility, "severe problem" was documented. -The resident needed assistance getting to the designated smoking area. -Under the heading, Resident Follows Safe Smoking Policy, "severe problem" was documented. -The resident Smoking Risk Total was scored as 16. -A score of 10-18 was potentially an unsafe smoker. -The Plan of Care action taken was documented as unsafe smoker, staff will provide supervision during designated smoke breaks. Resident #6's previous Smoking Risk	D 270		

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D 270	Continued From page 26 Assessment prior to 10/09/24 was requested on 10/23/24 at 7:33am and was not provided. Interview with Resident #6's guardian on 10/23/24 at 3:50pm revealed: -He was notified by the facility on 10/04/24 about the incident between Resident #3 and Resident #6. -Resident #6 had recently been placed in another facility for reasons aside from the 10/04/24 incident with Resident #3. -He was not aware of any previous incidents between Resident #3 and Resident #6. Interview with the previous Administrator on 10/04/24 at 2:45pm revealed: -She was sitting at her desk when another resident pushed Resident #6 into her office and stated that Resident #3 had attacked Resident #6 in the courtyard. -The resident stated that Resident #6 was put in a choke hold by Resident #3 and he was hitting her on the side of the head. -Resident #6's ear was red, so, she called Resident #6's guardian to get approval to call EMS to be sent to the ED for further observations. -She also called the local city Police Department to come out to speak with Resident #3. -Resident #6 was sent via ambulance to the hospital (unknown time, maybe 45 minutes after the incident occurred). -Resident #3 was interviewed by herself and the local city Police Department. -Resident #3 stated he wanted a kiss, and when Resident #6 would not kiss him, he grabbed her neck and started hitting her. -Resident #3 was placed on every 30-minute checks for 72 hours and was to be supervised when out on the patio smoking during the 72	D 270		

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hours.
-Resident #6 would be on every 30-minute checks for 72 hours and be supervised when out on the patio smoking during the 72 hours.

Interview with a medication aide (MA) on 10/04/24 at 12:15pm revealed:
-Resident #6 was not supervised and she could smoke anytime she wanted.
-Resident #6 required us to give her the cigarette and light it for her as she was not allowed to have a lighter.
-She was never told anything about a smoking assessment.

Interview with a PCA on 10/23/24 at 2:21pm revealed she took Resident #6 to the smoking area because Resident #6 was not allowed to have a lighter and staff had to light her cigarette for her.

Interview with the RCC on 10/23/24 at 3:40pm revealed:
-Smoking Assessments were performed on the residents on admission, every 6 months, or if there was a change in condition.
-Since 10/04/24, Resident #6 had a smoking assessment, and it was determined that she required supervised smoking.
-She had a tickler system for chart audits which included making sure FL2, care plans and smoking assessments were up to date.
-There was no set time to do chart audits and she did them when she could.
-She was not sure why Resident #6 did not have a previous smoking assessment on file.

Interview with the Interim Administrator on 10/23/24 at 5:19pm revealed:
-The previous Administrator resigned about a

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D 270	Continued From page 28 week ago. -The residents were to be checked hourly for incontinence, for any assistance needed, and to make sure they were not in distress. -The residents may require more frequent monitoring if they exhibited abnormal behaviors such as aggressiveness, increased agitation or if they appeared ill. -The frequency of monitoring for the residents depended on the situation and circumstances. -He expected the residents to be monitored and supervised to keep them from harm and injury. [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration] The facility failed to ensure supervision of 2 of 5 sampled residents (#3, #6) one with known diagnoses of behavioral issues and dementia (#3), and a resident with a known diagnosis of dementia with no smoking assessment (#6) which resulted in an altercation in the smoking area of the facility causing one of the residents (#6) being sent to the ED for a cervical strain. These failures were detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/23/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 07, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 29 (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 B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure physician notification for 2 of 5 sampled residents (#3, #5) related to a resident who was out of medications used to treat anxiety and elevated cholesterol (#3), and a resident who was out of insulin, a medication to treat elevated blood glucose levels (#5). The findings are: Review of the facility's undated Missed or Refused Medication Policy revealed: -No resident can be forced to take any medication. -Steps will be taken to avoid missed or refused doses of medications as per the medication policy. -Missed or refused medications are documented in the Resident's medication administration record (MAR) and the provider, responsible party/guardian is notified and documented. -The medication aide (MA) and or Resident Care Coordinator (RCC) notifies the prescribing provider of the missed or refused medications immediately using the Medication notification form after 3 consecutive refusals unless the medications are related to diabetic medications, coumadin or seizure disorder medications. -The RCC evaluates the resident refusals and contacts the physician and responsible party if the resident is continually refusing a medication(s) and documents the communication on the Care	D 273		

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D 273	Continued From page 30 Coordinator Meeting progress note. 1. Review of Resident #3's current FL-2 dated 01/23/24 revealed diagnoses included vascular dementia, diabetes mellitus type 2, insomnia, anxiety, mixed hyperlipidemia, atherosclerotic heart disease, hypertension, benign prostatic hypertrophy, and gastroesophageal reflux disease. a. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed an order for clonazepam 0.5mg (clonazepam is used to treat anxiety and mood disorders), take one tablet three times per day. Review of Resident #3's October 2024 eMAR revealed: -There was an entry for clonazepam 0.5mg, take one tablet three times daily scheduled for 6:00am, 2:00pm and 6:00pm. -Clonazepam 0.5mg was documented as not administered at 6:00am on 10/01/24 through 10/04/24 with the exception documented as "waiting on pharmacy". -Clonazepam 0.5mg was documented as not administered at 2:00pm on 10/01/24 through 10/04/24 with the exceptions documented as "waiting on med" on 10/01/24, "waiting on drug" on 10/02/24, "waiting on med" on 10/03/24, and "waiting on pharmacy" on 10/04/24. -Clonazepam 0.5mg was documented as not administered at 6:00pm on 10/01/24 through 10/03/24 with the exception documented as "waiting on pharmacy". Review of Resident #3's electronic progress notes dated 07/09/24 to 10/04/24 revealed there was no documentation that Resident #3's primary care provider (PCP) was notified of medication	D 273		

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refusals and unavailable medications.

Review of Resident #3's controlled substance log (CSL) dated 09/26/24 through 10/23/24 revealed:
-On 09/26/24 at 7:56am, there were 11 clonazepam 0.5mg tablets available for Resident #3.
-On 09/30/24 at 6:35pm, after 1 tablet of clonazepam 0.5mg was administered to Resident #3, a balance of 0 tablets was documented as available for Resident #3.
-The next documented entry was on 10/04/24 at 2:41pm, 21 tablets of clonazepam 0.5mg were documented as received for balance of 21 tablets.
-90 tablets of clonazepam 0.5mg were documented as received on 10/08/24 at 3:30pm for a balance of 99 tablets.
-90 tablets of clonazepam 0.5mg were documented as received on 10/15/24 at 4:46pm for a balance of 168 tablets.
-On 10/23/24 at 5:17am, the balance remaining of clonazepam 0.5mg for Resident #3 was 143 tablets.

Observation of Resident #3's medications on hand on 10/23/24 at 9:30am revealed:
-There was a medication bottle from the resident's mail order pharmacy, labeled with Resident #3's name and labeled clonazepam 0.5mg, take 1 tablet three times per day, dispensed on 10/10/24 for a quantity of 90 tablets.
-There were 143 clonazepam tablets remaining in the labeled medication bottle.

Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed:
-Medication refills could be requested via an

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automated voice system, via text or placed on auto-refill.
-Clonazepam could not be placed on auto-refill since it was a controlled substance.
-It usually took 5-7 days for medications to be processed and shipped after the request was received.
-Shipping of the medications could take 5-7 days as well.
-Clonazepam 0.5mg was dispensed for Resident #3 on 07/16/24 for a quantity of 90 tablets to take three times a day for a 30-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 08/12/24 for a quantity of 90 tablets to take three times per a day for a 30-day supply.
-A clonazepam refill was requested for Resident #3 on 09/21/24 through the automated voice request system.
-90 tablets of clonazepam 0.5mg, to take three times per day, for a 30-day supply were dispensed and shipped for Resident #3 on 10/10/24.

Telephone interview with a pharmacist from Resident #3's local retail pharmacy on 10/23/24 at 9:48am revealed:
-The facility staff or Resident #3's responsible party (RP) picked up his medications from the pharmacy,
-Clonazepam 0.5mg was dispensed for Resident #3 on 07/02/24 for a quantity of 21 tablets, to take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 09/21/24 for a quantity of 21 tablets, to take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 10/02/24 for a quantity of 21 tablets, take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 10/08/24 for a quantity of 90 tablets, take

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three times per day for a 30-day supply.
-Clonazepam was in a class of medications called benzodiazepines, that was used to treat certain types of seizures and anxiety.
-Missed doses of clonazepam could cause withdrawal symptoms such as nausea, sweating, and headaches and if taken for seizures, missed doses could lower the seizure threshold.
-If clonazepam was used for anxiety, missed doses could cause increased anxiety, agitation, shaking and tremors.

Review of a copy of a receipt and prescription print-out from Resident #3's local pharmacy revealed clonazepam 0.5mg, take one tablet three times per day, for a quantity of 21 tablets was purchased on 10/04/24 at 2:18pm.

Review of Resident #3's Incident/Accident (I/A) report dated 10/04/24 revealed:
-The date and time of the report was 10/04/24 at 11:21am.
-The time of the incident was 9:45am.
-The location of the I/A was the 100-hall smoking area.
-The type of incident was listed as Behavior-Physical Assault.
-The incident was not witnessed by staff.
-The incident was witnessed by two residents.
-Resident #3 was documented as saying he was playing around with another resident like he normally does.
-Resident #3 was not sent to the emergency department (ED) but the other resident was sent to the ED.

Review of Resident #3's progress note dated 10/04/24 at 9:45am revealed:
-The resident grabbed a female resident around the neck and pulled her.

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-The provider and the Resident #3's responsible party were notified.
-Supervision of Resident #3 was increased to every 30 minutes for 24 hours.

Interview with Resident #3 on 10/22/24 at 3:03pm revealed:
-He had lived at the facility for about 4 years.
-He was not aware of being without any of his medications.

Interview with Resident #3's responsible party (RP) on 10/23/24 at 10:36am revealed:
-Resident #3 received most of his medications through a mail order pharmacy.
-Short-term medications such as antibiotics were sent to a local retail pharmacy.
-If there was a delay in the mail order medications, sometimes these were sent to the local retail pharmacy as well.
-Either she or the facility staff picked up Resident #3's medications from the local pharmacy when needed.
-She supplied over the counter medications for Resident #3.
-She knew sometimes there was a delay in the mail order prescriptions.
-She was not aware of any delays of more than 24 hours for any of Resident #3's medications.
-She was not aware of any recent delays in Resident #3's medications.
-She knew that Resident #3 had laid hands on another resident a few weeks ago and the police were called and came out and talked to him.

Interview with the medication aide (MA) on 10/23/24 at 9:13am revealed:
-The MAs or the RCC were responsible for requesting medication refills for the residents.
-If a resident used a mail order pharmacy, he

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ordered the residents medications 2 weeks in advance to ensure time for the medications to arrive.
-If a resident's medication came from a local pharmacy, he ordered them 7 days in advance.
-Resident #3 used a mail order pharmacy and a local retail pharmacy.
-Medications from Resident #3's mail order pharmacy usually took two weeks to be delivered.
-Medications from the local retail pharmacy were usually ready the following day.
-The local retail pharmacy would notify either the facility or Resident #3's RP when medications were ready for pickup.
-If a medication was not received from either the local retail pharmacy or the facility's contracted pharmacy within 48 hours, he called the pharmacy or notified the Resident Care Coordinator (RCC).
-He contacted Resident #3's mail order pharmacy for a clonazepam refill on 09/21/24.
-He thought clonazepam was ordered for Resident #3 from his local pharmacy on 09/21/24 and 09/28/24 and picked up on both days, but it was possible the local pharmacy ran low on the clonazepam, and he was not sure what pharmacy they used as a backup pharmacy.
-He noticed that Resident #3 seemed a little more vocal and used rougher language while he was out of the clonazepam but did not feel he was physically aggressive or agitated.
-Resident #3 had received a 30-day supply of clonazepam from his local retail pharmacy and a 30-day supply of clonazepam from his mail order pharmacy; these bottles were combined into one bottle.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took clonazepam for vascular

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dementia, anxiety and agitation.
-She was not notified that Resident #3 was without clonazepam for 11 doses in October 2024.
-She was notified of the incident with Resident #3 on 10/04/24.
-Being without the clonazepam could have an effect on Resident #3's behavior, resulting in increased anxiety and/or agitation.
-It was possible being without the clonazepam could have triggered the 10/04/24 incident with Resident #3.

Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed:
-Resident #3 had been on clonazepam for quite a long time for anxiety and agitation.
-Without clonazepam, Resident #3 could become very aggressive and sexually focused.
-She was not made aware that Resident #3 was without clonazepam until the 10/04/24 incident.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-It was possible that being without the clonazepam contributed to the incident with Resident #3 on 10/04/24.
-She expected to be contacted when a resident was out of their medications.

Refer to second interview with the MA on 10/23/24 at 9:38am.

Refer to interview with the RCC on 10/23/24 at 3:48pm.

Refer to interview with the Administrator on 10/23/24 at 5:19pm.

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D 273	Continued From page 37 b. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed there was an entry for divalproex delayed release 250mg (divalproex is used to treat seizures, anxiety and can be used as a mood stabilizer), take one tablet at bedtime. Review of Resident #3's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for divalproex delayed release 250mg tablet, take one tablet at bedtime scheduled for 6:00pm. -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 08/15/24 through 08/18/24, with the exception documented as "waiting on pharmacy" for each day. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for divalproex delayed release 250mg tablet, take one tablet at bedtime scheduled for 6:00pm. -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/18/24 with the exception documented as "waiting on pharmacy". -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/19/24 with the exception documented as "refused". -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/20/24 through 09/22/24 with the exception documented as "waiting on pharmacy" for each day. Review of Resident #3's electronic progress notes dated 07/09/24 to 10/04/24 revealed:	D 273		

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-There was an entry on 09/13/24 at 7:27pm by the MA, "I called in a refill on divalproex and ezetimibe, the medications will be ready on 09/17/24 and the RCC was informed.
-There was no documentation that Resident #3's PCP was notified that divalproex was unavailable for administration.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took divalproex for vascular dementia, anxiety, agitation, and mood stabilization.
-She was not notified that Resident #3 was without divalproex.
-Being without the divalproex, could have an effect on Resident #3's behavior, resulting increased anxiety and or agitation.

Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed:
-Resident #3 had been on divalproex for quite a long time for anxiety and agitation.
-She was not made aware that Resident #3 was without divalproex.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-Being without the divalproex could cause Resident #3 to experience increased anxiety and agitation.

c. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed there was an entry for ezetimibe 10mg (ezetimibe is used to lower high cholesterol levels), take one tablet at bedtime.

Review of Resident #3's September 2024 eMAR

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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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revealed:
-There was an entry for ezetimibe 10mg, take one tablet at bedtime, scheduled for 6:00pm.
-Ezetimibe 10mg tablet was documented as not administered at 6:00pm on 09/19/24, with the exception documented as "refused".
-Ezetimibe 10mg tablet was documented as not administered at 6:00pm on 09/20/24 through 09/22/24, with the exception documented as "waiting on pharmacy".

Review of Resident #3's electronic progress notes dated 07/09/24 to 10/04/24 revealed:
-There was an entry on 09/13/24 at 7:27pm by the MA, "I called in a refill on divalproex and ezetimibe, the medications will be ready 09/17/24 and the Resident Care Coordinator (RCC) was informed.
-There was no documentation that Resident #3's primary care provider (PCP) was notified that ezetimibe was unavailable for administration.

Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed:
-Resident #3 took ezetimibe 10mg for high cholesterol.
-She was not made aware that Resident #3 was without ezetimibe.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.

Refer to second interview with the MA on 10/23/24 at 9:38am.

Refer to interview with RCC on 10/23/24 at 3:48pm.

Refer to interview with the Administrator on

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D 273	Continued From page 40 10/23/24 at 5:19pm. d. Review of Resident #3's subsequent physicians order sheet dated 04/26/24 revealed there was an order for Zoloft 25mg (Zoloft is the brand name for sertraline and is used to treat obsessive compulsive disorder, anxiety and panic disorder), take one tablet daily. Review of Resident #3's August 2024 electronic medication record (eMAR) revealed: -There was an entry for sertraline 25mg, take one tablet once daily, scheduled at 6:00am. -Sertraline 25mg tablet was documented as not administered at 6:00am on 08/16/24, with the exception documented as "waiting on pharmacy". -Sertraline 25mg tablet was documented as not administered at 6:00am on 08/17/24, with the exception documented as "reordered". -Sertraline 25mg tablet was documented as not administered at 6:00am on 08/18/24 and 08/19/24, with the exception documented as "waiting on pharmacy". Review of Resident #3's October 2024 eMAR revealed: -There was an entry for sertraline 25mg, take one tablet once daily, scheduled at 6:00am. -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/17/24, with the exception documented as "drug/item unavailable". -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/20/24 through 10/22/24, with the exception documented as "drug/item unavailable". -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/23/24, with the exception documented as "reordered".	D 273		

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Review of Resident #3's electronic progress notes dated 07/09/24 to 10/04/24 revealed there was no documentation that Resident #3's PCP was notified that he was out of sertraline.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took sertraline 25mg for vascular dementia, anxiety, agitation, and mood stabilization.
-She was not notified that Resident #3 was without sertraline 25mg.
-Being without the sertraline could have an effect on Resident #3's behavior, resulting in increased anxiety and or agitation.
-Sertraline should not be stopped suddenly due to the potential for withdrawal symptoms such as nausea, vomiting, insomnia, and fatigue but Resident #3 was on a very low dose of sertraline.

Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed:
-Resident #3 took sertraline for anxiety and agitation.
-She was not made aware that Resident #3 was without sertraline.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-Being without the sertraline could cause Resident #3 to experience increased anxiety and agitation.

Refer to second interview with the MA on 10/23/24 at 9:38am.

Refer to interview with the RCC on 10/23/24 at 3:48pm.

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D 273	Continued From page 42 Refer to telephone interview with the Administrator on 10/23/24 at 5:19pm. _____ Second interview with the MA on 10/23/24 at 9:38am revealed: -If a resident missed a dose of medication or refused a dose of a medication, it was documented on the eMAR. -A separate progress note was made concerning the missed or refused medication dose. -He thought the MAs or the RCC were to notify the PCP after the first missed dose of medication but was not sure. -He did not know why there were no progress notes made regarding Resident #3's missed doses of medications. Interview with the RCC on 10/23/24 at 3:48pm revealed: -She or the MAs ordered the residents' medications. -If using a local or the facility's contracted pharmacy, medications were ordered 7 days in advance. -If a resident used a mail order pharmacy, medications were ordered 2-3 weeks in advance. -Resident #3 used a mail order pharmacy and a local pharmacy. -Either staff or Resident 3's RP picked up his medications from the local pharmacy. -Usually if Resident #3's medication required a co-pay then his RP picked them up, otherwise staff would pick up his medications. -She or the MAs should have notified the residents' PCP of any missed doses of medications. -She was not sure why Resident #3's PCP was not notified of missed medications. Telephone interview with the Interim Administrator	D 273		

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D 273	Continued From page 43 on 10/23/24 at 5:19pm revealed: -The RCC and the MAs were responsible for ordering medication refills for the residents. -The RCC and MA should have followed up on all Resident #3's medication refill requests. -Resident #3's PCP should have been notified after the first missed dose of each medication. -The residents' PCP should be notified of all missed doses of medications. 2. Review of Resident #5's current FL2 dated 10/08/24 revealed diagnoses included hemiparesis, muscle weakness, heart failure, unspecified atrial flutter, aphasia following cerebral infarction, cerebrovascular accident (CVA) right side deficit, bilateral total knee arthroplasty (TKA) and type 2 diabetes mellitus. Review of Residents #5's signed physician order sheet dated 08/31/24 revealed an order for Toujeo Solostar U-300 insulin pen, 62 units to be injected subcutaneously daily. (Toujeo Solostar U-300 Insulin is a long acting insulin to used to control high blood sugar.) Review of Resident #5's current Licensed Health Professional Support (LHPS) assessment dated 10/14/24 revealed: -Tasks included were medications administration through injection and collecting and testing of finger stick blood samples. -Blood Sugars ranged from: 93-410 in the past 30 days -On finger stick blood sugars (FSBS) three times a day before meals; has sliding scale (SS) insulin ordered per FSBS reading. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed:	D 273		

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D 273	Continued From page 44 -There was an entry for Toujeo Solostar U-300, 62 units subcutaneously once daily at 9am. -Toujeo Solostar U-300, 62 units was documented as administered from 09/01/24 through 09/15/24 at 9:00am. -On 09/16/24 to 09/30/24,Toujeo Solostar U-300 insulin was documented as not administered at 9:00am with reasons documented as "Waiting on Pharmacy" or "on hold". -There were 15 of 30 doses of Toujeo Solostar U-300 insulin documented as not administered from 09/01/24 - 09/30/24. -His 7:00am blood sugars ranged from 106-220 from 09/01/24 to 09/15/24 with 1 FSBS over 200. -His 7:00am blood sugars ranged from 141-298 from 09/16/24 to 09/30/21 with 12 FSBS over 200. -His 11:00am blood sugars ranged from 103-299 from 09/01/24 to 09/15/24 with 3 FSBS over 200. -His 11:00am blood sugars ranged from 122-337 from 09/16/24 to 09/30/21 with 6 FSBS over 200 and 3 FSBS over 300. -His 5:00pm blood sugars ranged from 124-237 from 09/01/24 to 09/15/24 with 4 FSBS over 200. -His 5:00pm blood sugars ranged from 133-283 from 09/16/24 to 09/30/21 with 8 FSBS over 200. Telephone interview with a pharmacist for Resident #5 on 10/22/24 at 3:30 pm revealed: -Resident #5's Toujeo Solostar required a new prescription each month. -Toujeo was ordered to help control Resident #5's blood sugar. -The pharmacy received a prescription refill request for Resident #5's Toujeo Solostar U-300 on 09/30/24 and the medication was delivered to the facility on 10/01/24. -The pharmacy last received a refill request on 08/21/24 for a 21-day supply of Toujeo Solostar U-300.	D 273		

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D 273	Continued From page 45 Telephone Interview with Resident #5's Primary Care Physician (PCP) on 10/22/24 at 3:45pm revealed: -She treated Resident #5 for diabetes. -Missing the Toujeo doses could cause Resident #5's blood sugar to be elevated. -Elevated blood sugars would cause Resident #5's to become hyperglycemic and potentially be hospitalized. -Blood sugars ranging from 141 to 298 from 09/16/24 through 09/30/24 could cause damage. -The facility sent a refill request for Toujeo Solostar U-300 on 09/30/24. -The facility did not request any other refill for Toujeo Solostar U-300 Insulin in the month of September 2024. -It was the responsibility of the facility to notify the PCP via fax or phone if prescriptions were needed for refills. -It was her responsibility to complete new prescription request within 48 hours after receipt. -She was not aware Resident #5 was out of Solostar U-300 insulin for 15 days. -She was concerned about the 15 missed doses of Toujeo due to her elevated blood sugars. Interview with the Resident Care Coordinator (RCC) on 10/23/24 at 3:20pm revealed: -She was not aware until 10/23/24 that Resident #5 was without Toujeo Solostar U-300 insulin for 15 days in September. -Medication aides (MA) were responsible for sending prescriptions to the PCP to be signed and then send the script to the pharmacy to be filled. -MAs should always follow up with the PCP or pharmacy after the prescriptions have been sent to make sure the prescriptions have been received.	D 273		

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D 273	Continued From page 46 -MAs were responsible for sending prescriptions to either to the resident's PCP or pharmacy before the medication ran out. -The MAs were to notify the RCC if they difficulty receiving medications that were ordered or needed to be ordered. -She was responsible for reviewing the medication unavailable report daily. -She had not reviewed the daily medication unavailable report. -MAs on 11:00pm -7:00am shift were responsible for cart audits and should be sending any refill requests to the resident's PCP or pharmacy when insulin or other medications are running out within 5 days. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration] The facility failed to ensure physician notification for 2 of 5 sampled residents (#3, #5) who were out of medications. Resident #3, who had a diagnosis of dementia and had a known history of aggression and anxiety, was out of 3 medications which could effect the resident's behavior and Resident #5, who had a diagnosis of diabetes, went 15 consecutive days without a long-acting insulin which caused elevated blood glucose levels. These failures were 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 10/23/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 07, 2024.	D 273		

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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 for 3 of 5 residents sampled residents (#2, #3, and #5) pertaining to medications used to treat anxiety and mood disorders, a medication used to treat elevated cholesterol (#3), medications used to treat asthma and chronic obstructive pulmonary disease (COPD) and medications used to treat diabetes (#2 and #5). The findings are: Review of the facility's undated Cart Audit/Medications On-Hand Review policy revealed: -The facility should ensure that residents always have current orders in the facility. -The facility will develop a schedule so that all residents' medication orders are checked on a weekly basis by completing a cart audit. -Staff will check to see that all medications are available using a copy of the physicians orders.	D 358		

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-Staff will re-order as needed and the reorder will be placed in the Order Processing System for follow-up.
-Staff will check expiration dates on medications and remove any expired medications and reorder as needed and place in the Order Processing System for follow up.
-Staff will date and sign the physician orders once the cart audit is complete and leave for review by the Care Coordinator.

Review of facility's undated New Order Process policy revealed:
-All are reviewed by the Resident Care Coordinator (RCC) or designee.
-Orders must be complete, if incomplete, contact the prescriber immediately for clarification.
-The RCC will (medication aide if after hours or weekends) fax the order to the pharmacy and scan the order into the electronic scan.
-The RCC or designee will wait for the order to be placed in the electronic medication system for approval and then approves the order for administration and follow the steps in the order process system.
-Medication aides (MAs) will review the Facility Activity Report at the beginning of each shift for order changes when a new order, or change is received.
-Whenever there is a medication change, the RCC/designee discusses the change with the resident and responsible party or guardian as appropriate and documents.
-The RCC/designee will follow up timely to receive any necessary clarifications for physician's orders.

1.Review of Resident #3's current FL-2 dated 01/23/24 revealed diagnoses included vascular dementia, diabetes mellitus type 2, insomnia,

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anxiety, mixed hyperlipidemia, atherosclerotic heart disease, hypertension, benign prostatic hypertrophy, and gastroesophageal reflux disease.

a. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed an order for clonazepam 0.5mg (clonazepam is used to treat anxiety and mood disorders), take one tablet three times per day.

Review of Resident #3's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg, take one tablet three times daily scheduled for 6:00am, 2:00pm and 6:00pm.
-Clonazepam 0.5mg was documented as administered at 6:00am on 08/01/24 through 08/31/24.
-Clonazepam 0.5mg was documented as administered at 2:00pm on 08/01/24 through 08/14/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 08/15/24, with the exception documented as "refused".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 08/16/24 through 08/19/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 08/20/24, with the exception documented as "refused".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 08/21/24 through 08/27/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 08/28/24, with the exception documented as "refused".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 08/29/24 through

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08/31/24.
-Clonazepam 0.5mg was documented as administered at 6:00pm on 08/01/24 through 08/31/24.

Review of Resident 3's September 2024 eMAR revealed:
-There was an entry for clonazepam 0.5mg, take one tablet three times daily scheduled for 6:00am, 2:00pm and 6:00pm.
-Clonazepam 0.5mg was documented as administered at 6:00am on 09/01/24 through 09/22/24.
-Clonazepam 0.5mg was documented as not administered at 6:00am on 09/23/24, with the exception documented as "waiting on provider".
-Clonazepam 0.5mg was documented as administered at 6:00am on 09/24/24 through 09/30/24.
-Clonazepam 0.5mg was documented as administered at 2:00pm on 09/01/24 through 09/17/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 09/18/24, with the exception documented as "refused".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 09/19/24 through 09/21/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 09/22/24, with the exception documented as "waiting on family member to drop off".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 09/23/24 through 09/28/24.
-Clonazepam 0.5mg was documented as not administered at 2:00pm on 09/29/24, with the exception documented as "refused".
-Clonazepam 0.5mg was documented as administered at 2:00pm on 09/30/24.

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D 358	Continued From page 51 -Clonazepam 0.5mg was documented as administered at 6:00pm on 09/01/24 through 09/18/24. -Clonazepam 0.5mg was documented as not administered at 6:00pm on 09/19/24, with the exception documented as "refused". -Clonazepam 0.5mg was documented as administered at 6:00pm on 09/20/24 and 09/21/24. -Clonazepam 0.5mg was documented as not administered at 6:00pm on 09/22/24, with the exception documented as "waiting on pharmacy". -Clonazepam 0.5mg was documented as administered at 6:00pm on 09/23/24 and 09/30/24. Review of Resident #3's October 2024 eMAR revealed: -There was an entry for clonazepam 0.5mg, take one tablet three times daily scheduled for 6:00am, 2:00pm and 6:00pm. -Clonazepam 0.5mg was documented as not administered at 6:00am on 10/01/24 through 10/04/24 with the exception documented as "waiting on pharmacy". -Clonazepam 0.5mg was documented as administered at 6:00am on 10/05/24 through 10/23/24. -Clonazepam 0.5mg was documented as not administered at 2:00pm on 10/01/24 through 10/04/24 with the exceptions documented as "waiting on med" on 10/01/24, "waiting on drug" on 10/02/24, "waiting on med" on 10/03/24, and "waiting on pharmacy" on 10/04/24. -Clonazepam 0.5mg was documented as not administered at 6:00pm on 10/01/24 through 10/03/24 with the exception documented as "waiting on pharmacy". -Clonazepam 0.5mg was documented as administered at 6:00pm on 10/04/24 through	D 358		

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D 358	Continued From page 52 10/22/24. Observations of Resident #3's medications on hand on 10/23/24 at 9:30am revealed: -There was a medication bottle from the resident's mail order pharmacy, labeled with Resident #3's name and labeled clonazepam 0.5mg, take 1 tablet three times per day, dispensed on 10/10/24 for a quantity of 90 tablets. -There were 143 clonazepam tablets remaining in the labeled medication bottle. Review of Resident #3's controlled substance log (CSL) dated 09/26/24 through 10/23/24 revealed: -On 09/26/24 at 7:56am, there were 11 clonazepam 0.5mg tablets available for Resident #3. -On 09/30/24 at 6:35pm, after 1 tablet of clonazepam 0.5mg was administered to Resident #3, a balance of 0 tablets was documented as available for Resident #3. -The next documented entry was on 10/04/24 at 2:41pm, 21 tablets of clonazepam 0.5mg were documented as received for balance of 21 tablets. -90 tablets of clonazepam 0.5mg were documented as received on 10/08/24 at 3:30pm for a balance of 99 tablets. -90 tablets of clonazepam 0.5mg were documented as received on 10/15/24 at 4:46pm for a balance of 168 tablets. -On 10/23/24 at 5:17am, the balance remaining of clonazepam 0.5mg for Resident #3 was 143 tablets. Review of Resident #3's Incident/Accident (I/A) report dated 10/04/24 revealed: -The date and time of the report was 10/04/24 at 9:45am.	D 358		

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-The location of the I/A was the 100-hall smoking area.
-The type of incident was listed as Behavior-Physical Assault.
-The incident was not witnessed by staff.
-The incident was witnessed by two residents.
-Resident #3 was documented as saying he was playing around with another resident like he normally does.
-Resident #3 was not sent to the emergency department (ED) but the other resident was sent to the ED.

Review of Resident #3's progress note dated 10/04/24 at 9:45am revealed:
-The resident grabbed a female resident around the neck and pulled her.
-The provider and the Resident #3's responsible party were notified.
-Supervision of Resident #3 was increased to every 30 minutes for 24 hours.

Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed:
-Medication refills could be requested via an automated voice system, via text or placed on auto-refill.
-Clonazepam could not be placed on auto-refill since it was a controlled substance.
-It usually took 5-7 days for medications to be processed and shipped after the request was received.
-Shipping of the medications could take 5-7 days as well.
-Clonazepam 0.5mg was dispensed for Resident #3 on 07/16/24 for a quantity of 90 tablets to take three times a day for a 30-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 08/12/24 for a quantity of 90 tablets to take

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three times per a day for a 30-day supply.
-A clonazepam refill was requested for Resident #3 on 09/21/24 through the automated voice request system on 09/21/24.
-90 tablets of clonazepam 0.5mg, to take three times per day, for a 30-day supply were dispensed and shipped for Resident #3 on 10/10/24.

Telephone interview with a pharmacist from Resident #3's local retail pharmacy on 10/23/24 at 9:48am revealed:
-The facility staff or Resident #3's responsible party (RP) picked up his medications from the pharmacy,
-Clonazepam 0.5mg was dispensed for Resident #3 on 07/02/24 for a quantity of 21 tablets, to take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 09/21/24 for a quantity of 21 tablets, to take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 10/02/24 for a quantity of 21 tablets, take three times per day for a 7-day supply.
-Clonazepam 0.5mg was dispensed for Resident #3 on 10/08/24 for a quantity of 90 tablets, take three times per day for a 30-day supply.
-Clonazepam was in a class of medications called benzodiazepines, that was used to treat certain types of seizures and anxiety.
-Missed doses of clonazepam could cause withdrawal symptoms such as nausea, sweating, and headaches and if taken for seizures, missed doses could lower the seizure threshold.
-If clonazepam was used for anxiety, missed doses could cause increased anxiety, agitation, shaking and tremors.

Review of a copy of a receipt and prescription print-out from Resident #3's local pharmacy

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revealed clonazepam 0.5mg, take one tablet three times per day, for a quantity of 21 tablets was purchased on 10/04/24 at 2:18pm.

Interview with Resident #3's Responsible Party (RP) on 10/23/24 at 10:36am revealed:
-Resident #3 received most of his medications through a mail order pharmacy.
-If there was a delay in the mail order medications, sometimes these were sent to the local retail pharmacy as well.
-Either she or the facility staff picked up Resident #3's medications from the local pharmacy when needed.
-She knew sometimes there was a delay in the mail order prescriptions.
-She was not aware of any delays of more than 24 hours for any of Resident #3's medications.
-She was not aware of any recent delays in Resident #3's medications.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took clonazepam for vascular dementia, anxiety and agitation.
-She was not notified that Resident #3 was without clonazepam for 11 doses in October 2024.
-Being without the clonazepam could have an effect on Resident #3's behavior, resulting in increased anxiety and/or agitation.
-It was possible being without the clonazepam could have triggered the 10/04/24 incident with Resident #3

Telephone interview with Resident #3's primary care provider (PCP) on 10/23/24 at 3:29pm revealed:
-Resident #3 had been on clonazepam for quite a long time for anxiety and agitation.

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-Without clonazepam, Resident #3 could become very aggressive and sexually focused.
-She was not made aware that Resident #3 was without clonazepam until the 10/04/24 incident.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-It was possible that being without the clonazepam contributed to the incident with Resident #3 on 10/04/24.

Refer to interview with the medication aide (MA) on 10/23/24 at 9:13am.

Refer to interview with the Resident Care Coordinator (RCC) on 10/23/24 at 3:48pm.

Refer to interview with the Administrator on 10/23/24 at 5:19pm.

b. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed there was an entry for divalproex delayed release 250mg (divalproex is used to treat seizures, anxiety and can be used as a mood stabilizer), take one tablet at bedtime.

Review of Resident #3's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for divalproex delayed release 250mg tablet, take one tablet at bedtime scheduled for 6:00pm.
-Divalproex extended release 250mg tablet was documented as administered at 6:00pm on 08/01/24 through 08/14/24.
-Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 08/15/24 through 08/18/24, with the exception

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D 358	Continued From page 57 documented as "waiting on pharmacy" for each day. -Divalproex extended release 250mg tablet, was documented as administered at 6:00pm on 08/19/24 through 08/31/24. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for divalproex delayed release 250mg tablet, take one tablet at bedtime scheduled for 6:00pm. -Divalproex extended release 250mg tablet was documented as administered at 6:00pm on 09/01/24 through 09/17/24. -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/18/24 with the exception documented as "waiting on pharmacy". -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/19/24 with the exception documented as "refused". -Divalproex extended release 250mg tablets was documented as not administered at 6:00pm on 09/20/24 through 09/22/24 with the exception documented as "waiting on pharmacy" for each day. -Divalproex extended release 250mg tablet, was documented as administered at 6:00pm on 09/23/24 through 09/30/24. Review of Resident #3's October 2024 eMAR revealed: -There was an entry for divalproex delayed release 250mg tablet, take one tablet at bedtime scheduled for 6:00pm. -Divalproex extended release 250mg tablet was documented as administered at 6:00pm on 10/01/24 through 10/22/24.	D 358		

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Observation of Resident #3's medications on hand on 10/23/24 at 9:18am revealed:
-There was medication bottle labeled with Resident #3's name for divalproex 250mg delayed release, take one tablet at bedtime from a local retail pharmacy, with a dispense date of 09/14/24 for a quantity of 30 tablets.
-There were no divalproex tablets in the medication bottle.
-There was no additional divalproex for Resident #3 on the medication cart.

Telephone interview with a pharmacist from Resident #3's local retail pharmacy on 10/23/24 at 10:23am revealed:
-Divalproex delayed release 250mg tablets were dispensed for Resident #3 on 07/12/24, to take one daily for a quantity of 30 tablets for a 30-day supply.
-Divalproex delayed release 250mg tablets were dispensed for Resident #3 on 08/10/24, to take one daily for a quantity of 30 tablets for a 30-day supply.
Divalproex delayed release 250mg tablets were last dispensed for Resident #3 on 09/14/24, to take one daily for a quantity of 30 tablets for a 30-day supply.
-There was no refill request on file for Resident #3's divalproex extended release 250mg tablets.

Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed divalproex delayed release 250mg tablets were last dispensed on 01/19/24, to take one daily for a quantity of 90 for a 90 day-supply.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took divalproex for vascular

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dementia, anxiety, agitation, and mood stabilization.
-She was not notified that Resident #3 was without divalproex.
-Being without the divalproex, could have an effect on Resident #3's behavior, resulting increased anxiety and or agitation.

Telephone interview with Resident #3's PCP on 10/23/24 at 3:29pm revealed:
-Resident #3 had been on divalproex for quite a long time for anxiety and agitation.
-She was not made aware that Resident #3 was without divalproex.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-Being without the divalproex could cause Resident #3 to experience increased anxiety and agitation.

Refer to interview with the medication aide (MA) on 10/23/24 at 9:13am.

Refer to interview with the RCC on 10/23/24 at 3:48pm.

Refer to interview with the Administrator on 10/23/24 at 5:19pm.

c. Review of Resident #3's signed physicians order sheet dated 01/23/24 revealed there was an entry for ezetimibe 10mg (ezetimibe is used to lower high cholesterol levels), take one tablet at bedtime.

Review of Resident #3's September 2024 eMAR revealed:
-There was an entry for ezetimibe 10mg, take one

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tablet at bedtime, scheduled for 6:00pm.
-Ezetimibe 10mg tablet was documented as administered at 6:00pm on 09/01/24 through 09/18/24.
-Ezetimibe 10mg tablet was documented as not administered at 6:00pm on 09/19/24, with the exception documented as "refused".
-Ezetimibe 10mg tablet was documented as not administered at 6:00pm on 09/20/24 through 09/22/24, with the exception documented as "waiting on pharmacy".
-Ezetimibe 10mg tablet was documented as administered at 6:00pm on 09/23/24 through 09/30/24.

Review of Resident #3's October 2024 eMAR revealed:
-There was an entry for ezetimibe 10mg, take one tablet at bedtime, scheduled for 6:00pm.
-Ezetimibe 10mg tablet was documented as administered at 6:00pm on 10/01/24 through 10/22/24.

Observation of Resident #3's medications on hand on 10/23/24 at 9:18am revealed:
-There was medication bottle labeled with Resident #3's name for ezetimibe 10mg, take one tablet at bedtime from a local retail pharmacy, with a dispense date of 09/14/24 for a quantity of 30 tablets.
-There were no ezetimibe 10mg tablets in the medication bottle.
-There were no additional ezetimibe 10mg tablets for Resident #3 on the medication cart.

Telephone interview with a pharmacist from Resident #3's local retail pharmacy on 10/23/24 at 10:23am revealed:
-Ezetimibe 10mg tablets were dispensed for Resident #3 on 07/16/24, to take one daily for a

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quantity of 30 tablets for a 30-day supply.
-Ezetimibe 10mg tablets were dispensed for Resident #3 on 08/10/24, to take one daily for a quantity of 30 tablets for a 30-day supply.
-Ezetimibe 10mg tablets were last dispensed for Resident #3 on 09/14/24, to take one daily for a quantity of 30 tablets for a 30-day supply.
-There was no refill request on file for Resident #3's ezetimibe 10mg tablets.

Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed:
-There was no order on file for ezetimibe 10mg.
-The mail order pharmacy had never dispensed ezetimibe 10mg for Resident #3.

Telephone interview with Resident #3's primary care provider (PCP) on 10/23/24 at 3:29pm revealed:
-Resident #3 took ezetimibe 10mg for high cholesterol.
-She was not made aware that Resident #3 was without ezetimibe.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.

Refer to interview with the medication aide (MA) on 10/23/24 at 9:13am.

Refer to interview with the Resident Care Coordinator (RCC) on 10/23/24 at 3:48pm.

Refer to interview with the Administrator on 10/23/24 at 5:19pm.

d. Review of Resident #3's subsequent physicians order sheet dated 04/26/24 revealed

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there was an order for Zoloft 25mg (Zoloft is the brand name for sertraline and is used to treat obsessive compulsive disorder, anxiety and panic disorder), take one tablet daily.

Review of Resident #3's August 2024 electronic medication record (eMAR) revealed:
-There was an entry for sertraline 25mg, take one tablet once daily, scheduled at 6:00am.
-Sertraline 25mg tablet was documented as administered at 6:00am on 08/01/24 through 08/15/24.
-Sertraline 25mg tablet was documented as not administered at 6:00am on 08/16/24, with the exception documented as "waiting on pharmacy".
-Sertraline 25mg tablet was documented as not administered at 6:00am on 08/17/24, with the exception documented as "reordered".
-Sertraline 25mg tablet was documented as not administered at 6:00am on 08/18/24 and 08/19/24, with the exception documented as "waiting on pharmacy".
-Sertraline 25mg tablet was documented as administered at 6:00am on 08/20/24 through 08/31/24.

Review of Resident #3's September 2024 eMAR revealed:
-There was an entry for sertraline 25mg, take one tablet once daily, scheduled at 6:00am.
-Sertraline 25mg tablet was documented as administered at 6:00am on 09/01/24 through 09/21/24.
-Sertraline 25mg tablet was documented as not administered at 6:00am on 09/22/24 and 09/23/24, with the exception documented as "waiting on pharmacy".
-Sertraline 25mg was documented as administered at 6:00am on 09/24/24 through 09/30/24.

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D 358	Continued From page 63 Review of Resident #3's October 2024 eMAR revealed: -There was an entry for sertraline 25mg, take one tablet once daily, scheduled at 6:00am. -Sertraline 25mg tablet was documented as administered at 6:00am on 10/01/24 through 10/11/24. -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/12/24, with the exception documented as "waiting on pharmacy". -Sertraline 25mg tablet was documented as administered at 6:00am on 10/13/24 through 10/16/24. -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/17/24, with the exception documented as "drug/item unavailable". -Sertraline 25mg tablet was documented as administered at 6:00am on 10/18/24 and 10/19/24. -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/20/24 through 10/22/24, with the exception documented as "drug/item unavailable". -Sertraline 25mg tablet was documented as not administered at 6:00am on 10/23/24, with the exception documented as "reordered". Observation of Resident #3's medications on hand on 10/23/24 at 9:18am revealed there were no sertraline 25mg tablets available on the medication cart for Resident #3. Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed: -Sertraline 25mg tablets were dispensed on 07/13/24, to take one daily for a quantity of 30 for a 30 day-supply.	D 358		

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-Sertraline 25mg tablets were last dispensed on 08/10/24, to take one per day for a quantity of 30 for a 30-day supply.
-There was no refill request on file for sertraline 25mg tablets for Resident #3.

Telephone interview with a pharmacist from Resident #3's mail order pharmacy on 10/23/24 at 1:33pm revealed:
-There was no order on file for sertraline 25mg.
-The mail order pharmacy had never dispensed sertraline 25mg for Resident #3.

Telephone interview with Resident #3's behavioral health provider on 10/23/24 at 3:10pm revealed:
-Resident #3 took sertraline 25mg for vascular dementia, anxiety, agitation, and mood stabilization.
-She was not notified that Resident #3 was without sertraline 25mg.
-Being without the sertraline could have an effect on Resident #3's behavior, resulting in increased anxiety and or agitation.
-Sertraline should not be stopped suddenly due to the potential for withdrawal symptoms such as nausea, vomiting, insomnia, and fatigue but Resident #3 was on a very low dose of sertraline.

Telephone interview with Resident #3's primary care provider (PCP) on 10/23/24 at 3:29pm revealed:
-Resident #3 took sertraline for anxiety and agitation.
-She was not made aware that Resident #3 was without sertraline.
-Usually if a resident was out of a medication or had difficulty getting a medication, the facility contacted her and requested a new prescription or a hold order.
-Being without the sertraline could cause

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D 358	Continued From page 65 Resident #3 to experience increased anxiety and agitation. Refer to interview with the medication aide (MA) on 10/23/24 at 9:13am. Refer to interview with the Resident Care Coordinator (RCC) on 10/23/24 at 3:48pm. Refer to interview with the Administrator on 10/23/24 at 5:19pm. _____ Interview with the MA on 10/23/24 at 9:13am revealed: -The MAs or the RCC were responsible for requesting medication refills for the residents. -If a resident used a mail order pharmacy, he ordered the residents medications 2 weeks in advance to ensure time for the medications to arrive. -If a resident's medication came from a local pharmacy, he ordered them 7 days in advance. -Resident #3 used a mail order pharmacy and a local retail pharmacy. -Medications from Resident #3's mail order pharmacy usually took two weeks to be delivered. -Medications from the local retail pharmacy were usually ready the following day. -The local retail pharmacy would notify either the facility or Resident #3's RP when medications were ready for pickup. -If a medication was not received from either the local retail pharmacy or the facility's contracted pharmacy within 48 hours, he called the pharmacy or notified the RCC. -He was not sure why there was no sertraline, ezetimibe or divalproex available on the medication cart for Resident #3. -He felt the sertraline, ezetimibe and divalproex had been requested by the night shift MA but was	D 358		

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D 358	Continued From page 66 not certain. Interview with the RCC on 10/23/24 at 3:48pm revealed: -The MAs or herself ordered the residents' medications. -If using a local or the facility's contracted pharmacy, medications were ordered 7 days in advance. -If a resident used a mail order pharmacy, medications were ordered 2-3 weeks in advance. -Resident #3 used a mail order pharmacy and a local pharmacy. -Either staff or Resident 3's RP picked up his medications from the local pharmacy. -Usually if Resident #3's medication required a co-pay then his RP picked them up, otherwise staff would pick up his medications. -The MAs were to let her know if they had trouble getting medications for a resident. -She and the MAs were responsible for medication cart audits. -Medication cart audits involved making sure medications were available, looking for expired medications and pill packs were compared to the medication orders. -Medication cart audits were performed sporadically due to staffing. -The facility ran a medications unavailable report daily. -The medications unavailable reports were supposed to be reviewed daily by the RCC. -She had not reviewed the medications unavailable report daily. Telephone interview with the Interim Administrator on 10/23/24 at 5:19pm revealed: -The RCC and the MAs were responsible for ordering medication refills for the residents. -The RCC and MA should have followed up on all	D 358		

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Resident #3's refill requests.
-Medication cart audits were to be done weekly by the MAs or the RCC.
-He expected the residents' medications to be available at the facility to be administered as ordered.

[Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision]

[Refer to Tag 273 10A NCAC 13F .0902(b) Health Care]

2. Review of Resident #5's current FL2 dated 10/08/24 revealed diagnoses included hemiparesis, muscle weakness, heart failure, unspecified atrial flutter, aphasia following cerebral infarction, cerebrovascular accident (CVA) right side deficit, bilateral total knee arthroplasty (TKA), and type 2 diabetes mellitus

Review of Residents #5's signed physician order sheet dated 08/31/24 revealed an order for Toujeo Solostar U-300 insulin pen, 62 units to be injected subcutaneously daily. (Toujeo Solostar U-300 Insulin is a long acting insulin to used to control high blood sugar.)

Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Toujeo Solostar U-300, 62 units subcutaneously once daily at 9am.
-Toujeo Solostar U-300, 62 units was documented as administered from 09/01/24 through 09/15/24 at 9:00am.
-On 09/16/24 to 09/30/24,Toujeo Solostar U-300 insulin was documented as not administered at 9:00am with reasons documented as "Waiting on Pharmacy" or "on hold".

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D 358	Continued From page 68 -There were 15 of 30 doses of Toujeo Solostar U-300 insulin documented as not administered from 09/01/24 - 09/30/24. -His 7:00am blood sugars ranged from 106-220 from 09/01/24 to 09/15/24 with 1 FSBS over 200. -His 7:00am blood sugars ranged from 141-298 from 09/16/24 to 09/30/21 with 12 FSBS over 200. -His 11:00am blood sugars ranged from 103-299 from 09/01/24 to 09/15/24 with 3 FSBS over 200. -His 11:00am blood sugars ranged from 122-337 from 09/16/24 to 09/30/21 with 6 FSBS over 200 and 3 FSBS over 300. -His 5:00pm blood sugars ranged from 124-237 from 09/01/24 to 09/15/24 with 4 FSBS over 200. -His 5:00pm blood sugars ranged from 133-283 from 09/16/24 to 09/30/21 with 8 FSBS over 200. Interview with Resident #5 on 10/23/24 at 8:30 am revealed: -She did not receive her insulin injections last month but could not recall the days she did not receive the medication. -She did not have any complications and she was not sent out to the hospital. -Staff would monitor her blood sugars and tell her "they are good". Telephone interview with a pharmacist for Resident #5 on 10/22/24 at 3:30 pm revealed: -Toujeo was ordered to help control his blood sugar. -The pharmacy received a prescription refill request for Resident #5 Toujeo Solostar U-300 on 09/30/24 and the medication was delivered to the facility on 10/01/24. -The pharmacy last received a refill request on 08/21/24 for a 21-day supply of Toujeo Solostar U-300.	D 358		

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D 358	Continued From page 69 Telephone interview with Resident #5's primary care physician (PCP) on 10/22/24 at 3:45pm revealed: -She treated Resident #5 for diabetes. -Missing the Toujeo dose could cause Resident #5's blood sugar to be elevated. -Elevated blood sugars would cause Resident #5 to become hyperglycemic and potentially be hospitalized. -Elevated blood sugars could cause damage. -The facility sent a refill request for Toujeo Solostar U-300 on 09/30/24. -The facility had not requested a refill for Toujeo Solostar U-300 in the month of September 2024. -It was the responsibility of the facility to notify the PCP via fax or phone if prescriptions were needed for refills. -It was the responsibility of the PCP to complete new prescription request within 48 hours after receipt. -She was not aware Resident #5 out of Toujeo Solostar U-300 insulin for 15 days. -She was concerned about the 15 missed dosage of Toujeo due to her blood sugars and Resident #5 was not compliant with her diet. Interview with the Resident Care Coordinator (RCC) on 10/23/24 at 3:20pm revealed: -She was not aware until 10/23/24 that Resident #5 was without Toujeo Solostar U-300 insulin for 15 days in September. -Medication aides (MA) were responsible for sending prescriptions to the PCP to be signed and then send the script to the pharmacy to be filled. -MAs should always follow up with the PCP or pharmacy after the prescriptions have been sent to make sure the prescriptions have been received. -MAs were responsible for sending prescriptions	D 358		

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to either to the resident's PCP or pharmacy before the medication has run out.
-MAs were to report to the RCC if there was any difficulty receiving medications that were ordered or needed to be ordered.
-She was responsible for reviewing the medication unavailable report daily.
-She had not reviewed the medication unavailable report daily.
-MAs on 11:00pm -7:00am shift were responsible for cart audits and should be sending any refill requests to the resident's PCP or pharmacy when insulin or other medications are running out within 5 days.

3. Review of Resident #2's current FL-2 dated 07/15/24 revealed:
-Diagnoses included acute hypoxic respiratory failure, chronic obstructive pulmonary disease (COPD), and diabetes.
-There was an order for Trelegy Ellipta 100-625-25mcg, 1 puff to be administered via inhalation daily. (Trelegy Ellipta is used for the long-term treatment of breathing disorders such as COPD.)
-There was an order for metformin extended release 500mg to be administered daily. (Metformin is used to control blood glucose levels.)

Review of Resident #2's hospital discharge summary for hospitalization from 06/28/24 to 07/16/24 revealed Resident #2 was admitted for respiratory failure with hypoxia and hypercapnia. (Hypoxia occurs when there is too little oxygen in the blood to oxygenate tissue and sustain body functions. Hypercapnia occurs when carbon dioxide that is usually expelled by the lungs accumulates in the body.)

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a. Review of Resident 2's physician's orders dated 01/23/24 revealed fluticasone propion-salmeterol 250-50mcg, 1 puff was to be administered twice daily. (Fluticasone propion-salmeterol 250-50mcg is the generic name for Advair and is used to treat COPD.)

Review of Resident #2's hospital discharge summary for hospitalization from 06/28/24 to 07/16/24 revealed there was an order for fluticasone/umeclid/vilan 100-62.5-25mcg, 1 puff to be administered via inhalation daily. (Fluticasone/umeclid/vilan 100-62.5-25mcg is the generic name for Trelegy Ellipta 100-625-25mcg.)

Review of Resident #2's medication order clarification form dated 08/13/24 revealed there was an order to continue fluticasone/umeclid/vilan 100-62.5-25mcg, 1 puff via inhalation daily.

Review of Resident #2's electronic medication administration record (eMAR) for August 2024 revealed:
-There was a computerized entry for fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation to be administered twice daily.
-There was documentation fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was administered twice daily at 6:00am and 6:00pm each day on 08/01/24 to 08/02/24, on 08/04/24 to 08/15/24 and on 08/17/24 through 08/31/24.
-There was documentation fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was administered at 6:00pm on 08/03/24 and 08/16/24.
-There was documentation fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was not administered at 6:00am on 08/03/24 because Resident #2 was at the

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hospital and was not administered at 6:00am on 08/16/24 because delivery had not arrived.
-There was no entry for fluticasone/umeclid/vilan 100-62.5-25mcg, 1 puff to be administered via inhalation daily.

Review of Resident #2's eMAR for September 2024 revealed:
-There was a computerized entry for fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation to be administered twice daily.
-There was documentation fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was administered twice daily at 6:00am and 6:00pm each day on 09/01/24 through 09/30/24.
-There was no entry for fluticasone/umeclid/vilan 100-62.5-25mcg, 1 puff to be administered via inhalation daily.

Review of Resident #2's eMAR for October 2024 revealed:
-There was a computerized entry for fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation to be administered twice daily.
-There was documentation fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was administered twice daily at 6:00am and 6:00pm each day on 10/01/24 through 10/21/24 and at 6:00am on 10/22/24.
-There was no entry for fluticasone/umeclid/vilan 100-62.5-25mcg, 1 puff to be administered via inhalation daily.

Observation of medications on hand for Resident #2 on 10/23/24 at 10:24am revealed:
-There was no fluticasone/umeclid/vilan 100-62.5-25mcg available for administration.
-There was fluticasone propion-salmeterol 250-50mcg labeled with instructions to administer

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D 358	Continued From page 73 1 puff by mouth twice daily with a dispensing date of 09/21/24. Telephone interview with pharmacy technician for the facility's contracted pharmacy on 10/23/24 at 8:14am revealed: -They did not have an order for fluticasone/umeclid/vilan 100-62.5-25mcg for Resident #2 and none had been dispensed. -There was an order for fluticasone propion-salmeterol 250-50mcg, 1 puff by inhalation was administered twice daily dated 01/23/24 and was last dispensed on 09/21/24. -There had been no order to discontinue fluticasone/umeclid/vilan 100-62.5-25mcg or fluticasone propion-salmeterol 250-50mcg for Resident #2 received by the pharmacy. -The pharmacy had not received the FL-2 dated 07/15/24 or the clarification order sheet dated 08/13/24 for Resident #2. Telephone interview with Resident #2's primary care provider on 09/23/24 at 3:03pm revealed: -Fluticasone/umeclid/vilan 100-62.5-25mcg and fluticasone propion-salmeterol 250-50mcg were the same class of medications and both could be used to treat COPD. -Fluticasone/umeclid/vilan 100-62.5-25mcg was ordered when Resident #2 was hospitalized and she was unsure why it was ordered instead of fluticasone propion-salmeterol 250-50mcg. -She thought fluticasone/umeclid/vilan 100-62.5-25mcg may have been ordered because that was the elicitation the hospital had on formulary. Refer to telephone interview with Resident #2's primary care provider (PCP) on 10/23/24 at 3:03pm.	D 358		

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D 358	Continued From page 74 Refer to interview with the Resident Care Coordinator (RCC) on 10/23/24 at 9:36am. Refer to telephone interview with the Administrator on 10/23/24 at 5:25pm. b. Review of Resident #2's hospital discharge summary for hospitalization from 06/28/24 to 07/16/24 revealed there was an order for metformin ER 500mg 1 tablet to be administered each day. Review of Resident #2's medication order clarification form dated 08/13/24 revealed there was an order to continue metformin ER 500mg 1 tablet each day. Review of Resident #2's eMAR for August 2024 revealed: -There was a computerized entry for metformin ER 500mg, 2 tablets to be administered each day. -There was documentation metformin ER 500mg, 2 tablets was administered each day at 6:00am on 08/01/24 to 08/02/24 and on 08/04/24 through 08/31/24. -There was no entry for metformin ER 500mg, 1 tablet to be administered each day. Review of Resident #2's eMAR for September 2024 revealed: -There was a computerized entry for metformin ER 500mg, 2 tablets to be administered each day. -There was documentation metformin ER 500mg, 2 tablets was administered each day at 6:00am on 09/01/24 to 09/30/24. -There was no entry for metformin ER 500mg, 1 tablet to be administered each day.	D 358		

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D 358	Continued From page 75 Review of Resident #2's eMAR for October 2024 revealed: -There was a computerized entry for metformin ER 500mg, 2 tablets to be administered each day. -There was documentation metformin ER 500mg, 2 tablets was administered each day at 6:00am on 10/01/24 to 10/22/24. -There was no entry for metformin ER 500mg, 1 tablet to be administered each day. Observation of medications on hand for Resident #2 on 10/23/24 at 10:24am revealed there was a multidose pack that was labeled metformin ER 500mg, 2 tablets to be administered daily with a dispense date of 10/11/24. Interview with a medication aide (MA) on 10/23/24 at 10:24am revealed Resident #2 was administered metformin ER 500mg, 2 tablets each day per the multidose packs that were received from the pharmacy each week. Telephone interview with pharmacy technician for the facility's contracted pharmacy on 10/23/24 at 8:14am revealed: -Multidose packs were dispensed each week with a 7 day supply of medications. -Resident #2 was ordered metformin ER 500mg, 2 tablets to be administered daily on 01/23/24. -They had not received the orders dated 07/15/24 or 08/13/24 for Resident #2. Refer to telephone interview with Resident #2's primary care provider (PCP) on 10/23/24 at 3:03pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/23/24 at 9:36am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	R 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

(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 76 Refer to telephone interview with the Administrator on 10/23/24 at 5:25pm. _____ Telephone interview with Resident #2's primary care provider (PCP) on 10/23/24 at 3:03pm revealed: -New orders should be sent to pharmacy including medications that are prescribed while a resident was in the hospital and clarification orders. -The pharmacy could call if there was a question about medication changes but they had to receive new orders. Interview with the Resident Care Coordinator (RCC) on 10/23/24 at 9:36am revealed: -Resident #2 was in the hospital in July 2024 and his FL-2 was updated and medications clarified when he returned to the facility. -She thought she faxed the updated FL-2 and the clarification orders to the pharmacy. -The pharmacy sends an email confirmation when they received a fax but she was unable to locate the fax confirmation in her email. -She should have been paying closer attention to ensure medication orders were correct on the eMAR. -She should have verified the pharmacy received the faxes of the orders and she should have follow-up with the pharmacy the following day. Telephone interview with the Administrator on 10/23/24 at 5:25pm revealed: -The updated FL-2 and clarification of orders sheet were physician's orders and should have been sent to the pharmacy. -The RCC was responsible for ensuring the pharmacy received physician orders. -The RCC should have followed up on the new orders by ensuring the medication was received	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	R 10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

(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 77 in the facility and on the eMAR as it was ordered. _____ The failure of the facility to ensure medications were available and administered as ordered for a resident with a diagnosis of dementia and known to have aggressive behaviors who was not administered 10 consecutive doses of a medication used to prevent aggression and anxiety prior to a physical alteration with a female resident which resulted in her having to be seen in the emergency department. A second resident did not receive an injectable medication used to stabilize blood sugars for 15 consecutive days which resulted in elevated blood sugars. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 10/08/24 and on 10/23/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2024.	D 358		