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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow up, and complaint investigation on September 17 to September 19 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards as evidenced by personal care products being unsecured in residents' rooms in the Special Care Unit (SCU) including in the room of a SCU resident (#2) with a history of ingesting non-food items and wandering behaviors. The findings are: Review of the facility's census on 09/17/24 revealed there were 39 residents residing in the Special Care Unit (SCU). Observation of the SCU on 09/17/24 from 8:50am to 9:45am revealed: -The door to resident room 67 was open. -In the bathroom of room 67, there was a bottle of bottle of body wash with a warning on the label	D 079		

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reading "Caution: for external use only, avoid contact with eyes, should this occur, rinse thoroughly with water. Keep out of reach of children", a bottle of 2-in-1 shower gel and shampoo with a warning on the label reading "Keep out of reach of children, for external use only", and a can of shaving cream with a label reading "Keep out of reach of children".
-The door to resident room 71 was open.
-In room 71, on the windowsill, there was a stick of deodorant with a label reading "Keep out of reach of children, if swallowed, get medical help or contact a Poison Control Center right away", a bottle of hand sanitizer with a label reading "Keep out of reach of children, if swallowed, get medical help or contact a Poison Control Center right away".
-In the bathroom of room 71, there was a bottle of body wash with a warning on the label reading "Caution: for external use only, avoid contact with eyes, should this occur, rinse thoroughly with water. Keep out of reach of children".
-In room 49, on top of a plastic chest were 2 bottles of perfume, 4 bottles of body spray, a can of hairspray, a bottle of lotion with a label reading "for external use only, keep out of reach of children", spray deodorant with a label reading "for external use only, if swallowed, get medical help or contact a Poison Control Center right away", a box of denture cleaning tablets with a label reading "Keep tablets out of reach of children and those at risk of accidentally swallowing the tablet or solution, do not place tablets or solution in mouth, if swallowed: call a Poison Control Center or doctor, causes serious eye irritation".
-In the bathroom of room 42, there was a bottle of soap in the shower with a label reading "Keep out of reach of children, if swallowed, get medical help or contact a Poison Control Center right

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away".

Review of Resident #2's current FL2 dated 09/0924 revealed:
-Diagnoses included major neurocognitive disorder, type 2 diabetes mellitus, and hypertension.
-Recommended level of care was special care unit.
-On the orientation section, constantly disoriented was checked.
-On the behavior section, wanderer was checked.
-On the ambulatory status section, ambulatory was checked with an entry of "wheelchair".

Observation of Resident #2's room on 09/17/24 from 9:30am to 9:32am revealed:
-There was a tube of skin protectant with a label reading "Keep out of reach of children, if swallowed, get medical help or consult a Poison Control Center right away" located on a bedside table.
-In Resident #2's bathroom, there was a bottle of body wash and a bottle of skin and hair cleanser with a label reading "For external use only, avoid contact with eyes, keep out of reach of children".

Second observation of the SCU on 09/17/24 from 2:25pm to 2:55pm revealed:
-Resident #2 was propelling himself in his wheelchair in the hallway.
-Resident #2 entered resident room 45 and exited approximately 2-3 minutes later.
-Resident #2 propelled himself down the hallway to resident room 43 and entered the room.
-A personal care assistant (PCA) entered the room approximately 1-2 minutes later and redirected Resident #2 to his room.

Review of Resident #2's current care plan dated

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09/09/24 revealed:
-In the mental health section, Resident #2's behaviors included wandering.
-In the ambulation/locomotion section, Resident #2 was ambulatory with aide or device.
-For device(s) needed, there was nothing documented.

Review of Resident #2's facility progress notes dated 07/01/24 to 09/17/24 revealed:
-On 07/31/24 at 11:49am, Resident #2 had swelling to his face and tongue, he had a bar of soap with teeth marks in it and staff removed the soap. Resident #2 was sent to the emergency department for evaluation.
-On 07/31/24 at 2:41pm, Resident #2 returned to the facility with no significant findings.

Review of Resident #2's accident/injury report dated 07/31/24 at 10:30am revealed:
-Location of the incident was documented as hallway.
-Resident #2 had a bar of soap in a bag and a staff member took the bag from Resident #2.
-There were teeth marks noted in the bar of soap.
-Resident #2 had swelling to his mouth and tongue and was sent to the emergency department via emergency medical services (EMS).

Review of Resident #2's emergency department provider notes dated 07/31/24 revealed:
-Resident #2 was sent to the emergency department by the facility after he was found with a bar of soap in his mouth.
-There were no new medication or treatment orders.

Review of Resident #2's primary care provider (PCP) notes dated 08/05/24 revealed labs were

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ordered to rule out pica (Pica is a condition characterized by a person compulsively eating non-food items).

Review of Resident #2's mental health provider notes dated 08/27/24 revealed Resident #2 continued to eat non-food items.

Interview with a personal care aide (PCA) on 09/17/24 at 9:46am revealed:
-Personal care products were to be stored in a locked storage room.
-There should not be any personal care products in residents' rooms.
-She was unsure why there were personal care products in the residents' rooms.

Interview with the Special Care Coordinator (SCC) on 09/17/24 at 9:48am revealed:
-Personal care items in the SCU should be stored in a locked storage room.
-There were a couple of residents that were considered higher functioning who had some personal care items in their room.
-Residents should not have personal care items in their rooms, the items should be stored in the designated locked room.
-Resident #2 tried to ingest a bar of soap a few weeks ago, and she was unsure of the date this incident occurred.
-Resident #2 was sent to the emergency department of the local hospital after the staff realized he tried to eat soap.

Interview with a second PCA on 09/17/24 at 2:30pm revealed:
-Resident #2 needed assistance with bathing, dressing, grooming, incontinence care, and transfers.
-Resident #2 did not need assistance with eating,

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and he was able to feed himself.
-Resident #2 would often try to eat non-food items such as sugar packets, jelly packets, or hot sauce packets.
-She was not aware Resident #2 had put soap in his mouth.
-Resident #2 could propel himself in his wheelchair and would wander in and out of other residents' rooms.

Interview with a medication aide (MA) on 09/17/24 at 2:25pm revealed:
-Resident #2 needed assistance with bathing, dressing, grooming, toileting, and transfers.
-Resident #2 was able to feed himself.
-Sometimes when she was administering medications to Resident #2, he would attempt to put the paper medicine cup in his mouth and eat the medicine cup.
-Resident #2 needed supervision at meals because he would try to eat sugar packets or salt packets.
-She was not aware Resident #2 had put soap in his mouth and had not seen him try to ingest soap or other personal care products.
-There was a storage room where all personal care products in the SCU should be stored.
-Resident #2 could propel himself in his wheelchair and would often wander in other residents' rooms.

Interview with the Special Care Coordinator (SCC) on 09/18/24 at 8:10am revealed:
-She was unsure which staff member found Resident #2 with a bar of soap, but the staff member reported the incident to her.
-She was unsure if the bar of soap was in Resident #2's room or where he may have gotten the bar of soap.
-Resident #2's face appeared swollen when the

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staff discovered him with the soap, so he was sent to the emergency department of the local hospital.
-Resident #2 should not have personal care items in his room because he was known to place non-food items in his mouth.
-All personal care products should be secured in the locked storage area in the SCU for residents' safety.

Interview with the Administrator on 09/19/24 at 4:37pm revealed:
-She was aware some of the residents had personal care products in their rooms.
-Some of the residents were more confused than others.
-All personal products in the SCU should be stored in the locked supply closet.
-She was concerned about Resident #2 having personal care products in his room because he put non-food items in his mouth.
-Resident #2 tried to eat things like sugar packets, salt packets, and pepper packets and needed supervision at meals.
-Resident #2 should not have had personal care products in his room because he might try to put them in his mouth.
-The staff must have forgotten to take the personal care products out of Resident #2's room.
-Personal care products left in the residents' rooms in SCU were a safety concern for the residents because some products could be harmful.

Interview with a representative from Resident #2's mental health provider's office at 09/19/24 at 10:04am revealed:
-She was aware Resident #2 went to the emergency department for ingesting soap.

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-Resident #2 attempted to eat anything in front of him on the dining room table such as sugar packets.
-Resident #2 should not have personal care products in his room since there was a risk of him putting non-food items in his mouth.

Interview with Resident #2's primary care provider (PCP) on 09/18/24 at 3:54pm revealed:
-She saw Resident #2 on 08/05/24 for a follow-up visit after he went to the emergency department for eating soap.
-She ordered some blood tests at that visit to determine if Resident #2 may have pica.
-One test for pica was checking a person's hemoglobin level and she ordered this blood test at the visit on 08/05/24.
-The blood tests showed Resident #2's hemoglobin level was in normal limits, and she did not think Resident #2 had pica.
-Resident #2's issues with putting non-food items in his mouth were related to his dementia and was a behavior related to that diagnosis.
-She was concerned Resident #2 had personal care products in his room since it was established that Resident #2 had a history of putting items in his mouth.
-Resident #2 should not have any personal care products in his room.
-The facility should keep all personal care products out of Resident #2's reach.
-The side effects of ingesting personal care products could vary in severity depending on what was ingested.

_____

The facility failed to maintain an environment free of hazards including deodorant, hand sanitizer, skin protectant, body wash, shaving cream, and denture cleaning tablets unsecured in the Special Care Unit (SCU) resulting in one resident (#2)

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D 079	Continued From page 8 who had a history of wandering and known to routinely put non-food items in his mouth, most recently, a bar of soap requiring emergency care who also had skin protectant, body wash, and skin and hair cleaner stored in his room and not in the designated locked storage area. The failure of the facility to secure potentially caustic personal care items placed the residents at 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 09/17/24 for this violation. THE CORRECTION DATE FOR THE VIOLATION SHALL NOT EXCEED OCTOBER 20, 2024.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility had an adequate supply of towels, sheets, and pillowcases for residents' use. The findings are:	D 080		

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D 080	Continued From page 9 Review of the facility's census on 09/17/24 was 79 residents, with 40 residents residing on the assisted living (AL) halls and 39 residents residing in the Special Care Unit (SCU). Observation of the SCU linen closet on 09/17/24 at 2:30pm revealed there were 4 towels and 3 fitted sheets on the shelf. Observation of the right hall AL linen closet on 09/18/24 at 8:45am revealed: -The closet had no towels, flat sheets, fitted sheets, or pillowcases. -There were several hospital style gowns, 4 cloth incontinence pads, and 1 pillow on one shelf. Second observation of the right hall AL linen closet on 09/18/24 at 1:57pm revealed: -The closet had no towels, flat sheets, fitted sheets, or pillowcases. -There were several hospital style gowns, 4 cloth incontinence pads, and 1 pillow on one shelf. Observation of the laundry room on 09/19/24 at 8:31am revealed: -There were some linens in the washing machine. -There were shelves in the laundry room containing 8 flat sheets, 4 fitted sheets, and 8 towels. Observation of the left hall AL linen closet on 09/19/24 at 9:49am revealed: -There were 4 towels on the top shelf of the closet. -There were 2 fitted sheets and 1 pillowcase on the second shelf of the closet. -There were several hospital style gowns on the third shelf of the closet.	D 080		

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D 080	Continued From page 10 Third observation of the right hall AL linen closet on 09/19/24 at 9:47am revealed: -The closet had no towels,flat sheets, fitted sheets, or pillowcases. -There were several hospital style gowns, 4 cloth incontinence pads, and 1 pillow on one shelf. Interview with a resident on 09/18/24 at 2:02pm revealed: -He was admitted to the facility 5-6 weeks ago. -He did not think the facility had enough linen. -When the staff was going to make his bed yesterday, 09/17/24, they removed the sheets and there were not any sheets in the linen closet to replace them. -His bed was left without any sheets for a while until the staff could find clean sheets to make his bed. Interview with a personal care assistant (PCA) on 09/17/24 at 2:30pm revealed: -She usually worked from 6:00am to 6:00pm. -Sometimes there were not enough linens to start assisting residents with bathing or start changing sheets on the residents' beds. -Sometimes she had to wait until the laundry aide arrived and started washing linens before she could start assisting residents with bathing or changing sheets on the residents' beds. Interview with a second PCA on 09/18/24 at 7:20am revealed: -The facility did not have enough towels or sheets. -Sometimes she could not assist residents with bathing because she had to wait for towels to be washed. -Sometimes when she removed linens from the residents' beds, there was no clean linen to make the bed.	D 080		

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-The residents often had to wait for assistance with bathing or to have their beds made because there were not enough sheets and towels.

Interview with a third PCA on 09/18/24 at 7:33am revealed:
-The linen closets in the facility were empty most of the time.
-There were a few times she was unable to assist residents with bathing because there were not enough towels.
-There were not enough sheets in the facility.
-She had to wait until later in the afternoon to make beds because when she removed the linens, there were no clean sheets to replace them.
-She reported not having enough linen to the Administrator multiple times.

Interview with a medication aide (MA) on 09/17/24 at 2:25pm revealed sometimes PCAs threw away sheets and towels if the linens were soiled with urine or feces.

Interview with the laundry aide on 09/19/24 at 8:35am revealed:
-She was hired at the facility approximately one month ago.
-Her schedule was 5 days per week, Monday through Friday and her hours to work were 8:00am to 4:00pm.
-She washed sheets and towels every day.
-She thought the facility had enough sheets and towels because she always had some to wash when she came in for her shift.
-All the sheets and towels were usually restocked in the linen closets by 1:30-2:00pm each day.

Interview with the housekeeping supervisor on 09/19/24 at 8:40am revealed:

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D 080	Continued From page 12 -She was hired as the housekeeping supervisor in May 2024. -At one time, the facility's washing machine was broken, and the laundry aide was taking laundry to the laundromat to be washed. -The facility purchased a new washing machine 2-3 weeks ago. -The Administrator was responsible for ordering linens. -She was aware staff complained about not having enough linens. -Some of the linens had been thrown away because they were soiled with urine or feces. Interview with the Administrator on 09/19/24 at 4:37pm revealed: -She had not received any reports of the facility not having enough sheets and towels. -She was aware it took a while for the sheets and towels to be washed each day. -A couple of weeks ago, staff found a 60-gallon trash bag full of soiled linens that was almost thrown away. -She was unsure if any other linens, sheets, or towels were thrown away due to being soiled. -She had ordered linens several weeks ago and was unsure where all the linens were. -She stopped purchasing regular washcloths because they were usually thrown away or could not be found. -She now ordered disposable washcloths for the residents to use. -If the staff did not have enough sheets and towels, they should report it to her, and she could order more.	D 080		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff	D 125		

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D 125	Continued From page 13 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews the facility failed to ensure documentation that 2 of 6 sampled staff who administered medications to residents had a Health Care Personnel Registry (HCPR) check (Staff D), the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff D, Staff E), Licensed Health Professional Support (LHPS) skills (Staff D), the state approved medication clinical skills validation checklist (Staff D, Staff E) and a Medication Aide Employment Verification (Staff D) form prior to administering medications. The findings are: Observation of the medication pass on 09/18/24 from 7:15am to 7:34am revealed: -Staff D was passing medications to the residents in the Special Care Unit (SCU) down the right hall. -There was another medication aide (MA) near the office of the SCU checking finger stick blood sugars (FSBS). 1. Review of Staff D's personnel record revealed: -Staff D was hired on 09/17/24 as a medication	D 125		

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aide (MA).
-The Health Care Personnel Registry (HCPR) check was done on 09/18/24.
-There was no documentation Staff D completed the state approved 5-hour and 10-hour, or 15-hour medication aide training.
-There was no documentation Staff D completed the medication clinical skills or Licensed Health Professional Support (LHPS) skills validation checklists.
-There was no documentation Staff D completed a Medication Aide Employment Verification prior to being employed at this facility.

Interview with Staff D on 09/18/24 at 7:35am revealed:
-She had started at the facility two days ago (09/16/24).
-She had been a medication aide for 22 years.
-She had worked at the facility "a hundred years ago" meaning it had been a long time ago but did not remember the exact dates.
-She did not have a login to be able to access the electronic Medication Administration Records (eMARs).
-She had to use the other MAs login information.
-The other MA was checking finger stick blood sugar down the hall on the treatment cart.

Interview with the Special Care Coordinator (SCC) on 09/18/24 at 3:10pm revealed:
-The hiring process began with an application and the criminal background check and drug screen would be done at that time if possible.
-If not done with the application, the criminal background check and drug screen would be done the first day of orientation.
-The employee would shadow (follow another employee) for 3-5 possibly 7 days if needed for training.

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D 125	Continued From page 15 -Once the shadow training was completed, the Registered Nurse (RN) would come in and complete the check off lists for LHPS and Medication Administration skills if the new hire was a MA. -All of this was supposed to be done before the new hire was allowed to work independently. Interview with the Administrator on 09/18/24 at 3:20pm revealed: -The hiring process began with an application and the criminal background check and drug screen would be done at that time if possible along with an interview. -If not done with the application, the criminal background check, drug screen, and interview would be done the first day of orientation. -The employee would shadow (follow another employee) for 2-4 days for training, 5 days were ideal to give the new hire time to learn the residents and procedures. -The Registered Nurse (RN) was scheduled to come in today and complete the check off lists for LHPS and Medication Administration skills for Staff D. -The employment verification was sent to Staff D's previous employer today (09/18/24). -The MA that Staff D was supposed to be shadowing "knew better" than to let Staff D work alone. -Staff D was only supposed to watch the other MA give medications, not be left alone on the medication cart passing medications. 2. Review of Staff E's personnel record revealed: -Staff E was hired on 10/25/20 as a medication aide (MA). -There was no documentation Staff E completed the state approved 5-hour and 10-hour, or 15-hour medication aide training.	D 125		

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D 125	Continued From page 16 -There was no documentation Staff E completed the medication clinical skills validation checklist. Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed documentation that medications were administered by Staff E. Telephone interview with Staff E on 09/19/24 at 6:05pm revealed: -She helped pass medications in the facility sometimes. -On 09/14/24 she passed medications in the special care unit (SCU). -She did not have the state approved 5-hour and 10-hour, or 15-hour medication aide training or the medication clinical skills validation checklist. -She did not think she needed the training because she was a licensed practical nurse (LPN). -She did not have oversight from a Registered Nurse (RN). -She did not know she needed oversight from an RN. Interview with the Administrator on 09/19/24 at 6:05pm revealed: -She was aware that Staff E passed medications on 09/14/24. -Staff E was not supposed to pass medications. -Staff E did not have the state approved 5-hour and 10-hour, or 15-hour medication aide training or the medication clinical skills validation checklist. -She did not think staff E needed the medication trainings and clinical skills checklist because she was a LPN. -Staff E did not have oversight from an RN. -She did not know Staff E needed oversight from an RN.	D 125		

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D 143	10A NCAC 13F .0407 (c) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (c) If licensed practical nurses are employed by the facility and practicing in their licensed capacity as governed by the North Carolina Board of Nursing, there shall be a registered nurse available in accordance with the rules set forth in 21 NCAC 36 .0224 and 21 NCAC 36 .0225, which are hereby incorporated by reference including subsequent amendments. This ELEMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure oversight by a registered nurse (RN) for a licensed practical nurse (LPN) employed by the facility and practicing in their licensed capacity (Staff E). The findings are: Review of Staff E's personnel record revealed: -Staff E was hired on 10/25/20 as a medication aide (MA). -There was no documentation Staff E completed the state approved 5-hour and 10-hour, or 15-hour medication aide training. -There was no documentation Staff E completed the medication clinical skills validation checklist. -Staff E administered tuberculosis (TB) testing to residents and facility staff. Review of a resident's September 2024 electronic medication administration record (eMAR) revealed documentation that medications were administered by Staff E on 09/14/24 at 7:30am.	D 143		

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D 143	Continued From page 18 Review of a resident's record revealed Staff E administered a tuberculosis test on 07/27/23 and 08/07/23. Review of staff records revealed Staff E administered 2 step TB testing to new staff upon being hired. Telephone interview with Staff E on 09/19/24 at 6:05pm revealed: -She helped pass medications in the facility sometimes. -On 09/14/24 she passed medications in the special care unit (SCU). -She did not have the state approved 5-hour and 10-hour, or 15-hour medication aide training or the medication clinical skills validation checklist. -She administered tuberculosis (TB) testing to residents and staff members in the facility. -She did not think she needed the medication training because she was a licensed practical nurse (LPN). -She did not have oversight from a Registered Nurse (RN). -She did not know she needed oversight from a RN. Interview with the Administrator on 09/19/24 at 6:05pm revealed -Staff E passed medications in the facility. -Staff E did not have the state approved 5-hour and 10-hour, or 15-hour medication aide training or the medication clinical skills validation checklist. -Staff E administered TB tests to residents and facility staff. -She did not think staff E needed the trainings and clinical skills checklist because she was a LPN.	D 143		

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D 143	Continued From page 19 -Staff E did not have oversight from an RN.	D 143		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents	D 254		

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D 254	Continued From page 20 (#3) had a care plan completed annually. The findings are: Review of Resident #3's current FL-2 dated 08/26/24 revealed: -Diagnoses included hypertension, cerebrovascular accident with right sided paralysis and aphasia, transurethral resection vaporization prostatectomy, ischemic cardiomyopathy, atrial fibrillation, coronary artery disease, and indwelling catheter with urinary tract infection (UTI) with gross hematuria. -He was semi-ambulatory with a wheelchair. -He had an indwelling catheter. Review of Resident #3's Resident Register revealed he was admitted on 02/07/11. Review of Resident #3's care plan dated 09/01/23 revealed: -Resident #3 was ambulatory with the aid of an assistive device. -He needed assistance with set up for eating. -He needed limited assistance with ambulation. -He was totally dependent for bathing, dressing, grooming, and transferring. Review of Resident #3's record revealed there were no annual or significant change care plans after 09/01/23. Review of Resident #3's progress notes revealed: -He had been seen in the wound clinic 06/26/24 - 07/17/24 for a wound to his right lower leg. -He had been sent to the local emergency department (ED) on 07/31/24, 08/22/24 and 08/25/24 due to indwelling catheter leaking, hematuria (blood in the urine) and urine odor. -The ED visit on 08/25/24 resulted in a	D 254		

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hospitalization from 08/26/24 to 08/28/24.

Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 3:00pm revealed:
-She or the Administrator were responsible for completing care plans for residents within 30 days of admission, annually, and when there was a change in a resident's condition.
-She had the care plan for Resident #3 done on 09/01/24.
-She had been out right after completing the form before she had sent it to the primary care provider (PCP) for his signature.
-When she returned to work on 09/12/24, she faxed the form over to the PCP.
-She checked with the PCP's office, and they faxed the completed form back to the facility today 09/19/24.

Interview with the Administrator on 09/19/24 at 4:38pm revealed:
-The Special Care Coordinator (SCC) and RCC were responsible for ensuring the residents care plans were updated at least annually or more frequently if there was a significant change in condition.
-Resident #3's care plan should have been updated prior to 09/01/24.
-The RCC had made her aware of Resident #3's care plan not being done prior to 09/01/24.

Interview with Resident #3's nurse manager at the PCP's office on 09/20/24 at 12:25pm revealed:
-Resident #3 had a diagnosis of hypertension and had a significant history of cerebrovascular accidents (2-3) with right sided paralysis and aphasia (difficulty speaking).
-His age, diagnoses, and an indwelling catheter would predispose his health status and care to

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D 254	Continued From page 22 change frequently. -The PCP expected Resident #3's plan of care to be updated as his needs changed. -The PCP had completed the care plan for Resident #3 and it had been faxed back to the facility yesterday (09/19/24). Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	D 254		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 4 of 5 sampled residents related to daily blood pressure checks and daily weights (#3), weekly vital signs and monthly weights (#4), blood pressure and pulse checks weekly with parameters (#2), blood pressure checks weekly (#1). The findings are: The National Institutes of Health reports that hypertension was a major risk factor for coronary heart disease and cerebrovascular disease and the leading cardiovascular risk factor for deaths	D 276		

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D 276	Continued From page 23 worldwide. Undetected and uncontrolled hypertension was a major contributor to stroke worldwide. 1. Review of Resident #3's current FL-2 dated 08/26/24 revealed diagnoses included hypertension, cerebrovascular accident with right side paralysis and aphasia, transurethral resection vaporization prostatectomy, ischemic cardiomyopathy, atrial fibrillation, coronary artery disease, and indwelling catheter with urinary tract infection (UTI) with gross hematuria. a. Review of Resident #3's physician's order dated 12/27/19, 06/10/22, and 08/23/24 revealed an order to check blood pressure (BP) daily. Review of Resident #3's July 2024 electronic treatment administration record (eTAR) revealed: -There was an entry to check blood pressure daily at 2:00pm. -There was no documentation Resident #3's BP was checked 21 out of 31 opportunities daily at 2:00pm. -The resident was documented as out of the facility on 07/26/24-07/29/24. Review of Resident #3's August 2024 eTAR revealed: -There was an entry to check blood pressure daily at 2:00pm. -There was no documentation Resident #3's BP was checked 13 out of 31 opportunities daily at 2:00pm. -The resident was documented as out of the facility on 08/03/24-08/06/24 and 08/26/24 - 08/28/24. -There was documentation that Resident #3 reused on 08/19/24.	D 276		

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Review of Resident #3's September 2024 eTAR revealed:
-There was an entry to check blood pressure daily at 2:00pm.
-There was no documentation Resident #3's BP was checked 10 out of 19 opportunities daily at 2:00pm.

Interview with a personal care aide (PCA) on 09/19/24 at 2:30pm revealed:
-When a resident needed their blood pressure checked, the medication aide (MA) would do it or would let the PCA know to do it.
-When she checked blood pressures, she wrote the reading on a piece of paper and gave the paper to the MA to put into the computer.
-She had not been told that Resident #3 had needed his blood pressure checked.

Interview with a MA on 09/19/24 at 9:23am revealed:
-The PCAs normally checked the residents' vital signs and would give her the results on paper, and she would enter them into the computer.
-She did not know Resident #3 was supposed to have his BP checked daily.

Interview with Resident #3's nurse manager at the primary care physician's office (PCP) on 09/20/24 at 12:25pm revealed:
-Resident #3 had a diagnosis of hypertension and had a significant history of cerebrovascular accidents (2-3) with right sided paralysis and aphasia (difficulty speaking) and a close watch needed to be kept on his BP as this could be an indicator for complications such as strokes, heart attacks, and the risk of kidney disease.
-The PCP expected Resident #3's BP to be checked daily as ordered and to report any abnormal findings.

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-The nurse manager reported there was no documentation in Resident #3's PCP record that the facility had reported any BPs for Resident #3.

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

b. Review of Resident #3's physician's orders dated 12/27/19 and 08/23/24 revealed an order to check weight daily.

Review of Resident #3's July 2024 electronic treatment administration record (eTAR) revealed:
-There was an entry to check weight daily between 6:00am - 6:00pm.
-There was no documentation Resident #3's weight was checked 25 out of 31 opportunities between 6:00am - 6:00pm.
-There was documentation that Resident #3 refused to have his weight checked on 07/05/24.
-The resident was documented as out of the facility on 07/26/24-07/29/24.

Review of Resident #3's August 2024 eTAR revealed:
-There was an entry to check weight daily between 6:00am - 6:00pm.
-Resident #3's weight was documented as 230lbs on 08/31/24.
-There was no documentation Resident #3's weight was checked 22 out of 31 opportunities between 6:00am - 6:00pm.
-There was documentation that Resident #3 refused to have his weight checked on 08/19/24.
-The resident was documented as out of the facility on 08/03/24-08/06/24 and 08/26/24 - 08/28/24.

Review of Resident #3's September 2024 eTAR

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revealed:
-There was an entry to check weight daily between 6:00am - 6:00pm.
-There was no documentation Resident #3's weight was checked 20 out of 30 opportunities between 6:00am - 6:00pm.
-There was documentation that Resident #3 refused to have his weight checked on 09/13/24.

Interview with a personal care aide (PCA) on 09/19/24 at 2:30pm revealed:
-When a resident needed their weights checked, the medication aide (MA) would do it or would let the PCA know to do it.
-When she checked weights, she wrote the reading on a piece of paper and gave the paper to the MA to put into the computer.
-She had not been told that Resident #3 had needed his weights checked daily.

Interview with a MA on 09/19/24 at 9:23am revealed:
-The PCAs normally checked the residents' weights and would give her the readings on paper, and she would enter them into the computer.
-She did not know Resident #3 was supposed to have his weight checked daily.

Interview with Resident #3's nurse manager at the primary care physician's office (PCP) on 09/20/24 at 12:25pm revealed:
-Resident #3 had a diagnosis of hypertension and had a significant history of cerebrovascular accidents (2-3) with right side paralysis and aphasia (difficulty speaking) and a close watch needed to be kept on his weigh as this could be an indicator for complication such as congestive heart failure as well as the functioning of his kidneys.

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-The PCP expected Resident #3's weights to be checked daily as ordered and to report any abnormal findings.

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

2. Review of Resident #4's current FL-2 dated 08/29/24 revealed diagnoses included vascular dementia, cellulitis, anxiety, right hemiplegia, hypertension, pain disorder, chronic obstructive pulmonary disease, stroke, and hypercholesterolemia.

Review of Resident #4's primary care provider's (PCP) order dated 02/19/24 revealed there was an order for weekly blood pressure and pulse.

Observation of the Special Care Unit (SCU) medication cart on 09/17/24 at 3:38pm revealed:
-There were 2 electronic blood pressure monitoring devices.
-The battery indicator light came on when the power button was pressed on both monitoring devices.

Review of Resident #4's July 2024 electronic treatment administration record (eTAR) revealed:
-There was an entry for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift.
-There were no blood pressures or pulses documented from 07/01/24 to 07/31/24.

Review of Resident #4's August 2024 eTAR revealed:
-There was an entry for weekly blood pressure

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and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift.
-There were no blood pressure or pulse readings documented from 08/01/24 - 08/31/24.
-The resident was documented as being out of the facility from 08/23/24 to 08/28/24.

Review of Resident #4's September eTAR revealed:
-There was an entry for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift.
-There were no blood pressure or pulse readings documented from 09/01/24 - 09/17/24.

Interview with a personal care aide (PCA) on 09/19/24 at 2:30pm revealed:
-When a resident needed their blood pressure checked, the medication aide (MA) would do it or would let the PCA know to do it.
-When she checked blood pressures, she wrote the reading on a piece of paper and gave the paper to the MA to put into the computer.
-She had not been told that Resident #4 had needed his pulse and blood pressure checked weekly.

Interview with a MA on 09/17/24 at 3:38pm revealed:
-There were 2 blood pressure monitoring devices on the medication cart.
-The devices measured blood pressure and pulse.
-She was not aware of any issues with either device.
-The night shift MAs, who worked from

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6:00pm-6:00am took the residents' blood pressures and documented the readings.
-The facility did not keep batteries on the medication or treatment carts.
-If she needed batteries, she requested them from the Special Care Coordinator (SCC).

Refer to interview with the SCC on 09/17/24 at 3:55pm.

Refer to interview with the Administrator on 09/19/24 at 5:15pm.

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

3. Review of Resident #2's current FL2 dated 09/09/24 revealed:
-Diagnoses included major neurocognitive disorder, type 2 diabetes mellitus, and hypertension.
-On the special considerations section, blood pressure and pulse were marked with an entry for frequency as "weekly".

Review of Resident #2's primary care provider's (PCP) order dated 07/08/24 revealed there was an order for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50.

Observation of the Special Care Unit (SCU) medication cart on 09/17/24 at 3:38pm revealed:
-There were 2 electronic blood pressure monitoring devices.
-The battery indicator light came on when the power button was pressed on both monitoring devices.

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D 276	Continued From page 30 Review of Resident #2's July 2024 electronic treatment administration record (eTAR) revealed: -There was an entry for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift. -There were initials circled on 07/02/24, 07/23/24, and 07/30/24 with no blood pressure or pulse readings documented. -On 07/02/24 and 07/31/24 the reason documented was "machine down". -On 07/23/24, the reason documented was "resident refused". -There were no blood pressures or pulse documented from 07/03/24 to 07/22/24. Review of Resident #2's August 2024 eTAR revealed: -There was an entry for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift. -There were initials circled on 08/07/24, 08/14/24, 08/20/24, and 08/28/24 with no blood pressure or pulse readings documented. -On 08/07/24, 08/14/24, and 08/28/24, the reason documented was "machine down". -On 08/21/24, the reason documented was "resident refused". Review of Resident #2's September eTAR revealed: -There was an entry for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110, pulse of 140 or greater or less than 50 scheduled for the 6:01pm to 6:00am shift.	D 276		

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D 276	Continued From page 31 -There were initials circled on 09/04/24 and 09/10/24 with no blood pressure or pulse readings documented. -On 09/04/24 and 09/10/24, the reason documented was "machine down". Interview with a medication aide on 09/17/24 at 3:38pm revealed: -There were 2 blood pressure monitoring devices on the medication cart. -The devices measured blood pressure and pulse. -She was not aware of any issues with either device. -The night shift MAs, who worked from 6:00pm-6:00am took the residents' blood pressures and documented the readings. -The facility did not keep batteries on the medication or treatment carts. -If she needed batteries, she requested them from the Special Care Coordinator (SCC). Interview with the SCC on 09/17/24 at 3:55pm revealed: -The blood pressure monitoring device was stored on the medication cart. -She was not informed of any issues with the blood pressure monitoring device. -She checked the electronic medication administration records (eMARs) and eTARs randomly. -She did not have a schedule of when she checked the eMARs or eTARs for accuracy. -She had not checked the eMARs and eTARs recently and did not check them as often as she should. -MAs should have reported any issues with the blood pressure monitoring device. -She was unsure why the issue with the blood pressure monitoring device was not reported and	D 276		

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why Resident #2's blood pressures and pulses were not recorded.
-If Resident #2 had orders for his blood pressure and pulse to be checked, the MAs should be checking his blood pressure and pulse.
-MAs could not notify Resident #2's PCP of his blood pressure and pulse readings being out of parameters if they did not check and record the blood pressures and pulses as ordered.

Interview with the Administrator on 09/19/24 at 5:15pm revealed:
-If residents had PCP's orders for blood pressures and pulses, the blood pressures and pulses should be taken and recorded as ordered.
-She was not aware the residents' blood pressures and pulses were not being completed and recorded.
-The facility had batteries in the Administrator's office and Maintenance Director's office.
-She was not informed the staff needed to replace the batteries in the blood pressure monitoring device.
-If a resident had parameters in place for their blood pressure or pulse, the PCP needed to be informed because the residents' blood pressure or pulse could be too high or too low.
-There was not a current system in place to check the eMARs and eTARs for accuracy.
-The SCC and Resident Care Coordinator (RCC) should be checking the eMARs and eTARs monthly for any issues or concerns.

Interview with Resident #2's PCP on 09/18/24 at 3:54pm revealed:
-She ordered weekly blood pressure and pulse checks for Resident #2 because he had a diagnosis of hypertension and was on 3 medications that could impact his blood pressure.
-She had included parameters on the order so

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she could adjust his medications if needed.
-She had not received any calls or reports from the facility of Resident #2's blood pressure or pulse being outside of the parameters.
-She was not aware the facility was not checking and recording Resident #2's blood pressures and pulses weekly.
-The facility should check Resident #2's blood pressures and pulses as she ordered them and follow the established parameters.

4. Review of Resident #1's current FL-2 dated 08/30/24 revealed diagnoses included dementia with psychosis, hypertension, and insomnia.

Review of Resident #1's physician's order dated 10/01/21 revealed an order to check blood pressure (BP) weekly.

Review of Resident #1's July 2024 electronic treatment administration record (eTAR) revealed:
-There was an entry to check blood pressure weekly at 6:00pm to 6:00am.
-There was no documentation Resident #1's blood pressure was checked on 07/01/24 to 07/31/24.
-There was documentation that the BP machine was down on 07/02/24 and 07/30/24.
-There was documentation that Resident #3 refused on 07/23/24.

Review of Resident #1's August 2024 eTAR revealed:
-There was an entry to check blood pressure weekly at 6:00pm to 6:00am.
-Resident #1's blood pressure was checked on 08/20/24.
-There was documentation that the BP machine was down on 08/06/24, 08/13/24 and 08/27/24.

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D 276	Continued From page 34 Review of Resident #1's September 2024 eTAR revealed: -There was an entry to check blood pressure weekly at 6:00pm to 6:00am. -There was no documentation Resident #1's blood pressure was checked. -There was documentation that the machine was down on 09/03/24 and 09/10/24. Refer to interview with the SCC on 09/17/24 at 3:55pm. Refer to interview with the Administrator on 09/19/24 at 5:15pm. _____ Interview with the SCC on 09/17/24 at 3:55pm revealed: -The blood pressure monitoring device was stored on the medication cart. -She was not informed of any issues with the blood pressure monitoring device. -She checked the electronic medication administration records (eMARs) and eTARs randomly. -She did not have a schedule of when she checked the eMARs or eTARs for accuracy. -She had not checked the eMARs and eTARs recently and did not check them as often as she should. -MAs should have reported any issues with the blood pressure monitoring device. -She was unsure why the issue with the blood pressure monitoring device was not reported and why Resident #4's blood pressures and pulses were not recorded. -If Resident #4 had orders for his blood pressure and pulse to be checked, the MAs should be checking his blood pressure and pulse.	D 276		

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D 276	Continued From page 35 -MAs could not notify Resident #4's PCP of his blood pressure and pulse readings being out of parameters if they did not check and record the blood pressures and pulses as ordered. Interview with the Administrator on 09/19/24 at 5:15pm revealed: -If residents had PCP's orders for blood pressures and pulses, the blood pressures and pulses should be taken and recorded as ordered. -She was not aware of the residents' blood pressures and pulses were not being completed and recorded. -The facility had batteries in the Administrator's office and Maintenance Director's office. -She was not informed the staff needed to replace the batteries with the blood pressure monitoring device. -There was not a current system in place to check the eMARs and eTARs for accuracy. -The SCC and Resident Care Coordinator (RCC) should be checking the eMARs and eTARs monthly for any issues or concerns.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents' personal clothing and bedding items were returned when items were sent to be laundered by the facility.	D 338		

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D 338	Continued From page 36 The findings are: Review of receipts from local laundromats revealed from 05/20/24 to 08/28/24, the facility laundered clothes a total of 34 times. Review of a receipt from a local appliance retailer dated 08/30/24 revealed the facility purchased a 4.5 cubic feet high efficiency front load washing machine. Observation of the facility's laundry room on 09/19/24 from 8:30am to 8:37am revealed: -There were 2 washing machines and 3 dryers. -There was a table with several quilts and comforters. -Under the table, there was a laundry basket full of clothing, and a gray storage tote with numerous socks and other clothing items on top of the tote. -There was a counter along one wall with numerous socks in a pile. -There was a rack with clothes on hangers, with laminated name tags at the top of the hangers. -There was a room measuring 14 feet long by 8 feet wide with shelves along the walls. -On the left side of the room, there were shelves which contained numerous blankets, pillows, and various clothing items. -On the right side of the room, there were shelves containing numerous blankets, quilts, and comforters, a pillow, 4 fitted sheets, 8 flat sheets, 8 towels, several hospital style gowns, several bib-style clothing protectors, and a few clothing items. -In the middle of the room, there was a large pile of clothing measuring 6 feet in length, 5.5 feet in width, and 5 feet in height.	D 338		

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D 338	Continued From page 37 Interview with a resident on 09/19/24 at 8:15am revealed: -He was admitted to the facility 1 year ago. -He used to send his clothes to be washed by the facility, but he stopped when he did not receive his clothes back from the laundry room. -He sent a coat, 2 jackets, 6-7 pairs of underwear, several pairs of socks, several shirts, 3 undershirts, and 1 pair of shorts to be washed by the facility and never received the items back from the laundry room. -There were times when he did not have enough clothing to get dressed so he borrowed clothing from his roommate. -He had to purchase new clothing items to replace the missing items. -He attended a day program 3 times a week and now took his clothes there to be washed. Interview with a second resident on 09/19/24 at 9:12am revealed: -When he sent items to facility's laundry room, it was difficult to get clothing returned. -He had 2-3 new pairs of pants that he sent to be washed, and the pants were never returned. Interview with a third resident on 09/19/24 at 9:15am revealed: -She had several items that were never returned from the laundry room. -She had 16 pairs of underwear and several bras a few months ago. -She now had 2 bras that she washed in her bathroom sink because she thought if she sent them to be washed by the facility, they would not be returned. -She now only had 3 pairs of underwear out of the 16 pairs she originally had because the others were not returned from the laundry room. -She had reported the missing items to the	D 338		

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Administrator but she still had not seen the missing items.

Interview with the laundry aide on 09/19/24 at 8:38am revealed:
-She started working at the facility almost 1 month ago.
-The staff sent laundry to the laundry room in a laundry chute.
-When she washed the residents' laundry, she returned the laundry back to the residents' rooms.
-Some of the residents' clothing was labeled and some was not.
-If the residents' clothing was not labeled, she washed the clothing and put it to the side.
-She had not received any instructions about the large pile of clothing and bedding in the laundry room.
-She thought the clothing items and bedding in the pile and on the shelves were clean.
-Many items in the pile and on the shelves were not labeled.

Interview with the housekeeping supervisor on 09/19/24 at 8:40am revealed:
-She started working at the facility in May 2024.
-When she started working at the facility, the washing machine was broken.
-The facility had to go to the laundromat to wash residents' clothing and linens for a few months.
-The facility recently purchased a new washing machine 2-3 weeks ago.
-The facility currently had 1 washing machine and 2 dryers that were working.
-There was 1 washing machine and 1 dryer in the laundry room that did not work.
-There was 1 laundry aide who worked full-time Monday through Friday and another laundry aide who worked every Saturday and Sunday.
-There was some turnover in the full-time laundry

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position, and the current laundry aide was the third full-time laundry aide since she had started working at the facility in May 2024.
-Residents sometimes complained about missing laundry.
-The large pile of clothing and bedding was in the laundry room when she started working at the facility.
-She had reported the large pile of clothing and bedding to the Administrator.
-She was unsure why there were so many items in the pile in the laundry room.
-She and the laundry aide were trying to develop a plan to sort through the pile and return items to the residents.

Interview with the Administrator on 09/19/24 at 4:37pm revealed:
-The facility washed residents' laundry every day.
-Some residents had complained about not receiving items back from the laundry room.
-The facility tried to wash the residents' laundry daily, so items did not get lost.
-Many times, residents did not label their clothing and items were lost.
-The facility had a large commercial washer that stopped working in May or June 2024.
-The commercial washer was almost 30 years old, and it was difficult to get parts to repair the washer.
-The facility took clothing and linens to a local laundromat for several weeks.
-The facility purchased a new washing machine in August 2024.
-She started working at the facility 12 years ago, and the pile of clothing and bedding in the laundry room had always been in the laundry room.
-Most items in the pile were not labeled.
-She had attempted to find who the clothes belonged to several times but was unsuccessful.

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HERMITAGE RETIREMENT CENTER	139 MALLARD LANE ROCKINGHAM, NC 28379

(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 338	Continued From page 40 -She explained to residents and their families that clothing items needed to be labeled so they could be returned from the laundry room, but items often were still not labeled.	D 338		
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: Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#1) related to a narcotic used to treat moderate to severe pain. The findings are: Review of Resident #1's current FL-2 dated 08/30/24 revealed: -Diagnoses included dementia with psychosis, hypertension and insomnia. -An order for oxycodone (IR) 10mg 1 tablet every 6 hours (used for moderate to severe pain). Review of Resident #1's physician order dated 6/19/24 revealed there was an order for oxycodone (IR) 10mg 1 tablet every 6 hours (used for moderate to severe pain).	D 358		

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D 358	Continued From page 41 Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/19/24 at 3:55pm revealed: -Thirty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/08/24. -Thirty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/19/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/29/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 08/12/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 08/30/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 09/16/24. Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 10mg (IR) tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone (IR) 10mg was documented as not in the building from 07/06/24 at 6:00pm to 07/09/24 at 6:00am. -Oxycodone (IR) 10mg was documented as not in the building from 07/16/24 at 6:00pm to 07/20/24 at 6:00am. -Oxycodone (IR) 10mg was documented as not in the building from 07/28/24 at 12:00am to 07/30/27 at 6:00am. Review of Resident #1's August 2024 eMAR revealed: -There was an entry for oxycodone 10mg (IR) tablet every 6 hours scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone (IR) 10mg was documented as not in the building 08/29/24 at 6:00am to 08/31/24 at 6:00am.	D 358		

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D 358	Continued From page 42 Review of Resident #1's September 2024 eMAR revealed: -There was an entry for oxycodone 10mg (IR) tablet every 6 hours scheduled at 12:00am, 7:30am, 12:00pm, and 6:00pm. -Oxycodone (IR) 10mg was documented as not in the building from 09/15/24 at 7:30am to 09/17/24 at 6:00am. Interview with a medication aide (MA) on 09/19/24 at 3:30pm revealed there were times when Resident #1 ran out of her oxycodone. Interview with the Special Care Coordinator (SCC) on 09/19/24 at 9:00am revealed there have been times when Resident #1 did not have her oxycodone in the building because the pharmacy only sent a 2-week supply. Interview with the Administrator on 09/19/24 at 10:38am revealed she expected the SCC to check the medication carts weekly to ensure medications were in the building. Interview with hospice nurse on 09/20/24 at 11:15am revealed: -Resident #1 was prescribed scheduled oxycodone 10mg (IR) tablet every 6 hours because she was non-verbal and could not communicate when she was in pain. -Resident #1 had run out of her oxycodone in the past. -She was concerned that Resident #1 would go through withdrawal if she was not getting her oxycodone as prescribed.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 43 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the documentation on the electronic medication administration record was recorded by the medication aide (MA) who administered the medication to 1 of 5 residents (#1). The findings are: Review of Resident #1's current FL-2 dated 08/30/24 revealed diagnoses included dementia with psychosis, hypertension and insomnia. Review of Resident #1's physician order dated 6/19/24 revealed there was an order for oxycodone (IR) 10mg 1 tablet every 6 hours (used for moderate to severe pain). Review of Resident #1's physician order summary report dated 08/29/24 revealed: -There was an order for lorazepam 1mg 1 tablet every 6 hours (used to relieve anxiety). -There was an order for oxycodone (IR) 10mg 1 tablet every 6 hours (used for moderate to severe pain). -There was an order for senexon-S 8.6-50mg 2 tablets twice a day (used to treat constipation).	D 366		

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D 366	Continued From page 44 Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg was documented as administered on 09/14/24 at 7:30am by Staff C. -There was an entry for oxycodone (IR) 10mg 1 tablet was documented as administered on 09/14/24 at 7:30am by Staff C. -There was an entry for senexon-S 8.6-50mg 2 tablets was documented administered on 09/14/24 at 7:30am by Staff C. -There was a note in the eMAR that reported "done by Staff E". Interview with Staff C on 09/19/24 at 9:15am revealed: -On 09/14/24 she did not pass the 7:30am medications for her side of the Special Care Unit (SCU). -When she arrived at the facility at 6:00am she was told by the facility Licensed Practical Nurse (Staff E) that she had passed her medications at 5:30am. -The medications should not have been passed at 5:30am. -She was not told why the medications were passed so early. -She called the Administrator and informed her that Staff E had passed morning medications before she got to the facility. -She was told to log in and sign off that the medications had been administered. -She signed the eMAR under her name that the medications had been administered. -She made a note that Staff E had administered the medications. Telephone interview with Staff E on 09/19/24 at	D 366		

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D 366	Continued From page 45 6:05pm revealed: -On 09/14/24 she helped pass medications in the SCU. -She was not supposed to pass medications in the facility. -She was there because the MA working that night was new and was not cardiopulmonary resuscitation (CPR) certified. -She did not have a log-in to be able to pass medications. -She used the MA's login to review which medications to pass. -She passed medications from 5:30am-6:15am on 09/14/24. -She wanted to help because she had been informed the facility would be short staffed on first shift. Interview with the Special Care Coordinator (SCC) on 09/19/24 at 11:30am revealed: -She was not aware that the Staff E had passed medications on 09/14/24. -She should be checking the eMARs for accuracy at least every month. Interview with the Administrator on 09/19/24 at 4:40pm revealed: -She was told that the LPN had passed medications the morning of 09/14/24. -Staff E informed her that she was just helping. -Staff E should not have passed medications under another staff member's name. -She probably did not sign off on the medications that she passed because she knew that she was not supposed to be passing medications. -Staff E did not have a log-in because she was not supposed to pass medications. -Staff should not sign off that medications had been administered by them if someone else passed the medications.	D 366		

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D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 5 sampled residents (#1 and #6) including inaccurate documentation of a narcotic. The findings are: 1. Review of Resident #1's current FL-2 dated 08/30/24 revealed diagnoses included dementia with psychosis, hypertension and insomnia. Review of Resident #1's physician order dated	D 367		

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D 367	Continued From page 47 6/19/24 revealed there was an order for oxycodone (IR) 10mg 1 tablet every 6 hours (used for moderate to severe pain). Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/19/24 at 3:55pm revealed: -Thirty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/08/24. -Thirty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/19/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 07/29/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 08/12/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 08/30/24. -Sixty tablets of oxycodone (IR) 10mg were dispensed for Resident #1 on 09/16/24. Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Oxycodone (IR) 10mg scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm. -Oxycodone (IR) 10mg was documented as not in the building at 12:00am on 07/09/24. -Oxycodone (IR) 10mg as documented as administered at 12:00pm on 07/29/24. Review of Resident #1's controlled substance drug record for July 2024 revealed: -Oxycodone (IR) 10mg was documented as administered at 12:00am on 07/09/24. -Oxycodone (IR) 10mg was not documented as administered at 12:00pm on 07/29/24. Review of Resident #1's August 2024 eMAR revealed:	D 367		

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-There was an entry for Oxycodone (IR) 10mg scheduled at 12:00am, 6:00am, 12:00pm, and 6:00pm.
-Oxycodone (IR) 10mg was documented as administered at 6:00pm on 08/29/24.

Review of Resident #1's controlled substance drug record for August 2024 revealed oxycodone (IR) 10mg was not documented as administered at 6:00pm on 08/29/24.

Review of Resident #1's September 2024 eMAR revealed:
-There was an entry for Oxycodone (IR) 10mg scheduled at 12:00am, 7:30am, 12:00pm, and 6:00pm.
-Oxycodone (IR) 10mg was documented as administered at 7:30am on 09/16/24.
-Oxycodone (IR) 10mg was documented as administered at 6:00pm on 09/16/24.

Review of Resident #1's controlled substance drug record for September 2024 revealed:
-Oxycodone (IR) 10mg was not documented as administered at 7:30am on 09/16/24.
-Oxycodone (IR) 10mg was not documented as administered at 6:00pm on 09/16/24.

Interview with a medication aide (MA) on 09/19/24 at 3:30pm revealed:
-There were times when Resident #1 ran out of her oxycodone.
-On 08/29/24, she did not administer Resident #1's oxycodone, she must have documented it incorrectly.

Interview with the Special Care Coordinator (SCC) on 09/19/24 at 11:30am revealed:
-She was responsible for the accuracy of the eMARs in the special care unit (SCU).

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-She should be checking the eMARs for accuracy at least every month.
-She did not know why the MAs were documenting medication as not in building when they were administering it.
-She thought the MAs were rushing and documenting that the medication had been administered when it was not available.

Interview with the Administrator on 09/19/24 at 10:38am revealed:
-The SCC and herself were responsible for ensuring the eMARs were accurate.
-She expected the SCC to check the accuracy of the MARs monthly and to check the medication carts weekly to ensure medications were in the building.
-She believed the eMAR errors were due to a programing issue that occured within the eMAR system when information was being processed.

Attempted telephone call with a second MA on 09/19/24 at 4:00pm was unsuccessful.

2. Review of Resident #6's current FL2 revealed diagnoses included schizophrenia, chronic foot pain, overactive bladder, and hypertension.

Observation of Resident #6's left foot on 09/19/24 at 2:12pm revealed there were no open areas to Resident #6's left 3rd toe and there were no other open areas noted.

a. Review of Resident #6's wound center notes dated 07/22/24 revealed:
-Resident #6 had a wound on his 3rd left toe.
-The wound treatment was clean with normal saline moistened gauze, apply Aquacel Ag Advantage, cover with woven gauze, secure with paper tape three times per week (Aquacel Ag

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D 367	Continued From page 50 Advantage is a wound dressing containing ionic silver used to promote healing). Review of Resident #6's physician's order dated 08/12/24 revealed Resident #6 was discharged from the care of a local wound care center. Review of Resident #6's August 2024 electronic treatment administration record (eTAR) revealed: -There was an entry for Aquacel Ag Advantage, apply to left third toe three times a week as directed scheduled for 8:00am. -Aquacel Ag Advantage was not documented as administered from 08/01/24 to 08/13/24. -Aquacel Ag Advantage was documented as administered at 8:00am on 08/14/24, 08/19/24, 08/26/24, 08/28/24, 08/30/24. Review of Resident #6's September 2024 eTAR revealed: -There was an entry for Aquacel Ag Advantage, apply to left third toe three times a week as directed scheduled for 8:00am. -Aquacel Ag Advantage was documented as administered at 8:00am on 09/04/24, 09/09/24, 09/11/24, and 09/13/24. -On 09/16/24 and 09/18/24, Aquacel Ag Advantage was documented as resident refused. Observation of Resident #6's medications on hand on 09/19/24 at 2:16pm revealed: -Resident #6 did not have any Aquacel Ag Advantage on hand. -Resident #6 did not have any other wound supplies. Refer to interview with Resident #6 on 09/19/24 at 8:15am. Refer to interview with a medication aide (MA) on	D 367		

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D 367	Continued From page 51 09/19/24 at 2:16pm. Refer to interview with the Resident Care Coordinator (RCC) on 09/19/24 at 3:00pm. Refer to interview with the Administrator on 09/19/24 at 4:37pm. Refer to telephone interview with Resident #6's primary care provider (PCP) on 09/18/24 at 3:54pm. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/19/24 at 3:54pm. Refer to telephone interview with a representative from Resident #6's podiatry office on 09/19/24 at 2:38pm. Attempted telephone interview with the wound care center on 09/19/24 at 11:45am was unsuccessful. b. Review of Resident #6's physician's order dated 05/06/24 revealed an order for Mupirocin ointment, apply to left 3rd toe three times a day (Mupirocin ointment is a topical antibiotic ointment used to treat minor skin infections). Review of Resident #6's record revealed there were no other orders for Mupirocin 2% ointment in the record. Review of Resident #6's physician's order dated 08/12/24 revealed Resident #6 was discharged from the care of a local wound care center. Review of Resident #6's July 2024 electronic treatment administration record (eTAR) revealed:	D 367		

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D 367	Continued From page 52 -There was an entry for Mupirocin 2% ointment, apply topically to left 3rd toe twice a day scheduled for 9:00am and 9:00pm. -The date for the Mupirocin ointment order was 05/06/24. -Mupirocin ointment was documented as administered on 23 of 31 days in July 2024. -Mupirocin ointment was documented as refused on 07/05/24 at 9:00pm. Review of Resident #6's August 2024 eTAR revealed: -There was an entry for Mupirocin 2% ointment, apply topically to left 3rd toe twice a day scheduled for 9:00am and 9:00pm. -The date for the Mupirocin ointment order was 05/06/24. -Mupirocin ointment was documented as administered on 20 of 31 days in August 2024. Review of Resident #6's September eTAR revealed: -There was an entry for Mupirocin 2% ointment, apply topically to left 3rd toe twice a day scheduled for 9:00am and 9:00pm. -The date for the Mupirocin ointment order was 05/06/24. -Mupirocin ointment was documented as administered on 13 of 19 days in September 2024. -Mupirocin ointment was documented as refused on 09/01/24 at 9:00pm, 09/10/24 at 9:00am and 9:00pm, and 09/16/24, 09/18/24, and 09/19/24 at 9:00am. Observation of Resident #6's medications on hand on 09/19/24 at 2:16pm revealed Resident #6 did not have a supply of Mupirocin 2% ointment.	D 367		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 53 Refer to interview with Resident #6 on 09/19/24 at 8:15am. Refer to interview with a medication aide (MA) on 09/19/24 at 2:16pm. Refer to interview with the Resident Care Coordinator (RCC) on 09/19/24 at 3:00pm. Refer to interview with the Administrator on 09/19/24 at 4:37pm. Refer to telephone interview with Resident #6's primary care provider (PCP) on 09/18/24 at 3:54pm. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/19/24 at 3:54pm. Refer to telephone interview with a representative from Resident #6's podiatry office on 09/19/24 at 2:38pm. Attempted telephone interview with the wound care center on 09/19/24 at 11:45am was unsuccessful. _____ Interview with Resident #6 on 09/19/24 at 8:15am revealed: -He saw a podiatrist because he had foot pain. -He had not missed any appointments with his podiatrist. -The facility sent him to emergency department of the local hospital a couple of months because he had a sore on his left 3rd toe. -He went to the wound clinic a few times and now his toe was healed. -The staff applied an ointment to his toe before started going to the wound clinic, then the wound	D 367		

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	HAL077012	A. BUILDING: _____ B. WING _____	R 09/20/2024

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clinic gave him a dressing which he applied until the area was healed.
-The staff assisted him with applying a rolled gauze to his foot a few times.
-He did not use an ointment or dressing on his toe now because the area was healed.
-He did not currently have any other open areas or sores on his feet.

Interview with a medication aide (MA) on 09/19/24 at 2:16pm revealed:
-Resident #6 had a wound on his left foot on his toe which was treated at the wound center.
-Resident #6's wound on his toe was now healed.
-Resident #6 had a cream for his toe but he often refused it.
-She did not administer the Mupirocin yesterday, 09/18/24 or today, 09/19/24, because she asked Resident #6, and he said he did not need it.
-She was unsure of the last time she had seen Resident #6's Mupirocin ointment.
-She thought Resident #6's Aquacel Ag Advantage was a non-medicated rolled gauze which he used to wrap his foot.
-If she had questions about any medication or treatment orders, she would ask the Resident Care Coordinator (RCC) or the Administrator.
-She had not asked the RCC or Administrator for clarification about Resident #6's wound care orders.

Interview with the RCC on 09/19/24 at 3:00pm revealed:
-Resident #6 had an open area on his left foot and was treated at the wound center.
-Resident #6 was discharged from services at the wound center in August 2024.
-She was unsure why there were still wound care orders on Resident #6's electronic treatment administration record (eTAR) because the wound

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on his toe was healed.
-The pharmacy usually added or removed orders from the electronic medication administration record (eMAR) or eTARs, but she could add, remove, or change orders if needed.

Interview with the Administrator on 09/19/24 at 4:37pm revealed:
-The facility did not have a current system in place for checking the eMARs and eTARs for accuracy.
-MAs should check entries daily and report to the RCC or Special Care Coordinator (SCC) if there were any issues or concerns.
-The RCC and SCC should be checking the eMARs and eTARs monthly for accuracy.
-She was not aware Resident #6's wound treatment orders were still on the eTARs.
-All orders should have been removed because the wound on Resident #6's toe was healed and Resident #6 was discharged from the wound care center.
-She was unsure why the MAs were still signing for the Mupirocin and for Aquacel Ag Advantage, especially if the Mupirocin and Aquacel Ag Advantage were not in the facility.
-The facility's contracted pharmacy requested for the facility to send all medication orders to the pharmacy so the eMARs and eTARs could be changed.
-The facility's contracted pharmacy requested for the facility not to change medication orders on the eMARs and eTARs to avoid confusion.
-The RCC and SCC must not have checked the eMARs and eTARs recently so Resident #6's discontinued orders could be taken off the eMARs and eTARs.

Telephone interview with Resident #6's primary care provider (PCP) on 09/18/24 at 3:54pm

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revealed:
-She was aware Resident #6 saw a podiatrist regularly for chronic foot issues.
-She unsure what treatments were ordered for the wound on his left 3rd toe because he went to the podiatrist and was treated at the wound clinic.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/19/24 at 3:54pm revealed:
-The pharmacy dispensed a 22-gram tube of Mupirocin 2% ointment for Resident #6 on 05/06/24.
-The supply of Mupirocin was considered a 21-day supply but could potentially last a little longer depending on how much was applied to the area.
-There were no refills or any other orders for Resident #6's Mupirocin ointment.
-The pharmacy did not have a record of dispensing Aquacel Ag Advantage for Resident #6.
-The pharmacy had not received any orders from the facility to discontinue Mupirocin or Aquacel Ag Advantage.
-The pharmacy usually changed all medication and treatment orders when the orders were sent from the facility.
-The facility could manually change or discontinue medication or treatment orders and the electronic medication administration system generated a report of any changes so the pharmacy would be aware of changes made by the facility.

Telephone interview with a representative from Resident #6's podiatry office on 09/19/24 at 2:38pm revealed:
-Resident #6 was seen in their office on 05/06/24 and Mupirocin ointment was ordered three times daily..

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D 367	Continued From page 57 -If the wound was healed, Resident #6 should not need Mupirocin ointment or the Aquacel Ag Advantage. -Resident #6 was last seen at their office on 08/01/24 and was still being treated at the wound clinic at that time.	D 367		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were stored securely as evidenced by insulin pens being left on top of the medication cart unsecured and unsupervised while residents were near the medication cart. The findings are: Review of the facility's undated storage of medications policy revealed all medications, prescription and non-prescription administered by facility staff will be kept locked except when staff responsible for medication administration are in close proximity and can see the medications. Review of the facilty's census on 09/17/24 revealed there were 40 residents residing on the assisted living (AL) halls of the facility.	D 378		

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Observation of the facility on 9/17/24 from 8:30am to 8:38am revealed:
-There was 1 medication aide (MA) working on the medication carts on the AL halls.
-The MA locked the medication carts and walked down a hallway toward the Special Care Unit (SCU).
-There were 4 insulin pens on top of the medication cart and a plastic container with 8 insulin pens, lancets, and insulin pen needles (Insulin is an injectable medication used to lower blood sugar levels).
-There were no other staff members supervising the medication cart where the insulin pens, needles, and lancets were left.
-There were 5 residents approximately 2-4 feet away from the medication cart.
-The surveyor alerted the Special Care Coordinator (SCC) of the insulin pens being left unattended.
-The SCC approached the medication cart and alerted the MA of the insulin pens being left on the medication cart.

Interview with the MA on 09/19/24 at 8:52am revealed:
-The residents' insulin pens were stored in the bottom drawer of the medication cart in a plastic container.
-She was aware that medications should be stored securely and locked in the medication cart.
-She was distracted on 09/17/24, and must have left the insulin pens on the medication cart.
-All medications should be locked in the medication cart so residents could not access the medications.

Interview with the Resident Care Coordinator (RCC) on 09/19/24 at 3:00pm revealed:
-All medications should be stored securely on the

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D 378	Continued From page 59 medication carts. -The plastic container containing the insulin pens should either be locked on the cart or with the MA who was administering the insulin. -The MA should have locked the insulin pens in the medication cart before leaving the cart. -Residents could take the medications off the cart if the medications were left and the cart was unattended. Interview with the Administrator on 09/19/24 at 4:37pm revealed: -All medications should be stored securely on the medication carts. -The MA should have put the insulin pens on the medication cart and locked the cart before she walked away from the cart on 09/17/24. -She was unsure why the insulin pens were left on the medication cart because the insulin pens should have been locked on the medication cart. -Residents could access medications left on the cart and take something not prescribed to them.	D 378		