STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041084	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AGAPE CARE FAMILY HOMES #1	1801 BRITTON STREET GREENSBORO, NC 27406

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 10/30/24 and 10/31/24 with a telephone exit on 10/31/24.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review	C 007		

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C 007	Continued From page 1 of any possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 2 sampled residents who did not exit the facility during a fire drill (#1). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's undated policy on fire safety revealed: -Fire drills were conducted monthly, the fire drills were unannounced and at varying times of the month and varying times of the day including normal sleep time. -Additional drills may be conducted if the Supervisor-in-Charge (SIC) or the Administrator believed it was necessary. -The location of the fire changed from one drill to the next. -Fire drills would be conducted on each shift. -Residents and staff were to treat the fire drills as though it was an actual fire.	C 007		

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C 007	Continued From page 2 -Fire drill reports were completed by staff on duty and included the date of the fire, time, location, number of staff in the home, and the number of residents at the time of the fire drill and evacuation time. -New residents would be oriented to the fire drill procedure on the day of admission. Review of the facility's fire drill form revealed: -The fire rehearsal/drill schedule form was a pre-populated form with the description of actions taken. -The actions taken included the use of the alarm system to announce the fire drill. -Notifying the fire department of the simulated fire. -Notifying by intercom or word of mouth for the staff to begin the evacuation. -Locate and isolate the fire. -Evacuation of the immediate area. -Evacuation of the smoke compartment. -Evacuation completed when all participating staff and residents were at the predetermined meeting area. -All clear was announced. -Were all windows and doors shut? -Were vital records secured? -Were medications secured? -Was this a total evacuation? -Were all smoke detectors tested and found functional? -The date and time of the fire drill, total evacuation time, the number of residents evacuated, the number of residents not evacuated, and the reason not evacuated. -For all the fire drills reviewed, all areas on the pre-populated form were documented as completed except notifying the fire department of a simulated fire, which was documented as not completed.	C 007		

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C 007	Continued From page 3 -In September 2024 (no specific date indicated) at 8:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented. -In October 2024 (no specific date indicated) at 9:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented. Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed: -Resident #1 was sitting on the couch in the living room. -Resident #1 remained seated while the smoke detector was alarming. -Resident #1 did not exit the facility. Interview with the Administrator on 10/30/24 at 7:01pm revealed: -She did not have any non-ambulatory residents. -She did not admit any residents who were non-ambulatory. -She did not know she needed to contact construction for a non-ambulatory resident because she did not have any non-ambulatory residents. -She did not know verbally telling a resident it was a fire drill would make the resident non-ambulatory. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction	C 022		

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C 022	Continued From page 4 (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 6 sampled residents (#1) who did not respond to a fire alarm. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's undated policy on fire safety revealed: -Fire drills were conducted monthly, the fire drills were unannounced and at varying times of the month and varying times of the day including normal sleep time. -Additional drills may be conducted if the Supervisor-in-Charge (SIC) or the Administrator believed it was necessary. -The location of the fire changed from one drill to the next. -Fire drills would be conducted on each shift. -Residents and staff were to treat the fire drills as though it was an actual fire.	C 022		

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C 022	Continued From page 5 -Fire drill reports were completed by staff on duty and included the date of the fire, time, location, number of staff in the home, and the number of residents at the time of the fire drill and evacuation time. -New residents would be oriented to the fire drill procedure on the day of admission. Review of the facility's fire drill form revealed: -The fire rehearsal/drill schedule form was a pre-populated form with the description of actions taken. -The actions taken included the use of the alarm system to announce the fire drill. -Notifying the fire department of the simulated fire. -Notifying by intercom or word of mouth for the staff to begin the evacuation. -Locate and isolate the fire. -Evacuation of the immediate area. -Evacuation of the smoke compartment. -Evacuation completed when all participating staff and residents were at the predetermined meeting area. -All clear was announced. -Were all windows and doors shut? -Were vital records secured? -Were medications secured? -Was this a total evacuation? -Were all smoke detectors tested and found functional? -The date and time of the fire drill, total evacuation time, the number of residents evacuated, the number of residents not evacuated, and the reason not evacuated. -For all the fire drills reviewed, all areas on the pre-populated form were documented as completed except notifying the fire department of a simulated fire, which was documented as not completed.	C 022		

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C 022	Continued From page 6 -In September 2024 (no specific date indicated) at 8:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented. -In October 2024 (no specific date indicated) at 9:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented. Review of Resident #1's current FL-2 dated 10/24/24 revealed: -Diagnoses included schizophrenia, obesity, diabetes, chronic kidney disease, asthma, and hyperlipidemia. -He was ambulatory. -There was no information for orientation status. Review of Resident #1's previous FL-2 dated 10/03/24 revealed diagnoses included dementia. Review of Resident #1's Resident Register revealed an admission date of 09/23/24. Review of Resident #1's care plan dated 09/23/24 revealed: -There was no information for orientation or memory. -He required limited assistance with eating, bathing, dressing, grooming, and personal care. -The care plan had not been signed by the primary care provider (PCP). Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed: -Resident #1 was sitting on the couch in the living room. -Resident #1 remained seated while the smoke detector was alarming.	C 022		

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C 022	Continued From page 7 -Resident #1 did not exit the facility. Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 10:57am revealed: -When he did a fire drill, he set the alarm off to see how the residents would respond. -He did not tell the residents anything; the residents knew what to do when they heard the alarm. -Resident #1's memory was "pretty good." -He had to talk a "little loud" to the resident. -Resident #1 had participated in a fire drill. -Resident #1 was a "little slow" but the resident would exit the facility. Second interview with the SIC on 10/30/24 at 7:55pm revealed: -When he did fire drills, he "hollered fire, fire", sometimes clapping his hands to get the resident's attention. -The other SIC did the same; she "hollered fire, fire, get out." Interview with another SIC on 10/30/24 at 6:10pm revealed: -Resident #1 had not been at the facility for very long. -She could get Resident #1 to smile and maybe say a word but otherwise the resident was nonverbal. -She did fire drills once a month, on different shifts. -She "hollered fire." -She had not used the smoke detector to do a fire drill. -She usually said, "fire, fire" and the residents went outside. -She did not know she was not supposed to tell the residents it was a fire drill and to go outside.	C 022		

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C 022	Continued From page 8 Interview with the Administrator on 10/30/24 at 7:01pm revealed: -She did not have any non-ambulatory residents. -She did not admit any residents who were non-ambulatory. -She did not know verbally telling a resident it was a fire drill would make the resident non-ambulatory. -The smoke detectors were turned on for a fire drill. -The residents did not listen to the smoke detectors and automatically went outside. -Staff had to tell the residents it was a fire drill. -She thought it was "okay" to tell the residents it was a fire drill because the residents would not know if the alarm was sounding because someone was cooking or if it was a drill. -When the SIC told the residents it was a fire drill all the residents exited the facility. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -She had not gotten to know Resident #1 yet. -Resident #1 did not talk and he was hard of hearing. -She thought Resident #1 had a cognitive impairment. Telephone interview with Resident #1's family member on 10/31/24 at 1:08pm revealed: -Resident #1's memory was not good. -Resident #1 would not know what a smoke detector was if he heard one alarming. -Resident #1 might leave the facility if he saw smoke. Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed: -Resident #1 had a lot of cognitive issues.	C 022		

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C 022	Continued From page 9 -Resident #1 was verbally non-responsive. -Resident #1's speech was unintelligible. -He was concerned the resident did not respond to the fire drill. -He would want the resident to be able to know to evacuate the facility to be safe if there was a fire. Based on observations, record reviews, and interviews, it was determined that Resident #1 was not interviewable. _____ The facility failed to ensure the building was equipped and maintained in accordance with the facility's licensed capacity to allow a resident (#1) residing in the facility, who was known to have a cognitive impairment, to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2024.	C 022		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is	C 069		

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opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors that were accessible to two residents who were diagnosed with dementia (#1, #3), one resident who was constantly disoriented and was known to wander, was forgetful and needed reminders (#2), three residents who were intermittently disoriented, forgetful, and needed reminders (#3, #5, #6), and a resident who was forgetful and needed reminders (#4) had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents.

The findings are:

Review of the facility's undated policy for the identification and supervision of wandering residents revealed:
-When there was a resident who was determined by the physician to be disoriented or a wanderer, each exit door for the resident shall be equipped with a sounding device that was activated when the door was opened.
-The sound shall be of sufficient volume that it could be heard by staff.
-When there were residents in the home that were known to be wanderers, door alarms were to be activated 24 hours a day.

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-If there were no wanderers residing in the facility, it was the facility's policy to activate the door alarms during the night.
-The alarm system would be checked daily by the Supervisor-in-Charge (SIC) to ensure that it was operational.
-The facility's plan for supervision of disoriented or wandering residents if the door alarms were off or inoperable, was the resident would receive direct supervision by a staff member until all alarms were on and operable.

Observations of the facility on 10/30/24 between 8:09am-9:00am revealed:
-The facility was located on the corner lot of two streets.
-There were 3 entrance/exit doors into the facility.
-The main entrance door opened into the living room.
-There was a side door that opened into the kitchen.
-There was a second side door that was off the main hallway where the resident rooms were located.
-Five residents had left the facility for a day program at 8:05am.
-A sixth resident was in his bed asleep in the resident room beside the second side door.
-There was no sounding device on any of the doors when opened.

Observation of the facility on 10/30/24 at 2:47pm revealed the 5 residents returned to the facility from the day program.

Observation of the main entrance door on 10/30/24 at 3:11pm revealed there was no door alarm activated when re-entering the facility.

Interview with the SIC on 10/30/24 at 11:20am

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C 069	Continued From page 12	C 069		

reveled:
-He cut the door alarms off every morning and re-engaged the alarms when the residents returned to the facility in the afternoon.
-He had not been using the alarms during the day.
-He disengaged the door alarm this morning, 10/30/24.
-He attempted to re-engage the alarm and stated it was not working, and he did not know what was wrong with the alarm.

Interview with a resident on 10/30/24 at 3:12pm revealed:
-The door alarms were turned on at 10:00pm.
-None of the residents had walked away from the facility.

Interview with a second resident on 10/30/24 at 3:21pm revealed:
-The door alarms were turned on at night.
-A resident walked off last week, and a law enforcement officer brought the resident back to the facility.
-He could not recall the name of the resident who walked off.

Interview with a third resident on 10/30/24 at 3:24pm revealed:
-He had heard door alarms in the mornings and at night, but he could not recall the last time he heard the door alarms.
-None of the residents had left the facility and had to be returned by a law enforcement officer.

Interview with a fourth resident on 10/30/24 at 3: 25pm revealed:
-Door alarms were turned on at night when it was dark outside.
-A law enforcement officer brought a resident

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back to the facility a "long time ago."
-He could not recall the name of the resident, but the resident still lived at the facility.

Observation of the facility on 10/30/24 at 3:31pm revealed:
-The Administrator was in the office on the telephone.
-The SIC was sitting on the porch outside the side door off the kitchen.
-A resident was sitting on the couch in the living room.
-No alarm sounded when the main door into the living room was opened.
-Two residents were lying in their beds.
-An alarm sounded when the side door off the hallway was opened.

Interview with the SIC on 10/30/24 at 4:21pm revealed:
-He installed the door chime on at the end door (door at the end of the hallway) earlier today when the door alarms were discussed.
-He was going to order two more door chimes and install those on the other two doors.
-He could monitor the residents when the residents went outside by looking at the cameras.
-He could only see the cameras when he was in the office.
-He could not see the cameras on his telephone if he was out of the office.
-He did not sit in the office because he was always busy.

Observation of the cameras on 10/30/24 at 4:21pm revealed:
-A large monitor was sitting on top of the desk in the SIC's bedroom/office.
-There were 8 individual screens on the monitor.
-There was an image of the living room, the

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AGAPE CARE FAMILY HOMES #1	1801 BRITTON STREET GREENSBORO, NC 27406

(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
C 069	Continued From page 14 dining room, and the hallway. -There was an outside image of the two side doors and the main entrance door. -The outside image showed the immediate area outside the door Observation of the facility on 10/30/24 at 4:03pm revealed: -A resident exited the first side door to go outside and smoke. -There was no audible chime when the door was opened. -The resident exited the porch and walked around the side of the facility. Interview with a second SIC on 10/30/24 at 6:10pm revealed: -When she worked at the facility, she had not heard any door alarms chime when entering or exiting the facility. -She entered the facility as early as 7:00am and exited as late as 12:00am and there were no door alarms. -She did not recall any of the residents "walking off." -It seemed like someone may have walked off, but she may have been thinking about another facility, it had been a while. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -There had been no door alarms on the doors since the facility was remodeled in 2022 (she did not recall the exact date). -No chimes had been added to the doors at the facility when the alarms were disabled. -The facility had cameras to monitor the doors. -The facility did not have any residents who needed to be monitored until a [named] resident eloped.	C 069		

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Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-He would expect the facility to have door chimes to monitor the residents coming in and going out of the facility.
-He thought all the residents needed to be monitored for the residents' safety.

1. Review of Resident #2's current FL-2 dated 07/01/24 revealed:
-Diagnoses included schizophrenia, borderline intellectual and developmental disability (IDD), and hypertension.
-He was ambulatory, constantly disoriented, and wandered.

Review of Resident #2's previous FL-2 dated 04/16/24 documented the resident as constantly disoriented.

Review of Resident #2's Resident Register revealed an admission date of 02/23/24.

Review of Resident #2's care plan dated 04/16/24 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Review of Resident #2's referral form for a community treatment program dated 07/01/24 revealed:
-The resident was currently in a healthcare rehabilitation facility.
-The reason for the referral was the resident stated no one cared about him.
-The resident would yell at night and when the staff asked him what he needed he denied yelling.

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-On several occasions, the resident stated he was going to kill himself.
-He constantly walked out of the facility, usually within the camera site, however on many occasions, the local law enforcement had to be called to assist in locating the resident.
-Due to his elopement behaviors, he posed a liability to the facility.
-He was admitted to the facility with no historical behavior information.
-The form was signed by a Supervisor-in-Charge (SIC).

Review of Resident #2's local law enforcement incident/investigation report dated 03/15/24 revealed:
-At 6:22pm, Resident #2 was reported as a missing person.
-Resident #2 was last seen by facility staff at 5:30pm.
-At 6:45pm, Resident #2 was located and returned to the facility.

Review of Resident #2's incident reports revealed there was no incident report dated 03/15/24.

A request was made for Resident #2's care notes on 10/30/24 and care notes dated 03/15/24 were not provided prior to exit on 10/31/24.

Review of Resident #2's care notes dated 06/01/24 revealed:
-Upon arrival at the facility, the staff member (the care note was not signed) learned that Resident #2 was not in the facility (there was no time documented).
-The Supervisor-in-Charge (SIC) reported to the staff member that Resident #2 left the facility around 12:00pm; Resident #2 was upset over cigarettes.

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-The police department was notified and had been to the facility (there was no time documented).
-At 9:00pm, a law enforcement officer arrived at the facility to see if Resident #2 had returned to the facility.
-The officer stated he had searched the neighborhood, but no one had seen anyone who fit Resident #2's description.
-The officer reported he was putting Resident #2 into the system as a missing person.

Review of Resident #2's local law enforcement incident/investigation report dated 06/01/24 revealed:
-At 7:41pm, Resident #2 was reported as a missing person.
-There was no documentation as to the last time the resident was seen by facility staff.
-There was no documentation as to when the resident was located.

Review of Resident #2's care notes dated 06/02/24 revealed:
-The staff at the facility received a telephone call from Resident #2's family member who reported that the resident was in the hospital.
-Resident #2 injured his foot while away from the facility.

Review of Resident #2's incident and accident report dated 06/01/24 revealed:
-The incident happened at approximately 3:00pm.
-The incident report was signed by a [named] SIC.
-Upon arrival at the facility she was informed Resident #2 had not returned to the facility.
-The SIC reported she had called the police department.
-Resident #2 would leave the facility but could be

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monitored by the camera which covered the entire home, at this time he had left the area.
-A police officer arrived at the facility to see if Resident #2 had returned.
-The officer stated he had searched the neighborhood, but no one had seen anyone who fit Resident #2's description.
-The officer reported he was putting Resident #2 into the system as a missing person.

Review of Resident #2's hospital admissions summary dated 06/01/24 at 11:20pm revealed:
-Resident #2 presented to the emergency department today, 06/01/24 with pain in his left foot after a fall.
-His left foot was visibly bruised and swollen.
-The resident stated he fell a week ago.
-The resident was declared legally incompetent by a judge on 05/18/19.
-The resident was a poor historian and unable to give any other history.
-A scan showed multiple fractures in the left foot.
-The resident had a surgical procedure on his left foot.

Interview with the SIC on 10/30/24 at 3:57pm revealed:
-Resident #2 was constantly disoriented.
-Resident #2 thought a famous wrestler was his family member, "he told everyone that."
-Resident #2 had not "walked off" since he started working at the facility.
-Resident #2 had stated he was going to leave, but he watched him closely and the resident had not left.

Interview with a second SIC on 10/30/24 at 6:10pm revealed:
-Resident #2 was constantly disoriented.
-Resident #2 would become extremely agitated.

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C 069	Continued From page 19 Interview with the Administrator on 10/30/24 at 7:01pm revealed: -Resident #2 eloped from the facility in June 2024. -On the resident's way out of the facility, the resident fell and injured his foot. -The resident "ended up in rehabilitation." Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -Resident #2 was constantly disoriented. -Resident #2 did not remember his date of birth. -Resident #2 would ask for a cigarette at 2:00pm and then come back and not remember he had the cigarette. -Resident #2 eloped from the facility the first week of June 2024. -She did not recall law enforcement having to be called before June 2024. -Resident #2 had not eloped from the facility since June 2024. -It was going to be a problem eventually because Resident #2 was going to walk away again sooner or later, knowing his behavior. -Resident #2 walked away from the facility when he was agitated. -The staff monitored Resident #2's whereabouts by keeping the resident calm. -If Resident #2 was agitated the SIC would give the resident a cigarette. -Resident #2 threatened to walk out, he would go to the street, but staff would watch him until he came back inside. -Resident #2 was in a day program now so the resident was happy. -In June 2024, Resident #2 walked away from the facility in the afternoon, between 3:00pm-3:30pm. -Local law enforcement was notified and was not able to find Resident #2.	C 069		

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-Resident #2's family member called the facility the next day to report the resident was in the hospital.
-She was in the process of installing door chimes.
-Her long-term goal was to install more cameras with door alarms.
-She tried to get the additional cameras installed in June 2024, but the company facility had not returned her calls.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-Resident #2 had underlying confusion.
-Resident #2 was at high risk for elopement if elopement had already occurred.
-He would expect the facility to have door chimes to help staff monitor Resident #2's movement.

Attempted telephone interview with Resident #2's family member on 10/31/24 at 1:34pm was unsuccessful.

Attempt telephone interview with Resident #2's court-appointed legal guardian on 10/31/24 at 2:02pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated 10/24/24 revealed:
-Diagnoses included schizophrenia, obesity, diabetes, chronic kidney disease, asthma, and hyperlipidemia.
-He was ambulatory.
-There was no information for orientation status.

Review of Resident #1's previous FL-2 dated 10/03/24 revealed:
-Diagnoses dementia, intellectual developmental disability, schizophrenia, diabetes, asthma, diabetes, hyperlipidemia and hypertension.

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C 069	Continued From page 21 -He was ambulatory. -There was no information for orientation status. Review of Resident #1's Resident Register revealed an admission date of 09/23/24. Review of Resident #1's care plan dated 09/23/24 revealed: -There was no information for orientation or memory. -The care plan had not been signed by the primary care provider (PCP). Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed: -The resident had not been at the facility for very long. -She could get Resident #1 to smile and maybe say a word but otherwise the resident was nonverbal. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -She had not gotten to know Resident #1 yet. -Resident #1 did not talk and he was hard of hearing. -She thought Resident #1 had a cognitive impairment. Telephone interview with Resident #1's family member on 10/31/24 at 1:08pm revealed: -She was Resident #1's legal guardian. -Resident #1 had lived with her from 1986 until placement at the facility. -Resident #1's memory was not good. -Dementia ran in the family. -Resident #1 would get up and go outside during the night. -She had a lot of problems with Resident #1 walking off and she would have to call the local	C 069		

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law enforcement; they would bring him back.
-Over the last year, she had to call for law enforcement assistance 2-3 times per week when Resident #1 walked away from her home.
-One time Resident #1 walked to a store a long way from her home because she would not give him a soda.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-Resident #1 appeared to have a lot of cognitive issues.
-Resident #1 was verbally non-responsive.
-Resident #1's speech was unintelligible.

3. Review of Resident #5's current FL-2 dated 04/16/24 revealed:
-Diagnoses included mental retardation, obesity, hypertension, schizophrenia, and psychosis.
-He was ambulatory.
-He was intermittently disoriented.

Review of Resident #5's Resident Register revealed:
-Resident #5 was admitted to the facility on 09/22/11.
-Resident #5 was his own responsible party.

Review of Resident #5's care plan dated 04/16/24 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed:
-Resident #5 had short-term memory loss.
-She could talk to the resident and the resident might or might not remember what he was told.

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Telephone interview with the Administrator on 10/31/24 at 9:14am revealed:
-Resident #5's FL-2 was marked as intermittently disoriented because he would not remember certain things.
-Resident #5 did not remember everything but he knew his location.
-There were certain things Resident #5 would not know, his memory came and went.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #5 had cognitive issues.

4. Review of Resident #3's current FL-2 dated 04/16/24 revealed:
-Diagnoses included mild retardation, dementia, type 2 diabetes, schizoaffective disorder, and anxiety.
-He was ambulatory.
-He was intermittently disoriented.

Review of Resident #3's Resident Register revealed:
-Resident #3 was admitted to the facility on 04/16/23.
-Resident #3 was his own responsible party.

Review of Resident #3's care plan dated 04/16/24 revealed:
-He was oriented.
-He was forgetful and needed reminders.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed:
-Resident #3's memory was bad.
-The resident did not remember when he was told to do something.
-She would tell him to get his clothes together for

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the laundry and he would not do it.
-She would remind him, and he still did not do it.

Telephone interview with the Administrator on 10/31/24 at 9:14am revealed:
-Resident #3 had some type of dementia.
-Resident #3 did not remember his birth date and things like that.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #3 had cognitive issues.

5. Review of Resident #4's current FL-2 dated 04/16/24 revealed:
-Diagnoses included schizoaffective disorder, chronic kidney disease, hyperlipidemia, and hypertension.
-He was ambulatory.
-There was no information for orientation status.

Review of Resident #4's Resident Register revealed:
-Resident #4 was admitted to the facility on 04/17/23.
-Resident #4 was his own responsible party.

Review of Resident #4's care plan dated 04/16/24 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed:
-Resident #4 was very quiet and liked to be by himself.
-Resident #4 walked a lot.
-It was hard to tell anything about Resident #4's memory because he was so quiet.

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C 069	Continued From page 25 Telephone interview with the Administrator on 10/31/24 at 9:14am revealed she thought Resident #4's orientation was "okay." Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #4 had cognitive issues. 6. Review of Resident #6's current FL-2 dated 04/16/24 revealed: -Diagnoses included schizoaffective, bipolar, anxiety, and unspecified personality disorder. -He was ambulatory. -He was intermittently disoriented. Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 04/06/23. -Resident #6 did not have a responsible person listed. Review of Resident #6's care plan dated 04/16/24 revealed: -He was sometimes disoriented. -He was forgetful and needed reminders. Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed: Resident #6's memory was bad. -She could ask Resident #6 a question and the resident just stood there looking at her and did not answer the question. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -Resident #6's memory was okay. -Resident #6 was a typical schizophrenia, he had	C 069		

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problems remembering things.
-He was not diagnosed with dementia but forgot to do things when told.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-He recently performed a mini mental exam of Resident #6, and the resident did "pretty well."
-Resident #6's primary issue would be his schizophrenia.

_____

The facility failed to ensure the exit doors were equipped with sounding devices that were activated and enabled when the doors were opened resulting in 6 residents having access to the doors and possibly eloping: one resident who was constantly disoriented and wandered, with a history of elopement and had been injured when he wandered away from the facility on 06/01/24 (#2), one resident who had only been at the facility for one month, had an admitting diagnosis of dementia and history of wandering away from his family member's home on multiple occasions (#1), and three residents who were intermittently disoriented and were forgetful and needed reminders (#3, #5, #6), and a resident who was sometimes disoriented, forgetful and needed reminders (#4). This failure resulted in a substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/24 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2024.

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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
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents evacuated the facility when the smoke detector was activated and without verbal prompting resulting in 5 of 5 residents (#1,#3, #4, #5, and #6) who did not respond to a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's undated policy on fire safety revealed: -Fire drills were conducted monthly, the fire drills were unannounced and at varying times of the month and varying times of the day including normal sleep time.	C 100		

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C 100	Continued From page 28 -Additional drills may be conducted if the Supervisor-in-Charge (SIC) or the Administrator believed it was necessary. -The location of the fire changed from one drill to the next. -Fire drills would be conducted on each shift. -Residents and staff were to treat the fire drills as though it was an actual fire. -Fire drill reports were completed by staff on duty and included the date of the fire, time, location, number of staff in the home, and the number of residents at the time of the fire drill and evacuation time. -New residents would be oriented to the fire drill procedure on the day of admission. Review of the facility's fire drill form revealed: -The fire rehearsal/drill schedule form was a pre-populated form with the description of actions taken. -The actions taken included the use of the alarm system to announce the fire drill. -Notifying the fire department of the simulated fire. -Notifying by intercom or word of mouth for the staff to begin the evacuation. -Locate and isolate the fire. -Evacuation of the immediate area. -Evacuation of the smoke compartment. -Evacuation completed when all participating staff and residents were at the predetermined meeting area. -All clear was announced. -Were all windows and doors shut? -Were vital records secured? -Were medications secured? -Was this a total evacuation? -Were all smoke detectors tested and found functional? -The date and time of the fire drill, total	C 100		

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evacuation time, the number of residents evacuated, the number of residents not evacuated, and the reason not evacuated.
-For all the fire drills reviewed, all areas on the pre-populated form were documented as completed except notifying the fire department of a simulated fire, which was documented as not completed.
-On 03/17/24 at 9:30pm, 5 residents evacuated, the total time was 15 seconds.
-On 04/18/24 at 12:30am, 5 residents evacuated, the total time was 5 seconds.
-On 05/18/24 at 4:30pm, there was no documentation related to how many residents evacuated, or the total time for the evacuation.
-On 06/16/24 at 7:00pm, there was no documentation related to how many residents evacuated, the total time for the evacuation was 15 seconds.
-On 07/19/24 at 8:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation.
-In September 2024 (no specific date indicated) at 8:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented.
-In October 2024 (no specific date indicated) at 9:00am, there was no documentation related to how many residents evacuated, or the total time for the evacuation; the actual day of the fire drill was not documented.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 10:57am revealed:
-When he did a fire drill, he set the alarm off to see how the residents would respond.
-He did not tell the residents anything, the residents knew what to do when they heard the alarm.

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C 100	Continued From page 30 Second interview with the SIC on 10/30/24 at 7:55pm revealed: -When he did fire drills, he "hollered fire, fire", sometimes clapping his hands to get the resident's attention. -The Other SIC did the same, she "hollered fire, fire, get out." Interview with another SIC on 10/30/24 at 6:10pm revealed: -She did fire drills once a month, on different shifts. -She "hollered fire." -She had not used the smoke detector to do a fire drill. -She usually said, "fire, fire" and the residents went outside. -She did not know she was not supposed to tell the residents it was a fire drill and to go outside. Interview with the Administrator on 10/30/24 at 7:01pm revealed: -The SIC knew how to do fire drills. -The smoke detectors were turned on for a fire drill. -The residents did not listen to the smoke detectors and automatically went outside. -Staff had to tell the residents it was a fire drill. -She thought it was "okay" to tell the residents it was a fire drill because the residents would not know if the alarm was sounding because someone was cooking or if it was a drill. -When the SIC told the residents it was a fire drill all the residents exited the facility. 1. Review of Resident #1's current FL-2 dated 10/24/24 revealed: -Diagnoses included schizophrenia, obesity, diabetes, chronic kidney disease, asthma, and	C 100		

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hyperlipidemia.
-He was ambulatory.
-There was no information for orientation status.

Review of Resident #1's previous FL-2 dated 10/03/24 revealed diagnoses included dementia.

Review of Resident #1's Resident Register revealed an admission date of 09/23/24.

Review of Resident #1's care plan dated 09/23/24 revealed:
-There was no information for orientation or memory.
-He required limited assistance with eating, bathing, dressing, grooming, and personal care.
-The care plan had not been signed by the primary care provider (PCP).

Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed:
-Resident #1 was sitting on the couch in the living room.
-Resident #1 remained seated while the smoke detector was alarming.
-Resident #1 did not exit the facility.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 10:57am revealed:
-Resident #1's memory was "pretty good."
-He had to talk a "little loud" to the resident.
-Resident #1 had participated in a fire drill.
-Resident #1 was a "little slow" but the resident would exit the facility.

Interview with a second SIC on 10/30/24 at 6:10pm revealed:
-Resident #1 had not been at the facility for very long.
-She could get Resident #1 to smile and maybe

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say a word but otherwise the resident was nonverbal.

Telephone interview with the Administrator on 10/31/24 at 9:14am revealed:
-She had not gotten to know Resident #1 yet.
-Resident #1 did not talk and he was hard of hearing.
-She thought Resident #1 had a cognitive impairment.

Telephone interview with Resident #1's family member on 10/31/24 at 1:08pm revealed:
-Resident #1's memory was not good.
-Resident #1 would not know what a smoke detector was if he heard one alarming.
-Resident #1 might leave the facility if he saw smoke.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-Resident #1 had a lot of cognitive issues.
-Resident #1 was verbally non-responsive.
-Resident #1's speech was unintelligible.

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

Refer to the telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm.

2. Review of Resident #3's current FL-2 dated 04/16/24 revealed:
-Diagnoses included mild retardation, dementia, type 2 diabetes, schizoaffective disorder, and anxiety.
-He was ambulatory.

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C 100	Continued From page 33 -He was intermittently disoriented. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 04/16/23. Review of Resident #3's care plan dated 04/16/24 revealed: -He was oriented. -He was forgetful and needed reminders. -He required supervision with ambulation. -He required limited assistance with eating, toileting, bathing, dressing, grooming, and personal care. Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed: -Resident #3 was sitting on the couch in the living room. -Resident #3 remained seated while the smoke detector was alarming. -Resident #3 did not exit the facility. Interview with Resident #3 on 10/30/24 at 4:46pm revealed: -He heard the fire alarm. -He was supposed to go outside. -A staff member usually told the residents to go outside. -The staff member would say "get out" and "go to the pole." Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed: -Resident #3's memory was bad. -The resident did not remember when he was told to do something. -She would tell him to get his clothes together for the laundry and he would not do it. -She would remind him, and he still did not do it.	C 100		

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C 100	Continued From page 34 Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -Resident #3 had some type of dementia. -Resident #3 did not remember his birth date and things like that. Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #3 had cognitive issues. Refer to the telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm. 3. Review of Resident #4's current FL-2 dated 04/16/24 revealed: -Diagnoses included schizoaffective disorder, chronic kidney disease, hyperlipidemia, and hypertension. -He was ambulatory. -There was no information for orientation status. Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 04/17/23. Review of Resident #4's care plan dated 04/16/24 revealed: -He was sometimes disoriented. -He was forgetful and needed reminders. Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed: -Resident #4 was lying on his bed. -Resident #4 remained on his bed the smoke detector was alarming. -Resident #4 did not exit the facility.	C 100		

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Interview with Resident #4 on 10/30/24 at 4:52pm revealed:
-He heard the fire alarm.
-He usually went out the back door (door at the end of the hallway).
-He did not know it was a fire drill.
-He heard the smoke detector go off all the time.
-For fire drills, the staff usually told the residents to go outside.

Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed:
-Resident #4 was very quiet and liked to be by himself.
-Resident #4 walked a lot.
-It was hard to tell anything about Resident #4's memory because he was so quiet.

Telephone interview with the Administrator on 10/31/24 at 9:14am revealed she thought Resident #4's orientation was "okay."

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #4 had cognitive issues.

Refer to the telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm.

4. Review of Resident #5's current FL-2 dated 04/16/24 revealed:
-Diagnoses included mental retardation, obesity, hypertension, schizophrenia, and psychosis.
-He was ambulatory.
-He was intermittently disoriented.

Review of Resident #5's Resident Register revealed Resident #5 was admitted to the facility

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C 100	Continued From page 36 on 09/22/11. Review of Resident #5's care plan dated 04/16/24 revealed: -He was sometimes disoriented. -He was forgetful and needed reminders. -He required supervision with grooming and personal hygiene. -He required limited assistance with bathing and dressing. Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed: -Resident #3 was sitting on the couch in the living room. -Resident #3 remained seated while the smoke detector was alarming. -Resident #3 did not exit the facility. Interview with Resident #5 on 10/30/24 at 4:48pm revealed: -He heard the fire alarm. -He did not know why he did not do anything. -A staff member usually said it was a fire and to go outside. Interview with a Supervisor-in-Charge on 10/30/24 at 6:10pm revealed: -Resident #5 had short-term memory loss. -She could talk to the resident and the resident might or might not remember what he was told. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -Resident #5's FL-2 was marked as intermittently disoriented because he could not remember certain things. -Resident #5 did not remember everything but he knew his location. -There were certain things Resident #5 would not	C 100		

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know, his memory came and went.

Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed Resident #5 had cognitive issues.

Refer to the telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm.

5. Review of Resident #6's current FL-2 dated 04/16/24 revealed:
-Diagnoses included schizoaffective, bipolar, anxiety, and unspecified personality disorder.
-He was ambulatory.
-He was intermittently disoriented.

Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 04/06/23.

Review of Resident #6's care plan dated 04/16/24 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.
-He required limited assistance with eating, toileting, bathing, dressing, grooming, and personal care.

Observation of the facility on 10/30/24 at 4:42pm-4:43pm revealed Resident #6 was in his room with the door closed; Resident #6 did not exit the facility.

Observation of the facility on 10/30/24 at 4:54pm revealed:
-Resident #6's door to his room was closed.
-Resident #6 was lying on his bed.
-Resident #6's television was on, and he had a

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C 100	Continued From page 38 fan blowing toward him. Interview with Resident #6 on 10/30/24 at 4:54pm revealed: -He did not hear the fire alarm. -He did not know it was a fire drill. -A staff member usually told them when there was a fire drill. Interview with a Supervisor-in-Charge (SIC) on 10/30/24 at 6:10pm revealed: -Resident #6's memory was bad. -She could ask Resident #6 a question and the resident just stood there looking at her and did not answer the question. Telephone interview with the Administrator on 10/31/24 at 9:14am revealed: -Resident #6's memory was okay. -Resident #6 was a typical schizophrenia, he had problems remembering things. -He was not diagnosed with dementia but forgot to do things when told. Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed: -He recently performed a mini mental exam of Resident #6, and the resident did "pretty well." -Resident #6's primary issue would be his schizophrenia. Refer to the telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm. _____ Telephone interview with the facility's primary care provider (PCP) on 10/31/24 at 2:17pm revealed: -He was concerned the residents did not respond to the fire drill.	C 100		

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C 100	Continued From page 39 -He would want the residents to be able to know to evacuate the facility to be safe if there was a fire. _____ The facility failed to ensure fire drills were conducted appropriately to ensure 5 of 5 residents knew to respond to a fire alarm and exit the facility without being verbally prompted to do so. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/18/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 15, 2024.	C 100		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referral to a podiatrist for 2 of 4 sampled residents (#2, #4) related to a colonoscopy (#2) and toenail and fingernail care (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 04/16/24 revealed: -Diagnoses included schizoaffective disorder,	C 246		

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chronic kidney disease, hyperlipidemia, and hypertension.
-He was ambulatory.

Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 04/17/23.

Review of Resident #4's care plan dated 04/16/24 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.

a. Observation of Resident #4's toenails on 10/30/24 at 4:51pm revealed:
-The first toenail on his left foot was approximately three-fourths to one-inch long; it was turned toward the inside of his second toe and was thick, brownish/gray, and rippled in appearance.
-The second toenail had grown over the end of the toe and extended the entire length of the underside of the toe and was touching the ball of the foot.
-The third and fourth toenails had grown over the end of the toe and extended one-half the way down the underside of the toe.

-The first toenail on his right foot was approximately three-fourths to one-inch long; it was turned toward the inside of his second toe and was thick, brownish/gray and rippled in appearance.
-The second toenail had grown over the end of the toe and was beginning to curl over the end; it was broken and jagged.
-The third toenail had grown over the end of the toe and extended one-half the way down the underside of the toe; it was pressing into the skin on the toe.

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C 246	Continued From page 41 -The fourth toenail had grown over the end of the toe and extended the entire length of the underside of the toe and was touching the ball of the foot. Interview with Resident #4 on 10/30/24 at 4:52pm revealed: -He did not have assistance with his showers. -Staff usually cut his toenails. -He had not told anyone his toenails needed to be cut. -He would like to have his toenails cut. Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 7:55pm revealed: -He had seen Resident #4's toenails about 5 days ago. -He told the Administrator that Resident #4's toenails needed to be cut. -Only a nurse or a doctor could cut a resident's toenails. -The facility rule was the SIC could not cut toenails. Interview with another SIC on 10/30/24 at 6:10pm revealed: -All the residents went to a podiatrist quarterly to have their toenails cut. -She could not remember if Resident #4 had been to the podiatrist or not. -She reviewed his record and did not see a note from the podiatrist and stated, "Maybe he had not been." -The podiatrist usually scheduled the resident's appointments. -All the residents went "about" the same time. Telephone interview with a representative from the podiatrist office on 10/31/24 at 1:36pm revealed:	C 246		

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-Resident #4 was last seen at the podiatry office on 07/26/23.
-Resident #4 did not have an appointment scheduled for the podiatrist.
-The facility staff would need to call and make an appointment for the resident.

Telephone interview with Resident #4's primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-If Resident #4's toenails were long and needed to be cut, the resident would be at risk for infection because the resident's toenails could cut into his toes or foot.
-He expected the facility staff to make an appointment with a podiatrist as needed.

Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed:
-Residents' toenails were cut by a podiatrist twice a year.
-She had not seen Resident #4's toenails.
-Resident #4 was seen by the podiatrist at the end of last year (2023).
-She had not made Resident #4 an appointment to be seen by the podiatrist.
-Resident #4 had not told staff his toenails were long.

b. Observation of Resident #4's fingernails on 10/30/24 at 4:51pm revealed Resident #4's fingernails extended past the end of his fingers from three-fourths-one inch on both hands.

Interview with Resident #4 on 10/30/24 at 4:52pm revealed:
-He did not have assistance with his showers.
-He did not like long fingernails.
-Staff usually cut his fingernails.
-He had not told anyone his fingernails needed to

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be cut.
-He would like to have his fingernails cut.

Interview with the SIC on 10/30/24 at 7:55pm revealed:
-He had seen Resident #4's fingernails about 5 days ago.
-He told the resident his fingernails were a little long and the resident stated they were okay.
-Only a nurse or a doctor could cut a resident's fingernails.
-The facility rule was the SIC could not cut fingernails.

Interview with another SIC on 10/30/24 at 6:10pm revealed she did not know who cut the resident's fingernails.

Telephone interview with Resident #4's PCP on 10/31/24 at 2:17pm revealed:
-If Resident #4's fingernails were long and needed to be cut, the resident could accidentally harm himself, by cutting himself.
-The resident's fingernails would need to be trimmed.

Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed:
-Residents fingernails were cut by staff once a month.
-She would have the resident's fingernails trimmed.

2. Review of Resident #2's current FL-2 dated 07/01/24 revealed
diagnoses included schizophrenia, borderline intellectual and developmental disability (IDD), and hypertension

Review of Resident #2's record revealed a

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C 246	Continued From page 44 colonoscopy was scheduled for 10/29/24. Interview with the Administrator on 10/30/24 at 11:30am revealed Resident #2's colonoscopy had been rescheduled for November 2024 (she was not sure of the date). Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 3:57pm revealed: -He prepared Resident #2 for the colonoscopy scheduled for 10/29/24 based on the orders. -He administered the medication as ordered for prepping Resident #2 for a colonoscopy. -Resident #2 went to the bathroom a lot during the preparation. -He gave him the last drink he was supposed to drink on 10/29/24. -He called another SIC to make sure everything was still on; she did not answer the call. -When the SIC returned his call, she told him Resident #2's colonoscopy appointment had been changed. -He thought "All that for nothing." Telephone interview on 10/30/24 at 2:45pm with a scheduler at the colonoscopy clinic revealed: -Resident #2 was scheduled for a colonoscopy on 10/29/24 at 3:30pm. -Resident #2 was a "no-show" on 10/29/24. -As of now, 10/30/24, Resident #2's colonoscopy had not been rescheduled. Interview with Resident #1 on 10/30/24 at 5:49pm revealed: -He did not have a colonoscopy on 10/29/24. -He was "cleaned out." -He had to drink some kind of lemon drink. -He did not know why he was having a colonoscopy.	C 246		

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C 246	Continued From page 45 Interview with another SIC on 10/30/24 at 6:10pm revealed: -She took Resident #2 to the appointment for a consultation for a colonoscopy. -The colonoscopy was scheduled for 10/29/24 at 7:00am and she asked if the appointment could be later in the day. -The scheduler rescheduled the colonoscopy for 11/15/24. -She told the SIC who was working in the facility, that the colonoscopy had been rescheduled. Telephone interview on 10/31/24 at 8:07am with a second scheduler at the colonoscopy clinic revealed: -Resident #2 was scheduled for a colonoscopy on 10/29/24. -Resident #2's colonoscopy had not been rescheduled. -The resident was responsible for rescheduling the appointment. Telephone interview with Resident #2's primary care provider (PCP) on 10/31/24 at 2:17pm revealed he ordered the colonoscopy for Resident #2 for a screening; the appointment needed to be rescheduled. Telephone interview with the Administrator on 10/31/24 at 5:26pm revealed: -She received a telephone call from a staff member at the colonoscopy clinic on 10/29/24 reminding her Resident #2 had an appointment. -She thought the SIC told her the appointment had been rescheduled for November 2024. -While on the telephone, she was given a new date and told to use the prep paperwork Resident #2 already had. -At first, she was told the resident would be charged for the missed appointment but then they	C 246		

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C 246	Continued From page 46 changed it and told her the new appointment date. Attempt telephone interview with Resident #2's court-appointed legal guardian on 10/31/24 at 2:02pm was unsuccessful.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify orders for 1 of 3 sampled residents (#1) related to an order for an insulin and an anti-anxiety medication. The findings are: Review of Resident #1's current FL-2 dated 10/24/24 revealed diagnoses included schizophrenia, obesity, diabetes, chronic kidney disease, asthma, and hyperlipidemia. a. Review of Resident #1's current FL-2 dated	C 315		

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C 315	Continued From page 47 10/24/24 revealed an order for Lantus glargine pen [used to control the amount of glucose (sugar) in the blood] 7 units daily. Review of Resident #'1's hospital discharge summary dated 09/27/24 revealed an order for Lantus glargine 7 units daily. Review of Resident #1's previous FL-2 dated 10/03/24 revealed an order for Lantus glargine 15 units once daily. Review of Resident #1's October 2024 MAR from 10/03/24-10/24/24 revealed: -There was an entry for Lantus glargine inject 7 units once a day scheduled at 8:00am. -There was documentation Lantus glargine 7 units were administered daily from 10/03/24-10/24/24. -There was no entry for Lantus glargine 15 units. -There was no documentation that Lantus 15 units had been administered. Observation of Resident #1's medications on hand on 10/30/24 at 9:28am revealed a Lantus glargine pen was available to be administered; 7 units in the am was written on the pen. Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 10:12am revealed: -He did not know Resident #1 had an order for Lantus 15 units to be administered daily. -He had not looked at any of Resident #1's FL-2s or after-visit summaries. -He administered Resident #1's medications based on the hospital discharge summary dated 09/27/24. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on	C 315		

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C 315	Continued From page 48 10/30/24 at 2:00pm revealed: -There was no order on file for Lantus 15 units for Resident #1. -There was no FL-2 on file for Resident #1. -If Resident #1's FL-2 dated 10/03/24 had been received at the pharmacy, Resident #1's Lantus 15 units would have been dispensed. -The pharmacy had not received any information on Resident #1 until 10/28/24. Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed: -He completed Resident #1's FL-2 on 10/24/24 based on the most recent order he had seen. -He did not see Resident #1's FL-2 dated 10/03/24. -He did not know a different provider had ordered Resident #1 to receive 15 units of Lantus instead of 7 units. -He expected Resident #1's medication to have been administered based on the FL-2 available at the time. Telephone interview with a nurse from Resident #2's previous PCP's office on 10/31/24 at 4:38pm revealed if the provider had signed an FL-2 with Lantus 15 units, the staff at the facility should have contacted the provider for clarification of the orders, especially if another provider was involved. b. Review of Resident #1's current FL-2 dated 10/24/24 revealed no order for Lorazepam (used to treat anxiety Review of Resident #'1's hospital discharge summary dated 09/27/24 revealed no order for Lorazepam.	C 315		

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Review of Resident #1's previous FL-2 dated 10/03/24 revealed an order for Lorazepam one tablet daily; there was no dosage documented.

Review of Resident #1's October 2024 MAR from 10/03/24-10/24/24 revealed:
-There was no entry for Lorazepam.
-There was no documentation that Lorazepam had been administered.

Observation of Resident #1's medications on hand on 10/30/24 at 9:28am revealed no Lorazepam was available to be administered.

Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 10:12am revealed:
-He had only administered the medications he had on hand for the resident.
-He had not looked at any of Resident #1's FL-2's or after-visit summaries.
-He administered Resident #1's medications based on the hospital discharge summary dated 09/27/24.

Telephone interview with facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed:
-He completed Resident #1's FL-2 on 10/24/24 based on the most recent order he had seen.
-He did not see Resident #1's FL-2 dated 10/03/24.
-He expected Resident #1's medication to have been administered based on the FL-2 available at the time.

Telephone interview with a nurse from Resident #2's previous PCP's office on 10/31/24 at 4:38pm revealed:
-There was no documentation that Resident #1 was ordered Lorazepam.

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-If the provider had signed an FL-2 with Lorazepam listed as an active medication, the staff at the facility should have contacted the provider for clarification of the orders, especially if another provider was involved.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed:
-There was no order on file for Lorazepam for Resident #1.
-There was no FL-2 on file for Resident #1.
-If Resident #1's FL-2 dated 10/03/24 had been received at the pharmacy, Resident #1's Lorazepam would have been dispensed.
-The pharmacy had not received any information on Resident #1 until 10/28/24.

Telephone interview with the Administrator on 10/31/24 at 12:56pm revealed:
-Resident #1's medications were administered based on the discharge orders from 09/27/24-10/24/24 until the resident was seen by the facility's PCP.
-The SIC completed the FL-2 dated 10/03/24 in error by using the discharge orders from a previous hospitalization, not the discharge orders from 09/27/24.
-Resident #1 saw his previous PCP because the appointment was already scheduled before his hospitalization.
-The resident's previous PCP must have signed the FL-2 without even looking at the medications.
-She had not seen Resident #1's FL-2 dated 10/03/24 because she had been unavailable and had just returned.
-She called the facility's contracted PCP on 10/18/24 and asked that he see a new resident.
-The facility's contracted PCP saw Resident #1 on 10/24/24 and he did not make any changes to

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C 315	Continued From page 51 the resident's medications, the medications were the same as the discharge summary dated 09/27/24. -The facility's contracted PCP told her he did not make changes to Resident #1's medications from the hospital discharge. -She told the SIC to administer Resident #1's medications based on the hospital discharge summary because the hospital sent enough medication for a one-month supply, and she would get new prescriptions once the facility's contracted PCP saw the resident. -The SIC should have matched the FL-2 with the discharge summary and the current medications the resident brought to the facility on 09/27/24. -The SIC should have clarified the orders.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3), high blood pressure medication, an oral medication used to treat	C 330		

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diabetes (#1), a steroid, a pain medication, eye drops, a stool softener (#2), insulin and eye drops (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 04/16/24 revealed a diagnoses of type II diabetes, dry eyes, mild retardation, hypertension, and dementia.

a. Review of Resident #3's current FL-2 dated 04/16/24 revealed an order for Lantus (used to improve and maintain blood glucose levels) 20 units (there was no information for frequency or time).

Review of Resident #3's primary care provider (PCP) after-visit summary dated 08/13/24 revealed an order to discontinue Lantus 20 units daily and start Lantus 25 units daily.

Review of Resident #3's signed physician's orders dated 09/10/24 revealed a handwritten note that the order changed to Lantus 25 units on 08/13/24.

Review of Resident #3's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lantus to inject 20 units at bedtime; hold for finger stick blood sugar (FSBS) less than 100.
-There was documentation that Lantus 20 units was administered at 8:00pm from 08/01/24-08/31/24.
-There was no entry for Lantus 25 units.
-There was no documentation Lantus 25 units was administered from 08/13/24-08/31/24.

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C 330	Continued From page 53 Review of Resident #3's finger stick blood sugar (FSBS) levels for August 2024 revealed FSBS ranged from 138-325 at 8:00am; there were 4 readings of 300 or greater. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for Lantus to inject 20 units at bedtime; hold for FSBS less than 100. -There was documentation Lantus 20 units was administered at 8:00pm from 09/01/24-09/09/24. -There was an entry for Lantus 25 units at bedtime; hold for FSBS less than 100 with a start date of 09/10/24. -There was documentation Lantus 25 units was administered from 09/10/24-09/30/24. Review of Resident #3's FSBS levels for September 2024 revealed FSBS ranged from 154-328 at 8:00am; there were 2 readings of 300 or greater. Review of Resident #3's FSBS levels for October 2024 from 10/01/24-10/30/24 revealed FSBS ranged from 130-309 at 8:00am; there was one reading of 300 or greater. Observation of Resident #3's medications on hand on 10/30/24 at 1:07pm revealed Resident #3 had a Lantus Solostar injection pen with adjustable units available to be administered; the pen was dispensed on 07/09/24 . Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Resident #3's current order was for Lantus 25 units daily. -The order was dated 08/13/24 but was not received at the pharmacy until 09/10/24 when the	C 330		

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order was faxed to the pharmacy from a facility staff member.
-She would have expected the order to be faxed the same day it was received.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed:
-Lantus was used to lower FSBS.
-If Resident #3's Lantus was not administered as ordered the resident could have elevated FSBS.

Interview with Resident #3 on 10/30/24 at 3:16pm revealed:
-He was administered insulin every night at bedtime.
-He did not know what his insulin order was or if there had been any changes.

Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 4:21pm revealed:
-He administered Resident #3's Lantus based on the eMAR.
-He did not know about the change with Resident #3's Lantus until the eMAR was updated and he was told about the dosage change.

Interview with the Administrator on 10/30/24 at7:01pm revealed:
-The PCP would normally send new prescriptions to the pharmacy.
-The day the PCP changed Resident #3's Lantus, she told the SIC to start administering the new dose.
-She knew Resident #3's Lantus was not changed on the eMAR, but the SIC administered the correct amount because she told him to increase the dosage.

Second interview with the same SIC on 10/30/24

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C 330	Continued From page 55 at 7:39pm revealed: -He thought he started administering Resident #3's Lantus 25 units earlier this month or at the end of last month. -If he documented he administered Lantus 20 units, then he administered 20 units. -If he had administered a different amount than was entered on the eMAR, he would have documented the different amounts in the computer. Telephone interview with Resident #3's PCP on 10/31/24 at 2:17pm revealed: -He increased Resident #3's Lantus because the resident's FSBS had been running high. -He did not know Resident #3's Lantus order was not changed immediately. -If Resident #3's Lantus was not administered as ordered the resident's FSBS could stay elevated. -Long-term elevated FSBS could lead to diabetic complications including problems with the kidneys and the eyes. -Resident #3's FSBS needed to be controlled to prevent complications. -He expected Resident #3's Lantus to be administered as ordered. b. Review of Resident #3's current FL-2 dated 04/16/24 revealed an order for Restasis (used to treat dry eyes) 0.05% eye drops, one drop in each eye twice daily. Review of Resident #3's August 2024 eMAR revealed: -There was an entry for Restasis 0.05% eye emulsion, instill one drop in both eyes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Restasis 0.05% was administered at 8:00am and 8:00pm from	C 330		

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C 330	Continued From page 56 08/01/24-08/31/24. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for Restasis 0.05% eye emulsion, instill one drop in both eyes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Restasis 0.05% was administered at 8:00am and 8:00pm from 09/01/24-09/30/24. Review of Resident #3's October 2024 eMAR from 10/01/24-10/30/24 revealed: -There was an entry for Restasis 0.05% eye emulsion, instill one drop in both eyes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Restasis 0.05% was administered at 8:00am and 8:00pm from 10/01/24-10/29/24 and at 8:00am on 10/30/24. Observation of Resident #3's medications on hand on 10/30/24 at 1:07pm revealed Restasis 0.05% eye drops were dispensed on 05/02/24 for a quantity of 60 individual dose tubes; there were 8 individual tubes remaining in the box. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Resident #3's current order was for Restasis 0.05% instill one drop in each eye twice a day. -A box of sixty individual single-use doses of Restasis was dispensed on 02/03/24, 03/05/24, and 05/02/24. -Based on the order for one drop twice a day in each eye, one box would last for 30 days. -Restasis was not cycle filled and would need to be requested for a refill.	C 330		

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C 330	Continued From page 57 Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Restasis was used to treat dry eyes. -If Restasis was not administered as ordered the resident could experience symptoms of dry eyes. Interview with Resident #3 on 10/30/24 at 3:16pm revealed: -He used to get eye drops but the staff stopped administering the eye drops; he did not recall the last time he had eye drops administered. -His eyes felt good when the eye drops were administered, but now his eyes felt "itchy" because he had not had the eye drops administered. Interview with a SIC on 10/30/24 at 6:36pm revealed: -She administered Resident #3's eye drops as ordered. -She did not know why there was still medication on hand from the dispensing dated 05/02/24. Telephone interview with Resident #3's PCP on 10/31/24 at 2:17pm revealed: -Resident #3 had dry eyes. -Restasis was ordered to help with the symptoms of dry eyes. -If Resident #3's Restasis was not administered as ordered he would have ongoing dry eyes. -He expected Resident #3's Restasis to be administered as ordered. Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed: -She expected Resident #3's eye drops to be administered as ordered. -She was concerned staff were not taking the	C 330		

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C 330	Continued From page 58 administration of eye drops seriously. 2. Review of Resident #1's current FL-2 dated 10/24/24 revealed diagnoses included schizophrenia, obesity, diabetes, chronic kidney disease, asthma, and hyperlipidemia. Review of Resident #1's Resident Register revealed an admission date of 09/23/24. a. Review of Resident #1's current FL-2 dated 10/24/24 revealed an order for Metformin (used to control elevated blood sugar levels) 500mg daily. Review of Resident #'1's hospital discharge summary dated 09/27/24 revealed an order for two Metformin 500mg (1,000mg) take twice a day with meals. Review of Resident #1's previous FL-2 dated 10/03/24 revealed an order for Metformin 1,000mg twice daily. Review of Resident #1's September 2024 handwritten medication administration record (MAR) from 09/27/24-09/30/24 revealed: -There was an entry for Metformin 500mg twice a day, once daily, with a scheduled administration time of 8:00am. -There was documentation Metformin was administered at 8:00am from 09/27/24-09/30/24. -There was a second entry Metformin 500mg twice a day, once daily, with a scheduled administration time of 2:00pm. -There was documentation Metformin was administered at 2:00pm from 09/27/24-09/30/24. Review of Resident #1's October 2024 MAR from 10/01/24-10/24/24 revealed:	C 330		

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-There was an entry for Metformin 500mg twice a day, once daily, with a scheduled administration time of 8:00am.
-There was documentation Metformin was administered at 8:00am from 10/01/24-10/24/24.
-There was a second entry Metformin 500mg twice a day, once daily, with a scheduled administration time of 2:00pm.
-There was documentation Metformin was administered from 10/01/24-10/20/24 at 2:00pm.

Review of Resident #1's finger stick blood sugar (FSBS) from 10/21/24-10/28/24 revealed the resident's FSBS ranged from 133-269.

Observation of Resident #1's medications on hand on 10/30/24 at 9:28am revealed:
-A prescription bottle labeled as Metformin 500mg was dispensed from the hospital pharmacy dated 09/27/24 with the directions to take 2 tablets (1,000mg) twice daily with a meal; 120 tablets were dispensed.
-There were 58 tablets remaining in the bottle.

Interview with the Supervisor-in-Charge (SIC) on 10/30/24 at 10:12am revealed:
-He entered Resident #1's medication on the MAR based on the prescription bottles that came to the facility with the resident.
-He had not looked at any of Resident #1's FL-2's or after-visit summaries.
-Resident #1 had not been added to the facility's electronic MAR system yet.

Observation of a medication pass on 10/30/24 at 10:29am revealed Resident #1 was administered one tablet of Metformin 500mg.

Second interview with the SIC on 10/30/24 at 10:29am revealed he administered one tablet of

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C 330	Continued From page 60 Metformin to Resident #1 twice daily. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Metformin was used to lower blood sugar. -If Metformin was not administered as ordered the resident could have elevated blood sugar. Telephone interview with the SIC on 10/31/24 at 2:10pm revealed: -Resident #1 was administered one tablet of Metformin in the morning and one tablet at lunch. -He had administered Resident #'s Metformin the same way since he was admitted to the facility. -He missed seeing the prescription bottle had the directions to administer 2 tablets of Metformin twice daily. Based on observations, record reviews, and interviews, Resident #1 should have been administered a total of 108 tablets of Metformin 500mg from 09/27/24-10/23/24 and 7 tablets from 10/24/24-10/30/24 which would have left a remainder of 5 tablets and there were 58 tablets remaining. Telephone interview with the facility's contracted primary care provider (PCP) on 10/31/24 at 2:17pm revealed: -He completed Resident #1's Metformin order on 10/24/24 based on the most recent order he had seen. -He thought the most recent order was for Metformin 500mg once daily. -He did not see Resident #1's FL-2 dated 10/03/24. -He expected Resident #1's medication to have been administered based on the FL-2 available at the time.	C 330		

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-Facility staff were not clinicians and should have followed the order for Metformin on the FL-2 dated 10/03/24 as that was an order.

Telephone interview with a nurse from Resident #2's previous PCP's office on 10/31/24 at 4:38pm revealed:
-Resident #1 had been a patient of the PCP for at least two years.
-Resident #1's A1C (a blood test that measured the average blood sugar level over the past three months) was 8.6 on 10/03/24.
-Resident #1's current Metformin order, dated 10/03/24, was 1000mg twice daily.
-The PCP would expect Resident #1's medications to be administered as ordered or to be clarified if there was another provider involved in the resident's care.

Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed:
-She did not know the SIC was only administering one tablet of Metformin when the order was for two tablets.
-She expected Resident #1's medications to be administered as ordered.

b. Review of Resident #1's current FL-2 dated 10/24/24 revealed an order for Losartan (used to treat high blood pressure (BP)) 50mg once daily.

Review of Resident #1's previous FL-2 dated 10/03/24 revealed an order for Losartan 50mg once daily.

Review of Resident #1's October 2024 MAR from 10/03/24-10/30/24 revealed:
-There was no entry for Losartan 50mg once daily.
-There was no documentation Losartan 50mg

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C 330	Continued From page 62 was administered. Observation of Resident #1's medications on hand on 10/30/24 at 9:28am revealed there was no Losartan 50mg available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -There was no order on file for Losartan 50mg for Resident #1. -There was no FL-2 on file for Resident #1. -If Resident #1's FL-2 dated 10/03/24 had been received at the pharmacy, Resident #1's Losartan would have been dispensed. -The pharmacy did not receive any information on Resident #1 until 10/28/24. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/31/24 at 2:53pm revealed: -She did not have an order for Resident #1's Losartan. -Losartan had not been dispensed for Resident #1. -Losartan was used to treat high BP. -Long term high BP could cause heart problems. Interview with the SIC on 10/30/24 at 10:12am revealed: -He did not know Resident #1 had an order for Losartan 50mg to be administered daily. -He had not looked at any of Resident #1's FL-2's or after-visit summaries. -The Administrator and another SIC were responsible for reviewing a resident's discharge papers. Telephone interview with facility's contracted PCP on 10/31/24 at 2:17pm revealed:	C 330		

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-He completed Resident #1's FL-2 on 10/24/24 based on the most recent order he had seen.
-He could not recall if he had ordered Losartan for Resident #1.
-He did not see Resident #1's FL-2 dated 10/03/24.
-He expected Resident #1's medication to have been administered based on the FL-2 available at the time.
-Facility staff were not clinicians and should have followed the order for Losartan on the FL-2 dated 10/03/24 as that was an order.

Telephone interview with a nurse from Resident #2's previous PCP's office on 10/31/24 at 4:38pm revealed:
-Resident #1 had been a patient of the PCP for at least two years.
-On 12/14/23, Resident #1's Losartan order was 100mg once daily.
-On 10/03/24, Resident #1's Losartan was decreased to 50mg once daily.
-If Resident #1's Losartan was not administered as ordered, the resident could have elevated BP.
-Long-term elevated BP could lead to a stroke.
-The PCP expected Resident #1's Losartan to be administered as ordered.

Telephone interview with the Administrator on 10/31/24 at 12:56pm revealed:
-Resident #1's medications were administered based on the discharge orders from 09/27/24-10/24/24 until the resident was seen by the facility's PCP.
-The SIC completed the FL-2 dated 10/03/24 in error by using the discharge orders from a previous hospitalization, not the discharge orders from 09/27/24.
-Resident #1 saw his previous PCP because the appointment was already scheduled before his

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hospitalization.
-The resident's previous PCP must have signed the FL-2 without even looking at the medications.
-She had not seen Resident #1's FL-2 dated 10/03/24 because she had been unavailable and had just returned.
-She called the facility's contracted PCP on 10/18/24 and asked that he see a new resident.
-The facility's contracted PCP saw Resident #1 on 10/24/24 and he did not make any changes to the resident's medications, the medications were the same as the discharge summary dated 09/27/24.
-The facility's contracted PCP told her he did not make changes to Resident #1's medications from the hospital discharge.
-She told the SIC to administer Resident #1's medications based on the hospital discharge summary because the hospital sent enough medication for a one-month supply, and she would get new prescriptions once the facility's contracted PCP saw the resident.
-The SIC should have matched the FL-2 with the discharge summary and the current medications the resident brought to the facility on 09/27/24.

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

3. Review of Resident #2's current FL-2 dated 07/01/24 revealed diagnoses of schizophrenia, hypertension, and diabetes.

a. Review of Resident #2's after-visit summary dated 09/28/24 revealed:
-Resident #2 was seen for a foot problem.
-Resident #2 broke his foot and had foot surgery in June 2024.
-Resident #2's complaints included foot pain, foot

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swelling, foot numbness, and foot cramps.
-The onset of these symptoms had been gradual but was constant.
-Resident #2 described the symptoms as severe and worsening.
-Resident #2 was ordered Prednisone (used to treat inflammation) 5mg dose pack, take as instructed in the pack.

Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for Prednisone 5mg.
-There was no documentation Prednisone was administered from 09/2824-09/30/24.

Review of Resident #2's October 2024 eMAR from 10/01/24-10/30/24 revealed:
-There was no entry for Prednisone 5mg.
-There was no documentation Prednisone was administered from 10/01/24-10/30/24

Observation of Resident #2's medications on hand on 10/30/24 at 12:21pm revealed there was no Prednisone available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed no order had been received for Prednisone for Resident #2 and no Prednisone had been dispensed.

Telephone interview with a receptionist on 10/30/24 at 2:50pm from the provider's office who had seen Resident #2 on 09/28/24 revealed Resident #2's Prednisone order was called into a [named] local pharmacy.

Telephone interview with a medical assistant on 10/30/24 at 2:50pm from the provider's office who

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had seen Resident #2 on 09/28/24 revealed:
-Resident #2 was seen in the office with complaints of foot pain.
-Resident #2 was ordered Prednisone for exacerbation of symptoms.
-She would speak to the provider for further information.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed:
-Prednisone was used short-term to treat pain and inflammation.
-If Prednisone was not administered as ordered, the resident could continue to experience pain and inflammation.

b. Review of Resident #2's after-visit summary dated 09/28/24 revealed:
-Resident #2 was seen for a foot problem.
-Resident #2 broke his foot and had foot surgery in June 2024.
-Resident #2's complaints included foot pain, foot swelling, foot numbness, and foot cramps.
-The onset of these symptoms had been gradual but was constant.
-Resident #2 described the symptoms as severe and worsening.
-Resident #2 was ordered Naproxen (used to treat pain) 500mg delayed release, one tablet twice daily.

Review of Resident #2's September 2024 eMAR revealed:
-There was no entry for Naproxen 500mg twice daily.
-There was no documentation Naproxen 500mg was administered from 09/2824-09/30/24.

Review of Resident #2's October 2024 eMAR

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from 10/01/24-10/30/24 revealed:
-There was no entry for Naproxen 500mg twice daily.
-There was no documentation Naproxen 500mg was administered from 10/01/24-10/30/24

Observation of Resident #2's medications on hand on 10/30/24 at 12:21pm revealed there was no Naproxen available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed no order had been received for Naproxen for Resident #2 and no Naproxen had been dispensed.

Telephone interview with a receptionist on 10/30/24 at 2:50pm from the provider's office who had seen Resident #2 on 09/28/24 revealed Resident #2's Naproxen order had been called into a [named] local pharmacy.

Telephone interview with a medical assistant on 10/30/24 at 2:50pm from the provider's office who had seen Resident #2 on 09/28/24 revealed:
-Resident #2 was seen in the office with complaints of foot pain.
-Resident #2 was ordered Naproxen for pain.
-She would speak to the provider for further information.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed:
-Naproxen was used to treat pain and inflammation.
-If Naproxen was not administered as ordered, the resident could continue to experience pain.

Interview with Resident #2 on 10/30/24 at 5:49pm

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revealed:
-He hurt his foot, he did not remember when or where he hurt his foot, but he had to have surgery on the foot.
-His foot was hurting today, 10/30/24.
-He did not know if he was administered medication for foot pain or swelling.

Interview with the SIC on 10/30/24 at 3:57pm revealed:
-Resident #2 complained of his left foot hurting if he stood up for a long time.
-Resident #2 had been limping.
-He did not recall Resident #2 having any new prescriptions after seeing the provider for complaints of foot pain.
-He only administered the medications listed on Resident #2's eMAR.
-If medication for Resident #2 had been delivered and was not listed on the eMAR, he would not have administered the medication without calling and checking on the medication.
-He did not recall checking on any medication for Resident #2.

Interview with another SIC on 10/30/24 at 6:10pm revealed:
-She took Resident #2 to the clinic on 09/28/24 because he was complaining of foot pain.
-She did not pick up any medications from the [named] pharmacy.
-The providers usually faxed prescriptions to the facility's contracted pharmacy.

Interview with the Administrator on 10/30/24 at 7:01pm revealed:
-She reviewed Resident #2's after-visit summary dated 09/28/24.
-She did not recall seeing the order for the medications for Resident #2.

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-She thought Resident #2 complained of pain for attention.
-She remembered the medications ordered for Resident #2 were sent to another pharmacy.
-She used her judgment and because she did not think Resident #2 was really in pain, she did not pick the medications up from the pharmacy.

Attempted telephone interview with the [named] pharmacy on 10/30/24 at 2:56pm was unsuccessful.

c. Review of Resident #2's current FL-2 dated 07/01/24 revealed an order for Olopatadine (used to treat itchy eyes) 0.1% eye drops, instill one drop in both eyes two times daily.

Review of Resident #2's August 2024 paper MAR from 08/01/24-08/13/24 revealed:
-There was an entry for Olopatadine 0.1% eye drops, instill one drop in both eyes two times a day for dry eyes with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Olopatadine eye drops were administered at 8:00am and 8:00pm from 08/01/24-08/13/24.

Review of Resident #2's August 2024 eMAR from 08/13/24-08/30/24 revealed:
-There was an entry for Olopatadine 0.1% eye drops, instill one drop in both eyes two times a day for dry eyes with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Olopatadine eye drops were administered at 8:00am and 8:00pm from 08/13/24-08/30/24.

Review of Resident #2's September eMAR revealed:
-There was an entry for Olopatadine 0.1% eye

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drops, instill one drop in both eyes two times a day for dry eyes with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Olopatadine eye drops were administered at 8:00am and 8:00pm from 09/01/24-09/30/24.

Review of Resident #2's October eMAR from 10/01/24-10/30/24 revealed:
-There was an entry for Olopatadine 0.1% eye drops, instill one drop in both eyes two times a day for dry eyes with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Olopatadine eye drops were administered at 8:00am and 8:00pm from 10/01/24-10/29/24 and at 8:00am on 10/30/24.

Observation of Resident #2's medication on hand on 10/30/24 at 12:21pm revealed:
-Resident #2's Olopatadine eye drops provided were dispensed on 03/19/24.
-The directions were to instill one drop in each eye twice daily.
-The bottle was empty.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed:
-Resident #2's Olopatadine eye drops had been dispensed on 03/19/24, 05/22/24, and 07/23/24; each dispensing was a 25-day supply based on the order for one drop in both eyes twice daily.
-The medication was used for allergies and dry eyes.
-Eye drops were not cycle filled and would need to be requested for refill.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at

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C 330	Continued From page 71 2:00pm revealed: -Olopatadine eye drops were used to treat allergies. -If Resident #2's eye drops were not administered as ordered the resident could experience itchy eyes. Second observation of Resident #2's medication on hand on 10/30/24 at 4:05pm revealed: -Resident #2's Olopatadine eye drops were dispensed on 07/23/24. -The directions were to instill one drop in each eye twice daily. -The seal on the bottle had been broken and the bottle was full. Interview with Resident #2 on 10/30/24 at 5:49pm revealed: -He had not been administered eye drops "lately"; it had been a "little while." -If he did not have his eye drops administered, his eyes would itch and be red. -He pointed toward his right eye and stated see right here, it was red. Observation of Resident #2's right eye on 10/30/24 at 5:49pm revealed the eye was red from the right of the cornea to the corner of the eye lid. Interview with the SIC on 10/30/24 at 3:57pm revealed: -Resident #2 was administered eye drops twice daily. -If Resident #2 refused eye drops, he would document a refusal. -Resident #2 had only refused 2-3 times and it was "months ago."; he had not refused since he had been readmitted after rehabilitation. -He could tell when Resident #2 needed his eye	C 330		

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C 330	Continued From page 72 drops because the resident's eye would turn red. Interview with another SIC on 10/30/24 at 6:10pm revealed: -Resident #2 was administered eye drops in the morning when she worked. -She did not know why Resident #2's Olopatadine bottle dispensed on 07/23/24 was still full. -She thought Resident #2 brought an opened bottle of eye drops with him when he returned from rehabilitation. Telephone interview with Resident #2's PCP on 10/31/24 at 2:17pm revealed: -Resident #2 was ordered Olopatadine eye drops for allergies and if the eye drops were not administered as ordered the resident could have issues with his eyes being red and irritated. -He expected Resident #2's Olopatadine to be administered as ordered. Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed: -Resident #2 did not bring any eye drops to the facility from rehabilitation. -Resident #2 had extra bottles of eye drops at the facility because the medication had been delivered while the resident was in rehabilitation. -She was concerned staff were not taking the administration of eye drops seriously. d. Review of Resident #2's current FL-2 dated 07/01/24 revealed an order for Miralax (used to prevent and treat constipation) once daily. Review of Resident #2's August 2024 paper MAR from 08/01/24-08/13/24 revealed: -There was an entry for Miralax mix 17 grams in 8 ounces of water and drink at bedtime with a scheduled administration time of 8:00pm.	C 330		

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C 330	Continued From page 73 -There was documentation Miralax was administered at 8:00pm from 08/01/24-08/13/24. Review of Resident #2's August 2024 eMAR from 08/13/24-08/30/24 revealed: -There was an entry for Miralax mix 17 grams in 8 ounces of water and drink at bedtime with a scheduled administration time of 8:00pm. -There was documentation Miralax was administered at 8:00pm from 08/13/24-08/30/24. Review of Resident #2's September eMAR revealed: -There was an entry for Miralax mix 17 grams in 8 ounces of water and drink at bedtime with a scheduled administration time of 8:00pm. -There was documentation Miralax was administered at 8:00pm from 09/01/24-09/30/24. Review of Resident #2's October eMAR from 10/01/24-10/30/24 revealed: -There was an entry for Miralax mix 17 grams in 8 ounces of water and drink at bedtime with a scheduled administration time of 8:00pm. -There was documentation Miralax was administered at 8:00pm from 10/01/24-10/29/24. Observation of Resident #2's medication on hand on 10/30/24 at 12:21pm revealed: -There was a bottle of Miralax dispensed on 07/23/24. -The directions were to mix 17 grams in 8 ounces of water and drink at bedtime for constipation. -The bottle was three-fourths full. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Resident #2's Miralax had been dispensed one time, on 07/23/24.	C 330		

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C 330	Continued From page 74 -The bottle was for a 30-day supply based on the current order to mix 17 grams in 8 ounces of water and drink at bedtime for constipation. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/30/24 at 2:00pm revealed: -Miralax was used to treat and prevent constipation. -If Resident #2's Miralax was not administered as ordered the resident could experience constipation. Interview with Resident #2 on 10/30/24 at 5:49pm revealed: -He did not take Miralax daily. -He had taken Miralax about 3 days ago for a colonoscopy, but that was the only time he had taken the medication. -He did not have a bowel movement (BM) every day, sometimes he would have a BM every couple of days. -When he did not have a BM every day, he had more difficulty having a BM. Interview with the SIC on 10/30/24 at 3:57pm revealed: -Resident #2 was not administered Miralax daily. -He had administered Miralax to Resident #2 recently in preparation for a colonoscopy. -He did not recall ever administering Miralax to Resident #2 at any other time. -He "guessed he missed" that it was supposed to be administered daily. -He administered medications by comparing the medications on hand to the MAR and he would click on submit all after the medication was administered. -Resident #2's Miralax was documented as administered daily in error.	C 330		

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C 330	Continued From page 75 Interview with another SIC on 10/30/24 at 6:10pm revealed: -Resident #2 was not administered Miralax every day. -Resident #2 knew when he was constipated and would ask for the medication. -Resident #2 had asked for Miralax about 3-4 months ago because he was constipated. Telephone interview with Resident #2's PCP on 10/31/24 at 2:17pm revealed: -Resident #2 was ordered Miralax to prevent constipation. -If Resident #2's Miralax was not administered as ordered, the resident could become constipated. -Resident #2 had a history of constipation. -He expected Resident #2's Miralax to be administered as ordered. Telephone interview with the Administrator on 10/31/24 at 4:54pm revealed: -She thought Resident #2's Miralax was to be administered as needed. -She was concerned staff were not taking the administration of Resident #2's Miralax seriously. _____ The facility failed to administer medications as ordered for 3 of 3 sampled residents including a resident whose Lantus insulin dosage was increased because of high FSBS, and the medication was not increased as ordered for 28 days which put the resident at risk for ongoing elevated blood sugars, which increased the risk of diabetic complications including problems with the kidneys and the eyes (#3); and a residents blood pressure medication was not implemented placing the resident at risk for high blood pressure increasing the risk of a stroke, and an order for 1000mg of Metformin twice daily and 500mg was administered twice daily from	C 330		

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C 330	Continued From page 76 09/27/24-10/24/24 (#1); and a resident who was experiencing pain in his foot and was ordered two medications for inflammation and pain and the medications were not administered and the resident was experiencing ongoing pain, an eye drop used to treat allergies was not administered as ordered resulting in the resident's right eye was red and itching, and an order for a medication used to treat and prevent constipation was not administered resulting in the resident experienced difficulty with constipation. This failure resulted in substantial risk of physical harm and neglect of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2024.	C 330		