STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL019022	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation on September 19-21, 2024.	D 000		
D 222	10A NCAC 13F .0701 (a & b) Admission of Residents 10A NCAC 13F .0701 Admission of Residents (a) Any adult (18 years of age or over) who, because of a temporary or chronic physical condition or mental disability, needs a substitute home may be admitted to an adult care home when, in the opinion of the resident, physician, family or social worker, and the administrator the services and accommodations of the home will meet his particular needs. (b) People shall not be admitted: (1) for treatment of mental illness, or alcohol or drug abuse; (2) for maternity care; (3) for professional nursing care under continuous medical supervision; (4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or (5) who pose a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility allowed 7 people to reside within the facility who	D 222		

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did not need assisted living services, but were moved from an independent living facility that closed.

The findings are:

Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 86 residents.

Review of the census provided on 11/19/24 at 8:30am revealed:
-There were resident rooms labeled as the 200-hall, 300-hall, and 400-hall.
-There were 19 named residents listed.

Observation of the facility on 11/19/24 at 8:30am revealed there were 3 hallways with residents residing in the assisted living facility: the 200-hall, 300-hall, and 400-hall.

Observation of the 500-hall on 11/20/24 at 10:41am revealed:
-There was a locked door with a keypad between the 200-hall resident rooms and the 500-hall.
-A staff member was sitting at a desk in the 500-hall.
-There was a sitting area, tables with chairs, and a kitchenette.

Review of an electronic mail (email) from a representative with the local health department dated 05/30/24 revealed:
-The email was sent to a [named] representative with the local county Department of Social Services (DSS).
-The email was labeled as for your information (FYI), the residents from a [named] independent living facility had moved to the assisted living facility on the 500-hall, about two weeks ago.

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Telephone interview with one of the residents who resided on the 500-hall on 11/20/24 at 9:00am revealed:
-She resided on the 500-hall of the [named] assisted living facility.
-She moved into the assisted living facility in April 2024 from an independent living facility.
-The 500-hall had resident rooms and a dining room.
-She was not allowed to go into the assisted living area of the facility.
-There was not a staff member in the 500-hall area 24 hours a day.
-She did not need assistance with anything.
-The staff provided meals every day.
-There were 7 residents who resided on the 500-hall of the facility.

Telephone interview with one of the independent living residents' family members on 11/20/24 at 9:11am revealed:
-Her family member had moved into the assisted living facility when the independent living facility closed; she was not sure of the date.
-Her family member was considered an independent living resident.
-There was a separate entrance into the area where the independent living residents lived.
-The entrance to the independent living part of the facility was past the front entrance of the assisted living area and to the side of the facility.
-There was usually one person on duty in the independent living area 24 hours a day.
-The residents in the independent living were provided meals and were checked on "off and on."
-She thought 8 residents moved from the independent living facility into the assisted living facility's independent living area.

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D 222	Continued From page 3 Telephone interview with a representative from the local county DSS on 11/21/24 at 1:06pm revealed: -She was not aware the independent living residents had moved into the assisted living facility. -She knew the residents were walking from the independent living facility to the assisted living facility for meals, but she did not know the residents had moved into the facility. -A representative from the local health department and an ombudsman had voiced concerns about the residents going to the AL facility for meals. -She was at the facility in September 2024 and did not see the residents from the independent living facility at the assisted living facility. Telephone interview with a representative from the local health department on 11//21/24 at 3:56pm revealed: -Sometime in the summer of 2024, he went to the assisted living facility for an inspection. -He noted the residents from the independent living facility had moved into the assisted living facility on the 500-hall. -He changed the permit at the facility from an assisted living institutional food permit to a restaurant permit because of the independent living residents. -He notified a [named] representative with the local county DSS about the closing of the independent living and those residents had moved into the assisted living facility. Interview with the Administrator on 11/20/24 at 10:41am revealed: -The 500-hall was part of the facility's licensed assisted living beds.	D 222		

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D 222	Continued From page 4 -There were 10 private resident rooms on the 500-hall -The owner of the facility sold the independent living "building" and the residents of that facility moved into an unused wing of the assisted living facility; the 500-hall. -The residents who moved into the 500-hall were considered independent. -She reached out to a [named] staff member by email with Adult Care Licensure on 05/08/24 about the residents moving to the facility to see what she needed to do if anything, but did not hear back from the [named] person. -She did not know if the Chief Financial Officer (CFO) had done anything with the facility's licensed beds or not. -She was responsible for the independent living residents. -All the staff from the independent living facility transferred to the 500-hall to work with the independent residents. -She thought the residents moved from the independent living building to the assisted living facility in August 2024. Attempted telephone interview with the CFO on 11/21/24 at 1:48pm and 4:03pm was unsuccessful. _____ The facility failed to ensure the facility was in compliance with its current license for assisted living residents by allowing independent living residents to reside in the licensed assisted living beds. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/21/24 for this violation.	D 222		

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D 222	Continued From page 5 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 5, 2025.	D 222		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow-up to meet the health care needs of 1 of 3 sampled residents (#1) related to notifying the Primary Care Provider (PCP) of fingerstick blood sugars (FSBS) readings greater than 400. The findings are: Review of Resident #1's current FL-2 dated 10/10/24 revealed: -Diagnosis included diabetes mellitus type 2. -There was an order to check Resident #1's FSBS every morning and night and contact the PCP if the FSBS reading was greater than 400. Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks twice daily in the morning and at night; contact the PCP if the FSBS reading was greater than 400. -There was a FSBS readings of 501 on 09/01/24 at 8:00pm. -There was a FSBS readings of 469 on 09/02/24 at 8:00pm.	D 273		

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-There was a FSBS readings of 463 on 09/04/24 at 8:00pm.
-There was a FSBS readings of 433 on 09/08/24 at 8:00pm.
-There was a FSBS readings of 402 on 09/09/24 at 8:00pm.
-There was a FSBS readings of 454 on 09/10/24 at 8:00pm.
-There was a FSBS readings of 414 on 09/13/24 at 8:00pm.
-There was a FSBS readings of 476 on 09/17/24 at 8:00pm.
-There was a FSBS readings of 456 on 09/22/24 at 8:00pm.
-There was a FSBS readings of 438 on 09/23/24 at 8:00pm.
-There was a FSBS readings of 465 on 09/27/24 at 8:00pm.

Review of Resident #1's September 2024 progress notes revealed there was no documentation Resident #1's PCP was notified of the FSBS readings greater than 400.

Interview with Resident #1 on 11/20/24 at 9:30am revealed:
-She knew her FSBS readings were elevated.
-She did not eat like she should.
-She loved sweets, and she ate what she wanted.

Telephone interview with Resident #1's family member on 11/19/24 at 4:33pm revealed:
-Resident #1 loved to eat sweets.
-She brought Resident #1 sweets each time she visited.
-She was an elderly woman and if she wanted to eat sweets, she was fine with it.
-Resident #1's FSBS readings were always up and down, even before being admitted to the facility.

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D 273	Continued From page 7 Interview with the PCP on 11/20/24 at 1:23pm revealed: -He did not recall if he was notified of Resident #1's FSBS readings greater than 400 in September 2024. -He was notified many times of Resident #1 FSBS readings greater than 400. -He recently changed the order to notify the PCP if FSBS was greater than 500. Interview with a medication aide (MA) on 11/20/24 at 3:43 pm revealed: -Resident #1 had an order to notify the PCP when the FSBS reading was greater than 500. -He notified the RCC when the FSBS was greater than 500 and the Resident Care Coordinator (RCC) would notify the PCP. -He did not realize the order to notify the PCP was for FSBS readings greater than 400. -He did not document when he notified the PCP or the RCC when the FSBS readings were greater than 400 or 500. Interview with a second MA on 11/20/24 at 4:17pm revealed: -She notified the RCC when Resident #1's FSBS readings were greater than 400. -She thought she documented the communication with the RCC in the electronic progress notes. -She did not know she failed to document notification to the RCC of elevated FSBS readings greater than 400. -She would leave a note for the RCC when Resident #1's FSBS readings were greater than 400. Interview with the RCC on 11/20/24 at 3:45pm revealed:	D 273		

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D 273	Continued From page 8 -The MAs should notify the RCC of FSBS readings greater than 400. -She notified the PCP of FSBS readings greater than 400. -The MAs should document in the electronic progress notes anytime there was a FSBS greater than 400 and when the RCC was notified. Interview with the Administrator on 11/21/24 at 8:15am revealed: -The MA should notify the PCP when Resident #1's FSBS readings were greater than 400 as ordered. -She expected the MA to notify the PCP when Resident #1's FSBS reading was greater than 400 and to document the notification. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to a refrigerator with spills and foods not properly covered to prevent contamination.

The findings are:

Review of the local health department food establishment inspection report for the kitchen dated 07/15/24 revealed:
-The facility received a score of 98.
-The kitchen received a point deduction for storage of food in a clean, dry location, not exposed to contamination, food not kept at least six inches above the floor.
-Salt was observed stored three inches above the floor.
-The kitchen received a half point deduction relating to staff wearing a watch on arm while preparing food.
-The kitchen received a half point deduction for the floor needing to be cleaned of grime and debris.

Observation of the refrigerator in the kitchen on 11/18/24 at 8:57am revealed:
-There was a pan of spaghetti that was not completely covered with aluminum foil.
-There were three heads of cabbages uncovered in a bowl.
-There was a dried-up red substance in the

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bottom of the refrigerator.
-There was a thick sticky buildup of grease, dried food splatters, and food debris on the grates of the stove.
-There was a buildup of food particles, debris and dried food spills in various areas on the floor of the kitchen.
-A cleaning schedule was not observed in the kitchen.

Interview with a Dietary Aide (DA) on 11/21/24 at 8:29am revealed:
-The DA was responsible for cleaning the kitchen daily and assisted with preparing and serving meals.
-The Dietary Manager (DM) was responsible for cleaning the kitchen and the refrigerator.
-The DA was not aware there was a cleaning schedule in the kitchen.
-The DA could not find the kitchen cleaning schedule.

Telephone interview with the DM on 11/21/24 at 12:44pm revealed:
-There was a cleaning schedule posted in the kitchen.
-The DM and DA were responsible for cleaning the kitchen and refrigerator.
-The spill in the refrigerator occurred on 11/16/24 but DM had not cleaned the refrigerator.
-The kitchen was to be cleaned daily.
-The refrigerator was scheduled to be cleaned weekly, and spills were cleaned immediately.
-The DM was not aware the cabbage should have been covered in the refrigerator because the cabbage was in a bowl.
-The DM was not aware the spaghetti was not covered completely in the refrigerator.

Interview with the Administrator on 11/21/24 at

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D 283	Continued From page 11 8:29am revealed: -The DM and DA were responsible for overseeing the kitchen environment. -She was not aware of food not covered in the refrigerator or the kitchen not being cleaned. -She expected kitchen staff to follow the cleaning schedule in the kitchen. -She expected staff to ensure food was properly stored in the refrigerator.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime table service included a place setting consisting of a napkin, non-disposable knife, fork, spoon and cup. The findings are: Observation of the dining room on 11/18/24 at 8:42am revealed: -The place setting included a napkin and a fork;	D 286		

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D 286	Continued From page 12	D 286		

there was no spoon or knife provided.
-The residents were served scrambled eggs, oatmeal, bacon, and a biscuit.
-A resident was observed eating oatmeal with her fingers.

Interview with three residents on 11/18/24 at 8:44am revealed:
-They were given a knife and spoon on occasion at mealtimes.
-They would prefer to use a spoon and knife when eating their meals.
-It was difficult to eat some foods with a fork.

Interview with the Dietary Aide (DA) on 11/18/2024 at 9:02am revealed:
-She was responsible for the place setting.
-Spoons were given to residents when they ate cereal.
-The residents did not receive knives because there was no food that needed to be cut.
-If something needed to be cut up, the staff would cut it up for the residents.

Interview with the Dietary Manager (DM) on 11/18/24 at 9:20am revealed:
-The Dietary Aide (DA) was responsible for adding place settings a mealtimes.
-The residents should have been provided a spoon and knife.
-He did not realize the residents were not provided a spoon and knife with meal.

Interview with the Administrator on 11/18/24 at 2:21pm revealed:
-There should have been forks and knives for each resident to have at all meals.
-She expect the kitchen staff to provide a full place setting for the residents.

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D 296	Continued From page 13	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure there was a matching therapeutic diet menu for 1 of 1 resident (#4) who had physician ordered pureed diet. The findings are: Review of Resident #4's current FL2 dated 02/07/24 revealed: -Diagnoses included intellectual disability, alzheimer's disease, and anxiety disorder. -There diet was listed as regular. Review of Resident #4's diet order sheet dated 11/06/24 revealed an order for a pureed diet. Review of the facility's therapeutic diet list dated 11/06/24 posted on the wall in the kitchen on 11/18/24 revealed Resident #4 was to be served a pureed diet. Observation of the kitchen on 11/18/24 at 8:48am revealed:	D 296		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-There were no therapeutic diet menus being referenced for meal preparation.
-A list of a resident's therapeutic diet was posted for staff reference.
-The therapeutic diet on the diet list was a pureed diet.

Observation of the lunch meal service on 11/18/24 from 11:45am to 12:30pm revealed Resident #4 was served mechanical soft broccoli, mechanical soft pasta, mechanical soft meatballs, chocolate pudding, tea, and boost.

Observation of the dinner meal service on 11/18/24 from 5:00pm to 5:10pm revealed Resident #4 was served mechanical soft spaghetti, chopped salad, vanilla pudding, water, and boost.

Interview with a Dietary Aide (DA) on 11/18/24 at 12:39pm revealed:
-She worked as a DA some days and some days she cooked.
-When she cooked, she would refer to the resident therapeutic diet list posted above the serving area.
-She would chop some of the food and put some of the food in the blender.
-She served the resident a mechanical soft diet rather than a pureed diet because she could not locate the blender.

Interview with a Dietary Manager (DM) on 11/18/24 at 12:45pm revealed:
-The DM knew which resident received a pureed diet.
-The DM prepared the food for the pureed diet by placing the food in the blender with water and bread and blended the food until it was soft.
-The resident was served a mechanical soft diet

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D 296	Continued From page 15 because the diet was just changed to pureed on 11/07/24. -The DM could not locate the therapeutic diet menus. -The DM was going to ask the Administrator for the therapeutic diet menu to post in the kitchen. Interview with the Administrator on 11/20/24 at 2:21pm revealed: -The DM was responsible for ensuring the resident was served the correct therapeutic diet. -The DM was provided the therapeutic diet menu and should have followed the menu. -There should have been a therapeutic diet menu in the kitchen for the DM to follow. -The therapeutic menus were needed so the residents with therapeutic diet orders could receive the correct diet. -She expected the kitchen staff to follow the therapeutic diet as ordered by the doctor. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 296		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure snacks were offered to all residents between meals.

The findings are:

Review of the facility's current weekly menu Fall/Winter week 3 revealed no snacks were listed on the menu.

Interview with a resident on 11/19/24 at 9:00am revealed:
-He was not given a snack every day.
-For a while the facility staff gave snacks "pretty often," but it had been a while back.
-"Maybe" two weeks ago he had been offered a snack.

Interviews with three residents during the initial tour on 11/18/24 from 8:35am to 9:30am revealed 3 of 3 residents reported not receiving snacks during the day.

Interview with a fifth resident on 11/19/24 at 9:32am revealed:
-Snacks were passed when snacks were available.
-Sometimes there were no snacks in the facility, but if there were snacks in the facility, they would get snacks at least twice daily.
-The staff gave them water to drink when they passed snacks.

Interview with a sixth resident on 11/18/24 at 9:57am revealed:

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-She received snacks from family when the family visited the facility.
-She would eat snacks from the facility if snacks were offered.

Observations on 11/19/24 at 10:00am and at 2:00pm revealed no snacks were served to the residents.

Interview with a personal care aide (PCA) on 11/19/24 at 10:05am revealed:
-Snacks were given out to residents daily at 10:00am, 2:00pm, and 6:00pm.
-If a resident asked for a snack, staff would give them one.

Interview with the Dietary Manager (DM) on 11/19/24 at 10:09am revealed:
-Snacks were to be distributed at 10:00am, 2:00pm and 6:00pm.
-The snack cart was prepared by the kitchen staff and the PCA's were to take the snacks out to the residents.

Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 1:51pm revealed:
-Residents were to receive snacks three times a day at 10:00am, 2:00pm and 6:00pm.
-The kitchen staff or PCA passed out snacks to the residents.
-She saw snacks being offered at times.

Interview with the Administrator on 11/20/24 at 2:21pm revealed:
-The care staff were responsible for passing out snacks.
-The kitchen staff prepared the snacks on the cart and the care staff were to go and get the cart.
-No one had asked her about not receiving

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D 298	Continued From page 18 snacks.	D 298		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure water was served at each meal, in addition to other beverages. The findings are: Observation of the breakfast meal service on 11/18/24 between 8:37am and 9:10am revealed: -There were 18 residents present for the breakfast meal service. -The beverages had been placed on the dining tables prior to the residents being seated. -Two glasses of water had been placed on the dining tables for 2 residents, and all the other glasses contained other beverages. -Sixteen residents were not served water. Interview with the Dietary Aide (DA) on 11/18/24 at 9:02am revealed: -Beverages were placed on the tables prior to the residents arriving in the dining room.	D 306		

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-She knew what each resident liked to drink and placed the drinks on the tables according to the residents' preferences.
-The residents drank the same beverages every day.
-There were only 2 residents who drank water.

Observation of the lunch meal service on 11/18/24 between 11:50am and 12:30pm revealed:
-Beverages had been placed on the dining tables for 18 residents.
-Beverages included tea and milk.
-One resident was served water.
-Seventeen residents were not served water.

Observation of the kitchen on 11/18/24 at 12:32pm revealed there were 32 clean cups stored in the kitchen.

Interview with a resident on 11/18/24 at 2:08pm:
-Beverages served with meals usually included milk and tea.
-If she wanted water with her meals, she had to ask for it.
-She would drink water with every meal if it was served to her with each meal.

Interview with a second resident on 11/18/24 at 2:12pm revealed:
-Resident were not served water with each meal.
-She would drink water with her meals if it was served to her.
-She drank what was served to her and did not ask for water.

Interview with a personal care aide (PCA) on 11/20/24 at 8:33am revealed:
-She assisted in the dining room during meals.
-Beverages were already on the tables in the

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D 306	Continued From page 20 dining room when residents arrived for meals. -Water was not placed on the table or offered to all residents. -A few residents were served water, but the other residents preferred coffee, milk, or juice. -She did not know water should have been served to all residents with each meal. Interview with the Dietary Manager (DM) on 11/20/24 at 8:45am revealed: -The DM was not aware water should have been served to all residents with each meal. -Water was only served to 3 residents who drank water with meals. Interview with the Administrator on 11/20/24 at 2:21pm revealed: -She was not aware residents were to be served water daily with each meal. -Residents received water with snacks.	D 306		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an activities program that	D 315		

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D 315	Continued From page 21 promoted the active involvement of the residents. The findings are: Observation during the initial tour of the facility on 11/19/24 between 8:30am-9:30am revealed: -The activity calendar was posted in the hallway and labeled November 2024. -The activities listed for 11/19/24 were painting birdhouses at 10:00am, cloud dough at 2:00pm, and an outing at 3:30pm. -The activities listed for 11/20/24 were music makers at 10:00am, bingo at 2:00pm and an outing at 3:30pm. The activities listed for 11/21/24 were Thanksgiving craft at 10:00am, kickball at 2:00pm and an outing at 3:30pm. Observations of the facility at various times on 11/19/24 between 8:30am and 4:30pm revealed: -No activities were offered to residents. -Residents sat in the front lobby, in a TV room, walked the hallways, or sat in their rooms. Interview with a resident on 11/19/24 at 8:55am revealed: -There were no activities to attend. -They did not go out of the facility for activities. -She would like to attend activities because she got bored. Interview with a second resident on 11/19/24 at 9:00am revealed: -The facility staff did not offer "much of anything" for the residents to do. -The facility staff "used" to have activities but "not now." Interview with a third resident on 11/18/2024 from 9:00am revealed:	D 315		

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-There used to be activities but the facility stopped doing them a while ago.
-No one ever asked her to participate in any activities.
-She would participate in activities if they were offered.
-She did not know who was in charge of the activities.
-She wanted to participate in activities for fun but there were no activities.

Interview with a fourth resident on 11/18/2024 at 9:30am revealed he stayed in his bedroom because there was nothing else to do in the facility.

Interview with a fifth resident on 11/19/24 at 9:32am revealed:
-They played bingo about once a week.
-There were no other activities for the residents to do.
-They did not go out of the building on outings.
-He would like to have activities to stay busy.
-He would enjoy going out of the facility for events.

Telephone interview with a resident's family member on 11/19/24 at 4:33pm revealed:
-She did not see any activities happening when she was in the facility.
-Her family member went on one outing the last week of October and had a good time.
-The facility did not take the residents on outings very much.

Interview with a personal care aide (PCA) on 11/20/24 at 10:13am revealed:
-There was an Activity Director (AD) who was responsible for activities for the residents.
-She did activities on the weekends when time

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D 315	Continued From page 23 allowed. -She would gather the residents and do crafts on the weekends. -The residents were not taken out of the facility for outings. -She thought the residents would enjoy going on outings. Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 2:48pm revealed: -Activities were sporadically done at the facility. -She was the one who usually did activities with the residents. -She had not been able to do activities because she was busy with the survey process. Interview with the Administrator on 11/20/24 at 3:16pm revealed: -The facility had a full-time AD, but their last day was 11/04/24. -An AD from a sister facility came to the facility "roughly" two days a week. -The same AD also sent packets of things for the residents to do. -It was hard to do two activities a day when the facility did not have the staff available to do so. -The AD from the sister facility was at the facility last week. -Other [named] staff members assisted with activities when the staff members were available. Attempted telephone interview with the AD from the sister facility on 11/11/21/24 at 8:50am was unsuccessful.	D 315		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to maintain privacy for two residents related to a resident wandering into rooms and taking belongings which resulted in mental anguish for the residents (#8 and #9).

The findings are:

1. Review of Resident #8's current FL2 dated 08/08/24 revealed:
-Diagnoses included atherosclerotic heart disease, hypertensive heart, major depressive disorder, mild dementia, and abnormalities of gait.
-The resident was oriented.

Review of Resident #8's care plan dated 08/08/24 revealed the resident was independent with eating, toileting, ambulation, transferring, dressing, and grooming.

Interview with Resident #8 on 11/19/24 at 9:32am revealed:
-A resident walked up and down the halls all the time.
-The resident would stop at his door and look at him.
-The resident would try to come into his room sometimes.
-He would have to call staff to remove the resident from his room.
-He had mentioned his concern to the facility staff about the resident coming into his room, but nothing had been done.

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D 338	Continued From page 25 Interview with Resident #8 on 11/21/24 at 9:05am revealed: -He had trouble with a resident last night when a resident tried to come into his room. -He was "just telling" a visitor about the resident coming into his room. -He told the resident she could not come into his room. -He demonstrated how he spoke to the resident; his tone was frustrated. -Another resident had come into his room and took his belongings. -He was in the bathroom and when he came out the resident was leaving his room with numerous items. -He accused the resident of stealing his things and she hollered back at him that she was not stealing. -He liked to keep his door open, so he did not feel like he was closed in a box. -The staff at the facility were aware of the residents going into his room and that he did not like it. -He was tired of residents coming into his room uninvited. Interview with a housekeeper on 11/21/24 at 8:20am revealed Resident #8 complained about other residents going into his room. Telephone interview with a personal care aide (PCA) on 11/21/24 at 8:58am revealed: -Last night, 11/20/24, she could hear an argument between two residents down the hall from where she was assisting another resident. -A [named] resident was walking by Resident #8's room and it had frustrated the resident. -She had to redirect the two residents.	D 338		

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Interview with a second PCA on 11/21/24 at 9:12am revealed she had heard Resident #8 and a [named] resident going back and forth about the resident trying to go into the resident's room; the confrontation could be heard down the hall.

Interview with a medication aide (MA) on 11/21/24 at 9:51am revealed Resident #8 had voiced concerns about residents going into his room.

Interview with the Resident Care Coordinator (RCC) on 11/21/34 at 10:06am and 10:37am revealed she had heard Resident #8 holler at a resident to "move on" when in front of his door.

Interview with the Administrator on 11/21/24 at 10:16am revealed she had heard Resident #8 say a resident came into his room, but he did not say anything else about it.

Attempted telephone interview with Resident #8's family member on 11/21/24 at 9:36am was unsuccessful.

Refer to the interview with a housekeeper on 11/21/24 at 8:20am.

Refer to the telephone interview with a PCA on 11/21/24 at 8:58am.

Refer to the interview with a second PCA on 11/21/24 at 9:12am.

Refer to the interview with a MA on 11/21/24 at 9:51am.

Refer to the interview with the Administrator on 11/21/24 at 10:16am.

2. Review of Resident #9's current FL-2 dated

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05/17/24 revealed:
-Diagnoses included chronic atrial fibrillation, adjustment disorder with mixed anxiety and depressed mood, and mild cognitive impairment
-She was intermittently disoriented.

Review of Resident #9's care plan dated 05/17/24 revealed the resident was independent with eating, toileting, ambulation, transferring, dressing, and grooming.

Interview with Resident #9 on 11/21/24 at 9:23am revealed:
-A resident opened her door, and she had to send the resident back to their room.
-She had come into her room multiple times and found residents in her room.
-She told the staff she did not like the residents in her room.
-The staff knew "it was not right for other residents to meddle in her room."
-One of the residents who came into her room was "hateful."
-When she was in her room, she could "block" the residents from going into her room.
-She had a key to lock her door, but she had lost the key.

Telephone interview with Resident #9's family member on 11/21/24 at 9:37am revealed:
-Resident #8 had complained about other residents going into her room.
-One resident had picked things up in Resident #8's room.
-It aggravated Resident #8 for the other residents to go into her room.

Interview with a housekeeper on 11/21/24 at 8:20am revealed:
-Resident #9 complained about other residents

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going into her room.
-Resident #9 got really irritated when other residents went into her room.

Telephone interview with a personal care aide (PCA) on 11/21/24 at 8:58am revealed Resident #9 got upset because residents wandered into her room.

Interview with a second PCA on 11/21/24 at 9:12am revealed she has heard Resident #9 and a [named] resident going back and forth about the resident trying to go into the resident's room; the confrontation could be heard down the hall.

Interview with a medication aide (MA) on 11/21/24 at 9:51am revealed:
-Resident #9 had voiced concerns about residents going into her room.
-Resident #9 got frustrated when other residents went into her room.

Interview with the Resident Care Coordinator (RCC) on 11/21/34 at 10:06am revealed:
-Resident #9 complained about residents going into her room.
-Staff should redirect the residents if the resident was seen going toward Resident #9's room.
-She had heard Resident #9 holler at another resident who was at her door.
-Resident #9 was given a key to her room so the resident would feel a sense of security.

Interview with the Administrator on 11/21/24 at 10:16am revealed Resident #9 had complained about other residents going into her room, so the resident's door was changed, and she was given a key to her room.

Refer to the interview with a housekeeper on

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D 338	Continued From page 29 11/21/24 at 8:20am. Refer to the telephone interview with a PCA on 11/21/24 at 8:58am. Refer to the interview with a second PCA on 11/21/24 at 9:12am. Refer to the interview with a MA on 11/21/24 at 9:51am. Refer to the interview with the Administrator on 11/21/24 at 10:16am. _____ Interview with a housekeeper on 11/21/24 at 8:20am revealed: -She had seen two [named] residents wander into other residents' rooms. -No one had told her anything to do when she saw the residents go into other residents' rooms. Telephone interview with a PCA on 11/21/24 at 8:58am revealed: -There were a couple of residents who wandered into other resident rooms. -The RCC and the Administrator knew the residents wandered into other resident rooms. -No one had told her anything to do to prevent the residents from wandering into other residents' rooms. -If she saw a resident wander into another resident's room, she would redirect the resident out of the room. Interview with a second PCA on 11/21/24 at 9:12am revealed: -A [named] resident walked the halls holding on to the handrail and would go into a room thinking it was her room. -The [named] resident never took anything out of	D 338		

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the residents' rooms but would fuss with the resident who told her to get out; the two residents would go back and forth.
-Another [named] resident went into other residents' rooms and would take things.
-She had not heard any residents complain about the resident taking things but when they found the resident with things that did not belong to her, they would return the items.
-The staff told the residents who wandered into other residents' rooms to stop, but the residents did not remember because the resident's memory was very bad.
-No one had told her anything specific to do to stop the residents from wandering into other residents' rooms.
-The staff made sure the residents were "watched" and would redirect the residents who wandered into other residents' rooms.

Interview with a MA on 11/21/24 at 9:51am revealed:
-She had heard residents call out that a resident was in their room, but she had not heard the residents argue.
-The staff redirected the residents if they saw the resident go into another resident's room.
-The staff did not do anything to prevent the residents from going into other residents' rooms.
-There was nothing the staff could do because the residents did not understand what they were doing was not right.
-The RCC and the Administrator both were aware of the residents going into other residents' rooms.

Interview with the RCC on 11/21/34 at 10:06am and 10:37am revealed:
-There were 2 [named] residents who walked up and down the halls.
-One of the [named] residents went into other

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D 338	Continued From page 31 residents' rooms. -Staff could not stop the residents from walking the halls because "this was their home." -One of the 2 [named] residents' memory had progressed so "bad" the resident had no understanding. -All staff could do was try to stop the residents from going into other residents' rooms. -She was not aware of any verbal altercations where residents had to be separated. Interview with the Administrator on 11/21/24 at 10:16am revealed: -There were two [named] residents who wandered. -One of the [named] residents did not go into other residents' rooms, she just looked into the rooms. -She was not aware of residents arguing with other residents who were going into the residents' rooms. -The residents who wandered could be redirected.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record	D 358		

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reviews, the facility failed to administer medications as ordered for 1 of 4 residents (#5) observed during the 8:00am morning medication pass including errors with the administration of a medication for mood and 2 medications for constipation, and for 1 of 3 sampled residents (#1) for record review including two medications for brittle bones.

The findings are:

1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am medication pass on 11/20/24.

Review of Resident #5's current FL-2 dated 11/14/24 revealed diagnoses included unspecified dementia, anxiety disorder, major depressive disorder, and slow transit constipation.

a. Review of Resident #5's signed physician orders dated 11/14/24 revealed there was an order for venlafaxine 75mg (used to treat depression and anxiety) daily.

Observation of the medication pass for Resident #5 on 11/20/24 at 8:06am revealed:
-The medication aide (MA) removed a plastic container containing multiple bottles of medication.
-The MA removed 8 bottles of medication from the plastic container.
-The MA prepared 8 pills for administration to Resident #5.
-The MA administered the 8 pills to Resident #5.
-Venlafaxine 75 mg was not one of the 8 pills administration.

Review of Resident #5's November 2024

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electronic medication administration record (eMAR) on 11/20/24 revealed:
-There was an entry for venlafaxine 75mg daily with a scheduled administration time of 8:00am.
-There was documentation venlafaxine was administered on 11/20/24 at 8:00am.

Interview with MA on 11/20/24 at 10:40am revealed:
-She thought she administered venlafaxine 75mg to Resident #5 this morning, 11/20/24.
-She did not realize she forgot to administer venlafaxine to Resident #5 but signed the eMAR as if she administered the medication.

Interview with the Pharmacist at the facility's contracted pharmacy on 11/20/24 at 9:03am revealed Resident #5 had an order for venlafaxine 75mg daily.

Interview with the Primary Care Provider (PCP) on 11/20/24 at 1:23pm revealed:
-Resident #5 was ordered venlafaxine for her depression.
-Missing one dose should not affect Resident #5.

Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 3:45pm revealed:
-The MA should administer Resident #5 her medication as ordered.
-Resident #5 could have an increase in depression if she did not receive venlafaxine as ordered.

Attempted interview with a representative from Resident #5's local pharmacy on 11/20/24 at 11:49am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #5 was not

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D 358	Continued From page 34 interviewable. b. Review of Resident #5's signed physician orders dated 11/14/24 revealed there was an order for senna 8.6mg 2 tablets (used to treat constipation) daily. Observation of the medication pass for Resident #5 on 11/20/24 at 8:06am revealed: -The MA removed a plastic container containing multiple bottles of medication. -The MA removed 8 bottles of medication from the plastic container. -The MA prepared 8 pills for administration, one pill from each bottle. -The MA administered 8 pills to Resident #5. -The MA did not prepare 2 tablets of senna 8.6 for administration. Review of Resident #5's November 2024 eMAR on 11/20/24 revealed: -There was an entry for senna 8.6mg 2 tablets daily with a scheduled administration time of 8:00am. -There was documentation senna 2 tablets were administered on 11/20/24 at 8:00am. Interview with MA on 11/20/24 at 10:40am revealed: -She thought she administered two tablets of senna 8.6 this morning to Resident #5. -She did not realize she only administered one tablet this morning, 11/20/24, to Resident #5. Interview with a personal care aide (PCA) on 11/20/24 at 10:13am revealed: -She worked with Resident #5 and provided personal care with assistance. -She assisted Resident #5 to the toilet. -Resident #5 had a problem with constipation a	D 358		

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D 358	Continued From page 35 few months ago, but she did not have any problems with constipation at this time. Interview with the Pharmacist at the facility's contracted pharmacy on 11/20/24 at 9:03am revealed Resident #5 had an order for Senna 8.6mg 2 tablets daily. Interview with the PCP on 11/20/24 at 1:23pm revealed: -Resident #5 had problems with constipation several months ago. -She took three different medications to relieve her constipation. -She had improved with the use of the medications. Attempted interview with a representative from Resident #5's local pharmacy on 11/20/24 at 11:49am was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable. _____ Interview with the Pharmacist at the facility's contracted pharmacy on 11/20/24 at 9:03am revealed: -The pharmacy did not dispense Resident #5's medications; she received them from a local pharmacy. -The pharmacy profiled Resident #5's medications so the medication would appear on the eMAR for the MAs to document the administration of the medication. Interview with MA on 11/20/24 at 10:40am revealed: -She compared each medication to the eMAR, clicking on the medication, where a green check	D 358		

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appeared, indicating she had pulled the medication from the medication cart.
-When she popped the medication in the souffle cup, she would uncheck the medication on the eMAR, removing the green check; this was her second review of the medication.
-When she returned the medication to the medication cart she would click on the medication again, the green check would re-appear, indicating her third review of the medication.
-She did not do the process today, 11/20/24, because she felt overwhelmed and nervous.

Interview with the RCC on 11/20/24 at 3:45pm revealed:
-Resident #5 suffered with constipation several months ago.
-She was ordered several medications to help with the constipation.
-She has not had any problems with constipation for a month.
-Resident #5 could have an increase in constipation.
-The MAs should administer the medication as ordered.

Interview with the Administrator on 11/21/24 at 8:17am revealed:
-The MA should follow the PCPs orders and administer medications as ordered.
-She expected the MAs to administer medications as ordered.

c. Review of Resident #5's signed physician orders dated 11/14/24 revealed there was an order for polyethylene glycol powder mix 17gms (used to treat constipation) in a suitable liquid twice daily.

Observation of the medication pass for Resident

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#5 on 11/20/24 at 8:06am revealed:
-The MA removed a bottle of polyethylene glycol from the bottom drawer of the medication cart.
-The MA poured a capful of polyethylene glycol powder into a cup of water and mixed the powder well.
-The MA handed the cup of medication to Resident #5 and observed Resident #5 drink ½ of the medication.
-The MA returned to the medication room, leaving the cup with ½ of the medication remaining, with Resident #5.
-The MA did not observe Resident #5 take all the polyethylene glycol.

Review of Resident #5's November 2024 eMAR on 11/20/24 revealed:
-There was an entry for polyethylene glycol 17 gm in a suitable liquid and drink twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation polyethylene glycol was administered on 11/20/24 at 8:00am.

Interview with MA on 11/20/24 at 10:40am revealed:
-She left polyethylene glycol with Resident #5 to finish taking.
-She observed Resident #5 drink about ½ of the medications.
-Resident #5 always drank all her medication.
-She normally gave Resident #5 her medication in the dining room, and she would stay in the dining room and watch Resident #5 take the medication.
-She did not know if Resident #5 drank all the medication this morning.

Interview with the Pharmacist at the facility's contracted pharmacy on 11/20/24 at 9:03am

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revealed Resident #5 had an order for polyethylene glycol 17gm in a suitable liquid and drink twice daily.

Interview with the RCC on 11/20/24 at 3:45pm revealed:
-The MA who administered the medication to Resident #5 was expected to watch the resident take all the medication.
-There were residents who wandered in the facility and who could take the medication if Resident #5 sat the medication down without taking it all.

Interview with the Administrator on 11/21/24 at 8:17am revealed:
-The MA should observe Resident #5 taking all her medication.
-Resident #5 could have placed her cup down with medication and another resident could have taken it.

Attempted interview with a representative from Resident #5's local pharmacy on 11/20/24 at 11:49am was unsuccessful.

Based on observations, interviews, and record reviews it was determined Resident #5 was not interviewable.

2. Review of Resident #1's current FL-2 dated 10/10/24 revealed diagnoses included Alzheimer's Disease, diabetes mellitus type 2, chronic kidney disease, major depressive disorder, congestive heart failure, and hypertension.

a. Review of Resident #1's current FL-2 dated 10/10/24 revealed there was an order for alendronate 70mg (used to treat thinning of the

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bone) weekly on Fridays, 30 minutes before breakfast.

Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for alendronate 70mg weekly on Fridays at least 30 minutes before first food with 8-ounces of water with a scheduled administration time of 8:00am.
-There was documentation Resident #5 was administered alendronate on 09/06/24, 09/13/24, 09/20/24, and 09/27/24 at 8:00am.

Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for alendronate 70mg weekly on Fridays at least 30 minutes before first food with 8-ounces of water with a scheduled administration time of 8:00am.
-There was documentation Resident #5 was administered alendronate on 10/04/24. 10/11/24, 10/18/24, and 10/25/24 at 8:00am.

Review of Resident #1's November 2024 eMAR from 11/01/24 t0 11/18/24 revealed:
-There was an entry for alendronate 70mg weekly on Fridays at least 30 minutes before first food with 8-ounces of water with a scheduled administration time of 8:00am.
-There was documentation Resident #5 was administered alendronate on 11/01/24, 11/08/24, and 11/15/24 at 8:00am.

Observation of medications on hand on 11/19/24 revealed there were no alendronate 70mg available for administration.

Interview with a medication aide (MA) on 11/19/24 at 2:03pm revealed:

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-She administered the last tablet of alendronate this morning to Resident #1.
-The Resident Care Coordinator (RCC) kept the overstock medications in her office.

Observation of the box of alendronate 70mg retrieved from the RCC's office revealed there was a box of 4 alendronate 70mg tablets with a dispensed date of 10/22/24.

Telephone interview with the Pharmacist at Resident #1's local pharmacy on 11/19/24 at 2:52pm revealed:
-The pharmacy had an order for alendronate 70mg one tablet weekly.
-The pharmacy dispensed a box of 4 tablets of alendronate 70mg on 08/27/24, 09/19/24, and 10/22/24.
-She was preparing a box of alendronate 70mg 4 tablets to dispense today, 11/19/24.
-The facility should have one tablet of alendronate remaining from the box dispensed on 10/22/24.
-Alendronate was used to treat osteoporosis by increasing the bone mineral density.

b. Review of Resident #1's current FL-2 dated 10/10/24 revealed there was an order for calcitonin-salmon 200 (used to treat thinning of the bone) one spray alternating nostrils daily.

Review of Resident #1's September 2024 eMAR revealed:
-There was an entry for calcitonin-salmon 200 units nasal spray instill one spray alternating nostrils daily with a scheduled administration time of 8:00am.
-There was documentation calcitonin-salmon was administered daily from 09/01/24 to 09/30/24 at 8:00am.

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Review of Resident #1's October 2024 eMAR revealed:
-There was an entry for calcitonin-salmon 200 units nasal spray instill one spray alternating nostrils daily with a scheduled administration time of 8:00am.
-There was documentation calcitonin-salmon was administered daily from 10/01/24 to 10/01/24 at 8:00am.

Review of Resident #1's November 2024 eMAR from 11/01/24 to 11/18/24 revealed:
-There was an entry for calcitonin-salmon 200 units nasal spray instill one spray alternating nostrils daily with a scheduled administration time of 8:00am.
-There was documentation calcitonin-salmon was administered daily from 11/01/24 to 11/18/24 at 8:00am.

Observation of medications on hand on 11/19/24 at 2:03 pm revealed:
-There was a bottle of calcitonin-salmon nasal spray with a dispensed date of 08/27/24 on the medication cart.
-There was a handwritten date on the box containing the bottle of calcitonin-salmon spray of 10/29/24, indicating when the bottle was opened for administration.
-The bottle of calcitonin-salmon nasal spray was ¾ full.

Telephone interview with the Pharmacist at Resident #1's pharmacy on 11/19/24 at 2:52pm revealed:
-The pharmacy had an order for calcitonin-salmon nasal spray, one spray alternating nostril, once a day.
-The pharmacy dispensed a 3.7ml bottle of calcitonin-salmon nasal spray on 08/27/24,

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09/24/24, and 10/22/24; each bottle contained 30 doses.
-One bottle of calcitonin-salmon nasal spray should last 30 days.
-Calcitonin-salmon nasal spray was used to treat osteoporosis by increasing the bone mineral density.

_____

Interview with the PCP on 11/20/24 at 1:23pm revealed:
-Resident #1 had multiple falls over the past few years and had compression fractures and pelvis fractures.
-Resident #5 could have increased back pain and decreased strength if she did not receive medications as ordered.

Interview with the MA on 11/20/24 at 3:31pm revealed:
-She administered medications to Resident #1.
-Resident #1 did not refuse her medications.
-She did not know why Resident #1 had more medications that she should based on dispensed dates.
-She had not done a medication cart since she was employed in August 2024.
-There was a note in the medication room to select a hall to audit weekly, but she did not have time to audit the medication cart.

Interview with a second MA on 11/21/24 at 9:40am revealed:
-Resident #5 did not refuse her medications.
-When she opened a medication for the first time she would place the date on the medication bottle.
-She did not know why Resident #5 had extra medications on the medication cart.

Interview with the RCC on 11/20/24 at 3:45pm

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D 358	Continued From page 43 revealed: -Medication cart audits were completed weekly by the MAs. -The MAs looked for expired medications, opened medications without an open date, and medications that were not on the medication cart and available for administration. -She completed a medication cart audit monthly. -The pharmacy did a medication cart audit last week but she did not know what the representative from the pharmacy audited. Interview with the Administrator on 11/21/24 at 8:17am revealed: -The MA should follow the PCPs orders and administer medications as ordered. -She expected the MAs to administer medications as ordered. -The MAs completed a medication cart audit weekly and the RCC monthly. -The issues should have been caught with weekly medication cart audits.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 366		

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failed to ensure medication aides (MA) observed residents take their medications as evidenced by cups of medication observed on the dining room tables.

The findings are:

Observation of the dining room on 11/19/24 at 8:33am revealed:
-There were 16 residents in the dining room eating breakfast.
-There were 8 souffle cups on 4 dining room tables next to the residents' plates.
-Five of the 8 souffle cups had pills in them.

Interview with a resident on 11/20/24 at 2:45pm revealed:
-She was administered her medications in the dining room.
-Sometimes the cup of pills was placed beside her plate and sometimes they were administered to her.
-She would take her medications after she ate breakfast.

Interview with a second resident on 11/19/24 at 2:51pm revealed:
-She took 5 pills each morning.
-She was administered her medications in the dining room sometimes.
-The MA would place the pill cup by her plate, and she would take the pills after she ate.

Interview with a personal care aide (PCA) on 11/20/24 at 10:13am revealed:
-She had seen medications left on the dining room table.
-She had not seen medications left at the bedside.
-She was concerned about the medications left

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on the dining room table because there was a resident who wandered and would pick up things that did not belong to her.

Interview with a medication aide (MA) on 11/21/24 at 9:40am revealed:
-She placed a resident's medication on the dining room table because the resident would not take them in their room.
-She placed cups of pills by several residents' plates.
-She stayed in the dining room to ensure the residents took their medication.
-She usually administered medications to the residents before breakfast.
-Placing the cup of pills on the dining room table was not how she typically administered medications.
-She normally pushed the medication cart up and down the hallways and administered medication prior to breakfast.

Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 3:45pm revealed:
-Medications should not be administered in the dining room unless the residents requested their medications.
-No medications should be left on the dining room table for the residents to take.
-The MA should watch each resident take their medications before preparing another residents medication.
-A resident could walk by and pick up another resident's medication and take the medication.

Interview with the Administrator on 11/21/24 at 8:17am revealed:
-The MAs were to watch the residents take their medications.
-Medications were not to be left on the dining

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D 366	Continued From page 46 room tables for the residents to take when they wanted to. -Another resident could walk by, pick up the medication, and take it without the MA knowing.	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the electronic medication administration record was accurate for 1 of 3 sampled residents (#1) including a supplement.	D 367		

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D 367	Continued From page 47 The findings are: Review of Resident #1's current FL-2 dated 10/10/24 revealed: -Diagnoses included Alzheimer's disease, dementia, restless leg syndrome, major depression, and hypertension. -There was an order for Vitamin B complex (used as a supplement) daily. Review of Resident #1's October 2024 electronic medication administration record (eMAR) from 10/19/24 to 10/31/24 revealed: -There was an entry for vitamin B complex daily with a scheduled administration time of 8:00am. -There was documentation that vitamin B complex was discontinued on 10/19/24. -There was no documentation that vitamin B complex was administered from 10/19/24 to 10/31/24. Review of Resident #1's November 2024 eMAR from 11/01/24 to 11/19/24 revealed: -There was no entry for vitamin B complex to be administered. -There was no documentation that vitamin B complex was administered from 11/01/24 to 11/19/24. Observation of Resident #1's medications on hand on 11/19/24 at 2:03pm revealed: -There was a multi-dose pack that contained 13 pills in the 8:00am multi-dose pack. -There was a list on the multi-dose pack of each pill in the 8:00am multi-dose pack. -Vitamin B complex was listed as being in the multi-dose pack. Telephone interview with the Pharmacist at Resident #1's local pharmacy on 11/19/24 at	D 367		

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D 367	Continued From page 48 2:52pm revealed: -She worked for the local pharmacy that dispensed and delivered Resident #1's medications to the facility. -Resident #1 had an order for vitamin B complex daily. -The pharmacy dispensed vitamin B complex in a 7-day multi-dose pack to be administered to Resident #1 each morning at 8:00am. -The pharmacy did not have an order to discontinue vitamin B Complex for Resident #1. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/19/24 at 3:10pm revealed: -The pharmacy acquired the facility in the middle of October from another pharmacy. -The pharmacy did not dispense medications for Resident #1. -The pharmacy profiled Resident #1's medications so the medication would appear on the eMAR for the medication aide (MA) to document the administration of the medication. -The pharmacy did not have vitamin B complex as an active order. -It appeared vitamin B complex was discontinued just before or during the transfer of orders to the current pharmacy. Interview with a medication aide (MA) on 11/19/21 at 2:30pm revealed: -If a medication was discontinued, the Resident Care Coordinator (RCC) would let the MAs know. -The MA would remove the discontinued medication from the multi-dose pack before administering the morning medications. -Only one of Resident #1's medications had been discontinued and it was omeprazole (used to treat reflux). -Omeprazole had been ordered for every other	D 367		

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day.
-She would remove omeprazole on the days it was in the multi-dose pack and discard it.
-She did not remove any other medications to discard from the multi-dose pack.
-She administered all the other medication in the multi-dose pack.

Interview with a second MA on 11/20/24 at 10:40am revealed:
-She had noticed about a month ago the vitamin B complex was not on the eMAR.
-She did not tell anyone the vitamin B complex was not on the eMAR.
-She knew the vitamin B complex was in the multi-dose pack.
-She administered the vitamin B complex since it was in the multi-dose pack.
-She did not question whether the vitamin B complex had been discontinued.

Interview with the RCC on 11/20/24 at 3:45pm revealed:
-She did not audit Resident #1's medications when they were delivered to the facility by the local pharmacy.
-The vitamin B complex was not on the eMAR to be administered so it should not be administered,
-The MAs should have told her they noticed the vitamin B complex was not on the eMAR.
-She could have notified the pharmacy to see why the vitamin B complex was not on the eMAR.

Interview with the Administrator on 11/21/24 at 8:17am revealed:
-The MA should compare the medications on the medication cart with the medications listed on the eMAR.
-If there was a discrepancy, the MAs should have notified the RCC, so it could be corrected.

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D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the medication room door was closed and locked, the treatment cart was locked, and the refrigerator containing medications were locked, when not under the direct physical supervision of a medication aide (MA). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 86 residents. Review of the facility's resident census report dated 11/19/24 revealed there was a census of 19 residents. Observation of the nurse's station on 11/19/24 between 8:51am to 8:58am revealed: -The nurse's station door was open; there was a sign on the nurse's station door to keep door closed. -The medication room was in the nurse's station. -The door to the medication room was open; there was a sign on the medication room door to keep door closed. -There was no one supervising the medication	D 378		

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room while the door was opened.
-The unlocked treatment cart was inside the medication room.
-The treatment cart contained Aspercreme cream (used for itching and pain); Neosporin ointment (used for skin irritation); and Calmoseptine ointment (used to treat minor skin irritation).
-The refrigerator was in the medication room and did not have a lock on it.
-The refrigerator contained 3 flex pens of Lantus insulin (used to lower blood sugar) and 6 flex pens of Novolog insulin (used to lower blood sugar).
-The cabinet in the medication room that contained overstock medication was not locked.
-The cabinet contained a bottle of mucus relief (used to treat congestion), a bottle of Maalox (used for heartburn); a bottle of milk of magnesium (used to relieve constipation); and a box of anti-diarrhea pills (used to control diarrhea).

Interview with a medication aide (MA) on 11/21/24 at 9:40am revealed:
-The medication room should always be locked.
-She was in the dining room when the medication room was unlocked.
-There was a sign on the medication room door to keep the door closed.
-All employees knew the code to get into the medication room; anyone could have left it open.
-A resident could wander in the medication room and remove medications that were not theirs.

Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 3:45pm revealed:
-The door to the medication room should be locked when not under the supervision of the MA.
-When the medication room door was locked then all medications were secure, including the

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D 378	Continued From page 52 medications in the refrigerator, treatment cart, and in the cabinet. -A resident could walk in the medication room and get medications and take them or carry them out to other residents. -She expected the medication door to be closed and locked when there was no one in the medication room. Interview with the Administrator on 11/21/24 at 8:17am revealed: -She expected the medication room to be locked when the MA was not in the medication room. -There was a risk of residents wandering in the medication room and walking out of the medication room with medications. -The residents could then take the medications that were not intended for them.	D 378		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to notify the County Department of Social Services (DSS) of	D 451		

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incidents/accidents that required emergency medical evaluation for 1 of 1 resident (#2).

The findings are:

Review of Resident #2's current FL2 dated 10/17/24 revealed diagnoses included alzheimer's disease, dementia, history of transient ischemic attack, heart failure, and hypertension.

Review of Resident #2's incident and accident report dated 10/24/24 revealed:
-At 7:00am, Resident #2 was found on her bedroom floor with a laceration to her forearm.
-The resident was found by a personal care aide (PCA).
-The resident was sent to the emergency department (ED) by emergency medical service (EMS) at 7:28am.
-Resident #2's son was notified about the fall.
-Resident #2's Physician was notified of the fall.
-The report was signed by the Resident Care Coordinator (RCC) and Administrator.
-There was no documentation the Department of Social Services (DSS) was notified.

Review of Resident #2's progress notes dated 10/24/24 at 3:30pm revealed:
-The resident had an unwitnessed fall.
-Resident was seen sitting up on the floor of her bedroom.
-The medication aide (MA) checked Resident #2's vitals and skin.
-EMS was called and Resident #2 was transported to the hospital.
-Resident #2 returned with 11 sutures for an arm laceration.

Review of the progress notes for Resident #2

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DUNMORE SENIOR LIVING OF SILER CITY	260 VILLAGE LAKE ROAD SILER CITY, NC 27344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 54 dated 10/24/24-11/19/24 revealed there was no documentation the local county DSS had been notified of the incident dated 10/24/24. Telephone interview with the Adult Home Specialist (AHS) from the local county DSS on 11/20/24 at 2:12pm revealed: -The facility staff were told to fax the incidents and accident reports to her attention and to keep a copy for their record. -She did not encourage sending the incident and accident reports by email, but if the fax failed, the facility staff could call and let her know verbally and she could pick up the reports at the facility. -She had been at the facility multiple times, and no one had told her the fax was not working to send the incident and accident reports. -She had not received an incident and accident report for Resident #2's fall on 10/24/24. Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 2:48pm revealed: -She sent incident and accident reports to the AHS at the local DSS. -She only sent the reports if the resident had an injury from the accident. -The fax at DSS was not working; the fax would not go through. Interview with the Administrator on 11/20/24 at 3:16pm revealed: -The RCC was responsible for sending the incident and accident reports to the AHS at DSS within 48 hours. -All incident and accident reports for an injury above basic first aid should be sent to the AHS. -She expected the RCC to send the incident and accident reports.	D 451		