STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011377	A. BUILDING: ______ B. WING ______	R 12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 a follow-up survey on 12/04/24-12/06/24 and 12/09/24-12/10/24.	D 000		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to provide a clean top and bottom sheet on seven resident beds and at least one pillow with a clean pillowcase for four resident beds. The findings are:	D 087		

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Observation of the first resident's room during the initial tour on 12/04/24 at 9:30am revealed:
-There was not a top sheet on the bed.
-The resident was using a decorative couch pillow and a folded up fleece throw blanket as a pillow.
-The bottom sheet was dingy, stained and had light brown colored smear marks near the head of the bed.

Interview with the first resident on 12/04/24 at 9:30am and 12/06/24 at 3:10pm revealed:
-She needed to use a decorative couch pillow because she did not currently have a regular pillow for her bed.
-The light brown smear marks were from her wiping her fingers on the bed.
-The facility staff did not change the linens on her bed.
-The bottom sheet had not been changed or washed for "months".
-She had a hard time leaning over the bed to apply the bottom sheet and would fall onto the bed on her face so she did not change the sheet anymore.

Observation of a second resident's room during the initial tour on 12/04/24 at 9:37am revealed:
-The resident was lying in bed with a dirty cotton blanket pulled up over his head.
-There was no bottom sheet on the resident's bed.
-There was no top sheet on the resident's bed.

Interview with the second resident on 12/05/24 at 9:30am revealed:
-He had a fitted sheet for his bed but the sheet would not stay on the bed.
-He threw the fitted sheet away.
-All the residents had the same problem he did with the sheets not fitting their beds.

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Observation of a third resident's room during initial tour on 12/04/24 at 9:43am revealed:
-There was not a top sheet or a bottom sheet on his mattress.
-There was not a pillowcase on his pillow.

Interview with a third resident on 12/04/24 at 9:43am revealed:
-He had not had a top sheet, bottom sheet, or a clean pillowcase for about a month.
-He had a pillowcase but took it off to blow his nose since he had not been given any tissue.
-The Resident Care Coordinator (RCC) asked him two or three weeks ago if he wanted linens for his bed and he told her yes.
-The RCC or other facility staff never brought him a top sheet, bottom sheet, or clean pillowcase.
-He would like the staff to place sheets on his bed and a pillowcase on his pillow.

Observation of a fourth resident's room during the initial tour on 12/04/24 at 9:52 am revealed:
-There was no top sheet or a bottom sheet on his mattress.
-He had two pillows on his bed and neither of them had a pillowcase.

Interview with a fourth resident on 12/04/24 at 9:52am revealed it did not bother him to not have linens on his bed.

Observation of a fifth resident's room during the initial tour of the facility on 12/04/24 at 9:52am revealed:
-There was no bottom sheet or top sheet on the plastic mattress.
-There was a throw blanket being used as the top sheet and blanket for the bed.

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Interview with a fifth resident on 12/04/24 at 9:52am revealed:
-She did not have a bottom or top sheet on her mattress because she thought it was being washed by staff.
-She was using the throw blanket to cover up while she slept.
-It did not bother her to lay on the plastic mattress without any linens because she was used to it.

Observation of a sixth resident's bed on 12/05/24 at 8:42am revealed:
-There was no top or bottom sheet on the resident's bed.
-The mattress was made of a plastic material.

Interview with a sixth resident on 12/05/24 at 8:42am revealed:
-Staff had not put sheets on his bed in a long time.
-The sheets would come off the bed as soon as he moved around in the bed.

Observation of a seventh resident's bed on 12/06/24 at 2:55pm revealed:
-There was no bottom or top sheet on the bed.
-The resident had 3 pillows on her bed with no pillowcases.
-There was a blanket on her bed and clothes were in a heaping pile on top of the blanket.

Interview with a seventh resident on 12/06/24 at 2:55pm revealed:
-She did not know how long it had been since she had sheets put on her bed.
-She wanted sheets on her bed and pillowcases on her pillows.
-She did not know how to get sheets and pillowcases for her bed and staff did not ask her if she wanted some.

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Observation of the linen closet on 12/05/24 at 9:46am revealed:
-There were multiple sets of sheets and some blankets folded and stored on shelves.
-There were no pillows stored in the linen closet.

Second observation of the fifth resident's room on 12/06/24 at 3:38pm revealed:
-There were no sheets covering the plastic mattress on the bed.
-There were 4 black laundry bags sitting on the bed and 1 black laundry bag setting on the floor in front of the bed.
-There was a pile of dirty linens lying on the floor at the foot of the bed.
-The resident rummaged through a pile of dirty linens lying in the floor at the foot of the bed and pulled out a bottom sheet and applied the dirty sheet to her mattress

Second interview with the fifth resident on 12/06/24 at 3:38pm revealed:
-She had not had any sheets on her bed in about a week.
-She would like sheets on her bed.

Interview with the eight resident on 12/06/24 at 3:50pm revealed:
-She had resided at the facility for 13 years and staff had never changed the linens on her bed.
-Staff never offered to change the linens on her bed so she made her bed herself.

Second interview with the third resident on 12/06/24 at 2:51pm revealed:
-A county Ombudsman had spoken with him today and he expressed his concerns about not having linens for his bed.
-The county Ombudsman spoke with the RCC

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about his request for linens.
-The RCC gave him linens on 12/06/24 for his bed.
-The RCC did not offer to put them on for him.
-He had received a top sheet, bottom sheet, and a clean pillowcase
-He "bribed" another resident by offering him some books to make his bed for him.

Second observation of the third resident's room on 12/06/24 at 2:51pm revealed:
-There was a resident, that did not live in the room, placing a pillowcase on the pillow.
-The resident was then observed to place the comforter on the bed.
-The resident took six books from the other resident for his assistance in making his bed.

Telephone interview with a county Ombudsman on 12/06/24 at 4:00pm revealed:
-She had spoken with a resident who expressed concerns about not having linens on his bed on 12/06/24.
-She told the RCC who replied she did not know why he did not have sheets on his bed.
-The RCC brought linens to the resident while he was in the hallway.
-The RCC did not offer to put the linens on his bed.
-He was walking in the opposite direction of his room with his walker.
-The county Ombudsman offered to place the linens on top of his mattress for him so he would not have to return to his room.
-She did not know if other staff came back to his room and put linens on his bed.
-She did not ask him if he was able to put his linens on himself.
-She did not ask staff if he was able to put his linens on himself.

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Interview with a medication aide (MA) on 12/05/24 at 9:46am revealed:
-There was only one personal care aide (PCA) that worked for the facility and she worked as needed.
-Some of the residents asked her to change their bed linens and some residents asked for sheets so they could change the bed linens themselves.
-The bed linens were supposed to be changed on a resident's shower day.
-She did not document when the bed linens were changed.
-The residents who were missing linens from their beds preferred not to have sheets on the beds.
-She did not know one of the residents was using a couch cushion as a pillow.
-She did not know where the resident's pillow was.
-She did not usually go inside resident's rooms to respect their privacy.

Interview with the RCC on 12/09/24 at 2:00pm revealed:
-All staff were responsible to make sure residents had linens on their beds.
-On shower days, one staff member could assist with the residents' shower while the other staff could go and change the linens.
-When it was brought to her attention that someone did not have linens on their bed, she would make sure they got linens.
-There was no one who had to make their own beds.
-She became aware of a resident on 12/06/24 who did not have linens on his bed, but they never went in his room because he always came to the medication cart when it was time for his medication and he came out for meals.
-The resident could change his own linens.

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-The resident was not a fall risk.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-Residents were given linens but some of them did not use them or would kick them off the bed.
-If the linens were soiled, staff should be changing them.
-He expected the linens to be changed by staff twice a week.
-There was no documentation regarding how often linens were being changed.

____
The facility failed to ensure residents were provided a clean top and bottom sheet on seven sampled resident beds. This required residents to sleep on plastic mattresses with no sheets and dirty linens. One resident slept on a dirty sheet that was not changed or washed in 2 months because staff did not change her sheets, and when trying to change herself she fell on the bed. Another resident changed her own sheets because staff had not offered assistance, and a third resident rummaged through a pile of dirty linens on the floor and applied a dirty bottom sheet to her bed after not having a bottom sheet for about one week. A fourth resident bribed another resident by giving him books if the resident would apply sheets to his bed, because staff were not changing the linens. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation.

____
The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 12/19/24 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 24, 2025.

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

10A NCAC 13F .0901 Personal Care and Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 2 of 4 sampled residents (#2 and #4) who required assistance with bathing and grooming.

The findings are:

1. Review of Resident #4's current FL2 dated 08/26/24 revealed:
-Diagnoses included altered mental status, orthostatic hypotension, and schizoaffective bipolar type.
-The resident was constantly disoriented.
-The resident was verbally abusive.
-The resident was non-ambulatory.
-The resident needed assistance with bathing and dressing.
-The resident was incontinent of bladder and bowel.

Review of Resident #4's current Care Plan dated 08/26/24 revealed:
-The resident required limited assistance with bathing, dressing, eating, grooming/personal hygiene, and toileting.
-The resident was ambulatory with aid or device and required supervision.

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-The resident was independent with transfers.

Observation of Resident #4 on 12/04/24 at 9:37am revealed:
-Resident #4 was sitting on the side of his bed holding a blanket across his lap.
-Resident #4 wore a white t-shirt that was stained, a pair of gray sweat pants with dried food sticking to the pant legs, and a pair of white socks that were soiled to a gray color.
-There was a black substance matted in the back of his white hair on the back right of his head.
-Resident #4's beard was long and uneven, with a dried orange substance visible around his mouth.
-There was a dime sized area of the beard that was black and matted.
-Resident #4's fingernails on his right hand were long, jagged, and black in color.
-Resident #4's fingernails on his left hand were shorter in length, dark in color, and uneven and rough.
-Resident #4 smelled of body odor.

Interview with Resident #4 on 12/04/24 at 9:37am revealed:
-He got "no care" from staff.
-Staff only administered medications to him and provided meals to him.
-He was able to transfer himself into his wheelchair.
-The staff at the facility used to trim his fingernails, but "they don't do it no more."
-"My beard. I hate it."
-He did not like his beard being so long and uneven.
-Staff did not assist him with bathing, he took "care of that."
-He did not know the last time he had a shower.
-He did not need a shower and he would "take care of it."

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Review of Resident #4's mental health provider note dated 08/19/24 revealed continue to provide supportive care and encouragement particularly in regard to maintaining good hygiene.

Review of Resident #4's Resident Refusal forms dated 08/20/24-10/31/24 revealed the resident had been offered 32 showers and had refused all of the showers offered.

Observation of Resident #4 on 12/05/24 at 9:30am revealed:
-Resident #4 was wearing a cleaner white t-shirt than the previous day.
-Resident #4 was wearing the same pair of gray sweat pants with dried food sticking to them.
-Resident #4 was wearing white socks soiled to a gray color.
-Resident #4's hair, beard, and fingernails had not changed in appearance from the previous day.

Interview with Resident #4 on 12/05/24 at 9:30am revealed:
-It had been a "long" time since he had a shower.
-The staff who had given him the shower no longer worked there.
-There was another staff person who had worked there who used to trim his fingernails, beard, and hair, but it had been a "long" time and she no longer worked there.

Interview with a medication aide (MA) on 12/05/24 at 9:45am revealed:
-The facility employed one part-time personal care aide (PCA) and the PCA transported residents to appointments as needed.
-Resident #4 did not want to shower.
-He always refused to shower.
-"Sometimes" they could get Resident #4 to

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change his clothes.
-Resident #4 only came out of his room for meals.
-His primary care provider (PCP) was aware of his refusals to shower.
-His MHP was aware of his refusals to shower.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed:
-She had worked at the facility since January 2024.
-She had known Resident #4 to get a shower once since she had worked there.
-The podiatrist was in the facility once a month but Resident #4 would not let the podiatrist see him.
-Resident #4 would let the staff change his clothes twice a week.
-The staff were able to look at his skin and feet during the times they were able to change his clothing.

Telephone interview with Resident #4's PCP on 12/06/24 at 9:44am revealed:
-She was aware of Resident #4's refusals of assistance with personal care needs.
-She was not sure what to do to get him to comply that would not violate his rights.
-She would like for staff to change his clothes everyday "if he would allow it."
-She had observed Resident #4 walk limited distances in his room.
-She had observed Resident #4 utilize his wheelchair to get to the bathroom .

Telephone interview with Resident #4's MHP on 12/06/24 at 11:15am revealed:
-Resident #4's personal care refusals had been mentioned to her.
-Her role with Resident #4 was medication

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management not behavioral.
-There was not any recommendations she could make to staff to assist with the situation.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The staff had tried "everything" to get Resident #4 to shower.
-There had been multiple attempts from different staff members without success.

2. Review of Resident #2's FL2 dated 07/11/24 revealed diagnoses included type 2 diabetes and schizoaffective disorder.

Review of Resident #2's current FL2 dated 08/26/24 revealed:
-The resident required assistance with bathing and dressing.
-Sight was documented as a functional limitation.

Review of Resident #2's Care Plan dated 08/26/24 revealed the resident required limited assistance with bathing.

Review of Resident #2's August 2024 shower documentation from 08/20/24-08/31/24 revealed the resident was offered staff assistance with five showers, refused one shower, and received assistance with four showers.

Review of Resident #2's September 2024 shower documentation from 09/01/24-09/30/24 revealed the resident was offered staff assistance with nine showers, refused six showers, and received assistance with three showers.

Review of Resident #2's October 2024 shower documentation from 10/01/24-10/31/24 revealed the resident was offered staff assistance with nine

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WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

(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 269	Continued From page 13 showers, refused five showers, and received assistance with four showers. Review of Resident #2's November 2024 shower documentation from 11/01/24-11/30/24 revealed the resident was offered staff assistance with 13 showers, refused nine showers, and received assistance with four showers. Interview with Resident #2 on 12/06/24 at 11:15am revealed: -He did not feel he required staff assistance with showers. -He knew how to "bathe himself." -It had been "awhile" since his last shower. -He washed up in his bathroom. -He washed his "privates" and under his arms. -He had deodorant to use. -The last shower he took he did it himself. Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed: -They provided showering assistance to Resident #2 to make sure "it's done right." -Resident #2 refused showers "a lot." -If a staff went to Resident #2 and offered him assistance with a shower and he refuses, staff were supposed to come to her and let her know he refused. -She would then go back and check with him again and offer to give him a shower. -She tried to encourage him and "give him a soda" to get him to take a shower. -Staff documented showers taken and refusals of showers on a calendar for each resident.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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(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:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated. Non-compliance continues.

Based on observations, interviews and record reviews, the facility failed to ensure healthcare referral and follow-up to meet the routine health care needs for 1 of 3 sampled residents (Resident #2) related to missed eye exam appointments and notification of the mental health provider (MHP) of missed mental health medications.

The findings are:

Review of Resident #2's FL2 dated 07/11/24 revealed diagnoses included type 2 diabetes and schizoaffective disorder.

a. Observation of Resident #2 on 12/04/24 at 9:30am revealed:
-Resident #2 wore glasses.
-The lenses of the glasses he wore were different diameters in size and were of varying thickness.
-The lenses did not fit into the wire frame.
-The lenses were held onto the wire frame by pieces of wire bent around the frames at on both sides of the glasses.
-The wire was stiff and approximately the thickness of paperclip wire.
-The ends of the wire wrapped around the frames were sharp and protruded past the wire frames on both sides.

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-The right ear piece was missing from the wire frame.

Interview with Resident #2 on 12/04/24 at 9:31am revealed "eventually" he would like to get "setup" with an eye doctor to get new glasses.

Review of Resident #2's appointment card from a local ophthalmology group revealed an appointment was scheduled for an eye examination on 06/26/24 at 2:15pm.

Review of Resident #2's refusal form dated 09/10/24 at 9:30am revealed:
-Resident #2 refused to go to an appointment at a second local ophthalmology group.
-The reason for the refusal was documented as "anxiety."

Review of Resident #2's eye appointment reminder revealed Resident #2 had an appointment rescheduled on 12/05/24 at 10:10am after his refusal to attend the appointment on 09/10/24.

Telephone interview with local ophthalmology practice on 12/04/24 at 2:04pm revealed:
-Resident #2 was scheduled for an eye exam in their practice on 06/26/24 at 2:15pm and he was a "no show."
-Another appointment was then scheduled for 10/30/24 and it was canceled.
-Another appointment was scheduled for 11/15/24 at 10:45am and it was canceled.
-Resident #2 currently had an appointment scheduled for 05/28/25.

Telephone interview with a second local ophthalmology practice on 12/04/24 at 3:22pm revealed:

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-Resident #2 was scheduled for an eye exam on 12/05/24 at 10:10am.
-Resident #2 was previously scheduled for an eye exam on 09/10/24, but the appointment had been canceled.

Interview with Resident #2 on 12/04/24 at 2:39pm revealed:
-He had his last eye exam two years ago.
-The last pair of new eye glasses he had received was "three or four years ago."
-He "fell over" and that pair of glasses were damaged.
-He made his current pair of glasses himself by combining pieces of 3 pair of old prescription glasses he had kept.
-He denied ever having hurt himself on the protruding wires around the frames of the glasses he made for himself.

Interview with a medication aide (MA) on 12/05/24 at 9:45am revealed:
-Resident #2 had problems with becoming anxious when going out to appointments.
-Resident #2 had as needed medication to take prior to appointments to help him with his anxiety.
-His last eye appointment had to be rescheduled.
-When Resident #2 got out of the car his anxiety "got bad" and he refused to go into the appointment.
-Resident #2 "definitely" needed new glasses.

Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed on 10/30/24 there were no documented administrations of as needed clonazepam administered to Resident #2.

Review of Resident #2's November 2024 eMAR revealed on 11/15/24 there were no documented

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administrations of as needed clonazepam administered to Resident #2.

A second interview with the MA on 12/06/24 at 10:58am revealed:
-Resident #2 would not come out of his room when he was anxious.
-Resident #2 would hang onto the railing in the hallway when out of his room because he was afraid of falling.
-Resident #2 had to take a medication for anxiety prior to going to appointments.
-Once when they had taken Resident #2 to an eye appointment, he refused to go into the ophthalmology office and tried to get into cars parked in the parking lot due to his anxiety.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed:
-Resident #2 had a fear of going out of the facility.
-Resident #2 would refuse to go to an eye exam.
-She had scheduled appointments for Resident #2 between two different ophthalmology offices.
-Resident #2's was wearing the glasses he tried to fix.
-The facility had been trying to get Resident #2 to his eye appointments so he could get a new prescription and a pair of new glasses.

Telephone interview with Resident #2's primary care provider (PCP) on 12/06/24 at 9:44am revealed:
-The facility had notified her of the difficulty in getting Resident #2 to eye appointments.
-She did not know if the facility had tried administering the as needed anti-anxiety medication prior to taking Resident #2 for an eye appointment.

Interview with the RCC on 12/09/24 at 1:51pm

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D 273	Continued From page 18 revealed: -Resident #2 was a fall risk. -Resident #2 would come out into the hallway of the facility and hold onto the hand railing. -Resident #2 expressed to her he felt like the floor was going to "fall in." -Resident #2's eye doctor told her it was Resident #2's depth perception (ability to see objects in three dimensions, including their size and how far away they are from you) that made the resident feel like he would fall. -On 12/05/24, Resident #2 went to his scheduled eye appointment. -They administered an anti-anxiety medication prior to leaving for the appointment. -They used a wheelchair to take Resident #2 into the appointment, so Resident #2 would not be afraid of falling. Telephone interview with Resident #2's MHP on 12/06/24 at 11:15am revealed: -Resident #2 was ordered to receive clonazepam to treat anxiety due to a diagnosis of agoraphobia (an anxiety disorder that involves intense fear of being in situations where escape may be difficult or help may not be available). -Leaving the facility for appointments could trigger "acute anxiety" for Resident #2. -Resident #2 had an as needed clonazepam (used to treat anxiety) ordered to be administered prior to leaving for an appointment. Interview with the Administrator on 12/10/24 at 1:52pm revealed: -Staff had taken Resident #2 to multiple eye appointments and once there the resident would not go in. -On 12/05/24, Resident #2 had "curled up on the sidewalk" outside the ophthalmology practice. -The transporting staff eventually was able to talk	D 273		

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Resident #2 into going inside and completing the appointment.

b. Review of the facility's medication policies and procedures manual dated 06/21/23 revealed:
-Omissions and refusals of medications will be documented on the electronic medication administration record (eMAR).
-Resident's provider will be notified after three consecutive missed/refused doses of medication.

Review of Resident #2's FL2 dated 07/11/24 revealed:
-There was an order for clozapine 25mg (used to treat schizophrenia) two tablets every morning at 8:00am.
-There was an order for clozapine 100mg one tablet daily at bedtime.
-There was an order for clonazepam (used to treat anxiety) 0.5mg three times daily at 8:00am, 12:00pm, and 4:00pm.
-There was an order for clonazepam 1mg daily at bedtime.
-There was an order for hydroxyzine (used to treat anxiety) 25mg 1 capsule twice daily.
-There was an order for mirtazapine (used to treat depression) 15mg 1/2 tablet (7.5mg) daily at bedtime.

Review of Resident #2's August 2024 eMAR revealed:
-There was an entry for clonazepam 1mg one half tablet three times daily scheduled for 8:00am, 12:00pm, and 4:00pm.
-On 08/30/24 at 12:37pm, clonazepam was documented as not administered due to "resident refused."

Review of Resident #2's September 2024 eMAR revealed:

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D 273	Continued From page 20 -There was an entry for clozapine 25 mg two tablets every morning scheduled at 8:00am. -There was an entry for clonazepam 1mg one half tablet three times daily scheduled for 8:00am, 12:00pm, and 4:00pm. -There was an entry for hydroxyzine 25mg one capsule twice daily scheduled for 8:00am and 6:00pm. -On 09/08/24 at 8:03am, clozapine, clonazepam, and hydroxyzine were documented as not administered due to "didn't want this am." Review of Resident #2's October 2024 eMAR revealed: -There was an entry for clonazepam 1mg one half tablet three times daily scheduled for 8:00am, 12:00pm, and 4:00pm. -There was an entry for clozapine 100mg one tablet at bedtime scheduled for 6:00pm. -There was an entry for hydroxyzine 25mg one capsule twice daily scheduled for 8:00am and 6:00pm. -There was an entry for mirtazapine 15mg 1/2 tablet (7.5mg) daily at bedtime scheduled at 6:00pm. -On 10/05/24 at 4:00pm, clonazepam was documented as not administered due to "resident refused." -On 10/06/24 at 4:00pm, clonazepam was documented as not administered due to "resident refused." -On 10/07/24 at 8:55am, clonazepam was documented as not administered due to "resident refused." -On 10/16/24 at 4:00pm, clonazepam was documented as not administered due to "resident refused." -On 10/16/24 at 6:00pm, clozapine, hydroxyzine, and mirtazapine were documented as not administered due to "resident refused."	D 273		

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-On 10/18/24 at 12:28pm, clonazepam was documented as not administered due to "resident refused."
-On 10/19/24 at 5:43pm, clonazepam was documented as not administered due to "resident refused."
-On 10/21/24 at 7:06pm, clonazepam was documented as not administered due to "resident refused."
-On 10/22/24 at 12:26pm, clonazepam was documented as not administered due to "resident refused."
-On 10/31/24 at 12:31pm, clonazepam was documented as not administered due to "resident refused."

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for clozapine 25 mg two tablets every morning scheduled at 8:00am.
-There was an entry for clonazepam 1mg one half tablet three times daily scheduled for 8:00am, 12:00pm, and 4:00pm.
-There was an entry for clonazepam 1mg one tablet at bedtime scheduled for 6:00pm.
-There was an entry for hydroxyzine 25mg one capsule twice daily scheduled for 8:00am and 6:00pm.
-On 11/02/24 at 8:00am, clozapine and hydroxyzine were documented as not administered due to "resident refused."
-On 11/03/24 at 5:24pm, clonazepam was documented as not administered due to "resident refused."
-On 11/07/24 at 12:06pm, clonazepam was documented as not administered due to "resident refused."
-On 11/07/24 at 4:00pm, clonazepam was documented as not administered due to "resident refused."

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-On 11/08/24 at 5:18pm, clonazepam was documented as not administered due to "resident refused."
-On 11/18/24 at 6:33pm, clonazepam was documented as not administered due to "resident refused."

Review of Resident #2's chart note entry dated 11/25/24 at 4:07pm revealed the Mental Health Provider (MHP) was "advised about resident refusal of clonazepam."

Interview with Resident #2 on 12/05/24 at 9:37am revealed:
-He always took his medications.
-He did not refuse his medications.
-He took clonazepam for anxiety, "nervousness", and "tranquility."

Telephone interview with Resident #2's Mental Health Provider (MHP) on 12/06/24 at 11:15am revealed:
-She was not aware of the refusals of the mental health medications for Resident #2.
-"Generally" Resident #2 took his medications.
-If Resident #2 tells you he has taken his medications, then she could not account for why refusals were documented on the eMAR.

Interview with a medication aide (MA) on 12/05/24 at 9:45am revealed:
-Resident #2 did not refuse medications when she administered medications.
-Resident #2 would come out to the medication cart to get his medications as soon as he heard her in the hallway at the medication cart.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed:
-If she did not offer Resident #2 a soda, he would

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refuse his medications.
-Resident #2 would also refuse medications if he "got mad" about going to the dining room.
-She reported refused medications to the physician if a resident refused a medication for three consecutive doses.
-Resident #2 did not refuse medications "that much."

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The policy on medication refusals was to notify the health care provider after three consecutive doses were missed.
-Residents would "sometimes" refuse medications when they did not like the MA who was assigned to administer their medications.
-Resident #2's PCP was there weekly for them to discuss concerns with her about Resident #2's care.

____

The facility failed to ensure Resident #2 went to his ophthalmology appointment after four cancellations due to his anxiety when an as needed anxiety medication was not administered prior to appointments on 10/30/24 and 11/15/24 for Resident #2 who experienced a problem with depth perception and the primary care provider was not notified of the refusals which put Resident #2 at a higher risk of falls for five months. This failure was detrimental to the health, safety, and welfare of the resident and constituted a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/10/24 for this violation.

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D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to maintain a record of menu substitutions indicating what food was served to residents. The findings are: Interview with a resident during the initial tour on 12/04/24 at 9:34am revealed: -The food was not very good. -There was never a menu posted to see what was going to be served at mealtimes. Review of the breakfast menu for 12/09/24 revealed the menu consisted of four ounces (oz.) of orange juice, one-half cup of cooked cereal or three-fourths cup of cold cereal, two slices of toast, one teaspoon of margarine, two teaspoons of jelly, 1 scrambled egg, eight oz. of milk and	D 292		

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eight oz. of coffee.

Observation of the breakfast meal service on 12/09/24 at 8:43am revealed the residents were served one waffle with syrup, two slices of turkey bacon, a fruit cup or applesauce, and eight oz. of apple cider.

Interview with residents on 12/09/24 between 8:47am and 8:53am revealed:
-They rarely get eggs served at breakfast.
-They did not get any eggs for breakfast on 12/09/24.
-They had not been given real bacon for breakfast in a long time.
-They never knew what was going to be served to them.
-He was not asked if he wanted waffles for breakfast on 12/09/24.

Interview with a cook on 12/09/24 at 8:55am and 12:30pm revealed:
-He prepared the breakfast meal for 12/09/24.
-He prepared meals for the residents according to what was on the menu.
-He saw cereal on the menu for breakfast for 12/09/24 and thought the residents might want waffles instead because they sometimes complained about having cold foods at breakfast.
-He could not serve eggs because there were only six and that was not enough for everyone.
-Instead of serving eggs he gave turkey bacon and a fruit cup or applesauce instead.
-He did not know what a menu substitution form was.
-He had only worked at the facility for a few weeks and had not been trained to document meal substitutions.

Interview with the Resident Care Coordinator

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(RCC) on 12/09/24 at 1:52pm revealed:
-The cook was new and still in training.
-The cook may not have known he needed to complete a menu substitution form.
-The blank menu substitution forms were available in the kitchen.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-They had food delivered to the facility at least once or twice a week.
-He was not aware the cook had not documented the menu change for the morning meal on 12/09/24.
-The staff should be documenting everything that was substituted on the menu substitution form.

D 344 — 10A NCAC 13F .1002(a) Medication Orders — D 344

10A NCAC 13F .1002 Medication Orders
(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure contact with the prescribing practitioner for clarification of

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medication orders for 1 of 3 sampled residents (Resident #2) related to all prescription and over-the-counter medication orders on the current FL2.

The findings are:

Review of Resident #2's current FL2 dated 08/26/24 revealed:
-Diagnoses included type 2 diabetes mellitus and schizoaffective disorder.
-There was an order for acetaminophen (used to treat pain) 325mg tablet with no dosage, route, or frequency instructions.
-There was an order for aspirin EC (used to prevent blood clots) 81mg tablet with no dosage, route, or frequency instructions.
-There was an order for atorvastatin (used to treat high cholesterol) 20mg tablet with no dosage, route, or frequency instructions.
-There was an order for chlorhexidine (used to treat gingivitis and periodontal disease) 0.12% rinse with no dosage, route, or frequency instructions.
-There was an order for clonazepam (used to treat anxiety) 1mg tablet with no dosage, route, or frequency instructions.
-There was an order for clozapine (used to treat schizophrenia) 100mg tablet with no dosage, route, or frequency instructions.
-There was an order for clozapine 25mg tablet with no dosage, route, or frequency instructions.
-There was an order for diphenhist (used to treat allergy symptoms) 25mg capsule with no dosage, route, or frequency instructions.
-There was an order for famotidine (used to treat esophageal reflux disease) 20mg tablet with no dosage, route, or frequency instructions.
-There was an order for guaifenesin (used to help clear mucus) 100mg/5ml solution with no dosage,

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route, or frequency instructions.
-There was an order for hydrocortisone (used to relieve redness, itching, and swelling) 1% cream with no dosage, route, or frequency instructions.
-There was an order for hydroxyzine (used to treat anxiety) 25mg tablet with no dosage, route, or frequency instructions.
-There was an order for hydroxyzine 25mg capsule with no dosage, route, or frequency instructions.
-There was an order for Imodium A-D (used to treat diarrhea) 2mg tablets with no dosage, route, or frequency instructions.
-There was an order for lisinopril (used to treat high blood pressure) 40mg tablet with no dosage, route, or frequency instructions.
-There was an order for loratadine (used to treat allergies) 10mg tablet with no dosage, route, or frequency instructions.
-There was an order for metformin (used to treat high blood sugar) 500mg tablet with no dosage, route, or frequency instructions.
-There was an order for metoprolol (used to treat high blood pressure) 25mg tablet with no dosage, route, or frequency instructions.
-There was an order for milk of magnesia (used to treat constipation) 400,g/5ml suspension with no dosage, route, or frequency instructions.
-There was an order for mirtazapine (used to treat depression) 15mg tablet with no dosage, route, or frequency instructions.
-There was an order for oxcarbazepine (used to treat seizures) 300mg tablet with no dosage, route, or frequency instructions.
-There was an order for senna 8.6mg (used to treat constipation) tablet with no dosage, route, or frequency instructions.
-There was an order for sodium chloride (used to replenish salt in the body) 1gm tablet with no dosage, route, or frequency instructions.

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-There was an order for triple antibiotic ointment (used to prevent and treat minor skin infections) with no dosage, route, or frequency instructions.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 11:45am revealed:
-The facility had recently changed to a different software program provided by the facility's contracted pharmacy to produce new FL2s for the residents.
-Resident #2's current FL2 was completed using the new software program.
-Many of the residents had new FL2s completed with the new software program.
-The medication orders were incomplete on all the new FL2s created with the software program.
-She had not noticed medication orders were incomplete on the new FL2s.
-She had obtained signatures from the primary care providers (PCP) on the new FL2s.

Telephone interview with Resident #2's primary care provider (PCP) on 12/06/24 at 9:44am revealed:
-She signed Resident #2's FL2 dated 08/26/24.
-She was "embarrassed" she had not noticed the medication orders were incomplete.
-Resident #2's medication orders from his prior FL2 dated 07/11/24 were correct.
-The facility staff did not notify her concerning the incomplete medication orders on Resident #2's FL2.

Interview with the RCC on 12/09/24 at 1:51pm revealed she was responsible for notifying the PCP and obtaining clarification on orders on the resident's FL2s.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:

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D 344	Continued From page 30 -The RCC was responsible for clarifying any medication orders on the FL2 that were not clear and complete. -The facility did not go by the FL2 for medication orders. -The facility went by the active medication orders from the pharmacy. -The incomplete medication orders on the FL2 were an "oversight."	D 344		
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure the medication container had a correct label for 1 of 1 sampled resident (Resident #1) with an insulin pen used to control high blood glucose levels.	D 354		

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The findings are:

Review of Resident #1's current FL2 dated 06/06/24 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #1's physician's orders dated 06/06/24 revealed there was an order for Tresiba (a long-acting insulin to treat high blood glucose levels) 100units (u)/milliliters (ml) inject 36u twice daily.

Review of Resident #1's physician's order dated 11/30/24 revealed the facility may use another resident's unopened Tresiba 200u/ml inject 18u twice daily in place of 100u/ml until the facility received Resident #1's Tresiba from the pharmacy.

Observation of Resident #1's medications on hand on 12/04/24 at 4:45pm revealed there was no Tresiba 100u/ml available for administration.

Second observation of Resident #1's medications on hand on 12/05/24 at 10:32am revealed:
-There was a Tresiba pen 200u/ml with a name blacked out with black marker and Resident #1's name handwritten on a piece of paper and taped to the lid.
-There was no change of direction label on the pen.
-There was no documentation with instructions of how to administer Resident #1's Tresiba 200u/ml on the medication cart.

Interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 10:47am revealed:
-The pharmacy only printed labels for medications and would never have handwritten

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Resident #1's name on paper and taped it to the Tresiba pen.
-Resident #1's Tresiba pen was ordered with a concentration of 100u/ml.
-The pharmacy did not receive an order or dispense Resident #1's Tresiba pen with a concentration of 200u/ml.
-The facility should have placed a change of direction sticker on the Tresiba pen 200u/ml being administered to Resident #1 and faxed a copy of the new order with dosage instructions to the pharmacy so that the medication could be updated on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 4:45pm revealed:
-Resident #1's Tresiba 100u/ml was not available for administration.
-The MAs had borrowed another resident's Tresiba which was a "higher" dose to administer to Resident #1.
-The Administrator would have to explain the details of the Tresiba borrowed to administer to Resident #1.

Interview with the RCC on 12/05/24 at 11:45am revealed:
-On 11/30/24, another MA got permission from an on-call provider to use another resident's Tresiba insulin pen with instructions to administer Tresiba 200u/ml inject 18u twice daily since Resident #1's Tresiba 100u/ml insulin pen was unavailable.
-She did not place a change of direction sticker on the Tresiba pen because she wrote the dosage and instructions on a sticky note on the medication cart.
-She did not know what happened to the sticky note with the dosage and instructions for Resident #1's Tresiba.
-MAs and agency staff knew how much Tresiba

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insulin to administer to Resident #1 because the directions were communicated by "word of mouth" to the oncoming shift and were written on a sticky note.

Interview with the Administrator on 12/05/24 at 3:22pm revealed:
-He was made aware by the RCC on 12/01/24 that Resident #1 ran out of Tresiba and another resident's Tresiba in a different concentration was being substituted.
-The facility did not have to label the Tresiba 200u/ml pen with a change of direction sticker for Resident #1.
-MAs knew to administer 18u twice daily of the Tresiba 200u/ml because they passed off the instructions by "word of mouth" during shift change.
-The facility only had 1 permanent MA and the RCC who administered medications and used agency staff daily to cover shifts.
-The agency staff were also instructed by "word of mouth" during shift change to administer Resident #1 18u of Tresiba 200u/ml.
-The RCC also wrote on a sticky note the direction change for Resident #1's Tresiba and kept it on the medication cart.
-He saw no issues with safety concerns related to the administration of Tresiba 200u/ml 18u to Resident #1 when there was no change of direction sticker on the pen and the eMAR was still documented as Tresiba 100u/ml inject 36u twice daily.
-The RCC had taken all precautions by writing the instructions on a sticky note and placing the note on the medication cart and staff verbally telling each other at the change of shift.

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO AN UNABATED TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered or 2 of 4 sampled residents (#1 and #2) related to medications to treat high blood sugar (#1), anxiety (#2), and a medication used to prevent infection of the mouth (#2). The findings are: Review of the facility's medication policies and procedures manual dated 06/21/23 revealed: -Medications, prescriptions and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Facility will assure that all medications are in stock and ready for use at the time prescribed by	D 358		

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the resident's physician.
-In the event that a medication is not delivered by the pharmacy, then the facility will borrow that medication and document it on the medication information form.
-All medication information forms will be given to the Resident Care Coordinator (RCC) so that they may follow up with the pharmacy.
-Any medication that is borrowed will be replaced upon the arrival of the receiving resident's medication from the pharmacy.

1. Review of Resident #1's current FL2 dated 06/06/24 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #1's physician's orders dated 06/06/24 revealed there was an order for Tresiba (a long-acting insulin to treat high blood glucose levels) 100units (u)/milliliters (ml) inject 36u twice daily.

Review of Resident #1's physician's order dated 11/30/24 revealed the facility may use another resident's unopened Tresiba 200u/ml inject 18u twice daily in place of 100u/ml until the facility received Resident #1's Tresiba from the pharmacy.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Tresiba 100u/ml inject 36u twice daily at 8:00am and 6:00pm-8:00pm.
-There was documentation Tresiba 100u/ml 36u was administered twice daily at 8:00am and 6:00pm-8:00pm from 10/01/24-10/31/24.

Review of Resident #1's November 2024 eMAR revealed:

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-There was an entry for Tresiba 100u/ml inject 36u twice daily at 8:00am and 6:00pm-8:00pm.
-There was documentation Tresiba 100u/ml 36u was administered twice daily at 8:00am and 6:00pm-8:00pm from 11/01/24-11/27/24.
-There was documentation Tresiba 100u/ml 36u was administered on 11/28/24 at 8:00am and on 11/30/24 at 6:00pm-8:00pm.
-There was no documentation Tresiba 100u/ml 36u was administered on 11/28/24 at 6:00pm-8:00pm, 11/29/24 at 8:00am or 6:00pm-8:00pm, and 11/30/24 at 8:00am.
-There was no documentation regarding why Tresiba was not administered on 11/28/24 at 6:00pm-8:00pm, 11/29/24 at 8:00am or 6:00pm-8:00pm, and 11/30/24 at 8:00am.

Review of Resident #1's 12/01/24-12/04/24 eMAR revealed:
-There was an entry for Tresiba 100u/ml inject 36u twice daily at 8:00am and 6:00pm-8:00pm.
-There was no entry for Tresiba 200u/ml inject 18u twice daily at 8:00am and 6:00pm-8:00pm.
-There was an entry to check fingerstick blood sugars (FSBS) four times daily before meals and at bedtime.
-There was documentation FSBS were checked at 7:30am, 11:30am, 4:30pm, and 8:00pm with the results ranging from 108-236.
-There was documentation Tresiba 100u/ml 36u was administered twice daily at 8:00am and 6:00pm-8:00pm from 12/01/24-12/03/24.
-There was documentation Tresiba 100u/ml 36u was administered on 12/04/24 at 8:00am.
-There was no documentation Tresiba 200u/ml 18u was administered at 8:00am and 6:00pm-8:00pm from 12/01/24-12/03/24 and at 8:00am on 12/04/24.

Observation of Resident #1's medications on

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hand on 12/04/24 at 4:45pm revealed there was no Tresiba 100u/ml available for administration.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 4:45pm revealed:
-Resident #1's Tresiba 100u/ml was not available for administration.
-The MAs had borrowed another resident's Tresiba which was a "higher" dose to administer to Resident #1.
-The Administrator would have to explain the details of the Tresiba borrowed to administer to Resident #1.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 9:35am revealed:
-Resident #1's Tresiba 100u/ml pen was previously dispensed on 08/29/24 in the quantity of 21ml, 09/23/24 in the quantity of 21ml, and 10/09/24 in the quantity of 21ml and would last approximately 30 days with each refill.
-Resident #1's Tresiba would have run out towards the end of November 2024.
-The facility had to request refills from the pharmacy when a medication was in low supply or out and no request had been received for a refill for Resident #1's Tresiba since 10/09/24.

Second observation of Resident #1's medications on hand on 12/05/24 at 10:32am revealed:
-There was a Tresiba pen with a name blacked out with black marker and Resident #1's name handwritten on a piece of paper and taped to the lid.
-The concentration on the Tresiba pen was 200u/ml.
-There was no change of direction label on the pen.

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Second telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 10:47am revealed:
-The pharmacy only printed labels for medications and would never have handwritten Resident #1's name on paper and taped it to the Tresiba pen.
-Resident #1's Tresiba pen was ordered with a concentration of 100u/ml.
-The pharmacy did not dispense Resident #1's Tresiba pen with a concentration of 200u/ml.
-Insulin pens should never be shared for infection control purposes.
-She would never recommend for the MAs to convert the dosage of Resident #1's ordered Tresiba 100u/ml inject 36u twice daily with the Tresiba pen with Resident #1's name handwritten and taped to the lid with a concentration of 200u/ml.
-The dosage of Resident #1's Tresiba would have to be changed if the facility staff used the pen with 200u/ml along with medication and dosage instructions on the eMAR to make sure Resident #1's Tresiba was administered and documented accurately.
-The facility should have placed a change of direction sticker on the Tresiba pen 200u/ml being administered to Resident #1 and faxed a copy of the new order with dosage instructions to the pharmacy so that the medication could be updated on the eMAR.
-The pharmacy never received a fax with a new order for Resident #1's Tresiba.
-The facility requested a refill for Resident #1's Tresiba 100u/ml the evening of 12/04/24.
-The pharmacy dispensed a refill for Resident #1's Tresiba 100u/ml in the quantity of 21 millileters and will deliver it to the facility today (12/05/24).

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Interview with the RCC on 12/05/24 at 11:45am revealed:
-On 11/30/24, another MA got permission from an on-call provider to use another resident's Tresiba insulin pen with instructions to administer Tresiba 200u/ml inject 18u twice daily since Resident #1's Tresiba 100u/ml insulin pen was unavailable.
-The MA who got permission to use another resident's Tresiba for Resident #1 was responsible for requesting a refill for Resident #1's Tresiba from the pharmacy.
-The entry on Resident #1's eMAR was not changed from Tresiba 100u/ml inject 36u twice daily to Tresiba 200u/ml inject 18u twice daily.
-Sometimes she administered Resident #1's medications and she injected Tresiba 18u of the 200u/ml pen to Resident #1 and documented that she administered 36u of the 100u/ml twice daily on Resident #1's eMAR.
-The facility's policy allowed borrowing medications from other residents when medications were unavailable.
-Resident #1's Tresiba was not on a cycle-fill and had to be requested for refill from the facility's contracted pharmacy.
-She was responsible for auditing the medication cart and requested refills for medications every 2 weeks when they were in low supply.
-She did not call the pharmacy to see why Resident #1's Tresiba was not delivered because they were given permission by an on-call provider to use another resident's Tresiba pen.

Review of an electronic triage communication note for Resident #1's on-call provider dated 11/30/24 at 5:44pm revealed:
-A MA documented Resident #1 was out of Tresiba 100u/ml and another resident had Tresiba 200u/ml available and asked if the other resident's Tresiba could be used instead until

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Monday (12/02/24).
-The on-call provider asked the estimated time of arrival for Resident #1's Tresiba from the pharmacy.
-The MA responded back Monday (12/02/24) and the pharmacy was closed for the weekend.
-The provider asked if Resident #1 missed any doses.
-The MA responded, no. She thought Resident #1's Tresiba ran out that morning and it was not reported to her on shift change.
-The provider asked what time the next dose was scheduled.
-The MA responded at 6:00pm.
-The provider asked what Resident #1's current blood sugar reading was.
-The MA responded 286.
-The provider ordered may use Tresiba 200u/ml inject 18u twice daily in place of 100u/ml until the facility received Resident #1's Tresiba from the pharmacy delivery.

Interview with Resident #1 on 12/06/24 at 10:05am revealed:
-The facility ran out of her Tresiba for 2 days at the end of November 2024.
-The facility told her they got her Tresiba refilled by the pharmacy and was administering it to her.

Telephone interview with Resident #1's primary care provider (PCP) on 12/06/24 at 9:42am revealed:
-She was not notified by the facility that Resident #1 ran out of Tresiba 100u/ml.
-She was not notified by the facility that a different dosage or concentration of Tresiba was being administered to Resident #1 since 11/30/24.
-She was able to pull up the encounter of the conversation on the electronic triage note dated 11/30/24 at 5:44pm where the on-call provider

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currently and used agency staff daily to cover shifts.
-The agency staff were also instructed by "word of mouth" during shift change to administer Resident #1 18u of Tresiba 200u/ml.
-He saw no issues with safety concerns related to the administration of Tresiba 200u/ml 18u to Resident #1 when there was no change of direction sticker on the pen and the eMAR was still documented as Tresiba 100u/ml inject 36u twice daily.
-The RCC had taken all precautions by writing the instructions on a sticky note and placing the note on the medication cart and staff verbally telling each other at the change of shift.
-The facility would have to request a refill for the resident's Tresiba 200u/ml that was borrowed for Resident #1 and would cover the cost to pay back the Tresiba since Resident #1's concentration was 100u/ml.
-He was responsible for changing the dose and concentration on the eMAR for Resident #1's Tresiba 200u/ml inject 18u twice daily because no one else knew how to.
-The RCC or MAs were responsible for requesting refills for medications.
-The RCC did not fax the order to the pharmacy to change Resident #1's Tresiba 200u/ml inject 18u twice daily because she was not working when the MA got the order from Resident #1's on-call provider.

Observation of Resident #1's medications on hand on 12/05/24 at 12:03pm there were 7 pens of Tresiba 100u/ml delivered to the facility from the facility's contracted pharmacy with a dispense date of 12/04/24.

2. Review of Resident #2's FL2 dated 07/11/24

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revealed diagnoses included type 2 diabetes and schizoaffective disorder.

a. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for clonazepam (used to treat anxiety) 1mg one tablet at bedtime.

Review of Resident #2's mental health provider (MHP) prescription dated 09/03/24 revealed clonazepam 1mg one tablet at bedtime quantity 30 with five refills.

Review of Resident #2's August 2024 electronic medication administration record (eMAR) from 08/20/24-08/31/24 revealed:
-There was an entry for clonazepam 1mg one tablet daily at bedtime scheduled for 6:00pm.
-The clonazepam 1mg was documented as administered 11 occurrences out of 12 opportunities.
-On 08/31/24, the clonazepam was documented as not administered due to "other read chart note."

Review of Resident #2's August 2024 charting notes revealed there was no entry for 08/31/24.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet daily at bedtime scheduled for 6:00pm.
-The clonazepam 1mg was documented as administered 28 occurrences out of 30 opportunities.
-On 09/01/24, the clonazepam 1mg was documented as not administered due to "other read chart note."
-On 09/02/24, the clonazepam 1mg was documented as not administered due to "medication on order from pharmacy."

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Review of Resident #2's September 2024 charting notes revealed there was no entry for 09/01/24.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 08/28/24-09/06/24 for clonazepam 1mg 1/2 tab (0.5mg) tablets dispensed 07/15/24 quantity of 30 half tablets revealed:
-On 08/31/24 at 7:00pm, clonazepam 0.5mg was documented as administered.
-On 09/01/24 at 6:00pm, clonazepam 0.5mg was documented as administered.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet daily at bedtime scheduled for 6:00pm.
-The clonazepam was documented as administered 30 occurrences out of 31 opportunities.
-On 10/21/24 at 7:06pm, the clonazepam was documented as not administered due to "resident refused."

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet daily at bedtime scheduled for 6:00pm.
-The clonazepam was documented as administered 30 occurrences out of 30 opportunities.
-On 11/15/24 at 9:17pm, the clonazepam was documented as "borrowed from" as needed supply of clonazepam.

Review of Resident #2's CSCS dated 06/27/24-11/19/24 for clonazepam 0.5mg one tablet daily as needed for anxiety dispensed

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06/20/24 quantity of 30 revealed:
-On 09/15/24 at 6:00pm, clonazepam 0.5mg was documented as administered.
-On 11/03/24 no documented time, clonazepam 0.5mg was documented as administered.
-On 11/04/24 no documented time, clonazepam 0.5mg was documented as administered.
-On 11/15/24 no documented time, clonazepam 0.5mg was documented as administered.

Review of Resident #2's CSCS dated 10/01/24-10/11/24 for clonazepam 1mg 1/2 tab (0.5mg) tablets dispensed 09/03/24 quantity of 30 half tablets revealed on 10/04/24 at 6:00pm, clonazepam 0.5mg was documented as administered.

Review of Resident #2's CSCS dated 10/24/24-11/04/24 for clonazepam 1mg 1/2 tab (0.5mg) tablets dispensed 10/03/24 quantity of 30 half tablets revealed on 10/27/24 at 6:00pm, clonazepam 0.5mg was documented as administered.

Observation of Resident #2's medications on hand on 12/04/24 at 3:56pm revealed:
-There was one bubble pack labeled "bedtime" of clonazepam 1mg with one tablet remaining.
-The pharmacy label directions were clonazepam 1mg one tablet at bedtime.
-The dispense date was 11/04/24 quantity of 30 tablets.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 3:44pm revealed:
-The pharmacy provided a CSCS for each quantity dispensed to be used to document the administration for inventory control.
-The pharmacy dispensed and delivered 30

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tablets of clonazepam 1mg for Resident #2 on 09/03/24, 10/03/24, and 11/04/24.
-Each delivery provided a 30 day supply of the bedtime dose.
-The pharmacy provided a CSCS form with each bubble pack of the clonazepam 1mg tablets.

Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed:
-The entries on the CSCS dated 11/03/24 and 11/04/24 were documented "borrowed" by her.
-She borrowed clonazepam 0.5mg from Resident #2's as needed bubble pack.
-She borrowed the daily medication because she did not have a supply of clonazepam 1mg tablets available to administer.
-She had not realized at the time the strength of the clonazepam in the as needed bubble pack was 0.5mg instead of 1mg.

Interview with Resident #2 on 12/04/24 at 9:30am revealed:
-The facility "sometimes" ran "short" of his clonazepam.
-This usually occurred when it was time for the monthly cycle fill of medications to arrive from the pharmacy.

Telephone interview with Resident #2's mental health provider (MHP) on 12/06/24 at 11:15am revealed:
-Resident #2 was ordered to receive clonazepam to treat anxiety due to a diagnosis of agoraphobia (an anxiety disorder that involves intense fear of being in situations where escape may be difficult or help may not be available).
-There was a potential for increased anxiety when Resident #2 did not receive clonazepam as ordered.
-She was not aware of Resident #2 experiencing

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any increased anxiety.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-Their contracted pharmacy could do a partial or emergency supply of a medication at their discretion.
-Their medication policy allowed the medication aides (MAs) to borrow out of stock medications.
-The MAs were required to report any borrowed medications to the RCC.
-The MAs were not paying attention when they documented on the CSCS.
-The MAs had received training on the importance of documenting CSCS entries legibly and include a date and time.
-The eMAR was the prevailing record of the facility's medication administration policy.

b. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for chlorhexidine 0.12% rinse (used to reduce the inflammation and swelling of the gums and reduce gum bleeding) swish and spit 15ml by mouth twice daily at 8:00am and 6:00pm.

Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 59 occurrences out of 60 opportunities.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily

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scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 61 occurrences out of 62 opportunities.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 57 occurrences out of 60 opportunities.

Review of Resident #2's December 2024 eMAR 12/01/23-12/05/24 revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 10 occurrences out of 10 opportunities.
-On 12/03/24 at 5:38pm, chlorhexidine was documented as borrowed.
-On 12/04/24 at 8:04am, chlorhexidine was documented as borrowed.
-On 12/04/24 at 5:57pm, chlorhexidine was documented as borrowed.
-On 12/05/24 at 5:20pm, chlorhexidine was documented as borrowed.

Review of Resident #2's chart note entries dated 08/20/24 -12/05/24 revealed:
-On 12/02/24 at 6:20pm, the medication was documented as borrowed "waiting on d/c order."
-On 12/03/24 at 7:35am, the medication was documented as borrowed "temp waiting on d/c order."
-On 12/05/24 at 7:21am, the medication was documented as borrowed "waiting on d/c order."

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Observation of Resident #2's medications on hand on 12/04/24 at 3:56pm revealed there was no chlorhexidine available.

Interview with Resident #2 on 12/04/24 at 2:39pm revealed he refused to go to a dental appointment "once."

Interview with Resident #2 on 12/06/24 at 9:27am revealed:
-He received the chlorhexidine that morning.
-The chlorhexidine was used to clean his teeth and mouth.
-Prior to the morning of 12/06/24, he had not received the chlorhexidine in "two weeks."

Telephone interview with Resident #2's primary care provider (PCP) on 12/06/24 at 9:49am revealed:
-She did not prescribe the chlorhexidine for Resident #2.
-"Theoretically" the chlorhexidine would help keep down infections in the mouth.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 10:27am revealed:
-The current order for chlorhexidine 0.12% 15ml twice daily.
-They dispensed bottles of chlorhexidine to Resident #2 on 05/29/24, 06/25/24, 08/09/24, and on 12/05/24.
-One bottle of chlorhexidine was a 17-day supply with Resident #2 receiving it twice daily.

Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed:
-She removed Resident #2's chlorhexidine solution off the medication cart on 12/02/24.

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-She and Resident #2's PCP had discussed discontinuing the medication.
-She had borrowed chlorhexidine solution from another resident's supply to administer to Resident #2.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-He did not know why the medication aides (MAs) documented administration of chlorhexidine when there did not seem to have been enough supply sent from the pharmacy.
-The RCC was responsible for checking the medication carts to ensure the medications ordered were available for administration.
-The eMAR should reflect the medication administered.
-Their contracted pharmacy could do a partial or emergency supply of a medication at their discretion.
-They had extra stock of medications when they took over management of the facility and perhaps the MAs had been using from previous stock of chlorhexidine.
-The MAs must have borrowed the last few doses of chlorhexidine for Resident #2 from another resident because the "back log" of chlorhexidine was used up.
-Their medication policy allowed the MAs to borrow out of stock medications.
-They did not have a specific policy on how to pay back the resident whose medications were borrowed.
-The MAs were required to report any borrowed medications to the RCC prior to borrowing a medication.

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The facility failed to ensure medications were administered as ordered when Resident #1 was administered another resident's Tresiba 200u/ml

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D 358	Continued From page 51 with no change of direction sticker affixed to the insulin pen, the entry and dose/concentration were not changed on the eMAR, and Tresiba 100u/ml 36u was documented as administered twice daily with no way to tell if Resident #1 was administered the correct dosage of Tresiba placing Resident #1 at risk of receiving twice the dosage with each injection that would cause seriously low blood sugar levels requiring an emergency room evaluation and treatment. Resident #2 was administered a medication as ordered to treat anxiety by administering an as needed dose of clonazepam 0.5mg instead of the ordered clonazepam 1mg scheduled at 6:00pm for 5 instances between 08/20/24-11/19/24 placing Resident #2 at an increased risk of experiencing increased anxiety. This failure was detrimental to the health and safety of Resident #1 and #2 and constitutes a Type B Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/05/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 19, 2025.	D 358		
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;	D 367		

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(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 3 of 3 sampled residents (Resident #1, #2, and #3) including accurate documentation of a long-acting insulin to treat high glucose levels (#1), a medication used to treat anxiety (#2), and a steroid cream used to reduce skin inflammation and irritation (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 06/06/24 revealed diagnoses included diabetes mellitus type 2.

Review of Resident #1's physician's orders dated 06/06/24 revealed there was an order for Tresiba (a long-acting insulin to treat high blood glucose levels) 100units (u)/milliliters (ml) inject 36u twice daily.

Review of Resident #1's physician's order dated

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11/30/24 revealed the facility may use another resident's unopened Tresiba 200u/ml inject 18u twice daily in place of 100u/ml until the facility received Resident #1's Tresiba from the pharmacy.

Review of Resident #1's 12/01/24-12/04/24 electronic medication administration record (eMAR) revealed:
-There was an entry for Tresiba 100u/ml inject 36u twice daily at 8:00am and 6:00pm-8:00pm.
-There was no entry for Tresiba 200u/ml inject 18u twice daily at 8:00am and 6:00pm-8:00pm.
-There was an entry to check fingerstick blood sugars (FSBS) four times daily before meals and at bedtime.
-There was documentation FSBS were checked at 7:30am, 11:30am, 4:30pm, and 8:00pm with the results ranging from 108-236.
-There was documentation Tresiba 100u/ml 36u was administered twice daily at 8:00am and 6:00pm-8:00pm from 12/01/24-12/03/24.
-There was documentation Tresiba 100u/ml 36u was administered on 12/04/24 at 8:00am.
-There was no documentation Tresiba 200u/ml 18u was administered at 8:00am and 6:00pm-8:00pm from 12/01/24-12/03/24 or at 8:00am on 12/04/24.

Observation of Resident #1's medications on hand on 12/04/24 at 4:45pm revealed there was no Tresiba available for administration.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 4:45pm revealed:
-Resident #1's Tresiba 100u/ml was not available for administration.
-The MAs had borrowed another resident's Tresiba which was a "higher" dose to administer to Resident #1.

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D 367	Continued From page 54 -The Administrator would have to explain the details of the Tresiba borrowed to administer to Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 9:35am revealed: -Resident #1's Tresiba 100u/ml pen was previously dispensed on 08/29/24 in the quantity of 21ml, 09/23/24 in the quantity of 21ml, and 10/09/24 in the quantity of 21ml and would last approximately 30 days with each refill. -Resident #1's Tresiba would have run out towards the end of November 2024. -The facility had to request refills from the pharmacy when a medication was in low supply or out and no request had been received for a refill for Resident #1's Tresiba since 10/09/24. Second observation of Resident #1's medications on hand on 12/05/24 at 10:32am revealed: -There was a Tresiba pen with a name blacked out with black marker and Resident #1's name handwritten on a piece of paper and taped to the lid. -The concentration on the Tresiba pen was 200u/ml instead of Resident #1's ordered 100u/ml. -There was no change of direction label on the pen. Second telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 10:47am revealed: -Resident #1's Tresiba pen was ordered with a concentration of 100u/ml. -The pharmacy did not dispense Resident #1's Tresiba pen with a concentration of 200u/ml. -The dosage of Resident #1's Tresiba would have to be changed if the facility staff used the pen with	D 367		

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200u/ml along with medication and dosage instructions on the eMAR to make sure Resident #1's Tresiba was administered and documented accurately.
-The facility should have faxed a copy of the new order with dosage instructions to the pharmacy so that the medication could be updated on the eMAR.
-The pharmacy never received a fax with a new order for Resident #1's Tresiba.

Interview with the RCC on 12/05/24 at 11:45am revealed:
-On 11/30/24, another MA got permission from an on-call provider to use another resident's Tresiba insulin pen with instructions to administer Tresiba 200u/ml inject 18u twice daily since Resident #1's Tresiba 100u/ml insulin pen was unavailable.
-The MA who got permission to use another resident's Tresiba for Resident #1 was responsible for requesting a refill for Resident #1's Tresiba from the pharmacy.
-The entry on Resident #1's eMAR was not changed from Tresiba 100u/ml inject 36u twice daily to Tresiba 200u/ml inject 18u twice daily.
-Sometimes she administered Resident #1's medications, and she injected Tresiba 18u of the 200u/ml pen to Resident #1 and documented that she administered 36u of the 100u/ml twice daily on Resident #1's eMAR.
-Resident #1's Tresiba was not on a cycle-fill and had to be requested for refill from the facility's contracted pharmacy.

Interview with Resident #1 on 12/06/24 at 10:05am revealed:
-The facility ran out of her Tresiba for 2 days at the end of November 2024.
-The facility told her they got her Tresiba refilled by the pharmacy and was administering it to her.

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Interview with the Administrator on 12/05/24 at 3:22pm and 12/10/24 at 1:53pm revealed:
-The RCC also wrote on a sticky note the direction change for Resident #1's Tresiba and kept it on the medication cart.
-He was made aware by the RCC on 12/01/24 that Resident #1 ran out of Tresiba and another resident's Tresiba in a different concentration was being substituted.
-MAs knew to administer 18u twice daily of the Tresiba 200u/ml because they passed off the instructions by "word of mouth" during shift change.
-He saw no issues with safety concerns related to the administration of Tresiba 200u/ml 18u to Resident #1 when there was no change of direction sticker on the pen and the eMAR was still documented as Tresiba 100u/ml inject 36u twice daily.
-The RCC had taken all precautions by writing the instructions on a sticky note and placing the note on the medication cart and staff verbally telling each other at the change of shift.
-He was responsible for changing the dose and concentration on the eMAR for Resident #1's Tresiba 200u/ml inject 18u twice daily because no one else knew how to.
-The RCC faxed orders to the pharmacy and the pharmacy changed the orders on the eMAR.
-The RCC did not fax the order to the pharmacy to change Resident #1's Tresiba 200u/ml inject 18u twice daily because she was not working when the former MA got the order from Resident #1's on-call provider.

2. Review of Resident #2's FL2 dated 07/11/24 revealed diagnoses included type 2 diabetes and schizoaffective disorder.

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a. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for chlorhexidine 0.12% rinse (used to reduce the inflammation and swelling of the gums and reduce gum bleeding) swish and spit 15ml by mouth twice daily at 8:00am and 6:00pm.

Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 59 occurrences out of 60 opportunities.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 61 occurrences out of 62 opportunities.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 57 occurrences out of 60 opportunities.

Review of Resident #2's December 2024 eMAR 12/01/23-12/05/24 revealed:
-There was an entry for chlorhexidine 0.12% rinse swish and spit 15ml by mouth twice daily

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scheduled at 8:00am and 6:00pm.
-The chlorhexidine was documented as administered 10 occurrences out of 10 opportunities.
-On 12/03/24 at 5:38pm, chlorhexidine was documented as borrowed.
-On 12/04/24 at 8:04am, chlorhexidine was documented as borrowed.
-On 12/04/24 at 5:57pm, chlorhexidine was documented as borrowed.
-On 12/05/24 at 5:20pm, chlorhexidine was documented as borrowed.

Review of Resident #2's chart note entries dated 08/20/24 -12/05/24 revealed:
-On 12/02/24 at 6:20pm, the medication was documented as borrowed "waiting on d/c order."
-On 12/03/24 at 7:35am, the medication was documented as borrowed "temp waiting on d/c order."
-On 12/05/24 at 7:21am, the medication was documented as borrowed "waiting on d/c order."

Observation of Resident #2's medications on hand on 12/04/24 at 3:56pm revealed there was no chlorhexidine available.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 10:27am revealed:
-The current order for chlorhexidine 0.12% 15ml twice daily.
-They dispensed bottles of chlorhexidine to Resident #2 on 05/29/24, 06/25/24, 08/09/24, and on 12/05/24.
-One bottle of chlorhexidine was a 17-day supply with Resident #2 receiving it twice daily.

Interview with Resident #2 on 12/06/24 at 9:27am revealed prior to the morning of 12/06/24, he had

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not received the chlorhexidine in "two weeks."

Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed:
-She removed Resident #2's chlorhexidine solution off the medication cart on 12/02/24.
-She had borrowed chlorhexidine solution from another resident's supply to administer to Resident #2.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The MAs should only document administration of the chlorhexidine when they administered it to the resident.
-The eMAR should reflect the medication administered.

b. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for clonazepam (used to treat anxiety) 0.5mg three times daily at 8:00am, 12:00pm, and 4:00pm.

Review of Resident #2's mental health provider (MHP) prescription dated 09/03/24 revealed:
-Clonazepam 1mg one tablet at bedtime quantity 30 with five refills.
-There was a note on the prescription to refill half tablets three times a day #45 with five refills.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/24 at 3:44pm revealed:
-The pharmacy dispensed and delivered three bubble packs of 30 half tablets of clonazepam 1mg for Resident #2 on 09/03/24, 10/03/24, and 11/04/24.
-Each delivery provided a 30 day supply of the morning, noon, and evening scheduled doses.
-The pharmacy provided a Controlled Substance

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Count Sheet (CSCS) form with each bubble pack of the clonazepam for inventory.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for clonazepam 1mg take one half tablet three times daily scheduled at 8:00am, 12:00pm, 4:00pm.
-The clonazepam 0.5mg was documented as administered 89 occurrences out of 90 opportunities from 09/01/24-09/30/24.
-On 09/27/24 at 12:00pm, clonazepam 0.5mg was documented as administered.
-On 09/27/24 at 4:00pm, clonazepam 0.5mg was documented as administered.
-On 09/28/24 at 12:00pm, clonazepam 0.5mg was documented as administered.
-On 09/28/24 at 4:00pm, clonazepam 0.5mg was documented as administered.
-On 09/29/24 at 12:00pm, clonazepam 0.5mg was documented as administered.
-On 09/29/24 at 4:00pm, clonazepam 0.5mg was documented as administered.
-On 09/30/24 at 12:00pm, clonazepam 0.5mg was documented as administered.
-On 09/30/24 at 4:00pm, clonazepam 0.5mg was documented as administered.

Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 09/03/24 quantity of 30 half tablets revealed:
-Administration dates on the CSCS included 09/18/24-09/28/24.
-There was no documented administration of clonazepam 0.5mg on 09/27/24 at 12:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/27/24 at 4:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/28/24 at 12:00pm.
-There was no documented administration of

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clonazepam 0.5mg on 09/28/24 at 4:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/29/24 at 12:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/29/24 at 4:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/30/24 at 12:00pm.
-There was no documented administration of clonazepam 0.5mg on 09/30/24 at 4:00pm.
-The last entry on the CSCS was 09/29/24 at 8:00am.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for clonazepam 1mg take one half tablet three times daily scheduled at 8:00am, 12:00pm, 4:00pm.
-The clonazepam 0.5mg was documented as administered 81 occurrences out of 90 opportunities from 11/01/24-11/30/24.
-On 11/01/24 at 12:00pm, clonazepam 0.5mg was documented as administered.
-On 11/05/24 at 4:00pm, clonazepam 0.5mg was documented as administered.
-On 11/20/24 at 12:00pm, clonazepam 0.5mg was documented as administered.

Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 10/03/24 quantity of 30 half tablets revealed:
-Administration dates on the CSCS included 10/24/24-11/04/24.
-There was no documented administration of clonazepam 0.5mg on 11/01/24 at 12:00pm.
-The last entry on the CSCS was 11/04/24 at 12:00pm.

Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 10/03/24 quantity of 30 half tablets revealed:

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-Administration dates on the CSCS included 10/24/24-11/15/24.
-There was no documented administration of clonazepam 0.5mg on 11/05/24 at 4:00pm.
-The last entry on the CSCS was 11/15/24 at 12:00pm.

Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 11/04/24 quantity of 30 half tablets revealed:
-Administration dates on the CSCS included 11/17/24-11/27/24.
-There was no documented administration of clonazepam 0.5mg on 11/20/24 at 12:00pm.
-The last entry on the CSCS was 11/27/24 at 12:00pm.

Interview with the Resident Care Coordinator (RCC) on 12/09/24 at 1:51pm revealed:
-She called the pharmacy and asked them to stop sending bubble packs of clonazepam 1mg half tablets quantity 30 with administration times on each card (morning, noon, and evening).
-When the pharmacy continued to send the bubble packs with administration time stickers on them, she would pull the stickers off and just write the times of administration on the top of the bubble packs.
-The medication aides (MAs) had been instructed by her to sign out morning, noon and evening doses on one CSCS inventory sheet.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The eMAR was the prevailing record of the facility's medication administration policy.
-The MAs were "not paying attention" when they documented on CSCS inventory sheets.
-The MAs had not been able to follow directions on how to document on three different CSCS

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sheets (morning, noon, and evening) for Resident #2's clonazepam 0.5mg scheduled doses.
-So "we pulled those" and asked the MAs to just document on one CSCS for all administration times of clonazepam 0.5mg for Resident #2.
-He had trained the MAs on how to properly document CSCS entries.
-He also trained the MAs to count off and verify the accuracy of the counts of all controlled substances on the medication cart with the oncoming MA at the end of their shifts.

3. Review of Resident #3's current FL2 dated 12/29/23 revealed:
-Diagnoses included chronic lung disease and high blood pressure.
-He was intermittently disoriented.

Review of Resident #3's physician orders revealed an order dated 04/15/24 for triamcinolone 0.1% cream apply to affected area twice daily with a stop date of 12/28/24.

Review of Resident #3's November 2024 eMAR revealed:
-There was an order for triamcinolone cream 0.1% apply to affected area twice daily.
-The RCC documented she administered the triamcinolone cream 0.1% to Resident #3 on 11/02/24, 11/04/24, 11/15/24, 11/16/24 and 11/21/24 at 8:00am.
-The RCC documented she administered the triamcinolone cream 0.1% to Resident #3 on 11/01/24, 11/02/24, 11/03/24, 11/05/24, 11/06/24, 11/07/24, 11/22/24 and 11/23/24 at 6:00pm.

Review of Resident #3's December 1-5, 2024, eMAR revealed:
-The RCC documented she administered the

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triamcinolone cream 0.1% to Resident #3 on 12/03/24 at 6:00pm.

Review of Resident #3's available medications for administration on 12/04/24 revealed there was a tube of triamcinolone 0.1% cream for Resident #3.

Interview with Resident #3 on 12/04/24 at 4:38pm revealed:
-He used to have a rash in his "private area" and pointed to his groin.
-Some staff offered him the medicated cream and some did not.
-Staff would give him the cream and he would self-administer it.

Interview with the Resident Care Coordinator (RCC) on 12/05/24 at 12:09pm revealed:
-She had never administered Resident #3's triamcinolone cream 0.1%.
-Anytime she offered the triamcinolone cream to Resident #3, he would refuse it.
-She had contacted the pharmacy recently to have the triamcinolone cream 0.1% removed from the electronic medication administration record (eMAR) because Resident #3 refused it.
-Any documentation she made that she administered Resident #3's triamcinolone cream was an error.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-He was not aware that staff had been erroneously documenting triamcinolone cream was being administered to Resident #3.
-The eMAR documentation should reflect medications that are administered.

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D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 3 sampled residents (#7, #8, and #3) had a physician order to self-administer medications related to treat gastric reflux (#7), treat lung disease (#8), and a medicated cream for a skin rash (#3). The findings are: Review of the facility's Medication Policies related to Resident Self-Administration of Medication dated 06/21/23 revealed: -A resident must be competent and physically able to self-administer medications. -The medication to be self administered will be ordered by a physician or other legally authorized person to prescribe and kept in the resident's record.	D 375		

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1) Review of Resident #7's current FL2 dated 06/06/24 revealed:
-Diagnoses included schizoaffective disorder and gastric esophageal reflux disease (GERD).
-There was no information listed regarding his orientation.

Observation of Resident #7's room during the initial tour on 12/04/24 at 9:26am revealed:
-There was a plastic bottle of calcium carbonate (used to treat GERD) on his bedside table.
-The plastic bottle of calcium carbonate label indicated there were 72 chewable 1000mg tablets.
-The plastic bottle of calcium carbonate was approximately 75% empty.

Interview with Resident #7 on 12/04/24 at 9:26am revealed:
-He had to take the calcium carbonate tablets to help with his heartburn.
-The last time he took a calcium carbonate tablet was last week.
-A family member brought him the calcium carbonate tablets.

Review of Resident #7's physician orders revealed:
-There was no order for calcium carbonate.
-There was no order to self-administer calcium carbonate.

Interview with a medication aide (MA) on 12/04/24 at 2:40pm revealed:
-Resident #7 did not have orders to self-administer calcium carbonate.
-She was not aware he had calcium carbonate in his room.
-She was not aware he was self-administering

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calcium carbonate in his room.
-She did not always give medication to the residents in their rooms.
-Sometimes she gave medication in the hallway, on the smoking porch, or residents may come to the medication cart when it was time for their medication administration.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 3:02pm revealed:
-Resident #7 did not have an order to self-administer calcium carbonate.
-She was not aware the calcium carbonate was in his room.
-Resident #7 would walk to the medication cart when it was time for his medications to be administered.
-Resident #7 did not see the facility primary care provider (PCP).
-A family member took Resident #7 to all his medical appointments outside the facility.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-In order for a resident to self-administer medications, the PCP had to write an order for it.
-If the PCP wrote an order for a resident to self-administer medications, there was not an assessment completed to verify the resident could safely and accurately self-administer the medication.
-Calcium carbonate was not a medication Resident #7 needed a physician's order to self-administer since it was an over-the-counter medication.

2) Review of Resident #8's current FL2 dated 06/06/24 revealed:
-Diagnoses included Parkinson's disease and anxiety.

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-He had intermittent disorientation.

Review of a medical report from a local hospital dated 09/23/24 revealed Resident #8 had pulmonary hypertension (a type of high blood pressure affecting the arteries in the lungs and the heart) and mild to moderate emphysema (chronic lung disease).

Observation of Resident #8's room during the initial tour on 12/04/24 at 10:01am revealed:
-There was a nebulizer machine in his room.
-He had a cup with 4 unopened vials of a liquid medication beside the nebulizer.

Interview with Resident #8 on 12/04/24 at 10:01am and 12/05/24 at 11:45am revealed:
-He had breathing problems, so he took medicine for it when he needed it.
-He could self-administer his breathing treatments.
-He had a breathing treatment with the medication about a week ago.

Review of Resident #8's physician orders revealed:
-The original order dated 07/07/23 for Ipratropium/Albuterol (used to treat various lung diseases) 0.5-3 (2.5) inhale 1 vial via nebulizer once daily as needed.
-The original order also indicated Resident #8 could self-administer the nebulized medication.
-There was an order dated 05/02/24 indicating Resident #8's as needed (PRN) Ipratropium/Albuterol had not been used in the last 90 days and could it be discontinued.
-The PCP signed off on the order for the PRN Ipratropium/Albuterol to be discontinued on 05/06/24.

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Interview with a MA on 12/04/24 at 2:40pm revealed:
-Resident #8 could not self-administer his medications.
-She was not aware he had medication in his room.
-He usually came out to the medication cart for his medication.

Interview with the RCC on 12/04/24 at 2:49pm revealed:
-Resident #8 did not have any PRN medication that he could self- administer.
-She was not aware he had four medication vials for his nebulizer in his room.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The staff had been in and out of Resident #8's room and had not seen the nebulizer or the four medication vials for the nebulizer.
-Resident #8 should not have medications in his room to self-administer that have been discontinued.

3) Review of Resident #3's current FL2 dated 12/29/23 revealed:
-Diagnoses included chronic lung disease and high blood pressure.
-He was intermittently disoriented.

Review of Resident #3's physician orders revealed:
-An order dated 04/15/24 for triamcinolone 0.1% cream apply to affected area twice daily.
-There was a stop date of 12/28/24 on the electronic medication administration record (eMAR).

Review of Resident #3's available medications for

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administration on 12/04/24 revealed there was a tube of triamcinolone 0.1% cream for Resident #3.

Interview with Resident #3 on 12/04/24 at 4:38pm revealed:
-He used to have a rash in his "private area" and pointed to his groin.
-Staff would give him the cream and he would self-administer it.
-He refused the triamcinolone cream recently because the rash was healed.
-He had not used the triamcinolone cream in a few weeks.

Interview with the MA on 12/05/24 at 9:58am revealed:
-Resident #3 did not have an order to self-administer medications.
-Resident #3 came to the medication cart for his medication when it was time to administer them.
-She gave him the triamcinolone cream to self-administer.
-She had never administered the triamcinolone cream to Resident #3 and she did not know where the "affected area" was.

Interview with the RCC on 12/05/24 at 12:09pm revealed Resident #3 did not have an order to self-administer any prescribed medicated creams.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-He was not aware the MA was giving the triamcinolone cream to Resident #3 to self-administer.
-Resident #3 did not have a self-administration order for the triamcinolone cream.

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D 377 10A NCAC 13F .1006(a) Medication Storage D 377

10A NCAC 13F .1006 Medication Storage
(a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure medications were stored in a safe and secure manner for 2 of 8 sampled residents (#7 and #8).

The findings are:

Review of the facility's Medication Policies or Storage of Medications dated 06/21/23 revealed self-adminstered medications that are kept in a resident's room will be stored in a safe and secure manner.

1) Review of Resident #7's current FL2 dated 06/06/24 revealed diagnoses included gastric esophageal reflux disease (GERD).

Observation of Resident #7's room during initial tour on 12/04/24 at 9:26am revealed there was a plastic bottle of calcium carbonate (used to treat GERD) on his bedside table.

Interview with a medication aide (MA) on 12/04/24 at 2:40pm revealed:
-She was not aware Resident #7 had calcium carbonate in his room.
-She did not always give medication to the residents in their rooms.
-Sometimes she gave medication in the hallway,

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on the smoking porch, or residents may come to the medication cart when it was time for their medication administration.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 3:02pm revealed:
-She was not aware Resident #7 had calcium carbonate in his room.
-Resident #7 would walk to the medication cart when it was time for his medication administration.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The facility offered all residents a lock box for use if they had medications or other valuables they wanted to keep in their rooms.
-He had not been aware medications were sitting out on Resident #7's bedside table.
-Resident #7 did not have a lock box in his room.

2) Review of Resident #8's current FL2 dated 06/06/24 revealed:
-Diagnoses included Parkinson's disease and anxiety.
-He had intermittent disorientation.

Review of a medical report from a local hospital dated 09/23/24 revealed Resident #8 had pulmonary hypertension (a type of high blood pressure affecting the arteries in the lungs and the heart) and mild to moderate emphysema (chronic lung disease).

Observation of Resident #8's room during initial tour on 12/04/24 at 10:01am revealed:
-There was a nebulizer machine in his room.
-He had a cup with 4 vials of a liquid medication beside the nebulizer.
-He had a black metal box with a lock on it at his

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bedside table.

Interview with Resident #8 on 12/04/24 at 10:01am and 12/05/24 at 11:45am revealed:
-He had breathing problems, so he used the medication in the vials and placed it in his nebulizer.
-He did not lock his medications up in his room.
-He used his lock box to secure his valuables.

Interview with a medication aide (MA) on 12/04/24 at 2:40pm revealed:
-She was not aware Resident #8 had a nebulizer with four Ipratropium/Albuterol (used to treat lung disease) vials in his room.
-She did not always give medication to the residents in their rooms.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 3:02pm revealed she was not aware Resident #8 had a nebulizer with four Ipratropium/Albuterol vials in his room.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-The facility offered all residents a locked box for use if they had medications or other valuables they wanted to keep in their rooms.
-He had not been aware medications were sitting out in Resident #8's room.

D 392 10A NCAC 13F .1008 (a) Controlled Substances D 392

10A NCAC 13F .1008 Controlled Substances
(a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility

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and in such an order that there can be accurate reconciliation of controlled substances.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 2 of 3 sampled residents (#2 and #8) related to a controlled substance for anxiety (#2 and #8).

The findings are:

Review of the facility's medication policies and procedures manual dated 06/21/23 revealed:
-Documentation of controlled substances will be maintained by the facility and will be available for review.
-The record of documentation will be kept in the resident record.
-Documentation of receipt of the controlled substance by the pharmacy will be maintained.
-The documentation will be maintained within the facility for a minimum of five years.

1. Review of Resident #2's FL2 dated 07/11/24 revealed diagnoses included type 2 diabetes and schizoaffective disorder.

a. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for clonazepam (used to treat anxiety) 1mg daily at bedtime.

Review of Resident #2's August 2024 electronic medication administration record (eMAR) from 08/20/24-08/31/24 revealed:
-There was an entry for clonazepam 1mg take one tablet at bedtime scheduled at 6:00pm.
-There were 12 documented administrations of

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clonazepam from 08/20/24-08/31/24.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) for clonazepam 1mg tablets dispensed on 07/15/24 quantity of 31 tablets revealed:
-Administration dates on the CSCS included 08/01/24-08/30/24.
-On 08/27/24 at 6:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.

Review of Resident #2's charting notes dated 08/20/24-09/10/24 revealed there was no entry concerning the borrowed clonazepam dose on 08/27/24.

Review of Resident #2's mental health provider (MHP) prescription dated 09/03/24 revealed:
-Clonazepam 1mg one tablet at bedtime quantity 30 with five refills.
-There was a note on the prescription to refill half tablets three times a day #45 with five refills.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/05/24 at 3:44pm regarding Resident #2's clonazepam 1mg daily at bedtime revealed:
-The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document the administration for inventory control.
-The prescription was for clonazepam 1mg quantity of 30 tablets with five refills.
-On 09/03/24, quantity 30 clonazepam 1mg tablets were dispensed in one bubble pack a 30-day supply.
-On 10/03/24, quantity 30 clonazepam 1mg tablets were dispensed in one bubble pack a

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D 392	Continued From page 76 30-day supply. -On 11/04/24, quantity 30 clonazepam 1mg tablets were dispensed in one bubble pack a 30-day supply. Review of Resident #2's November 2024 eMAR revealed: -There was an entry for clonazepam 1mg take one tablet at bedtime scheduled at 6:00pm. -There were 30 documented administrations of clonazepam. Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 11/04/24 quantity of 30 revealed: -Administration dates on the CSCS included 11/05/24-12/04/24. -On 11/05/24 at 6:00pm, one tablet documented administered, 29 tablets documented remaining. -On 11/06/24 at 6:00pm, one tablet documented administered, 28 tablets documented remaining. -On 11/07/24 at 6:00pm, one tablet documented administered, 27 tablets documented remaining. -On 11/08/24 at 6:00pm, one tablet documented administered, 26 tablets documented remaining. -On 11/09/24 at 6:00pm, one tablet documented administered, 25 tablets documented remaining. -On 11/10/24 at 6:00pm, one tablet documented administered, 24 tablets documented remaining. -On 11/11/24 at 6:00pm, one tablet documented administered, 23 tablets documented remaining. -On 11/12/24 at 6:00pm, one tablet documented administered, 22 tablets documented remaining. -On 11/13/24 at 6:00pm, one tablet documented administered, 21 tablets documented remaining. -On 11/14/24 at 6:00pm, one tablet documented administered, 20 tablets documented remaining. -On 11/15/24 at 6:00pm, one tablet documented administered, 19 tablets documented remaining. -On 11/16/24 at 6:00pm, one tablet documented	D 392		

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D 392	Continued From page 77 administered, 18 tablets documented remaining. -On 11/17/24 at 6:00pm, one tablet documented administered, 17 tablets documented remaining. -On 11/18/24 at 6:00pm, one tablet documented administered, 16 tablets documented remaining. -On 11/19/24 at 6:00pm, one tablet documented administered, 17 tablets documented remaining. -On 11/20/24 at 6:00pm, one tablet documented administered, 16 tablets documented remaining. -On 11/21/24 at 6:00pm, one tablet documented administered, 15 tablets documented remaining. -On 11/22/24 at 6:00pm, one tablet documented administered, 14 tablets documented remaining. -On 11/23/24 at 6:00pm, one tablet documented administered, 13 tablets documented remaining. -On 11/24/24 at 6:00pm, there was one entry with a single handwritten line and "wasted popped wrong" with 12 tablets documented remaining. -On 11/24/24 at 6:00pm, one tablet documented administered, 11 tablets documented remaining. -On 11/25/24 at 6:00pm, one tablet documented administered, 10 tablets documented remaining. -On 11/26/24 at 6:00pm, one tablet documented administered, 9 tablets documented remaining. -On 11/27/24 at 6:00pm, one tablet documented administered, 8 tablets documented remaining. -On 11/28/24 at 6:54pm, one tablet documented administered, 7 tablets documented remaining. -On 11/28/24 at 7:24pm, one tablets was documented "borrowed" with 6 documented clonazepam 1mg tablets documented remaining. -On 11/29/24 at 6:00pm, one tablet documented administered, 5 tablets documented remaining. -On 11/30/24 at 6:00pm, one tablet documented administered, 4 tablets documented remaining. -On 12/01/24 at 6:00pm, one tablet documented administered, 3 tablets documented remaining. -On 12/02/24 at 6:00pm, one tablet documented administered, 2 tablets documented remaining. -On 12/03/24 at 5:10pm, one tablet documented	D 392		

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administered, 1 tablet documented remaining.
-On 12/04/24 at 5:57pm, one tablet documented administered, 0 tablets remained.

Interview with Resident #2 on 12/04/24 at 9:30am revealed:
-The facility "sometimes" ran "short" of his clonazepam.
-This usually occurred when it was time for the monthly cycle fill of medications to arrive from the pharmacy.

Interview with the Resident Care Coordinator (RCC) on 12/10/24 at 10:40am revealed:
-She was responsible for auditing the CSCS entries.
-She would audit them when she had time or when she worked as a medication aide (MA).
-She did not have a set schedule to audit the CSCS entries.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-He performed audits on resident CSCS entries.
-CSCS audits consisted of looking for missed doses, entries being legible, time and dates, and having one line through an entry that was in error.
-He had last audited the CSCS entries on 12/03/24 or 12/04/24.
-He had trained the MAs and RCC on how to properly document on CSCS entries.
-The MAs were supposed to do a count of every controlled substance on the medication cart prior to handing off the keys to the medication cart to the oncoming shift MA.
-The MAs who performed the controlled substance count should visualize each controlled substance bubble pack and compare the amounts on those carts with the CSCS counts.
-If the count was off, the staff tried to figure out

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why the count was off.
-He did not keep track of the MAs who would have performed the controlled substance count verification for any given shift.
-The issues with the discrepancies on the CSCS entries were a "documentation issue."

b. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for clonazepam (used to treat anxiety) 0.5mg three times daily at 8:00am, 12:00pm, and 4:00pm.

Review of Resident #2's August 2024 electronic medication administration record (eMAR) from 08/20/24-08/31/24 revealed:
-There was an entry for clonazepam 1mg take half tablet three times daily scheduled at 8:00am, 12:00pm, 4:00pm.
-There were 35 documented administrations of clonazepam from 08/20/24-08/31/24.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) for clonazepam 1mg tablets dispensed on 07/15/24 quantity of 31 half tablets revealed:
-Administration dates on the CSCS included 08/20/24-08/28/24.
-On 08/20/24 at 12:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-On 08/21/24 at 12:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-On 08/22/24 at 12:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-On 08/23/24 at 12:00pm, two doses were

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signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-On 08/26/24 at 12:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-On 08/27/24 at 12:00pm, two doses were signed out on the CSCS, one dose was documented as "borrowed" on the CSCS, one dose documented as administered on the eMAR.
-The entry on 08/20/24 at 12:00pm was documented by the Resident Care Coordiantor (RCC).
-The entries on 08/1/24, 08/22/24, 08/23/24, 08/26/24, and 08/27/24 were documented by one medication aide (MA).

Review of Resident #2's charting notes dated 08/20/24-09/10/24 revealed there were no entries concerning the borrowed clonazepam doses on 08/20/24, 08/21/24, 08/23/24, 08/26/24, and 08/27/24.

Review of Resident #2's mental health provider (MHP) prescription dated 09/03/24 revealed:
-Clonazepam 1mg one tablet at bedtime quantity 30 with five refills.
-There was a note on the prescription to refill half tablets three times a day #45 with five refills.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/05/24 at 3:44pm regarding Resident #2's clonazepam 1mg 1/2 tablet three times daily revealed:
-The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document the administration for inventory control.
-The prescription was for clonazepam 1mg

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quantity of 30 tablets with five refills.
-The prescriber allowed the pharmacy to refill clonazepam 1mg half tablets three times a day #45 with five refills.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for clonazepam 1mg take half tablet three times daily scheduled at 8:00am, 12:00pm, 4:00pm.
-There were 84 documented administrations of clonazepam from 10/01/24-10/31/24.

Review of Resident #2's CSCS for clonazepam 1mg tablets dispensed on 10/03/24 quantity of 30 half tablets revealed:
-Administration dates on the CSCS included 10/24/24-11/04/24.
-On 10/24/24 at 8:00am, one tablet documented administered, 29 tablets documented remaining.
-On 10/24/24 at 4:00pm, one tablet documented administered, 28 tablets documented remaining.
-On 10/25/24 at 7:00am, one tablet documented administered, 27 tablets documented remaining.
-On 10/25/24 at 12:00pm, one tablet documented administered, 26 tablets documented remaining.
-On 10/25/24 at 4:00pm, one tablet documented administered, 25 tablets documented remaining.
-On 10/26/24 at 8:00am, one tablet documented administered, 24 tablets documented remaining.
-On 10/26/24 at 12:00pm, one tablet documented administered, 23 tablets documented remaining.
-On 10/26/24 at 4:00pm, one tablet documented administered, 22 tablets documented remaining.
-On 10/27/24 at 8:00am, one tablet documented administered, 21 tablets documented remaining.
-On 10/27/24 at 12:00pm, one tablet documented administered, 22 tablets documented remaining.
-On 10/27/24 at 4:00pm, one tablet documented administered, 21 tablets documented remaining.

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D 392	Continued From page 82 -On 10/27/24 at 6:00pm, one tablet documented administered, 20 tablets documented remaining. -On 10/28/24 at 7:00am, one tablet documented administered, 19 tablets documented remaining. -On 10/28/24 at 12:00pm, one tablet documented administered, 18 tablets documented remaining. -On 10/28/24 at 4:00pm, one tablet documented administered, 17 tablets documented remaining. -On 10/29/24 at 8:00am, one tablet documented administered, 16 tablets documented remaining. -On 10/29/24 at 12:00pm, one tablet documented administered, 15 tablets documented remaining. -On 10/29/24 at 4:00pm, one tablet documented administered, 14 tablets documented remaining. -On 10/30/24 at 8:00am, one tablet documented administered, 13 tablets documented remaining. -On 10/30/24 at 12:00pm, one tablet documented administered, 12 tablets documented remaining. -On 10/30/24 at 4:00pm, one tablet documented administered, 11 tablets documented remaining. -On 10/31/24 at 8:00am, one tablet documented administered, 10 tablets documented remaining. -On 10/31/24 at 4:00pm, one tablet documented administered, 9 tablets documented remaining. -On 11/01/24 at 8:00am, one tablet documented administered, 8 tablets documented remaining. -On 11/01/24 at 4:00pm, one tablet documented administered, 7 tablets documented remaining. -On 11/02/24 at 8:00am, one tablet documented administered, 6 tablets documented remaining. -On 11/02/24 at 12:00pm, one tablet documented administered, 5 tablets documented remaining. -On 11/02/24 at 4:00pm, one tablet documented administered, 4 tablets documented remaining. -On 11/03/24 at 8:00am, one tablet documented administered, 3 tablets documented remaining. -On 11/03/24 at 12:00pm, one tablet documented administered, 2 tablets documented remaining. -On 11/04/24 at 8:00am, one tablet documented administered, 1 tablets documented remaining.	D 392		

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-On 11/04/24 at 12:00pm, one tablet documented administered, 0 tablets remained.

Interview with Resident #2 on 12/04/24 at 9:30am revealed:
-The facility "sometimes" ran "short" of his clonazepam.
-This usually occurred when it was time for the monthly cycle fill of medications to arrive from the pharmacy.

Interview with the medication aide (MA) on 12/06/24 at 9:08am revealed:
-She was the MA who documented "borrowed" on Resident #2's CSCS entries for 12:00pm on 08/21/24, 08/22/24, 08/23/24, 08/26/24, and 08/27/24.
-She did not remember the circumstances as to why she wrote "borrowed."

Interview with the Resident Care Coordinator (RCC) on 12/10/24 at 10:40am revealed:
-She was responsible for auditing the CSCS entries.
-She would audit them when she had time or when she worked as a MA.
-She did not have a set schedule to audit the CSCS entries.

Interview with the Administrator on 12/10/24 at 1:52pm revealed:
-When an MA borrowed a medication, he expected the MA to notify the RCC about the situation.
-The RCC was expected to make a note in the progress note of where they borrowed the medication from and which resident it was given to.
-He performed audits on resident CSCS entries.
-CSCS audits consisted of looking for missed

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doses, entries being legible, time and dates, and having one line through an entry that was in error.
-He had last audited the CSCS entries on 12/03/24 or 12/04/24.
-He had trained the MAs and RCC on how to properly document on CSCS entries.
-The MAs were supposed to do a count of every controlled substance on the medication cart prior to handing off the keys to the medication cart to the oncoming shift MA.
-The MAs who performed the controlled substance count should visualize each controlled substance bubble pack and compare the amounts on those carts with the CSCS counts.
-If the count was off, the staff tried to figure out why the count was off.
-He did not keep track of the MAs who would have performed the controlled substance count verification for any given shift.
-The issues with the discrepancies on the CSCS entries were a "documentation issue."

c. Review of Resident #2's FL2 dated 07/11/24 revealed there was an order for clonazepam (used to treat anxiety) 0.5mg one tablet daily as needed for anxiety give prior to leaving for appointments/outings.

Observation of Resident #2's medications on hand on 12/04/24 at 3:56pm revealed:
-There was one bubble pack of clonazepam 0.5mg tablets with quantity 15 remained.
-The label directions clonazepam 0.5mg one tablet daily as needed for anxiety given prior to leaving for appointments/outings.
-The dispense date was 06/20/24 quantity of 30.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) for clonazepam 0.5mg tablets dispensed on 06/20/24 quantity of 30

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tablets on 12/04/24 at 4:00pm revealed:
-There was a handwritten label with directions clonazepam 0.5mg one tablet daily as needed for anxiety give prior to leaving for appointments/outings.
-There was no documented prescription number on the handwritten label.
-There was no date on the first entry, the time was 8:33am, and the starting count was 27.
-Administration dates began 09/15/24 at 12:00pm and ended on 11/19/24 at 7:00am.
-On 09/15/24 at 12:00pm, one tablet was documented as "borrowed."
-On 09/15/24 at 6:00pm, one tablet was documented as "borrowed."
-On 09/16/24 no time documented, one tablet was documented as "borrowed."
-On 09/16/24 at 12:00pm, one tablet was documented as "borrowed."
-On 11/03/24 no time documented, one tablet was documented as "borrowed."
-O 11/04/24 no time documented, one tablet was documented as "borrowed."
-On 11/08/24 no time documented, one tablet was documented as "borrowed."
-On 11/11/24 no time documented, one tablet was documented as "borrowed."
-On 11/15/24 no time documented, one tablet was documented as "borrowed."
-On 11/16/24 no time documented, one tablet was documented as "borrowed."
-On 11/19/24 7:00am, there was no documented name of the staff who administered the clonazepam 0.5mg tablet.
-The remaining count was 15 tablets.

Interview with the Resident Care Coordinator (RCC) on 12/04/24 at 4:22pm revealed:
-She did not know why Resident #2's original CSCS from the pharmacy was not available for

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the as needed clonazepam 0.5mg tablets.
-The pharmacy "usually" provided a CSCS with a pharmacy label with each bubble pack of controlled substances.
-She did not know why the prescription number was not included in the handwritten label on the as needed clonazepam 0.5mg bubble pack.
-"Borrowed" entries on Resident #2's as needed clonazepam 0.5mg CSCS meant the resident did not have a supply of clonazepam to administer for the scheduled doses so the medication aides (MA) would take a dose from the as needed supply instead.
-They had trouble getting prescriptions for Resident #2's clonazepam from his mental health provider (MHP).

Telephone interview with the facility's contracted pharmacy on 12/04/24 at 4:47pm revealed:
-The pharmacy dispensed quantity 30 tablets of clonazepam 0.5mg one tablet daily as needed for anxiety give prior to leaving for appointments/outings for Resident #2 on 06/20/24.
-They send a CSCS with each bubble pack of controlled substance.
-The CSCS they provided would have a preprinted pharmacy label affixed.

Review of Resident #2's pharmacy provided CSCS for clonazepam 0.5mg one tablet daily as needed for anxiety give prior to appointments/outings dispensed on 06/20/24 quantity of 30 tablets revealed:
-Administration dates were 06/27/24-07/07/24.
-The label directions were clonazepam 0.5mg one tablet daily as needed for anxiety give prior to leaving for an appointment/outing.
-On 06/27/24 no time documented, one tablet was documented as administered, 29 tablets

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documented remaining.
-On 07/07/24 no time documented, one tablet was documented as administered, 28 tablets documented remaining.
-On 07/07/24 no time documented, one tablet was documented as administered, 27 tablets documented remaining.

2. Review of Resident #8's current FL2 dated 06/06/24 revealed:
-Diagnoses included Parkinson's disease and anxiety.
-He was intermittently confused.

Review of Resident #8's physician's orders dated 06/06/24 revealed an order for clonazepam (used to treat anxiety) 0.5mg tablet three times daily (tid).

Review of Resident #8's electronic medication administration record (eMAR) for October 2024 revealed:
-Documentation of clonazepam 0.5mg tablet tid at 8:00am, 1:00pm, and 6:00pm.
-No doses were missed or refused during the month.

Review of Resident #8's eMAR for November 2024 revealed:
-Documentation of clonazepam 0.5mg tablet tid at 8:00am, 1:00pm, and 6:00pm.
-No doses were missed or refused during the month.

Review of Resident #8's eMAR for December 1-5, 2024, revealed:
-Documentation of clonazepam 0.5mg tablet tid at 8:00am, 1:00pm, and 6:00pm.
-No doses were missed or refused during the first

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WILHAM RIDGE	30 DALEA DRIVE ASHEVILLE, NC 28805

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five days of the month.

Review of Resident #8's Controlled Substance Count Sheet (CSCS) for October 2024 revealed:
-The clonazepam 0.5mg tablet was documented as administered on 10/21/24 at 12:00pm.
-The clonazepam 0.5mg tablet was documented as administered on 10/21/24 at 12:00pm.
-There was no documentation the 8:00am dose or the 6:00pm dose of clonazepam was administered on 10/21/24.
-The clonazepam 0.5mg tablet was documented as administered on 10/24/24 at 1:00pm.
-The clonazepam 0.5mg tablet was documented as administered on 10/24/24 at 6:00pm.
-There was no documentation the 8:00am dose of clonazepam was administered on 10/24/24.
-The clonazepam 0.5mg tablet was documented as administered on 10/27/24 at 4:00pm although the scheduled time was 6:00pm.

Review of Resident #8's CSCS for November 2024 revealed:
The clonazepam 0.5mg was documented as administered on 11/17/24 at 12:00pm, 1:00pm and 6:00pm.
-There was no documentation the 8:00am dose of clonazepam was administered on 11/17/24.
-The clonazepam 0.5mg was documented as administered on 11/18/24 at 1:00pm and 6:00pm.
-There was no documentation the 8:00am dose of clonazepam was administered on 11/18/24.
-The clonazepam 0.5mg was documented as administered on 11/21/24 at 8:00am, 12:00pm, and 6:00pm.
-The clonazepam 0.5mg was documented as administered on 11/21/24 at 1:00pm.
-The clonazepam 0.5mg was documented as administered on 11/22/24 at 1:00pm.
-The clonazepam 0.5mg was documented as

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administered on 11/22/24 at 6:00pm.
-There was no documentation the 8:00am dose of clonazepam was administered on 11/22/24.
-The clonazepam 0.5mg was documented as administered on 11/23/24 at 8:00am.
-The clonazepam 0.5mg was documented as administered on 11/23/24 at 12:00pm and 6:00pm.
-The clonazepam 0.5mg was documented as administered on 11/23/24 at 1:00pm..
-The clonazepam 0.5mg was documented as administered on 11/28/24 at 1619 (4:19pm).
-The clonazepam 0.5mg was documented as adminstered on 11/30/24 at 6:00pm.
-The clonazepam 0.5mg was documented as "borrowed" on 11/30/24 at 6:00pm.

Review of Resident #8's CSCS for December 1-5, 2024, revealed no errors in documentation of administration of clonazepam 0.5mg tid.

Review of Resident #8's medication variance report for October 2024 revealed the clonazepam 0.5mg was given timely tid.

Review of Resident #8's medication variance report for November 2024 revealed the clonazepam 0.5mg was given timely tid.

Review of Resident #8's medication variance report for December 1-5, 2024 revealed the clonazepam 0.5mg was given timely tid.
Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 12/10/24 at 9:32am and 10:40am revealed:
-She did not know why the documentation of the declination on the CSCS was not in order for the date and time that Resident #8's clonazepam was administered.
-Sometimes her and other MAs forget to sign the

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D 392	Continued From page 90 CSCS after administering Resident #8's clonazepam and would document the medication as administered later when they were counting how much of Resident #8's clonazepam was available at the end of a shift and compared it to the CSCS. -On 10/21/24, 11/21/24, and 11/23/24, her and another MA documented on Resident #8's clonazepam CSCS that the scheduled 1:00pm dose was administered, but Resident #8's clonazepam was only administered once and the second dose documented was supposed to be documented at a different time or on a different date. -She did not know why there were 2 doses of clonazepam documented as administered on 11/23/24 at 12:00pm and 1:00pm. -She thought one dosage of Resident #8's clonazepam was a borrowed dose administered to another resident who did not have clonazepam available to administer and the clonazepam was not documented as borrowed. -Resident #8 had 2 doses of clonazepam documented on the CSCS on 11/30/24 at 6:00pm with "borrowed" handwritten next to one of the doses. -She did not know which resident the "borrowed" dose of clonazepam was administered to because the MAs only had to document the medication as borrowed. -All controlled substances were counted at the end of each shift and compared to the CSCS. -When there was a discrepancy between the remaining amount of a controlled substance and the decline on the CSCS, the MA coming on shift was supposed to not accept the keys to the medication cart and notify a supervisor. -She was notified before that some of the controlled substances available did not match what was documented on the CSCS and most of	D 392		

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the time it was because someone forgot to document the declination on the CSCS.
-The facility's policy for borrowing medications allowed for controlled substances to be borrowed for other residents if the medication was needed.
-Her and the Administrator were responsible for auditing the number of controlled substances available on the medication cart and comparing them to the CSCS.
-She audited the CSCS and compared them to the amount of controlled substances available to administer when she had time, but there was no set schedule.

Interview with an MA on 12/10/24 at 9:45am revealed:
-She only administered Resident #8's scheduled 1:00pm clonazepam because she did not work during the morning or evening medication pass.
-Sometimes the RCC helped her administer medications to residents when the RCC was not busy in the office.
-She always documented the declination of a medication on the CSCS after she administered the controlled substance medications.
-She administered Resident #8's 1:00pm scheduled clonazepam on 11/21/24 and 11/23/24 and documented the declination on the CSCS at 1:00pm and did not know why the RCC also documented the clonazepam on Resident #8's CSCS at 12:00pm.

Interview with the Administrator on 12/10/24 at 1:53pm revealed:
-The facility's policy for borrowing medications allowed medications including controlled substances to be borrowed from one resident and administered to another resident if a medication was unavailable.
-The MAs were responsible for documenting on

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the CSCS when a medication was borrowed for another resident but did not have to document who the medication was borrowed for.
-The MAs were supposed to document in a chart note in the other resident's record when a medication was borrowed and document the medication administered on the electronic medication administration record (eMAR).
-He audited the CSCS for missed documentation about every other day since 09/27/24 when the facility experienced a power outage for 5 days and the MAs documented the medications administered to residents on notebook paper since they could not use the eMAR.
-The CSCS were messy, and he instructed staff to only use a single line when marking a mistake out.
-He last audited the CSCS on 12/03/24 or 12/04/24.
-The issues with the discrepancies on the CSCS entries were a "documentation issue."
-The facility used to have controlled substances on a cycle fill from the pharmacy and had months of controlled substances in stock so he stopped the cycle filling and now MAs must request the controlled substances to be refilled when the supply stock was low.
-He did not know why some medications would run out and some controlled substances had to be borrowed from other residents.
-The RCC was responsible for medication cart audits to check for medications in low supply and request refills from the pharmacy including controlled substances.
-The facility did not have a policy regarding when controlled substances were supposed to be documented on the CSCS.
-The MAs were never instructed to document the administration of a controlled substance on the CSCS at the time the controlled substance was

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D 392	Continued From page 93 administered. -The MAs were instructed to make the CSCS legible and to check the documented amount remaining of the medication on the sheet and compare it to the actual amount remaining of the controlled substance at the change of shifts.	D 392		