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D 000	Initial Comments The Adult Care Licensure Section conducted an annual, follow-up, and complaint investigations from 12/04/24 to 12/06/24. The complaint investigations were initiated by the county on 11/12/24 and 11/15/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff (A) who administered medications had completed the medication clinical skills validation checklist; the 5, 10, or 15-hour medication aide training course; or passed the state-approved medication aide written exam. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired as a personal care aide (PCA) on 06/12/24. -There was no documentation of Staff A being hired to work as a medication aide (MA).	D 125		

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D 125	Continued From page 1 -There was no documentation of Staff A completing the medication administration clinical skills validation checklist. -There was no documentation of Staff A passing the state-approved MA written exam. -There was no documentation of Staff A completing the state-approved 5, 10, or 15-hour MA training courses. Review of residents' October 2024 - December 2024 electronic medication administration records (eMARs) revealed: -Staff A was not listed or included as a MA on the eMAR system. -Staff A had not documented administering medications. Observation of the 7:00am/8:00am medication pass on 12/05/24 revealed: -There was a male MA administering medications to residents residing on the West Hall. -There was a female MA administering medications to residents residing on the East Hall. -Staff A was working in the facility as a PCA. Interview with Staff A on 12/05/24 at 10:57am revealed: -She was a PCA, not a MA. -She had no MA training or qualifications. -A male MA usually gave her Lidocaine patches in the morning when she was working to apply to a female resident on the West Hall. -She applied the Lidocaine patches to the resident's shoulder and hip. -The female resident did not want a male to put the patches on her body. -The male MA did not go in the room or observe her put the Lidocaine patches on the resident. -She applied the Lidocaine patches	D 125		

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D 125	Continued From page 2 independently, without assistance from the MA. Interview with the male MA on 12/05/24 at 11:02am revealed: -A female resident on the West Hall would not allow him to apply her Lidocaine patches. -There was not usually another female MA working when he was working as a MA, so he usually got a PCA to apply the Lidocaine patches. -The female resident would not allow him to go into the room when the Lidocaine patches were applied. Interview with the female resident on 12/06/24 at 11:17am revealed: -Usually only female staff put Lidocaine patches on her body. -She did not want a male to apply the patches because one patch was for her hip. -She did not know if the female staff who applied the patches were MAs. Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed: -The male MA was not the only MA at the facility 90% of the time. -The male MA should either get her or a female MA to administer any topical medication that a female resident was not comfortable with a male applying. -No one had reported to her that a female resident did not allow male MAs to apply topical medication to the resident. -Staff A was not a MA and should not be administering any medications.	D 125		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director	D 129		

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D 129	Continued From page 3 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C; (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting; (c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D; (d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or (e) the required basic activity course was completed prior to September 1, 2024. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a qualified Activity Director (AD).	D 129		

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D 129	Continued From page 4 The findings are: Observation upon initial tour of the facility on 12/04/24 revealed there was a December (no year noted) activity calendar posted on the wall in the facility. Interview with a resident on 12/04/24 at 9:46am revealed: -The facility did not have an Activity Director (AD). -They had activities 2 or 3 times a week, like bingo or coloring. -One of the personal care aides (PCAs) usually did activities with the residents. Interview with a second resident on 12/04/24 at 10:01am revealed: -The facility used to have an AD, but they did not have one now. -The PCAs usually did activities with the residents daily. Interview with a third resident on 12/05/24 at 2:06pm revealed: -The facility did not have an AD. -The previous AD left about 6 months ago. -The PCAs did activities whenever they "feel like it". Observation of the designated activity area on 12/04/24 at 11:08am revealed: -There were 6 residents playing bingo. -There was a PCA assisting the residents with the bingo game. Interview with the Executive Director (ED) on 12/06/24 at 5:21pm revealed: -The facility did not currently have an AD. -The AD position had been vacant since June 2024.	D 129		

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D 129	Continued From page 5 -The PCAs were currently doing activities with the residents. -She was currently responsible for doing the monthly activities calendar in the absence of an AD. -She was also responsible for doing the bimonthly outings with residents. -They had been trying to hire a new AD but had been unsuccessful. Interview with the Office Manager on 12/06/24 at 5:23pm revealed: -She had done 3 interviews to try to fill the vacant AD position. -She offered the AD position to someone in September 2024, but that person changed their mind and did not accept the position. -In October 2024, she tried to offer the position to another applicant, but that person never called back. -She interviewed another applicant last week, but that person could not take a full-time position. -They had advertised the vacant position on websites. -They were still trying to find someone to hire for the AD position.	D 129		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care	D 273		

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coordination and follow-up for 2 of 5 sampled residents (#2, #5) including failing to obtain podiatry care for residents with diabetes (#2, #5); failing to coordinate referrals for ophthalmology, pulmonology, and cardiology (#2); failing to coordinate referrals for physical therapy and occupational therapy (#5); failing to ensure a resident received a chest scan, an echocardiogram, and abdominal ultrasound (#2); and failing to obtain dentures as ordered for a resident with no teeth (#2).

The findings are:

1. Review of Resident #2's current FL-2 dated 10/03/24 revealed:
-Diagnoses included type 2 diabetes mellitus, atrial fibrillation, atrial flutter, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and history of seizures.
-The resident was semi-ambulatory and required assistance with bathing and dressing.

Review of Resident #2's Resident Register revealed:
-The resident was admitted to the facility on 12/27/23.
-The resident required assistance for dressing, bathing, nail care, shaving, ambulation, hair/grooming, and skin care.
-The resident's memory was documented as adequate.
-The resident used a wheelchair.

Review of Resident #2's current assessment and care plan dated 07/26/24 revealed:
-The resident was documented as having limited ability with ambulation.
-The resident used a wheelchair and a motorized

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scooter to move around.
-The resident had a very unsteady gait.
-The resident had limited range of motion and limited strength in his upper extremities.
-The resident was documented as sometimes disoriented, forgetful and needed reminders.
-The resident required supervision by staff with eating, toileting, ambulation, dressing, and transferring.
-The resident required limited assistance by staff with bathing and grooming.

a. Review of the facility's computer-generated routine podiatry provider visit form dated 06/26/24 revealed:
-There were multiple residents' names included on the list to be seen by the facility's contracted podiatry provider on 06/26/24.
-Resident #2's name was included on the list but marked through with a black marker.
-Under the column for scheduled visit beside Resident #2's name there was note indicating "no scheduled visit".

Review of Resident #2's provider visit notes revealed no documentation the resident had been seen by a podiatrist.

Observation of Resident #2 on 12/06/24 at 11:30am revealed:
-The resident's toenails on both feet were yellowish brown and extremely long and thick.
-The great toenail on his right foot was so long it curved down and over the top of his toe and pressed into the second toe.
-The skin on the right second toe had a dark pink area of skin and indentation where the great toenail rubbed into the second toe.
-The toenail on the right second toe was so long it curved and made a half circle and touched the

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great toenail that was resting on the second toe.
-The third, fourth and fifth right toenails were long and curved over the top of the toes and into the skin on the bottom of the toes.
-The great toenail on the left foot was long, thick, and jagged.
-The toenail on the left second toe was so long it curved and made a half circle and touched the great toe.
-The third, fourth and fifth left toenails were long and curved over the top of the toes and into the skin on the bottom of the toes.
-The resident's skin on both feet was extremely dry with large, white, and loose flakes of skin.

Interview with Resident #2 on 12/06/24 at 11:27am revealed:
-He had not received treatment from a podiatrist since he was admitted to the facility in December 2023.
-He saw the facility's contracted podiatry provider (could not recall date) and was told his feet were too bad to treat at the facility and he needed to see an outside podiatry provider.
-His family member brought "tin snippers" (a tool for cutting tin/metal) to the facility last week and he and his roommate trimmed his left great toenail because it was causing so much pain.
-It hurt when they cut it with the tin snippers.
-His toenails bothered him because it hurt when he walked.
-His toenails were so long that he walked on the toenails which cause the toenails to push into the skin on the bottom of his toes.
-He usually tried to walk on his heels to prevent walking on his toenails.
-He mostly walked when he was in his room; he used a wheelchair for long distances around the facility.

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D 273	Continued From page 9 Interview with the Executive Director (ED) on 12/06/24 at 8:40am revealed: -Resident #2 was diabetic so facility staff were not allowed to trim his toenails. -She could not find any podiatry visit notes for Resident #2 since he was admitted in December 2023. -She did not know why the resident had not been treated by a podiatry provider. -The facility's contracted podiatry provider usually came to the facility to see all residents every 6 months. -The facility's contracted podiatry provider last came to the facility on 06/26/24. -Resident #2 was included on the podiatry provider's list that day but no visit scheduled was documented beside his name. -Resident #2 reported to her today that the facility's contracted podiatry provider looked at his feet that day but told him she could not trim his toenails, and he would have to see an outside podiatrist. -She, the medication aides (MAs), and the personal care aides (PCAs) were responsible for making sure that all residents were seen by the podiatry provider when the provider came to the facility. Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed: -Resident #2 was diabetic and not receiving care from a podiatry provider could cause the resident to get an infection. -The infection could spread to his bones and cause the resident to need toe amputations. Attempted telephone interview with Resident #2's family member on 12/06/24 at 4:01pm was unsuccessful.	D 273		

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Attempted telephone interview with the facility's contracted podiatry provider on 12/06/24 at 10:56am was unsuccessful.

b. Review of Resident #2's hospital discharge summary dated 05/19/24 revealed:
-The resident was admitted to the hospital on 05/19/24 and discharged on 05/20/24.
-The resident had past medical history of previous stroke with right-sided deficit.
-The resident presented with right-sided eye pain, vision changes, headache, and worsening right-sided weakness.
-The resident stated earlier today that he was in normal health until he developed eye pain, change in vision, and worsening right-sided weakness.
-After arriving to the emergency room (ER), the resident stated his symptoms had resolved and he was back to baseline.
-The resident's diagnoses included visual disturbance, other migraine, stroke-like episode, right-sided weakness, and lymphadenopathy (swelling of the lymph nodes). (Swollen lymph nodes can be caused by inflammation, infection, and/or diseases such as cancer.)
-There were numerous prominent and mildly enlarged mediastinal (the part of the chest that lies between the breastbone and spinal column and between the lungs) lymph nodes; the greatest was "1.3M" in size.
-There was a referral for pulmonology for mediastinal lymphadenopathy.

Review of Resident #2's facility progress notes and provider visit notes for May 2024 - December 2024 revealed no documentation that the resident had been seen by a pulmonologist.

Interview with Resident #2 on 12/05/24 at 2:06pm

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revealed:
-He had not seen a pulmonologist in about 2 years.
-He had problems with wheezing and coughing; he was currently wheezing.

Interview with the Executive Director (ED) on 12/06/24 at 10:20am revealed:
-She was responsible for referrals for residents.
-She overlooked the pulmonology referral for Resident #2 in May 2024, so no appointment was made.
-There was currently no system to check or monitor to make sure referrals were being done.

Telephone with a medical assistant at Resident #2's pulmonologist's office on 12/06/24 at 9:29am revealed:
-No one had called to make an appointment for Resident #2 until yesterday, 12/05/24.
-The resident was scheduled to be seen on 01/07/25.
-They did not have any medical records for the resident because he was a new patient.
-No one notified them when the appointment was made about a referral for swollen lymph nodes.
-If they had known, the resident would need to be seen sooner because if the resident had swollen lymph nodes, it was a medical condition that needed to be evaluated by the pulmonologist as soon as possible to determine how serious the problem might be.

Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed:
-She was concerned about Resident #2 not seeing the pulmonologist for the enlarged lymph nodes.
-The lymph nodes could get larger and cause further disease progression.

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D 273	Continued From page 12 c. Review of Resident #2's hospital discharge summary dated 05/19/24 revealed: -The resident was admitted to the hospital on 05/19/24 and discharged on 05/20/24. -The resident had past medical history of previous stroke with right-sided deficit. -The resident presented with right-sided eye pain, vision changes, headache, and worsening right-sided weakness. -The resident stated earlier today that he was in normal health until he developed eye pain, change in vision, and worsening right-sided weakness. -After arriving to the emergency room (ER), the resident stated his symptoms had resolved and he was back to baseline. -The resident's diagnoses included visual disturbance, other migraine, stroke-like episode, right-sided weakness, and lymphadenopathy (swelling of the lymph nodes). (Swollen lymph nodes can be caused by inflammation, infection, and/or diseases such as cancer.) -There were numerous prominent and mildly enlarged mediastinal (the part of the chest that lies between the breastbone and spinal column and between the lungs) lymph nodes; the greatest was "1.3M" in size. -There was an order for CT (computed tomography) scan of chest for lymphadenopathy. (A chest CT is a detailed x-ray that uses a computer to create pictures of the chest and upper abdomen to help diagnose medical conditions.) Review of Resident #2's facility progress notes, procedures notes, and provider notes for May 2024 - December 2024 revealed no documentation of a CT chest scan being completed as ordered.	D 273		

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D 273	Continued From page 13 Interviews with Resident #2 on 12/05/24 at 2:06pm and 12/06/24 at 11:27am revealed: -He had problems with wheezing and coughing; he was currently wheezing. -He did not recall having a CT chest scan. Interview with the Executive Director (ED) on 12/06/24 at 8:40am revealed: -She was responsible for scheduling appointments and referrals. -The CT scan was overlooked so it was not done. -There was currently no system to check to make sure ordered procedures were done. Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed: -She was concerned about Resident #2 not having the CT chest scan for the enlarged lymph nodes. -The lymph nodes could get larger and cause further disease progression. d. Review of Resident #2's hospital discharge summary dated 05/19/24 revealed: -The resident was admitted to the hospital on 05/19/24 and discharged on 05/20/24. -The resident had past medical history of previous stroke with right-sided deficit. -The resident presented with right-sided eye pain, vision changes, headache, and worsening right-sided weakness. -The resident stated earlier today that he was in normal health until he developed eye pain, change in vision, and worsening right-sided weakness. -After arriving to the emergency room (ER), the resident stated his symptoms had resolved and he was back to baseline. -His eyes were positive for pain and visual	D 273		

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disturbance.
-The resident's diagnoses included visual disturbance, other migraine, stroke-like episode, right-sided weakness, and lymphadenopathy (swelling of the lymph nodes).
-There was a referral for ophthalmology for right eye issues.

Review of Resident #2's facility progress notes and provider visit notes from May 2024 - December 2024 revealed no documentation that the resident had been seen by an ophthalmologist as ordered.

Interviews with Resident #2 on 12/05/24 at 2:06pm and 12/06/24 at 4:59pm revealed:
-He thought that he had a stroke behind his eye when he went to the hospital in May 2024.
-He did not go to an eye doctor because the Executive Director (ED) told him the facility's van was broken down.
-He had blurred vision and headaches every day.
-He thought his eye problems caused his headaches.
-His family used to take him to appointments prior to being admitted to the facility.
-It was his understanding after he moved into the facility that the facility staff would make his appointments and take him to his appointments.

Telephone interview with a call center representative at Resident #2's eye care provider's office on 12/06/24 at 9:06am revealed:
-Resident #2 had an appointment to be seen on 08/01/24 but the resident was a "no call, no show".
-The appointment on 08/01/24 was scheduled on 06/10/24.
-When the appointment was scheduled in June 2024, it was scheduled as a routine eye

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appointment.
-No one notified them that the resident had been in the hospital and there was a referral for an eye pain and eye disturbances.
-If they had known, they would have had the resident brought in for an appointment that same week in June 2024.
-The optometrist would have assessed whether the resident needed to see an ophthalmologist (a physician who performs eye surgeries).
-No one had called to reschedule the appointment until yesterday, 12/05/24.
-The resident now had an appointment for 01/02/25.

Interview with the ED on 12/06/24 at 10:20am revealed:
-She was responsible for referrals for residents.
-There was currently no system to check or monitor to make sure referrals were being done.
-Resident #2's ophthalmology referral in May 2024 must have been overlooked.
-The facility also had no way to transport residents to appointments in May 2024 because the facility's transportation vehicle was not drivable.
-There was no way to transport residents to appointments until July 2024 when the facility started renting vehicles.
-She was not aware Resident #2 had an appointment to see the ophthalmologist on 08/01/24 so she was not sure why he missed the appointment.

e. Review of Resident #2's hospital discharge summary dated 05/19/24 revealed:
-The resident was admitted to the hospital on 05/19/24 and discharged on 05/20/24.
-The resident had past medical history of previous stroke with right-sided deficit.

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-The resident presented with right-sided eye pain, vision changes, headache, and worsening right-sided weakness.
-The resident stated earlier today that he was in normal health until he developed eye pain, change in vision, and worsening right-sided weakness.
-After arriving to the emergency room (ER), the resident stated his symptoms had resolved and he was back to baseline.
-The resident's diagnoses included visual disturbance, other migraine, stroke-like episode, right-sided weakness, and lymphadenopathy (swelling of the lymph nodes).
-There was a referral for cardiovascular for carotid stenosis (narrowing of the blood vessels in the neck that carry blood from the heart to the brain) and history of stroke.

Review of Resident #2's facility progress notes and provider visit notes from May 2024 - December 2024 revealed:
-There was no documentation that the resident had been seen by a cardiovascular provider until 09/18/24.
-There was no documentation regarding the reason for the delay.

Review of Resident #2's cardiology visit note dated 09/18/24 revealed:
-The resident had a stable cardiovascular exam.
-There were no changes at this time.
-There were no new orders.
-The resident was to continue current cardiac medications.
-The resident was to follow-up in 6 months.

Interviews with Resident #2 on 12/05/24 at 2:06pm and 12/06/24 at 4:59pm revealed:
-He thought he was supposed to see a cardiology

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provider after his hospital visit in May 2024.
-The Executive Director (ED) canceled his cardiology appointment 3 times.
-He finally went to a new cardiology provider in September 2024.
-His family used to take him to appointments prior to being admitted to the facility.
-It was his understanding after he moved into the facility that the facility staff would make his appointments and take him to his appointments.

Interview with the ED on 12/06/24 at 10:20am revealed:
-She was responsible for referrals for residents.
-There was currently no system to check or monitor to make sure referrals were being done.
-The facility had no way to transport residents to appointments in May 2024 because the facility's transportation vehicle was not drivable.
-There was no way to transport residents to appointments until July 2024 when the facility started renting vehicles.
-A cardiology appointment was made for the resident for 07/18/24 and she thought the resident's family member was taking him to the appointment.
-Resident #2's family member was supposed to take him to a cardiology appointment in August 2024 but she spoke with one of the family members and was told the family would not be taking the resident to appointments anymore (could not recall the date).

Telephone interview with a scheduler at Resident #2's previous cardiology provider on 12/06/24 at 9:53am revealed:
-The resident was last seen in their office on 08/15/23.
-There was an appointment set up on 06/10/24 for 07/18/24.

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-The resident was a "no call, no show" for the 07/18/24 appointment.
-No one had contacted them to reschedule the appointment.
-The resident was still listed as active in their system and could reschedule at any time.

Telephone interview with a patient registration staff at Resident #2's current cardiology provider on 12/06/24 at 9:41am revealed:
-Resident #2's first visit with them was set up on 08/19/24 for 09/18/24.
-The resident was seen by the cardiology provider on 09/18/24.
-No one called to set up an appointment prior to that time.

Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed a delay in seeing a cardiology provider for carotid stenosis could have resulted in the resident having a stroke or causing more problems with the resident's blood pressure.

Attempted telephone interview with Resident #2's family member on 12/06/24 at 4:01pm was unsuccessful.

f. Review of Resident #2's labwork collected on 11/18/24 revealed the resident's potassium level was low at 2.6 (reference range = 3.5 - 5.5). (Low potassium levels can cause symptoms such as heart palpitations, skipped heart beats, abnormal heart rhythms, muscle weakness, low blood pressure, nausea, and vomiting.)

Review of Resident #2's primary care provider (PCP) progress note dated 11/20/24 revealed:
-There was an incoming call from the lab reporting the resident's potassium level was 2.6

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(reference range = 3.5 - 5.5).
-Staff reported the resident was asymptomatic and his vital signs were stable.
-The resident refused to go to the hospital emergency room (ER) for evaluation and treatment.
-There was an order to start a potassium supplement.

Review of Resident #2's PCP order dated 11/21/24 revealed:
-There was an order to increase Potassium Chloride from 20mEq to 40mEq daily. (Potassium Chloride is used to treat low potassium levels.)
-There was an order to get "EKG!!" (An EKG is an electrocardiogram. An EKG is a non-invasive test that measure the electrical activity of the heart. An EKG is used to screen for heart conditions or diagnose heart problems.)

Review of Resident #2's facility progress notes, provider visit notes, and lab and test results for November 2024 revealed:
-There was no EKG completed in November 2024.
-There was no documentation to indicate why the EKG was not done as ordered.

Review of Resident #2's PCP progress note dated 12/02/24 revealed:
-There was an incoming call from the lab reported the resident's potassium level was still at 2.6 (reference range = 3.5 - 5.5).
-Medications were reviewed and noted the resident had been refusing potassium throughout last week.
-The PCP ordered to continue Potassium Chloride 40mEq as ordered and recheck potassium level in 2 weeks.

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D 273	Continued From page 20 -There was another order to get an EKG. Review of Resident #2's facility progress notes, provider visit notes, and lab and test results for December 2024 revealed: -There was an EKG on 12/04/24, almost 2 weeks after it was first ordered on 11/21/24. -The EKG noted the resident was in normal sinus rhythm (a normal EKG.) Interview with Resident #2 on 12/05/24 at 2:06pm revealed: -His potassium level was checked last week, and it was still low at 2.6. -He just had an EKG done at the facility in the last day or two; he thought it was yesterday. -He did not have an EKG done last month to his knowledge. Interview with the Executive Director (ED) on 12/06/24 at 8:40am revealed: -She was responsible for scheduling appointments and referrals. -For the EKG ordered on 11/21/24, she was delayed in getting the paperwork out to schedule the appointment. -This caused there to be a delay in getting the EKG done. Interview with Resident #2's PCP on 12/06/24 at 1:54pm revealed: -She ordered an EKG on 11/21/24 because the resident's potassium was low. -When she ordered the EKG, she expected it to be done immediately because low potassium could have caused the resident to have heart arrythmias. -An EKG was eventually done in December 2024 and it was normal.	D 273		

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g. Review of Resident #2's primary care provider (PCP) visit notes 10/17/24 revealed:
-The resident reported his last bowel movement was one month ago.
-The resident reported this was his baseline.
-There was an order for an abdominal ultrasound to rule out constipation.

Review of Resident #2's facility progress notes, provider visit notes, and lab and test results for October 2024 - December 2024 revealed there was no documentation of an abdominal ultrasound being completed.

Interview with Resident #2 on 12/05/24 at 2:06pm revealed:
-He was supposed to have an abdominal ultrasound done but it was never done.
-His stomach had been "paralyzed" for 15 years meaning he only had a bowel movement about once a month.

Interview with the Executive Director (ED) on 12/06/24 at 8:40am revealed:
-She was responsible for scheduling appointments and referrals.
-She must have overlooked the order for Resident #2's abdominal ultrasound.
-There was currently no system to check or monitor to ensure procedures were done.

Interview with Resident #2's PCP on 12/06/24 at 1:54pm revealed:
-She ordered an abdominal ultrasound because of the resident concerns about not having a bowel movement.
-She was trying to rule out constipation.
-It was important to have the abdominal ultrasound because the resident could have a bowel obstruction or an ileus (inability of the

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intestine to contract normally and move waste out of the body), which could lead to death.

h. Review of Resident #2's Dental Services form dated 02/23/24 revealed:
-There was a note indicating the resident wore dentures 30 years ago and wanted a new set of dentures.
-There was an order for upper and lower dentures.
-A patient approval form would be emailed to the facility to be completed for insurance approval.

Review of Resident #2's Dental Services form dated 09/04/24 revealed:
-There was a note the resident wanted dentures if the resident's insurance would approve it.
-There was an order for upper and lower dentures.
-There was a dental prior approval form with the dentist signature and dated 09/04/24 attached to the Dental Services form.
-The resident information section and the attending physician section were blank.
-There were instructions to send a face sheet and medication administration records with the completed form.
-The form was not completed and there was no documentation the form had been forwarded to anyone.

Review of Resident #2's facility progress notes and provider visit notes revealed:
-There was no documentation the resident had received any dentures.
-There was no documentation of any follow-up with the insurance company or dental provider regarding dentures for the resident.

Interviews with Resident #2 on 12/05/24 at

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2:06pm and 12/06/24 at 11:27am revealed:
-The dentist came to the facility about every 8 weeks.
-The dentist checked his gums and said they were perfect for dentures.
-He did not have any teeth.
-He did not know why he did not get dentures unless they were waiting for his insurance company.
-He wanted dentures because he was told if he chewed his food more, he would not get so many blockages in his intestines.
-He usually ate less because he could not chew the food.

Interview with the Executive Director (ED) on 12/06/24 at 10:20am revealed:
-The paperwork for Resident #2's dentures was overlooked and not completed in February 2024 or September 2024.
-She was responsible for referrals for residents.
-There was currently no system to check or monitor to make sure referrals were being done.

Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed:
-She was just asked to sign paperwork today, 12/06/24, for the resident's dentures.
-She had no current concerns about the resident not having the dentures since the resident was able to eat.

Attempted telephone interview with Resident #2's dental provider on 12/06/24 at 4:20pm was unsuccessful.

2. Review of Resident #5's current FL-2 dated 01/05/24 revealed:
-Diagnoses included diabetes mellitus type 2, COPD (chronic obstructive pulmonary disease),

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heart failure, hypertension, anemia, vitamin B12 deficiency, GERD (gastroesophageal reflux disease), and bipolar disorder.
-The resident was semi ambulatory.

Review of Resident #5's Resident Register dated 12/27/23 revealed:
-The resident was admitted to the facility on 12/27/23.
-The resident required assistance with dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, hair/grooming, skin care, and scheduling appointments.
-The resident used a walker and a wheelchair.

Review of Resident #5's assessment and care plan dated 01/26/24 revealed:
-The resident was ambulatory with aide or device and used a wheelchair.
-The resident required supervision with grooming.
-The resident required limited assistance with toileting, ambulation, bathing and transferring.

a. Review of a physician's order dated 10/31/24 revealed an order for a physical therapy and occupational therapy (PT/OT) evaluation and treatment for strength/mobility, balance, and energy conservation.

Review of the primary care provider's (PCP) progress note dated 10/31/24 revealed:
-Resident #5 reported being in her wheelchair most of the time.
-Resident #5 requested PT/OT because she wanted to use a walker more.

Review of Resident #5's record revealed there was no documentation of a PT/OT evaluation or treatment.

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D 273	Continued From page 25 Observation of Resident #5 on 12/05/24 at 1:29pm revealed she was in the bathroom unassisted. Interview with the personal care aide (PCA) on 12/06/24 at 9:00am revealed Resident #5 transferred herself and could walk but was unsteady. Interview with the medication aide (MA) on 12/06/24 at 9:40am revealed: -Resident #5 self-transferred with no assistance. -Resident #5 could walk short distances but gave out of breath quickly and easily. Interview with the Executive Director (ED) on 12/05/24 at 12:40pm revealed: -When orders were made, she or the MA received the order and placed it in a basket on her door. -She was responsible for making appointments after an order was made by the PCP. -The PT/OT order for Resident #5 was an oversight on her part. -She did not know how she missed the order for PT/OT. -There was no one else responsible for making the PT/OT evaluation appointment. -Resident #5 utilized a wheelchair and had not walked since being admitted to the facility so she was unsure why the PT/OT referral was made. -She would let the PCP know that Resident #5's PT/OT referral had not been sent to a provider and would follow up with scheduling an appointment. Interviews with the ED on 12/06/24 at 8:30am and 4:17pm revealed: -She spoke with 2 different agencies that provide PT/OT services on yesterday.	D 273		

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-Resident #5 had been declined for PT/OT services due to her insurance coverage.
-She would keep trying different agencies for PT/OT services.
-The PCP had been informed of the PT/OT referral being declined.
-The PCP informed her of a new program that Resident #5 could be referred to for PT/OT services.

Interview with the Administrator on 12/05/24 at 12:48pm revealed:
-The PCP wrote orders, and the orders were faxed to the appropriate providers.
-The ED was responsible for faxing orders to the appropriate providers.
-No one checked behind the ED to ensure orders were faxed.
-After the order was faxed to the appropriate provider, the order was put in a folder until services started.
-The ED informed her today that Resident #5's PT/OT order was not sent to a provider; she was not aware prior to today.
-Resident #5 had not had a PT/OT evaluation.
-The ED informed her that Resident #5's PT/OT referral was an oversight on her part.
-Resident #5 did not walk independently.
-They wanted to see if Resident #5 could become more mobile.
-There was a delay in the PT/OT referral being sent for Resident #5.

Interview with Resident #5's PCP on 12/06/24 at 2:30pm revealed:
-She had seen Resident #5 once or twice.
-She ordered a PT/OT evaluation for Resident #5.
-She wrote the order specifically so insurance would approve the evaluation.
-She was not aware the order for PT/OT was not

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sent to a provider.
-The PT/OT referral not being sent affected Resident #5's activities of daily living and ability to be functional in the facility.
-She expected Resident #5 to be evaluated.
-Insurance was sometimes a barrier but the referral not being sent to the appropriate provider for services was a lack of care.
-If insurance did not approve the services, the process was to keep trying different agencies for approval.

b. Observation of Resident #5 on 12/06/24 at 9:29am with the medication aide (MA) present revealed:
-She was in bed sleeping under the covers with socks on.
-She moaned when awaken but agreed to allow her feet to be seen.
-The resident had very dry feet with 2 dark calluses on the inner side of the left foot.
-All toenails on the left foot were thick and dark with the cuticle area appearing extremely thick and dry.
-The right foot had a dark scaly area on the bottom near the outer side of the foot.
-The skin just below the nails on the 2nd, 3rd and 5th toenail on the right foot were very thick and dry
-Both feet were very dry and scaly on the top and bottom with thick dry skin on both heels.

Interview with Resident #5 on 12/06/24 at 9:29am revealed:
-She had not had any issues with her feet.
-She had not had any foot pain.

Interview with the MA on 12/06/24 at 9:29am revealed:
-They only checked residents' feet if there was a

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complaint of pain.
-A lot of the residents did not like to be touched.
-She had not seen Resident #5's feet.
-Resident #5 had not complained of foot pain or skin issues.
-There had been no concerns with her feet or skin as a diabetic.

Interview with the Executive Director (ED) on 12/06/24 at 10:52am and 4:17pm revealed:
-Resident #5 had not seen podiatry since being admitted to the facility.
-The facility's contracted podiatrist saw the residents based on insurance coverage.
-Resident #5's name was scratched off the facility's contracted podiatrist's list by the podiatrist in June 2024.
-She was unsure why Resident #5 was not seen by the facility's contracted podiatrist.
-The facility's contracted podiatrist saw diabetic residents every 3 months unless there was a specific order from the primary care provider (PCP) for visits more often.
-She saw Resident #5's feet yesterday and observed "dry skin and hard shields (calluses)".
-She informed the PCP of the condition of Resident #5's feet yesterday and the PCP made a podiatry referral.
-She made a podiatry appointment yesterday for Resident #5 for 12/11/24.
-She had not made a podiatry appointment for Resident #5 prior to yesterday.
-The concern with Resident #5 not being seen by podiatry was the risk of ulcers and toenails growing inward.

Interview with Resident #5's PCP on 12/06/24 at 2:30pm revealed:
-She had seen Resident #5 once or twice.
-She saw Resident #5's feet on 10/31/24 and her

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feet were dry with no open wounds.
-Resident #5 had no complaints about her feet on 10/31/24.
-She had not seen Resident #5's feet since 10/31/24, prior to the pictures shown to her today.
-Resident #5 had a lot of dryness on her feet.
-Something was rubbing Resident #5's feet.
-Resident #5's toenails needed to be cut.
-There were no open wounds on Resident #5's feet.
-The expectation was that Resident #5's feet were checked every 1 to 2 hours to make sure she had not stepped on anything or hit her feet because she was diabetic.
-Failure to monitor Resident #5's feet could have led to an open wound that turned into a bone infection, which could have led to amputation.
-Resident #5 needed to be seen by podiatry.
-She would write a podiatry referral.
-The facility needed to assess Resident #5's hygiene and feet every shift until seen by podiatry.
-The expectation for diabetic foot care was that Resident #5's feet were checked every shift, cleaned with soap and water, and moisturized.
-She expected to be notified immediately of any skin breakdown.
-She was not aware of the condition of Resident #5's feet.

Attempted interview with the facility's contracted podiatry provider on 12/06/24 at 10:56am was unsuccessful.

Attempted interview with Resident #5's responsible party on 12/05/24 at 11:07am was unsuccessful.

_____

The facility failed to ensure health care referral and follow-up for Resident #2 and Resident #5.

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D 273	Continued From page 30 The facility did not coordinate podiatry care for Resident #2 and Resident #5, who both had diabetes putting the residents at risk for infections which could lead to amputations. Resident #2's toenails were extremely long and thick including the right great toenail that was curved under the toe and over to the second toe causing an indention in the skin of the second toe. Resident #2 experienced pain when walking to due to his toenails being so long they curved over the top of the toes and he walked on them causing the toenails to press into the underside of his toes. Resident #5 had thick toenails and dry skin with calluses on both feet. Resident #2, who had symptoms of wheezing and coughing, did not have a chest scan or pulmonology referral in May 2024 for numerous swollen lymph nodes in the chest putting the resident at risk of the lymph nodes getting larger or disease progression. Resident #2, who was experiencing blurred vision and headaches, did not have a referral to the ophthalmologist. There was a delay in getting an echocardiogram for Resident #2 who had low potassium and was at risk of heart arrythmias. Resident #2 did not get an abdominal ultrasound putting the resident at risk of bowel obstruction or ileus, which could lead to death. The failure of the facility to provide health care referral and follow-up resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/06/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 5, 2025.	D 273		

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D 276	Continued From page 31	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure documentation and implementation for 1 of 5 residents (#2) sampled who had an order for blood pressure to be checked weekly and was receiving medication that lowers blood pressure. The findings are: Review of Resident #2's current FL-2 dated 10/03/24 revealed: -Diagnoses included type 2 diabetes mellitus, atrial fibrillation, atrial flutter, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and history of seizures. -There was an order to check blood pressure (BP) weekly, notify primary care provider (PCP) if systolic blood pressure (SBP) was greater than (>) 180 or diastolic blood pressure (DBP) was > 105. Review of Resident #2's physician's orders for October 2024 - December 2024 revealed no order to discontinue the weekly BP checks.	D 276		

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Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lisinopril 40mg 1 tablet once daily at 7:00am. (Lisinopril lowers blood pressure.)
-Lisinopril was documented as administered daily from 10/01/24 - 10/31/24.
-There was an entry to check BP weekly, notify provider if SBP > 180 or DBP > 105 scheduled for first shift from 6:00am - 2:00pm.
-There was one BP documented on 10/02/24 with a reading of 158/72.
-There was a stop date of 10/08/24 and no other weekly BPs were documented.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for Lisinopril 40mg 1 tablet once daily at 7:00am.
-Lisinopril was documented as administered daily from 11/01/24 - 11/30/24.
-There was no entry to check BP weekly.
-There were no BPs documented as checked on the eMAR from 11/01/24 - 11/30/24.

Review of Resident #2's December 2024 eMAR dated 12/01/24 - 12/06/24 revealed:
-There was an entry for Lisinopril 40mg 1 tablet once daily at 7:00am.
-Lisinopril was documented as administered daily from 12/01/24 - 12/06/24.
-There was no entry to check BP weekly.
-There were no BPs documented as checked on the eMAR from 12/01/24 - 12/06/24.

Review of facility's monthly BP log for Resident #2 for September 2024 - November 2024 revealed:
-The resident's BP was 114/68 in September

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2024.
-The resident's BP was 103/62 in October 2024.
-The resident's BP was 119/69 in November 2024.

Interview with a medication aide (MA) on 12/05/24 at 1:48pm revealed:
-She did not check Resident #2's BP if it was not on the eMAR.
-She was not aware Resident #2 had an order for weekly BP checks.

Interview with Resident #2 on 12/05/24 at 2:06pm revealed:
-The facility staff did not check his BP on a routine basis, only when he asked them to check it.
-He did not recall the last time his BP was checked.
-He sometimes had headaches.

Interview with the Executive Director (ED) on 12/06/24 at 5:04pm revealed:
-She could not locate an order to discontinue Resident #2's weekly BP checks.
-She was not sure why the weekly BP checks were stopped on the eMAR.
-There was no system to check the eMARs for accuracy.

Interview with Resident #2's PCP on 12/06/24 at 1:54pm revealed:
-Resident #2 took medication for high BP.
-If Resident #2's BP was not checked weekly, it would be difficult to know if his medication was effective or if she needed to make any adjustments to his dosage.

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D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 2 of 3 sampled residents (#2, #5) with LHPS tasks included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for testing of fingerstick blood sugars, medication through injection, and medication through inhalation.	D 280		

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D 280	Continued From page 35 The findings are: 1. Review of Resident #2's current FL-2 dated 10/03/24 revealed: -Diagnoses included type 2 diabetes mellitus, atrial fibrillation, atrial flutter, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and history of seizures. -The resident was semi-ambulatory and required assistance with bathing and dressing. -There was an order for Humalog Kwikpen inject 5 units 3 times a day with meals, hold if blood sugar is less than 150 and give within 15 minutes of food. (Humalog is rapid-acting insulin used to lower blood sugar.) -There was an order for Lantus insulin inject 25 units once daily. (Lantus is long-acting insulin used to lower and control blood sugar levels.) -There was an order for Trulicity inject 0.75mg once a week. (Trulicity is a weekly injectable used to treat type 2 diabetes.) -There was an order to check fingerstick blood sugar 3 times a day before meals. -There was an order for Albuterol solution 2.5mg/3ml use 1 vial via nebulizer every 4 hours as needed for cough or wheezing. (Albuterol is used to treat breathing problems associated with chronic obstructive pulmonary disease.) Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 12/27/23. -The resident required assistance for dressing, bathing, nail care, shaving, ambulation, hair/grooming, and skin care. -The resident's memory was documented as adequate.	D 280		

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D 280	Continued From page 36 -The resident used a wheelchair. Review of Resident #2's current assessment and care plan dated 07/26/24 revealed: -The resident was documented as having limited ability with ambulation. -The resident used a wheelchair and a motorized scooter to move around. -The resident had a very unsteady gait. -The resident limited range of motion and limited strength in his upper extremities. -The resident was documented as sometimes disoriented, forgetful and needed reminders. -The resident required supervision by staff with eating, toileting, ambulation, dressing, and transferring. -The resident required limited assistance by staff with bathing and grooming. Observation of Resident #2 on 12/06/24 at 11:30am revealed: -The resident's toenails on both feet were yellowish brown and extremely long and thick. -The great toenail on his right foot was so long it curved down and over the top of his toe and pressed into the second toe. -The skin on the right second toe had a dark pink area of skin and indentation where the great toenail rubbed into the second toe. -The toenail on the right second toe was so long it curved and made a half circle and touched the great toenail that was resting on the second toe. -The third, fourth and fifth right toenails were long and curved over the top of the toes and into the skin on the bottom of the toes. -The great toenail on the left foot was long, thick, and jagged. -The toenail on the left second toe was so long it curved and made a half circle and touched the great toe.	D 280		

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-The third, fourth and fifth left toenails were long and curved over the top of the toes and into the skin on the bottom of the toes.
-The resident's skin on both feet was extremely dry with large, white, and loose flakes of skin.

Interviews with Resident #2 on 12/05/24 at 2:06pm and 12/06/24 at 11:27am revealed:
-His blood sugar was usually checked about 3 times a day.
-He received insulin at bedtime and another injection once a week for his diabetes.
-He had not received treatment from a podiatrist since he was admitted to the facility in December 2023.
-He saw the facility's contracted podiatry provider (could not recall date) and was told his feet were too bad to treat at the facility and he needed to see an outside podiatry provider.
-His toenails bothered him because it hurt when he walked.
-His toenails were so long that he walked on the toenails which cause the toenails to push into the skin on the bottom of his toes.
-He usually tried to walk on his heels to prevent walking on his toenails.
-He had problems with wheezing and coughing; he was currently wheezing.

Review of Resident #2's current Licensed Health Professional Support (LHPS) review dated 10/01/24 revealed:
-The nurse documented the resident's LHPS tasks were collecting and testing fingerstick blood samples, medication administration through injection, and inhalation medication by machine.
-The nurse documented the observing the resident self-propelling in his wheelchair coming from outside.
-The resident was alert, oriented, and pleasant.

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-The resident had orders for fingerstick blood sugars 3 times a day with Humalog 5 units 3 times a day if blood sugar was greater than 150.
-The resident received Lantus insulin 25 units daily.
-The resident received Trulicity weekly to help with blood sugars.
-The resident had an order for Albuterol nebulizer solution as needed.
-The resident required assistance by staff with activities of daily living.
-The resident was on a No Concentrated Sweets diet.
-The nurse noted she had no concerns at the time of the assessment.
-The nurse noted to continue to follow plan of care.
-There was no physical assessment related to any of the resident's LHPS tasks.
-There was no physical assessment related to the resident's skin or foot care for a resident with diabetes.
-There was no physical assessment related to the resident's medication for inhalation including no documentation of the resident's lung sounds or noting if the resident was having any shortness of breath, coughing, or wheezing.
-There were no recommendations related to a physical assessment of the resident.

Telephone interview with the facility's contracted LHPS nurse on 12/06/24 at 4:04pm revealed:
-She observed Resident #2 during the LHPS review completed on 10/01/24.
-She did not physically assess the resident because she did not know she needed to do a physical assessment.
-She did not check Resident #2's skin or check his feet.
-She did not listen to his lungs or check his vital

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signs.
-She checked to make sure the resident was getting his medications or treatments.
-If a resident was diabetic, she tried to make sure they had a yearly eye exam and had been seen by a podiatrist.
-She could not recall if Resident #2 had an eye exam or if he had been seen by a podiatrist.

Refer to interview with the Executive Director (ED) on 12/06/24 at 8:40am.

Refer to telephone interview with the facility's contracted LHPS nurse on 12/06/24 at 4:04pm.

2. Review of Resident #5's current FL-2 dated 01/05/24 revealed:
-Diagnoses included diabetes mellitus type 2, COPD (chronic obstructive pulmonary disease, heart failure, hypertension, anemia, vitamin B12 deficiency, GERD (gastroesophageal reflux disease), and bipolar disorder.
-The resident was semi ambulatory.

Review of Resident #5's Resident Register dated 12/27/23 revealed:
-The resident was admitted to the facility on 12/27/23.
-The resident required assistance with dressing, bathing, nail care, ambulation, getting in/out of bed, toileting, hair/grooming, skin care, and scheduling appointments.
-The resident used a walker and a wheelchair.

Review of Resident #5's assessment and care plan dated 01/26/24 revealed:
-The resident was ambulatory with aide or device and used a wheelchair.
-The resident required supervision with eating, dressing and grooming.

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D 280	Continued From page 40 -The resident required limited assistance with toileting, ambulation, bathing and transferring. Observation of Resident #5 on 12/06/24 at 9:29am with the medication aide (MA) present revealed: -She was in bed sleeping under the covers with socks on. -She moaned when awaken but agreed to allow her feet to be seen. -The resident had very dry feet with 2 dark calluses on the inner side of the left foot. -All toenails on the left foot were thick and dark with the cuticle area appearing extremely thick and dry. -The right foot had a dark scaly area on the bottom near the outer side of the foot. -The skin just below the nails on the 2nd, 3rd and 5th toenail on the right foot were very thick and dry -Both feet were very dry and scaly on the top and bottom with thick dry skin on both heels. Interview of Resident #5 on 12/06/24 at 9:29am revealed: -She had not had any issues with her feet. -She had not had any foot pain. Interviews with the Executive Director (ED) on 12/06/24 at 10:52am and 4:17pm revealed: -Resident #5 had not seen podiatry since being admitted to the facility. -The facility's contracted podiatrist saw the residents based on insurance coverage. -Resident #5's name was scratched off the facility's contracted podiatrist's list by the podiatrist. -She was unsure why Resident #5 was not seen by the facility's contracted podiatrist. -The facility's contracted podiatrist saw diabetic	D 280		

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D 280	Continued From page 41	D 280		

residents every 3 months unless there was a specific order from the primary care provider (PCP) for visits more often.
-She saw Resident #5's feet yesterday and observed "dry skin and hard shields (calluses)".
-The concern with Resident #5 not being seen by podiatry was the risk of ulcers and toenails growing inward.

Review of Resident #5's current Licensed Health Professional Support (LHPS) review dated 10/01/24 revealed:
-The nurse checked collecting and testing of fingerstick blood samples, inhalation medication by machine and medication administration through injections as personal care tasks currently present.
-In the physical assessment section of the LHPS form, the nurse wrote the resident observed resting in recliner, was alert, oriented and pleasant, used a wheelchair for ambulation independently, had orders for finger-stick blood sugar (FSBS) 3 times a day (TID), was getting Novolog TID 8 units if blood sugar over 150, was getting 32 units of Lantus twice daily, had an order for nebs prn, required assistance with activities of daily living, was on a no concentrated sweets diet, no concerns noted and no significant changes since last assessment. (Novolog and Lantus are insulins used to treat diabetes.)
-There was no physical assessment documentation related to diabetic skin assessment or foot care.
-Changes and follow-up recommendations included continue to assess resident's needs.

Telephone interview with the facility's contracted LHPS nurse on 12/06/24 at 4:04pm revealed:
-She did a quarterly review and an observation but did not undress the residents or look at their

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D 280	Continued From page 42 feet. -She had not seen Resident #5's feet. -She was not aware she was supposed to complete a physical assessment of the residents. Refer to interview with the Executive Director (ED) on 12/06/24 at 8:40am. Refer to telephone interview with the facility's contracted LHPS nurse on 12/06/24 at 4:04pm. _____ Interview with the Executive Director (ED) on 12/06/24 at 8:40am revealed: -She was not aware the LHPS nurse did not do a physical assessment on the residents during the quarterly LHPS reviews. -There was currently no system to check the LHPS reviews to ensure they were completed and included a physical assessment for the residents' LHPS tasks. Telephone interview with the facility's contracted LHPS nurse on 12/06/24 at 4:04pm revealed: -She started doing LHPS reviews for this facility in August 2024. -She usually observed the residents during the LHPS review process, but she did not usually do any type of skin assessment. -She did not usually check vital signs during the LHPS review process. -She usually looked at any vital signs documented by the facility staff for the past 90 days. -She was not aware a physical assessment specific to the residents' LHPS tasks were required with the quarterly LHPS reviews.	D 280		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service	D 282		

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D 282	Continued From page 43 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) Facilities with a licensed capacity of 7 to 12 residents shall ensure food services comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the residents' food was free from contamination as evidence by the cook using her hands to serve food. The findings are: Observation of the kitchen on 12/05/24 between 11:58am and 12:51pm revealed: -There were residents in the dining room waiting to eat their lunch. -The cook was in the kitchen plating food on the residents' plates. -The cook had gloves on both her hands. -The cook used her right hand to pick up noodles and place a dinner roll on the residents' plate. -The cook used her right hand to pick up a ladle to scoop vegetables that were being served. -The surveyor prompted the cook to obtain a serving utensil for the noodles. -The cook left the serving table, removed her glove on her left hand, placed her right hand on	D 282		

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the table, and used her left hand to open a drawer to get a serving utensil.
-The cook removed the glove from her right hand and put new gloves on both hands.
-The cook returned to the serving table with a serving utensil for the noodles.
-The cook started plating the noodles with her left hand and the vegetables with her right hand using the serving utensils.
-The cook held the residents' plates in her left hand and used her right gloved hand to put the dinner roll on residents' plates.

Interview with the cook on 12/05/24 between 12:15pm and 12:57pm revealed:
-She was responsible for ensuring the food was pulled and ready to cook for the next day.
-She was back up for kitchen staff who called out of work.
-She supervised the kitchen staff and ensured the food that was on the menu was served.
-She knew she was not supposed to pick up the noodles with her hands, but it was a habit, and she was comfortable doing it.

Interview with the Executive Director on 12/05/24 at 1:33pm revealed:
-She was responsible for ensuring the food for the kitchen was ordered and the menus were posted.
-She supervised the cooks in the kitchen.
-She expected the cooks to serve food with the proper utensils and not their hands.
-She expected the cooks to serve the dinner rolls using gloves but not touching serving utensils at the same time.
-She was concerned about proper sanitation issues and cross contamination because the cook used the same hand for touching the serving utensils and picking up the dinner rolls.

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D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the kitchen was stocked with a 5-day supply of nonperishable foods based on their census. The findings are: Review of the facility's census for 12/05/24 revealed there were 55 residents in the facility. Observation of the kitchen on 12/05/24 between 6:36am and 6:45am revealed: -There were 8 cans of cream of chicken soup, with servings per can for 11. -According to the census of 55 and the serving	D 285		

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D 285	Continued From page 46	D 285		

size per can, the facility would use 5 cans during one meal, with a remainder of 3 cans, needing an additional 17 cans for a 5-day supply.
-There were 6 cans of cream of mushroom soup, with servings per can for 11.
-According to the census of 55 and the serving size per can, the facility would use 5 cans during one meal, with a remainder of 1 can, needing an additional 19 cans for a 5-day supply.
-There were 4 canisters of oatmeal, with servings per canister for 30.
-According to the census of 55 and the serving size per canister, the facility would use 2 cans during one meal, with a remainder of 2 cans, needing an additional 6 canister for a 5-day supply.
-There were 11 boxes of spaghetti noodles, with servings per box for 8.
-According to the census of 55 and the serving size per box, the facility would use 7 boxes during one meal, with the remainder of 1 box, needing an additional 41 boxes for a 5-day supply.
-There were 4 bags of scalloped potatoes, with servings per bag for 17.
-According to the census of 55 and the serving size per bag, the facility would use 4 bags during one meal, with a remainder of 0 boxes, needing an additional 16 bags for a 5-day supply.
-There were 2 boxes of rice pilaf, with servings per box for 18.
-According to the census of 55 and the serving size per box, the facility would use 4 boxes during one meal, with a remainder of 0 boxes, needing an additional 18 boxes for a 5-day supply.
-There were 3 cans of collard greens, with servings per can for 24.
-According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 0 cans, needing an additional 12 cans for a 5-day supply.

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D 285	Continued From page 47 -There were 4 cans of mandarin oranges, with a serving per can for 19. -According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 1 can, needing an additional 11 cans for a 5-day supply. -There were 3 cans of pineapple tidbits with servings per can for 25. -According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 0 cans, needing an additional 12 cans for a 5-day supply. -There were 6 cans of green beans with serving per can for 24. -According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 3 cans, needing an additional 9 cans for a 5-day supply. -There were 4 cans of northern beans with serving per can for 24. -According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 1 can, needing an additional 11 cans for a 5-day supply. -There were 6 cans of baked beans with serving per can for 26. -According to the census of 55 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 3 cans, needing an additional 9 cans for a 5-day supply. -There were 6 cans of beef stew with serving per can for 12. -According to the census of 55 and the serving size per can, the facility would use 5 cans during one meal, with a remainder of 1 can, needing an additional 19 cans for a 5-day supply. -There were 7 cans of chef Boyardee with serving per can for 12. -According to the census of 55 and the serving size per can, the facility would use 5 cans during	D 285		

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D 285	Continued From page 48 one meal, with a remainder of 2 cans, needing an additional 18 cans for a 5-day supply. Interview with the cook on 12/05/24 between 12:15pm and 12:57pm revealed: -She was responsible for ensuring the food was pulled and ready to cook for the next day. -She was back up for kitchen staff who called out of work. -She supervised the kitchen staff and ensured the food that was on the menu was served. -She thought there should be at least a week's supply of dry food for example vegetables, cereal, and any other food item in the dry storage in case of a disaster. -She knew there was not enough food in the dry storage for a 5-day supply. -She did not complete the food order. Interview with the Executive Director on 12/05/24 at 1:33pm revealed: -She supervised the cooks in the kitchen. -She was responsible for ensuring the food for the kitchen was ordered. -She thought there was enough nonperishable food for a 5-day supply in the kitchen.	D 285		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) If residents require feeding assistance, food shall be maintained at serving temperature until assistance is provided.	D 288		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure food was maintained at serving temperature for 1 of 2 residents who required feeding assistance.

The findings are:

Review of Resident #9's current FL-2 dated 10/03/24 revealed diagnoses included dementia with behaviors, heart failure, and asthma.

Observation during the breakfast meal on 12/05/24 at 8:02am revealed the residents who required feeding assistance received their breakfast trays in their rooms.

Observation of the facility on 12/05/24 at 10:08am revealed an unknown female warming a resident's breakfast plate in the employee lounge area.

Interview with the female on 12/05/24 at 10:08am revealed:
-She was Resident #9's family member.
-She was warming Resident #9's breakfast plate.
-She did not know how long the breakfast plate was in her room.
-The facility served breakfast around 7:30 am and 8:00am.
-She came to the facility some mornings and afternoons.
-She had to warm Resident #9's food when she visited because the plates were left after a meal.

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Observation during the lunch meal on 12/05/24 between 12:53pm and 2:06pm revealed:
-There was a personal care aide (PCA) who left the kitchen with Resident #9's food tray.
-At 12:54pm, the PCA walked down the hallway and went back into the kitchen.
-At 12:55pm, Resident #9's lunch food tray was in her room, placed on her bedside table untouched.
-At 1:27pm, Resident #9's lunch food tray was in her room, placed on her bedside table untouched.
-At 2:09pm, Resident #9's lunch food tray was in her room, placed on her bedside table untouched.
-The surveyor prompted the Executive Director.
-At 2:12pm, a PCA was in the kitchen warming Resident #9's lunch plate.

Interview with a PCA on 12/05/24 at 2:12pm revealed:
-She had been working in the facility for two weeks.
-She worked the second shift from 2:00pm to 11:00pm.
-She was asked to heat Resident #9's lunch plate and feed her.
-Resident #9's food trays were never touched when she came on shift.
-She informed the Executive Director and was told she would look into it.

Interview with the cook on 12/05/24 at 12:57pm revealed as soon as she plated the residents' food, the PCAs were to take the food to their rooms and serve them.

Interview with the Executive Director on 12/05/24 at 1:33pm revealed:
-There were two residents in the facility who required feeding assistance.
-The residents who required feeding assistance should be served their food immediately upon

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D 288	Continued From page 51 receiving their trays. -She was not aware Resident #9's food tray was not being served to her.	D 288		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service staff guidance for 2 of 6 sampled residents (#2 and #5) with physician orders for No Concentrated Sweets (NCS). The findings are: Review of the facility's menus on 12/05/24 revealed: -There were menus for a regular diet, diabetic (DB)- consisted carbohydrate (CCHO) diet, mechanical soft (MS) chop diet, MS ground diet, puree diet, no added salt (NAS) diet, and finger foods (FF) diet. -There were no menus for a No Concentrated Sweets (NCS) diet.	D 296		

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D 296	Continued From page 52 1. Review of Resident #2's current FL-2 dated 10/03/24 revealed diagnoses included type 2 diabetes, atrial fibrillation, chronic obstructive pulmonary disease, and congestive heart failure. Review of Resident #2's diet order dated 10/03/24 revealed a diet order for No Concentrated Sweets (NCS). 2. Review of Resident #5's current FL-2 dated 01/05/24 revealed diagnosis included type 2 diabetes, bipolar, hypertension, heart failure and chronic obstructive pulmonary disease. Review of Resident #5's diet order dated 10/03/24 revealed a diet order for No Concentrated Sweets (NCS). Interview with the cook on 12/05/24 at 12:57pm revealed she did not know what to serve residents with a NCS diet because it was not on the menu extension. Interview with the Executive Director on 12/05/24 at 1:33pm revealed: -She was aware the menus needed to match the diet order. -She was responsible for ensuring the menus matched the diet orders. -She thought there was a NCS diet on the menus.	D 296		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule.	D 297		

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SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(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 297	Continued From page 53 Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents received the portion sizes of food and beverages based on the menu. Review of the facility's breakfast menu on 12/05/24 revealed 6 ounces of 100% juices were to be served. Review of the facility's recipe for scrambled eggs on 12/05/24 revealed 1/3 cup of eggs were to be served. Observation in the kitchen on 12/05/24 between 7:02am and 8:00am revealed: -There were glasses of orange juice and apple juice on the dining room tables. -The surveyor removed a glass of orange juice and apple juice from a table and used a liquid measuring cup to determine how many ounces of juice were in each glass. -There was 4 ounces of orange juice and apple juice in each glass. -The cook used an 11 inch perforated stainless steel spoon to serve scrambled eggs. (level scoops, ladles, and portion servers provide more accurate portion control than serving spoons that are not volume-standardized measure). Interview with a resident on 12/04/24 at 9:55am	D 297		

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D 297	Continued From page 54 revealed she complained to the facility about the small portion sizes of food. Interview with the cook on 12/05/24 at 12:57pm revealed: -She did not know how much of the scrambled eggs were served. -She did not look on the menu to see what the portion size of the eggs should have been. -She knew the juice cups were 4 ounces and needed to be 6 ounces. Interview with the Executive Director on 12/05/24 at 1:33pm revealed: -She was aware the juice served to the residents should be 6 ounces. -She was not aware of the size of the juice cups in the kitchen. -She conducted rounds in the kitchen daily to ensure the cooks were using the correct serving utensils but had not done any rounds lately.	D 297		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident during the	D 306		

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breakfast meal.

The findings are:

Observation of the breakfast meal on 12/05/24 between 7:00am and 8:30am revealed:
-There were 3 residents who were served water in the dining room.
-There was no water served to the other residents in the dining room.
-No staff asked the other residents if they wanted water.

Interview with a dietary aide on 12/05/24 at 12:05pm revealed:
-She never gave all the residents water during their breakfast meal.
-She was trained to give all the residents water during their lunch meal.

Interview with the cook on 12/05/24 at 12:57pm revealed:
-Water should be served at each meal.
-She did not know why water was not served for breakfast.
-She was not aware water was not served for breakfast because she was doing her "own thing."

Interview with the Executive Director on 12/05/24 at 1:33pm revealed:
-The dietary aides were trained by the cook and other dietary aides.
-The dietary aides should serve water at all three meals.
-She was not aware water was not being served during the breakfast meal.

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D 310	Continued From page 56	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a nutritional supplement was served as ordered for 1 of 1 residents sampled (#9) who had a physician's order for a nutritional shake with each meal. The findings are: Review of Resident #9's current FL-2 dated 10/03/24 revealed diagnoses included dementia with behaviors, heart failure, and asthma. Review of Resident #9's physician order dated 11/06/24 revealed: -There was a diet order to downgrade to puree foods. -There was an order to add a nutritional shake to each meal tray. Observation of Resident #9's lunch tray on 12/05/24 at 12:55pm, 1:27pm and 2:09pm revealed: -The plate consisted of puree noodles, puree chicken, and puree vegetables. -There was an unrecognizable beverage in a glass on the food tray. -There was no nutritional shake on the food tray. Interview with the Executive Director on 12/06/24	D 310		

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D 310	Continued From page 57 at 4:01pm revealed: -She did not receive the diet order for Resident #9's nutritional shake for each meal. -If she received the nutritional shake order, she would have sent the order to the pharmacy, placed it on the electronic medication administration record (eMAR), and sent the order to the kitchen. -She was made aware of the nutritional shake order for Resident #9 today, 12/06/24.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide feeding assistance to Resident #9 upon receipt of her meal. The findings are: Review of Resident #9's current FL-2 dated 10/03/24 revealed diagnoses included dementia with behaviors, heart failure, and asthma. Observation during the breakfast meal on 12/05/24 at 8:02am revealed the residents who required feeding assistance received their breakfast trays in their rooms.	D 312		

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D 312	Continued From page 58 Observation of the facility on 12/05/24 at 10:08am revealed an unknown female warming a resident's breakfast plate in the employee lounge area. Interview with the female on 12/05/24 at 10:08am revealed: -She was Resident #9's family member. -She was warming Resident #9's breakfast plate. -She did not know how long the breakfast plate was in her room. -The facility served breakfast around 7:30 am and 8:00am. -She came to the facility some mornings and afternoons. -She had to feed and warm Resident #9's food when she visited because the plates were left after a meal. Observation during the lunch meal observation on 12/05/24 between 12:53pm and 2:06pm revealed: -There was a personal care aide (PCA) who left the kitchen with Resident #9's food tray. -At 12:54pm, the PCA walked down the hallway and went back into the kitchen. -At 12:55pm, Resident #9's lunch food tray was in her room, placed on her bedside table. -At 1:27pm, Resident #9's lunch food tray was in her room, placed on her bedside table. -At 2:09pm, Resident #9's lunch food tray was in her room, placed on her bedside table. -The surveyor prompted the Executive Director. -At 2:12pm, a PCA was in the kitchen warming Resident #9's lunch plate. Interview with a PCA on 12/05/24 at 2:12pm revealed: -She had been working in the facility for two weeks. -She worked the second shift from 2:00pm to	D 312		

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D 312	Continued From page 59 11:00pm. -Resident #9's food trays were never touched when she came on shift. -She informed the Executive Director and was told she would look into it. Interview with the Executive Director on 12/05/24 at 1:33pm revealed: -There were two residents in the facility who required feeding assistance. -The residents who required feeding assistance should be served their food immediately upon receiving their trays. -She was not aware Resident #9's food tray was not being served to her.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#7, #8) observed during the medication pass including errors with an ointment used to treat and prevent skin rashes and skin irritation (#7), a medicated cream used to treat and prevent dry, scaly, itchy skin (#7), a laxative used to treat and prevent constipation (#8), and a medicated cream	D 358		

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used to treat skin infections and inflammation (#8); and for 1 of 5 residents (#2) sampled for record review including errors with an inhaler for breathing problems and a laxative used to treat and prevent constipation.

The findings are:

1. The medication error rate was 14% as evidenced by 4 errors out of 27 opportunities during the 7:00am/8:00am medication pass on 12/05/24.

a. Review of Resident #7's current FL-2 dated 10/08/24 revealed:
-Diagnoses included type 2 diabetes mellitus, hypothyroidism, hypertension, dementia, osteoarthritis, cerebral infarction, and mild cognitive impairment.
-There was an order for Zinc Oxide 20% ointment apply topically 3 times daily to perineal area (area between the anus and genitals). (Zinc Oxide is a used to treat and prevent skin rashes and skin irritation.)

Observation of the 7:00am medication pass on 12/05//24 revealed:
-The medication aide (MA) prepared Resident #7's oral medications scheduled for 7:00am.
-The MA administered Resident #7's oral medications at 7:25am.
-The MA did not prepare or offer to administer Zinc Oxide ointment during the 7:00am medication pass.
-Zinc Oxide ointment was not administered as ordered.

Review of Resident #7's December 2024 electronic medication administration record (eMAR) revealed:

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-There was an entry for Zinc Oxide 20% ointment apply topically 3 times daily to perineal area.
-Zinc Oxide ointment was scheduled at 7:00am, 1:00pm, and 7:00pm.
-Zinc Oxide ointment was documented as administered 3 times a day from 12/01/24 - 12/04/24.
-Zinc Oxide ointment was documented as not being administered on 12/05/24 at 7:00am due to the medication was not on cart and waiting on pharmacy.

Observation of Resident #7's medications on hand on 12/05/24 at 10:48am revealed there was no Zinc Oxide 20% ointment available for administration.

Interview with Resident #7 on 12/05/24 at 10:37am revealed:
-The MAs put an ointment on her bottom for about a week (could not recall dates) because they said it was red but it had gotten better.
-No one had put any ointment on her bottom in "more than a few days".

Observation of Resident #7 on 12/06/24 at 11:17am revealed:
-There were no open areas on Resident #7's skin on her bottom or perineal area.
-There was redness in between the crack of her buttocks.

Second interview with Resident #7 on 12/06/24 at 11:17am revealed she denied any pain in her buttocks area.

Interview with the MA on 12/05/24 at 7:35am revealed:
-He did not administer Resident #7's Zinc Oxide ointment that morning because he could not find

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it in the medication cart.
-He did not know how long the resident had been out of the ointment.
-The MAs were responsible for reordering medications before they ran out.
-He was not sure when the Zinc Oxide ointment would be delivered to the facility.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 4:26pm revealed:
-The pharmacy dispensed Zinc Oxide 20% ointment for Resident #7 on 10/13/24.
-A refill had not been requested again until 12/05/24.

Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed:
-The MAs were responsible for ordering topical medications when there was about a fourth of the supply remaining.
-If a medication was ordered by 5:00pm, it would be delivered to the facility the same night.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 12/06/24 at 3:53pm was unsuccessful.

b. Review of Resident #7's current FL-2 dated 10/08/24 revealed an order for Ammonium Lactate 12% cream apply topically to both feet/legs twice daily. (Ammonium Lactate cream is used to treat and prevent dry, scaly, itchy skin.)

Observation of the 7:00am medication pass on 12/05//24 revealed:
-The medication aide (MA) prepared Resident #7's oral medications scheduled for 7:00am.
-The MA administered Resident #7's oral medications at 7:25am.

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D 358	Continued From page 63 -The MA did not prepare or offer to administer Ammonium Lactate 12% cream during the 7:00am medication pass. -Ammonium Lactate 12% cream was not administered as ordered. Review of Resident #7's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Ammonium Lactate 12% cream apply topically to both feet/legs twice daily. -Ammonium Lactate 12% cream was scheduled at 7:00am and 7:00pm. -Ammonium Lactate 12% cream was documented as administered from 12/01/24 - 12/05/24 (7:00am). Observation of Resident #7's medications on hand on 12/05/24 at 10:48am revealed: -There was a tube of Ammonium Lactate 12% cream dispensed on 05/08/24. -The instructions were to apply topically to both feet/legs twice daily. -The tube was approximately 3/4th full of Ammonium Lactate 12% cream. Interview with the MA on 12/05/24 at 10:40am revealed: -He offered to administer Ammonium Lactate 12% cream that morning to the resident but she refused. -He could not recall when he offered to administer it that morning. -He could not explain why he did not offer to administer it during the 7:00am medication pass observed when the resident received her other morning medications scheduled for 7:00am. -He should have documented the cream as being refused not administered.	D 358		

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Interview with Resident #7 on 12/05/24 at 10:37am revealed:
-She had very dry skin on her legs and feet.
-The MAs did not put any kind of cream on her feet or legs.
-The MAs had not offered to put any kind of cream on her feet or legs.

Observations of Resident #7 on 12/05/24 at 10:41am and 12/06/24 at 11:20am revealed:
-The resident's feet and legs from the knees down had dry, flaky skin.
-There were loose, flakes of skin peeling away from the skin on her feet and legs and between her toes.

Second interview with Resident #7 on 12/06/24 at 11:17am revealed the skin on her legs and feet were dry and itchy.

Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed:
-Resident #7 did not refuse medications.
-Resident #7's Ammonium Lactate 12% cream should have been administered at the same time as her other medications scheduled for 7:00am.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 12/06/24 at 3:53pm was unsuccessful.

c. Review of Resident #8's current FL-2 dated 10/17/24 revealed:
-Diagnoses included diabetes mellitus, essential hypertension, hyperlipidemia, atrial fibrillation, congestive heart failure, infection and inflammatory reaction, atherosclerotic heart disease, and urogenital candidiasis.
-There was an order for Miralax give 17 grams twice day every Tuesday and Friday for

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constipation. (Miralax is used to treat and prevent constipation.)

Review of Resident #8's hospital discharge summary dated 11/15/24 revealed:
-The resident was admitted to the hospital on 11/11/24.
-The resident was diagnosed with chronic anemia and complicated urinary tract infection associated with indwelling urethral catheter.
-There was an order for Miralax mix 17 grams in 8 ounces of water and drink twice a week on Mondays and Thursdays.

Observation of the 7:00am medication pass on 12/05/24 (Thursday) revealed:
-The medication aide (MA) prepared Resident #8's medications scheduled for 7:00am.
-The MA administered Resident #8's medications at 7:56am.
-The MA did not prepare or offer to administer Miralax during the 7:00am medication pass.
-Miralax was not administered as ordered.

Interview with the MA on 12/05/24 at 8:02am revealed she did not administer Miralax to the resident that morning because it did not "pop up" on the eMAR to be administered.

Review of Resident #8's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax mix 17 grams in 8 ounces of water and drink twice a week on Tuesdays and Friday scheduled at 7:00am.
-Miralax was documented as administered on Tuesday, 12/03/24.
-There was no entry for the most current order for Miralax to be administered on Mondays and Thursdays.

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D 358	Continued From page 66 Observation of Resident #8's medications on hand on 12/05/24 at 12:40pm revealed: -There was a bottle of Miralax dispensed on 06/17/24. -The instructions were to Mix 1 capful (17 grams) in 8 ounces of water and drink twice a week on Mondays and Thursdays. -The bottle was over half full of medication. Interview with Resident #8 on 12/05/24 at 10:26am revealed: -He was not sure how often he received Miralax. -He denied any current issues with constipation or diarrhea. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 4:26pm revealed: -The pharmacy usually entered orders into the eMAR system, but the facility staff was responsible for reviewing and approving the order entry before it became active in the eMAR system. -The pharmacy did not receive the signed discharge summary dated 11/15/24. Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed: -The MAs should read the medication labels and compare it to the eMARs. -If it did not match, the MAs should notify her or the Office Manager. -The pharmacy usually entered orders into the eMAR system and either she or the MAs would review and approve the orders before they became active on the eMAR system. -Resident #8 should have received the Miralax today because it was Thursday.	D 358		

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D 358	Continued From page 67 Interview with Resident #8's primary care provider (PCP) on 12/06/24 at 2:10pm revealed: -Resident #8's Miralax should be administered as ordered to help prevent constipation. -She was not concerned about one missed dose of Miralax causing any significant issues with the resident. d. Review of Resident #8's current FL-2 dated 10/17/24 revealed an order for Nystatin-Triamcinolone cream apply to infected area topically two times a day for irritation. (Nystatin-Triamcinolone cream is used to fungal infections and inflammation of the skin.) Review of Resident #8's primary care provider (PCP) visit note dated 10/31/24 revealed an order for Nystatin-Triamcinolone cream apply topically to abdominal folds and inner thighs twice a day. Review of Resident #8's hospital discharge summary dated 11/15/24 revealed: -The resident was admitted to the hospital on 11/11/24. -The resident was diagnosed with chronic anemia and complicated urinary tract infection associated with indwelling urethral catheter. -There was an order to continue Nystatin-Triamcinolone cream apply topically to abdominal folds and inner thighs twice a day. Observation of the 7:00am medication pass on 12/05/24 revealed: -The medication aide (MA) applied Nystatin-Triamcinolone cream to Resident #8's inner thighs at 7:59am. -The MA did not offer or attempt to apply Nystatin-Triamcinolone cream to the resident's abdominal folds.	D 358		

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D 358	Continued From page 68 Review of Resident #8's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin-Triamcinolone cream apply topically to abdominal folds/inner thighs twice a day scheduled for 7:00am and 7:00pm. - Nystatin-Triamcinolone cream was documented as administered from 12/01/24 - 12/05/24 (7:00am). Interview with the MA on 12/05/24 at 8:00am revealed: -She only applied Nystatin-Triamcinolone cream to Resident #8's inner thighs. -She did not realize abdominal folds meant the folds of skin on the resident's stomach. -She thought it meant the folds in the crease of his legs. -She would go back and apply the cream to the resident's abdominal folds. Observation on 12/05/24 at 8:02am revealed: -The MA went back to Resident #8's room and applied Nystatin-Triamcinolone cream to the resident's abdominal folds at 8:02am. -There was no rash on the resident's abdominal folds. Interview with Resident #8 on 12/05/24 at 10:26am revealed: -Today was the first time the MAs had put cream on him. -He did not have a rash and his skin was not itching or burning in his groin area or his abdominal folds. Observation of Resident #8's medications on hand on 12/05/24 at 12:40pm revealed: -There was a tube of Nystatin-Triamcinolone	D 358		

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cream dispensed on 10/30/24.
-The instructions were to apply topically to abdominal folds and inner thighs twice a day.
-The tube was over half full of medication.

Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed:
-The MAs should read the medication labels and compare it to the eMARs.
-If the MA did not understand the instructions, the MA should notify her or the Office Manager.

Interview with Resident #8's PCP on 12/06/24 at 2:10pm revealed:
-Resident #8's Nystatin-Triamcinolone cream should be applied as ordered.
-If not applied to the abdominal folds, it could cause a fungal infection, redness, itching, and skin breakdown.

2. Review of Resident #2's current FL-2 dated 10/03/24 revealed diagnoses included type 2 diabetes mellitus, atrial fibrillation, atrial flutter, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and history of seizures.

a. Review of Resident #2's primary care provider (PCP) visit note dated 10/17/24 revealed:
-The resident reported his last bowel movement was one month ago, which was his baseline.
-The resident reported a history of gastrointestinal issues.
-There was an order for Miralax mix 17 grams with 8 ounces of fluid and drink once daily for constipation. (Miralax is a laxative used to treat and prevent constipation.)

Review of Resident #2's October 2024 electronic medication administration record (eMAR)

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revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-The original date of the order was documented as 10/17/24.
-Documentation for the administration of Miralax started on 10/19/24.
-Miralax was documented as administered daily at 7:00am from 10/19/24 - 10/31/24.
-There were 13 doses of Miralax documented as administered in October 2024.
-There were no refusals documented.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-Miralax was documented as administered daily at 7:00am from 11/01/24 - 11/12/24, 11/14/24 - 11/22/24, 11/26/24, and 11/28/24 - 11/30/24.
-There were 25 doses of Miralax documented as administered in November 2024.
-Miralax was documented as refused 5 times on 11/13/24, 11/23/24 - 11/25/24, and 11/27/24.

Review of Resident #2's December 2024 eMAR dated 12/01/24 - 12/06/24 revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-Miralax was documented as administered daily at 7:00am on 12/01/24 and 12/02/24.
-There were 2 doses of Miralax documented as administered from 12/01/24 - 12/06/24.
-Miralax was documented as refused 4 times on 12/03/24 - 12/06/24.

Observation of Resident #2's medications on

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hand on 12/05/24 at 1:58pm revealed:
-There was a bottle of Miralax powder (510 grams - a 30-day supply) dispensed on 10/18/24.
-The instructions were to mix 17 grams into 8 ounces of fluid and drink every day for constipation.
-When the cap was removed, the seal was still in place.
-The Miralax bottle had not been opened and none had been used.

Interview with a medication aide (MA) on 12/05/24 at 1:48pm revealed:
-She could not explain why Resident #2's Miralax bottle had not been opened but was documented as being administered on the eMAR.
-The resident sometimes refused medication, including Miralax.
-If a medication was refused, the MAs were supposed to document it as refused on the eMAR system.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 4:26pm revealed:
-They received Resident #2's order dated 10/17/24 for Miralax on 10/18/24.
-They dispensed one bottle of Miralax on 10/18/24.
-They did not dispense any other bottles of Miralax for Resident #2 either prior to or after 10/18/24.

Interview with Resident #2 on 12/05/24 at 2:06pm revealed:
-He had problems with his stomach for 15 years.
-He usually had a bowel movement about once a month; that was normal for him.
-The MAs did not offer any Miralax to him.
-If the MAs offered Miralax and he was hurting,

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he would take it.

Interview with the Executive Director (ED) on 12/06/24 at 5:04pm revealed:
-She was not aware Resident #2's Miralax bottle had not been opened and the resident was not receiving Miralax as ordered.
-The MAs should not document a medication as administered if a resident was not taking the medication.
-If a resident refused a medication, the MAs should document the medication as refused on the eMAR.
-There was no system to check the eMARs for accuracy to ensure medications were being administered as ordered.

Interview with Resident #2's PCP on 12/06/24 at 1:54pm revealed:
-She was under the impression that Resident #2 was receiving Miralax as ordered.
-If the resident did not receive Miralax, it could cause a bowel obstruction or ileus (condition in which the bowel cannot push waste out of the body), which could lead to death.

b. Review of Resident #2's current FL-2 dated 10/03/24 revealed an order for Advair HFA 230/21mcg inhaler inhale 1 puff twice a day, rinse mouth after use. (Advair is used to treat breathing problems associated with chronic obstructive pulmonary disease.)

Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Advair HFA 230/21mcg inhale 1 puff twice daily, rinse mouth after use.
-Advair was scheduled to be administered at 7:00am and 7:00pm.

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-Advair was documented as not administered at 7:00pm on 10/14/24 and 10/15/24 due to the medication being on order and waiting on pharmacy.

Review of Resident #2's December 2024 (eMAR) revealed:
-There was an entry for Advair HFA 230/21mcg inhale 1 puff twice daily, rinse mouth after use.
-Advair was scheduled to be administered at 7:00am and 7:00pm.
-Advair was documented as not administered at 7:00am on 12/04/24 due to the medication not being on the medication cart.

Observation of Resident #2's medications on hand on 12/05/24 at 1:55pm revealed:
-There was an Advair HFA 230/21mcg inhaler dispensed on 12/04/24.
-The instructions were to inhale 1 puff twice daily, rinse mouth after use.

Interview with Resident #2 on 12/05/24 at 2:06pm revealed:
-He was out of the Advair inhaler for 2 weeks.
-He just started back receiving it last night, 12/04/24.
-He felt tight in his chest when he did not receive the Advair.
-He thought he usually used 1 puff of Advair.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/06/24 at 4:26pm revealed:
-The pharmacy dispensed and delivered an Advair inhaler to the facility for Resident #2 on 12/04/24.
-This was a 60-day supply.
-The resident's insurance would not pay for the Advair again until 12/04/24 because it was too

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D 358	Continued From page 74 soon to refill. -The resident should only get 1 puff, not 2 puffs when it was administered to prevent it from running out early. Interview with a medication aide (MA) on 12/05/24 at 1:48pm revealed: -She did not recall Resident #2 running out of Advair inhaler. -The medications usually came in monthly cycle fills from the pharmacy. -She thought the resident usually got just 1 puff. Interview with the Executive Director (ED) on 12/06/24 at 5:04pm revealed: -The scheduled medications, including inhalers were delivered on monthly cycle fills from the pharmacy. -If a medication was running out before time for the next cycle fill, the MAs were supposed to contact the pharmacy to get some on hand until the next cycle fill. -Resident #2 should not have run out of the Advair inhaler. -The resident should be administered 1 puff each time. Interview with Resident #2's primary care provider (PCP) on 12/06/24 at 1:54pm revealed: -The resident should get the Advair inhaler as ordered. -Missing doses of the Advair inhaler could cause the resident to have an exacerbation of chronic obstructive pulmonary disease symptoms, like shortness of breath.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration	D 367		

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D 367	Continued From page 75 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#2) for a medication used to treat and prevent constipation. The findings are: Review of Resident #2's current FL-2 dated 10/03/24 revealed diagnoses included type 2 diabetes mellitus, atrial fibrillation, atrial flutter, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, and history of seizures.	D 367		

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Review of Resident #2's primary care provider (PCP) visit note dated 10/17/24 revealed:
-The resident reported his last bowel movement was one month ago, which was his baseline.
-The resident reported a history of gastrointestinal issues.
-There was an order for Miralax mix 17 grams with 8 ounces of fluid and drink once daily for constipation. (Miralax is a laxative used to treat and prevent constipation.)

Review of Resident #2's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-The original date of the order was documented as 10/17/24.
-Documentation for the administration of Miralax started on 10/19/24.
-Miralax was documented as administered daily at 7:00am from 10/19/24 - 10/31/24.
-There were 13 doses of Miralax documented as administered in October 2024.
-There were no refusals documented.

Review of Resident #2's November 2024 eMAR revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-Miralax was documented as administered daily at 7:00am from 11/01/24 - 11/12/24, 11/14/24 - 11/22/24, 11/26/24, and 11/28/24 - 11/30/24.
-There were 25 doses of Miralax documented as administered in November 2024.
-Miralax was documented as refused 5 times on 11/13/24, 11/23/24 - 11/25/24, and 11/27/24.

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Review of Resident #2's December 2024 eMAR dated 12/01/24 - 12/06/24 revealed:
-There was an entry for Miralax mix 17 grams of powder (1 capful) into 8 ounces of fluid and drink every day for constipation scheduled at 7:00am.
-Miralax was documented as administered daily at 7:00am on 12/01/24 and 12/02/24.
-There were 2 doses of Miralax documented as administered from 12/01/24 - 12/06/24.
-Miralax was documented as refused 4 times on 12/03/24 - 12/06/24.

Observation of Resident #2's medications on hand on 12/05/24 at 1:58pm revealed:
-There was a bottle of Miralax powder (510 grams - a 30-day supply) dispensed on 10/18/24.
-The instructions were to mix 17 grams into 8 ounces of fluid and drink every day for constipation.
-When the cap was removed, the seal on top of the bottle opening was still in place.
-The Miralax bottle had not been opened and none had been used.

Interview with a medication aide (MA) on 12/05/24 at 1:48pm revealed:
-She could not explain why Resident #2's Miralax bottle had not been opened but was documented as being administered on the eMAR.
-The resident sometimes refused medication, including Miralax.
-If a medication was refused, the MAs were supposed to document it as refused on the eMAR system.
-There was no other supply of Miralax for the resident.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/06/24 at 4:26pm revealed:

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D 367	Continued From page 78 -They received Resident #2's order dated 10/17/24 for Miralax on 10/18/24. -They dispensed one bottle of Miralax on 10/18/24. -They did not dispense any other bottles of Miralax for Resident #2 either prior to or after 10/18/24. Interview with Resident #2 on 12/05/24 at 2:06pm revealed: -He had problems with his stomach for 15 years. -He usually had a bowel movement about once a month; that was normal for him. -The MAs did not offer any Miralax to him. -If the MAs offered Miralax and he was hurting, he would take it. Interview with the Executive Director (ED) on 12/06/24 at 5:04pm revealed: -The MAs should not document a medication as administered if a resident was not taking the medication. -If a resident refused a medication, the MAs should document the medication as refused on the eMAR. -There was no system to check the eMARs for accuracy.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

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	HAL043006	A. BUILDING: _____ B. WING _____	R 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS VILLAGE	504 WEST CANAL DRIVE DUNN, NC 28334

(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 371	Continued From page 79 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the medication pass on 12/05/24 by 1 of 2 medication aides observed who used ungloved hands to touch medications prepared and administered to two residents and administered a medication to a resident that had been dropped on top of the medication cart. The findings are: Observation of a medication aide (MA) administering medications on the West Hall during the 7:00am/8:00am medication pass on 12/05/24 from 7:20am - 7:36am revealed: -At 7:20am, the MA sanitized his hands prior to preparing medications for a resident. -The MA pulled medications out of the medication cart, touching the drawer, the top of the medication cart, and the medication packages with ungloved hands. -The MA used his ungloved hands to touch the computer to click on medications being prepared. -The MA punched 11 different medications from the bubble packages into his ungloved hands and then put the oral pills in a medication cup with his ungloved hands. -This included touching and using a key to unlock the controlled substance drawer of the medication cart and retrieving and preparing one medication from the controlled substance drawer with ungloved hands. -The MA dropped one of the pills on top of the medication cart, picked it up with his ungloved hands, and placed it in the medication cup to administer to the resident. -The MA administered the medications to the resident at 7:25am.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 371	Continued From page 80	D 371		

-The MA returned to the medication cart and sanitized his hands.
-The MA then started touching the computer and began preparing medications for a second resident with ungloved hands, including touching the medication cart.
-The MA punched 5 different medications from the bubble packages into his ungloved hands and then put the oral pills in a medication cup with his ungloved hands.
-The MA administered the medications to the resident at 7:34am.
-The MA returned to the medication cart and used his ungloved hands to document administration of the medications on the computer.

Interview with the MA on 12/05/24 at 10:40am revealed:
-He usually punched the medications in bubble cards into his hands because if he tried to punch the medications directly into the medication cup, the pills would spill out.
-He did not want to drop or spill a medication.
-He should have discarded the pill that fell on top of the medication cart that morning and replaced it with another one.
-He did not realize he needed to wear gloves when he punched the medications into his hands.

Interview with the Executive Director (ED) on 12/05/24 at 11:45am revealed:
-The MAs had been trained on using proper infection control during the medication pass by the facility's registered nurse (RN) when the MAs were checked off for validation.
-The MAs should not punch medications into their ungloved hands.
-The MAs should punch the medications into a medication cup.
-If a pill fell on top of the medication cart or on the

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D 371	Continued From page 81 floor, the MA was supposed to dispose of it and get another pill from the medication supply. -Touching the pills with ungloved hands or dropping the pills could cause contamination with germs.	D 371		