STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09901h	A. BUILDING: _____ B. WING: _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments	D 000		

The Adult Care Licensure Section and Yadkin County Department of Social Services conducted a complaint investigation from 11/21/24 through 11/22/24, and from 11/25/24 through 11/26/24. The complaint investigation was initiated by the Yadkin County Department of Social Services on 11/07/24.

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

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

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to provide personal care assistance for 2 of 6 sampled residents (#1, #4) who required staff assistance with bathing and grooming/hygiene who refused personal care (#1) and a resident who required staff assistance with bathing, dressing, and grooming who refused personal care (#4).

The findings are:

Review of Resident #1's current FL2 dated 08/21/24 revealed:
-Diagnoses included acute renal failure, peripheral vascular disease, Parkinson's disease, hypertension, osteoarthritis, paranoia, anxiety, tremors, bipolar disorder, syncope, and abnormal

Facility will monitor monthly 12/23/24 to increase the interaction of PRN staff and residents who refuse to perform personal care services. This will be done by increasing the number of different staff who will speak, distract and encourage residents to allow staff to perform personal care. Facility will educate residents and contact the resident's Guardian, Primary Care Physician (PCP), therapist, Psychological Medications doctor and local DSS as appropriate if resident's continue to refuse services. If all efforts are made and the resident continues to refuse care, the resident will be made aware that chronic refusal of

SIGNATURE OF DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mindy Brooks/RL — Administrator/Director of Nursing Specialist — 12/20/24

STATE FORM 6899 — YGJK11 — If continuation sheet 1 of 10

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D 269	Continued From page 1	D 269	DC Staff if resident refuses to have needed care. Management staff will review Resident care documentation routinely to ensure staff are following facility practices, resident's provider's ordered care services.	

gait.
-The resident was intermittently disoriented.
-He was semi-ambulatory.
-He needed assistance with bathing and dressing.
-He was incontinent of bladder.

Review of Resident #1's current assessment and care plan dated 05/01/24 revealed:
-He had limited ambulatory ability and used a wheelchair.
-He had occasional incontinence of the bladder.
-He was sometimes disoriented, forgetful, and needed reminders.
-He required limited assistance with eating, toileting, ambulating, dressing, and transferring.
-He required extensive assistance with bathing and grooming/personal hygiene.
-Resident #1 was being seen by a mental health provider (MHP).

Review of Resident #1's November 2024 personal care aide (PCA) weekly task report dated 11/01/24-11/11/24 revealed:
-There was a section for bathing with tasks under the heading including sponge bath and shower/tub assistance.
-Staff documented a sponge bath was completed on 11/01/24 and 11/03/24.
-Staff documented the resident refused shower/tub assistance 11/02/24, 11/04/24-11/07/24, and 11/11/24.
-There was no documentation of bathing completed from 11/08/24-11/10/24.
-Staff documented shampoo/hair care was completed on 11/01/24 - 11/08/24.
-Staff documented the resident refused assistance with shampoo/hair care on 11/11/24.

Review of Resident #1's progress notes dated

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03/31/23-11/12/24 revealed:
-Staff documented Resident #1 refused to see podiatry on 03/31/23, 05/17/23, and 08/07/23
-Staff documented Resident #1 refused all assistance with Activities of Daily Living (ADLs) on 08/01/24, 08/08/24, 08/13/24, 08/16/24, 08/21/24, 08/29/24, 09/05/24, 09/10/24, 09/18/24, 09/26/24, 10/02/24, 10/11/24, 10/17/24, 10/29/24, 11/05/24, and 11/07/24.

Review of a nurse's note time stamped on 11/11/24 at 11:00pm from the hospital discharge summary dated 11/13/24 revealed:
-The resident was admitted at the Emergency Department (ED) on 11/12/24 visibly soiled to his body and clothing.
-Resident #1 was admitted to the hospital with acute diagnoses of falls, acute kidney injury, and urinary tract infection.
-The resident had a very strong foul odor.
-The resident's clothes and socks were saturated with urine and had a very foul odor.
-Thick layers of the resident's skin came off the resident's feet upon removal of his socks.
-The resident reported that he was never offered a shower at the facility and that he washed up in the bathroom sink.
-The nurse had high concerns for resident neglect related to hygiene and care.

Review of a second nurse's note time stamped on 11/12/24 at 12:07am from the hospital discharge summary dated 11/13/24 revealed:
-The resident arrived at the ED with heavily soiled areas noted on his body.
-The resident had a strong odor.
-The resident's socks were soaked through with urine and several layers of the resident's skin came off upon removal of his socks.
-The resident reported that he was never offered

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help with a bath at the facility and had to wash off in the bathroom sink.

Review of a third nurse's note time stamped on 11/12/24 at 1:57am from the hospital discharge summary dated 11/13/24 revealed a report was made to the local Department of Social Services (DSS) Adult Protective Services (APS) due to concerns for the resident's appearance and hygiene upon arrival to the hospital.

Review of pictures of Resident #1's feet upon arrival to the hospital dated 11/11/24 at 8:30pm revealed:
-The skin on the top and sides of the resident's right foot were layered cracked, peeling skin.
-The toes on the resident's right foot were fused together by layers of cracked, peeling skin.
-The toenails on the resident's right foot were very long and appeared to be overgrown with brownish-yellow discoloration.
-The bottom of the resident's right foot was covered in layers of cracked, peeling skin.
-There were layers of brownish-yellow discolored skin covering the bottom portion of the resident's toes fusing them together.
-The bottom and sides of the resident's left foot was covered in layers of cracked peeling skin.
-The toenails on the left foot were thick and appeared to be overgrown

Observation of Resident #1 outside in smoking area on 11/19/24 at 11:57am revealed:
-The resident was sitting in a wheelchair smoking a cigarette.
-The resident was wearing a red shirt that was wet with urine from the naval down, and black pants that were wet down to the knees.
-The resident smelled of urine.
-The resident had on two pairs of dirty socks worn

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on top of each other with no shoes on.

Interview with Resident #1 on 11/19/24 at 11:57am revealed:
-He had been back from the hospital for a few days.
-The staff sometimes helped him put on his clothes or take them off since he returned from the hospital, but the staff had not helped him with putting on or taking off his clothes before he went to the hospital.
-No staff helped him with his feet or with personal hygiene before he went to the hospital, but he allowed the staff to assist him with personal care based on their approach and attitude toward him needing care.
-No staff would help him with his showers; he had to bath himself in the bathroom sink.
-He had not seen a foot doctor in a long time and it was hard for him to walk because his feet hurt.
-His feet felt better since the doctors at the hospital cleaned them, but they still hurt.

Interview with Resident #1's PCP on 11/19/24 at 12:45pm and 11/26/24 at 10:29am revealed:
-She had been Resident #1's PCP for over ten years.
-She had only seen Resident #1's feet one time in the last ten years.
-Resident #1 refused every skin assessment and would refuse to let any staff see his feet
-She was aware Resident #1 refused to see the podiatrist in the past but was not aware he had not been regularly seeing podiatry.
-The staff had verbally informed her in the past of Resident #1's chronic refusals for assistance with personal care tasks.
-She was not aware of how often Resident #1 was refusing personal care tasks.
-She was not aware Resident #1 was having

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issues with his feet until he returned from the hospital.
-She had seen Resident #1's feet during her last visit to the facility on 11/21/24 and she had not made a referral for the resident to see a podiatrist with not disclosing of the reason.

Interview with the Resident #1's MHP on 11/26/24 at 1:35pm revealed:
-Staff communicated different things about Resident #1 through emails.
-She expected the facility staff to communicate with her about resident refusals related to behavior.
-In some instances, so she could provide interventions for personal care as part of a residents' mental health care plan.
-If the PCP had concerns related to residents' health care, the PCP documented in computer care notes which were visible to her also.
-She was not aware of multiple refusals of personal care.

Interview with the APS Social Worker on 11/25/24 revealed:
-She had seen Resident #1 on 11/12/24 at the hospital.
-Resident #1 reported that he had not been showered in months because the staff at the facility had not offered him showers.
-Resident #1 knew he was supposed to be assisted with showering.
-The hospital nurse informed the APS Social Worker that Resident #1 arrived at the hospital with all his clothing soaked in urine, a very strong foul odor and large chunks of peeling skin on his face and feet.
-The hospital nurse made an APS report due to concerns that Resident #1 had been neglected at the facility.

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-She did not know if Resident #1 had been seen by home health yet.

Interview with a personal care aide (PCA) on 11/19/24 at 12:48pm revealed:
-Before Resident #1 returned from the hospital no staff would complete any personal care tasks for him.
-She had never seen Resident #1's feet or assisted the resident with personal hygiene tasks, but she knew Resident #1 was known for refusing care.
-She had tried to assist Resident #1 with bathing in the past, but he would refuse assistance.
-She had not seen or heard of any other PCA assisting Resident #1 with a bath.
-She had seen Resident #1 soaked in urine on more than one occasion since he returned from the hospital, but Resident #1 would refuse assistance to be changed.
-She reported Resident #1's refusals to a medication aide (MA) in the past.

Interview with Resident #1 on 11/25/24 at 3:49pm revealed:
-No staff had assisted him with showering or bathing; he preferred to wash himself in the bathroom sink.
-The staff had not assisted him with changing his clothes or his personal hygiene but he allowed the staff to assist him with personal care based on their approach and attitude toward him needing care.
-No staff would help him with his showers, he had to bath himself in the bathroom sink.
-The staff had done nothing about his feet, and he wished he could get help cutting his toenails because it was hard for him to walk because his feet hurt.
-He had shown his feet to his PCP last week and

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the PCP did not say he needed to see a foot doctor about his toes.

Observation of Resident #1 in his room on 11/25/24 at 3:49pm revealed:
-The resident was lying in bed with the covers on top of him.
-There were two urinal bottles next to the resident's bed, one urinal bottle was full, the other urinal bottle was over half full.
-When asked to see his feet the resident pulled back the covers and moved to show his feet.
-The resident had on a red shirt that was wet from the naval down
-The resident was wearing blue sweatpants that were visibly wet from the waist down and the resident smelled of urine.
-The resident's feet were swollen, red, with dry peeling skin on the tops, sides and bottoms of both feet.
-The resident's toenails on both feet were overgrown by a quarter inch, thick, and were a discolored brownish-yellow.

Interview with another PCA on 11/25/24 at 4:00pm revealed:
-He had provided care for Resident #1 in the past, but the resident would constantly refuse assistance with personal care tasks.
-Since he had been working at the facility, he had only assisted Resident #1 one time with bathing.
-He had never seen Resident #1's feet and very rarely assisted him with any personal care tasks.
-He would offer to assist Resident #1 with personal case tasks such as bathing and grooming, but the resident would refuse assistance from him and the other care staff.
-He had reported Resident #1's refusals to a MA, the Resident Care Coordinator (RCC), and the Operations Manager (OM) more than two months

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ago.

Interview with the RCC on 11/12/24 at 3:46pm and 11/26/24 at 4:13pm revealed:
-She was aware Resident #1 refused assistance with personal care tasks.
-She had attempted to assist Resident #1 with pushing his wheelchair, bathing, and personal hygiene tasks, but the resident would always refuse assistance.
-Resident #1 would refuse skin assessments and refused to let staff touch or see his feet.
-Resident #1 often had an odor of urine.
-She was aware Resident #1 had refused to see the podiatrist in the past.
-She had been informed many times that Resident #1 refused assistance and had verbally reported the refusals to the OM and the Resident #1's PCP in the past.
-Resident #1's PCP informed her to continue to encourage the resident to allow staff to assist him with personal care tasks, but there was nothing that could be done if the resident continued to refuse.
-There were no other interventions put in place by her or the PCP to ensure Resident #1 was receiving personal care.

Interview with the OM on 11/12/24 at 3:00pm and 11/26/24 at 5:05pm revealed:
-She was aware Resident #1 refused assistance with personal care tasks and had refused skin assessments in the past.
-She was aware Resident #1 had refused to see the podiatrist in the past.
-She was not aware Resident #1 was not seeing the podiatrist when they came to the facility.
-She had never seen Resident #1's feet before he went to the hospital, but knew the resident had issues with his feet upon return from the hospital

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-She had attempted to encourage Resident #1 to allow staff to assist him with personal care tasks, but the resident always refused.
-The staff had reported Resident #1's refusals for assistance in the past, but did not report every time there was a refusal.
-She had verbally reported Resident #1's refusals to the resident's PCP in the past, but did not report every refusal.
-Resident #1's PCP informed her to continue to encourage the resident to allow staff to assist him with personal care tasks.
-There were no other interventions put in place by her or the PCP to ensure Resident #1 was receiving personal care.
-She had not spoken to the Resident #1's PCP about referring the resident to podiatry since he returned from the hospital.

Interview with the Administrator on 11/26/24 at 11:30am revealed she was aware that Resident #1 "chronically refused" assistance with personal care tasks but was unaware of how much the resident had been refusing care.

Refer to the interview with a PCA on 11/19/24 at 12:48pm.

Refer to the interview with another PCA on 11/25/24 at 4:00pm.

Refer to the interview with a MA on 11/25/24 at 3:30pm.

Refer to the interview with another MA on 11/26/24 at 3:15pm.

Refer to the interview with the RCC on 11/26/24 at 2:35pm.

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Refer to the interview with the OM on 11/26/24 at 5:05pm.

Refer to the interview with the Manager on 11/26/24 at 11:15am.

Refer to the interview with the Administrator on 11/26/24 at 5:30pm.

2. Review of Resident #4's current FL2 dated 05/02/24 revealed:
-Diagnoses included chronic kidney disease, hyponatremia, hypertension, anemia, a history of right lung aspiration, pneumonia, adrenal adenoma, breast legion, acute urinary tract infection, prediabetes, anemia, and morbid obesity.
-She was semi-ambulatory and used a rollator walker.
-She needed assistance with bathing and dressing.
-She was incontinent of bladder.

Review of Resident #4's current assessment and care plan dated 04/30/24 revealed:
-She had limited ambulation and used a rollator walker.
-She had occasional incontinence of bowel and daily incontinence of bladder.
-She was sometimes disoriented, forgetful, and needed reminders.
-The resident required limited assistance by staff with ambulation.
-She required extensive assistance by staff with toileting, bathing, dressing, and grooming.
-She refused personal care such as showers.
-Resident #4 was being seen by a mental health provider (MHP).

Review of Resident #4's August 2024 personal care aide (PCA) weekly task report dated

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08/01/24-08/31/24 revealed:
-There was a section for bathing with tasks under the heading including sponge bath and shower/tub.
-Staff documented a sponge bath was completed on 08/02/24, 08/04/24, 08/05/24, 08/07/24, 08/09/24, 08/14/24, 08/16/24, 08/23/24, 08/26/24, 08/28/24, and 08/30/24.
-Staff documented Resident #4 refused a sponge bath on 08/11/24, 08/12/24, 08/18/24, 08/19/24, 08/21/24, and 08/29/24.
-Staff documented Resident #4 refused shower/tub assistance on 08/03/24, 08/10/24, 08/17/24, and 08/29/24.
-There was a section for skin/hair/feet care with several tasks under the heading including skin care (includes face, hands, feet) and shampoo/hair care.
-Staff documented skin care (including face, hands, and feet) was completed daily from 08/01/24-08/18/24, 08/20/24-08/28/24, and 08/30/24-08/31/24.
-Staff documented Resident #4 refused a skin care on 08/19/24 and 08/29/24.
-Staff documented shampoo/hair care was completed on 08/01/24, 08/04/24-08/06/24, 08/08/24, 08/13/24-08/16/24, 08/20/24, 08/22/24, 08/24/24, 08/26/24 - 08/28/24, and 08/30/24 - 08/31/24.
-Staff documented Resident #4 refused shampoo/hair care on 08/29/24.
-There was a section for dressing that included the tasks of shoes/clothing off, shoes/clothing on and hang/retrieve clothing.
-Staff documented the tasks of shoes/clothing off, shoes/clothing on and hang/retrieve clothing was completed daily from 08/01/24 - 08/31/24.
-There was no documentation of any concerns about the resident's personal care from 08/01/24-08/31/24.

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	HAL099016	B. WING	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Review of Resident #4's September 2024 PCA weekly task report dated 09/01/24-09/30/24 revealed:
-There was a section for bathing with tasks under the heading including sponge bath and shower/tub.
-Staff documented a sponge bath was completed on 09/02/24, 09/03/24, 09/05/24, 09/07/24, 09/10/24, 09/12/24, 09/14/24 09/15/24, 09/17/24, 09/24/24-09/27/24 and 09/30/24.
-Staff documented Resident #4 refused a sponge bath on 09/12/24.
-Staff documented Resident #4 refused shower/tub assistance on 09/04/24, 09/11/24, 09/13/24, 09/23/24, and 09/28/24-09/29/24.
-There was a section for skin/hair/feet care with several tasks under the heading including skin care (includes face, hands, feet) and shampoo/hair care.
-Staff documented skin care (including face, hands, and feet) was completed daily from 09/01/24 - 09/30/24.
-There was no documentation of shampoo/hair care completed from 09/01/24-09/30/24.
-There was a section for dressing that included the tasks of shoes/clothing off, shoes/clothing on and hang/retrieve clothing.
-Staff documented the tasks of shoes/clothing off, shoes/clothing on and hang/retrieve clothing was completed daily from 09/01/24-09/30/24.
-There was no documentation of any concerns about the resident's personal care from 09/01/24-09/30/24.

Review of Resident #4's October 2024 PCA weekly task report dated 10/01/24-10/31/24 revealed:
-There was a section for bathing with tasks under the heading including sponge bath and

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	HAL099018	A. BUILDING _____ B. WING _____	C 11/26/2024

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PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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shower/tub.
-Staff documented a sponge bath was completed on 10/01/24, 10/04/24, 10/06/24-10/07/24, 10/11/24, 10/13/24 - 10/14/24, 10/18/24, and 10/20/24-10/21/24.
-Staff documented Resident #4 refused a sponge bath on 10/09/24 and 10/16/24.
-Staff documented Resident #4 refused shower/tub assistance on 10/08/24, 10/10/24, 10/15/24, and 10/22/24
-There was a section for skin/hair/feet care with several tasks under the heading including skin care (includes face, hands, feet) and shampoo/hair care.
-Staff documented skin care (including face, hands, and feet) was completed daily from 10/01/24-10/21/24, and 10/23/24-10/26/24.
-Staff documented Resident #4 refused a skin care on 10/22/24.
-Staff documented shampoo/hair care was completed on 10/01/24, 10/02/24, 10/10/24, 10/13/24 10/20/24-10/21/24, and 10/23/24-10/26/24.
-Staff documented Resident #4 refused a shampoo/hair care on 08/29/24.
-There was a section for dressing that included the tasks of shoes/clothing off, shoes/clothing on and hang/retrieve clothing.
-Staff documented shampoo/hair care was completed daily from 10/01/24-10/26/24
-There was no documentation of any concerns about the resident's personal care from 10/01/24-10/31/24 except for Resident #4 being out-of-facility from 10/27/24-10/31/24.

A request was made on 11/22/24, 11/25/24, and 11/26/24 for the November 2024 PCA weekly task report related to Resident #4 but was not provided prior to exit.

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Review of Resident #4's primary care provider (PCP) visit note dated 11/07/24 revealed:
-She was being seen due to a recent hospital visit.
-She had a diagnosis of schizophrenia and often refused baths and hygiene care.
-She was to continue to be monitored, and staff were to notify the provider of any changes in condition.

Review of Resident #4's MHP visit notes dated 09/11/24 revealed:
-There was no documentation of staff reporting any resident behaviors.
-There was no documentation of staff reporting the resident had refused bathing or any other personal care tasks.

Observation of Resident #4 in the hallway on 11/25/24 at 9:50am revealed:
-The resident was independently ambulating down the hall using a rollator walker and walking very slowly, taking very small steps.
-She had a foul odor, her hair was not brushed, and her clothes were stained.

Interview with Resident #4 on 11/25/24 at 3:20pm revealed:
-The personal care aides (PCA) rarely helped her with showering so she would bathe herself at times.
-She had gone long time periods without staff bathing her and without providing her with clean clothes.
-She could not recall the last time the PCAs had fixed her hair or asked her about changing her clothes; but she had not refused assistance from the PCAs.

Interview with a PCA on 11/25/24 at 4:00pm

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revealed:
-Resident #4 refused showers but would try to "wipe" herself off at times.
-The PCAs and medication aides (MA) used 3 attempts to get Resident #4 to take a shower, fix her hair, and change her clothes but Resident #4 refused personal care often from him and the other PCAs.
-The PCA noticed Resident #4 had filthy clothes on and her hair was not fixed at times but was advised by management to honor the residents' right to refuse personal care.

Interview with a MA on 11/25/24 at 3:30pm revealed.
-Resident #4 needed staff assistance with showers, changing clothes, and brushing her hair but the resident refused to take showers, change her clothes daily, and for staff to brush her hair.
-The PCAs were responsible to assist Resident #4 with her sponge baths, showers, hair care, and dressing.
-She did not think Resident #4 was mentally able to provide her personal care due to her delusions.
-She was aware Resident #4 had refused personal care, but the PCAs and MAs were responsible to attempt personal care with 3 attempts before accepting a resident's refusal.
-She had notified the Resident Care Coordinator (RCC) and Operations Manager (OM) within the last week of Resident #4's refusals to personal care but was unsure if the RCC or the OM had notified the PCP or the MHP.

Interview with another MA on 11/26/24 at 3:15pm revealed:
-She did not think Resident #4 was physically or mentally able to provide her own personal care.
-Resident #4 needed staff assistance with changing clothes, showering, and with fixing her

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hair.
-She was aware Resident #4 had refused personal care, but the PCAs and MAs were still responsible to attempt personal care with 3 attempts before accepting a resident's refusal.
-She noticed Resident #4 had filthy clothes on and her hair was not brushed at times but was advised by management to honor the residents' right to refuse personal care.

Interview with Resident #4's PCP on 11/26/24 at 10:30am revealed:
She was aware Resident #4 often refused bathing, changing clothes, and personal care and it was a never-ending battle due to the resident's mental health issues.
-She did not think Resident #4 had the mental or physical capacity to provide her own personal care.
-Resident #4 had an undesirable appearance with unbrushed hair and filthy clothes due to lack of personal care.

Interview with Resident #4's MHP on 11/26/24 at 1:35pm revealed:
-She had not noticed Resident #4 having any personal care concerns.
-The facility staff just reported to her on 11/07/24 that Resident #4 refused personal care tasks, and she expected the facility staff to follow suggested interventions for redirecting and approaching Resident #4 by her and the resident's PCP.
-She had not been notified of Resident #4's refusal of personal care by the facility staff before 11/07/24

A request was made on 11/26/24 at 2:00pm for the MHP visit notes from 11/07/24 related to Resident #4 but were not provided prior to exit

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Observation of Resident #4 in the hallway on 11/26/24 at 1:50pm revealed:
- The resident was independently ambulating down the hall using a rollator walker.
The resident was walking very slowly, taking very small steps.
- The resident had an odor, her hair was not brushed and she had on the same stained clothes observed from 11/25/24.

Interview with the RCC on 11/26/24 at 2:35pm revealed:
-She had notified the PCP of Resident #4's refusals but could not recall if the PCP offered interventions other than for staff to attempt to provide continued care according to the resident's care plan.
-She did not if Resident #4's personal care logs had been reviewed because she had been filling in as an MA for third shift.
-She did not know if Resident #4's MHP was notified of the resident's refusal of personal care because she had been filling in as an MA for third shift.

Interview with the OM on 11/26/24 at 5:05pm revealed:
-Resident #4's PCP informed her to continue to encourage the resident to allow staff to assist her with personal care tasks but there was nothing that could be done if the resident continued to refuse.
-There were no other interventions put in place by her or the PCP to ensure Resident #4 was receiving proper care.
-She was aware Resident #4 was refusing personal care, but she expected the PCAs and MAs to assist Resident #4 with care according to her care plan.

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Interview with the Administrator on 11/26/24 at 5:30pm revealed the PCAs should assist Resident #4 with her sponge baths, showers, hair care, and dressing according to her care plan.

Refer to the interview with a PCA on 11/19/24 at 12:48pm.

Refer to the interview with another PCA on 11/25/24 at 4:00pm.

Refer to the interview with a MA on 11/25/24 at 3:30pm.

Refer to the interview with another MA on 11/26/24 at 3:15pm.

Refer to the interview with the RCC on 11/26/24 at 2:35pm.

Refer to the interview with the OM on 11/26/24 at 5:05pm.

Refer to the interview with the Manager on 11/26/24 at 11:15am.

Refer to the interview with the Administrator on 11/26/24 at 5:30pm.

Interview with a PCA on 11/19/24 at 12:48pm revealed if a resident refused assistance, the PCAs had to make three attempts to encourage the resident to allow staff to assist them and if the resident continued to refuse, the PCA's were required to report the refusal to an MA, the RCC, or the OM.

Interviews with another PCA on 11/25/24 at 4:00pm revealed:

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-If a resident refused assistance with personal care tasks the PCA's had to make three attempts to encourage the resident to allow staff to assist them; and if the resident continued to refuse the PCAs were required to report the refusal to a MA, the RCC or the OM.
-The PCAs documented personal care on the personal care logs.

Interview with a MA on 11/25/24 at 3.30pm revealed if a resident refused assistance. PCAs had to make three attempts to encourage the resident to allow staff to assist them and if the resident continued to refuse, the PCAs were required to report the refusal to an MA, the RCC, or the OM.

Interview with another MA on 11/26/24 at 3:15pm revealed if a resident refused assistance, PCAs had to make three attempts to encourage the resident to allow staff to assist them and if the resident continued to refuse, the PCAs were required to report the refusal to an MA, the RCC, or the OM.

Interview with facility's PCP on 11/26/24 at 10:30am revealed:
-She expected the facility staff to provide personal care for according her signed care plans.
-She expected the facility staff to follow up with her and the MHP for interventions with redirecting and approaching residents related to a residents' mental health issues hindering personal care

Interview with the facility's MHP on 11/26/24 at 1:35pm revealed she expected the facility staff to communicate with her about resident refusals related to behavior so she could provide interventions for personal care as part of a

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residents' mental health care plan.

Interview with the RCC on 11/26/24 at 2:35pm revealed:
-If a resident required extensive assistance with personal care tasks, the PCAs and MAs should assist the resident.
-If a resident refused assistance with personal care tasks the PCA's had to make three attempts to encourage the resident to allow staff to assist them and if the resident continued to refuse the PCAs were required to report the refusal to a MA, the RCC, or the OM.
-She and the OM were responsible to review the personal care logs and would notify the PCP of personal care refusals.

Interview with the OM on 11/26/24 at 5:05pm revealed:
-If a resident required extensive assistance with personal care tasks, the PCAs and MAs should assist the resident.
-She expected the facility staff to make three attempts to encourage the resident to allow staff to assist them.
-The PCAs were required to report the refusal to a MA, the RCC or the OM if the resident continued to refuse personal care.
-She or the RCC were responsible to review the PCA personal care records weekly and would notify the PCP of personal care refusals.

Interview with the Manager on 11/26/24 at 11:15am revealed:
-She expected the facility staff to make three attempts to encourage the resident to allow staff to assist them.
-The PCAs were required to report the refusal to a MA, the RCC or the OM if the resident continued to refuse personal care.

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-The RCC or the OM were responsible to review the personal care logs weekly and would notify the resident's PCP when a resident has "chronic" refusals for personal care.
-If a behavior was associated with the resident's refusal of personal care, the resident's PCP and MHP should be notified of the refusals.

Interview with the Administrator on 11/26/24 at 2:30pm revealed:
She expected the facility staff to make three attempts to encourage the resident to allow staff to assist them; and the PCAs were required to report the refusal to a MA, the RCC or the OM if the resident continued to refuse personal care.
-The PCAs and MAs should notify the RCC and OM when a resident refused personal care.
-The RCC or the OM were responsible to review the PCA personal care records weekly and would notify the resident's PCP when a resident had "chronic" refusals for care.
-If a behavior was associated with the resident's refusal of personal care, the resident's PCP and MHP should be notified of the refusals.
-Her expectation for a resident that chronically refused all care was to talk to them about the importance of letting staff provide the necessary care and then look into discharging the resident if the refusals continued.
-The facility did not have a policy in place for resident refusals for care.
-It was the OM and RCC's responsibility to ensure residents were receiving the proper care.

The facility failed to provide personal care assistance including bathing, dressing, and personal hygiene to a resident (#1) resulting in deterioration of the resident's feet causing the resident to be hospitalized due to multiple falls with the residents feet having several layers of

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FORM APPROVED

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D 269	Continued From page 22 cracked and peeling skin, and toes that were fused together with thick layers of skin, that had to be removed and decontaminated at a local hospital due to the lack of bathing and personal hygiene assistance; a resident who was not provided personal care assistance by staff including bathing, dressing, and personal hygiene to a resident (#4) resulting in a foul body odor with stained clothing and messy hair with a diagnosis of schizophrenia. This failure resulted in physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 26TH, 2024.	D 269		
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 coordination and follow-up for 1 of 5 sampled residents (#4) related to a [illegible] referral for personal care assistance from staff to the primary care provider (PCP) as well as a mental health provider (MHP) and a referral to a podiatrist related to foot care	D 273	The facility will ensure that referral and follow up will meet the routine and acute health care needs of the residents and physician orders are followed up. Resident Care Coordinator and/or Designee will write all referrals on order log, designed to track all orders from start to completion. After logging the	12/23/24

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D 269	Continued From page 22 cracked and peeling skin, and toes that were fused together with thick layers of skin, that had to be removed and decontaminated at a local hospital due to the lack of bathing and personal hygiene assistance; a resident who was not provided personal care assistance by staff including bathing, dressing, and personal hygiene to a resident (#4) resulting in a foul body odor with stained clothing and messy hair with a diagnosis of schizophrenia. This failure resulted in physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 26TH, 2024.	D 269		
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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow up for 1 of 5 sampled residents (#1) related to notification of repeated refusals of personal care assistance from staff to the primary care provider (PCP) as well as to the mental health provider (MHP) and a referral for a podiatrist related to foot care.	D 273		

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The findings are:

Review of Resident #1's current FL2 dated 08/21/24 revealed:
-Diagnoses included acute renal failure, peripheral vascular disease, Parkinson's disease, hypertension, osteoarthritis, paranoia, anxiety, tremors, bipolar disorder, syncope, and abnormal gait.
-He was intermittently disoriented.
-He was semi-ambulatory.
-He needed assistance with bathing and dressing.
-He was incontinent of bladder.

Review of Resident #1's current assessment and care plan dated 05/01/24 revealed:
-He had limited ambulatory ability and used a wheelchair.
-He had occasional incontinence of the bladder.
-He was sometimes disoriented, forgetful, and needed reminders.
-He required limited assistance with eating, toileting, ambulating, dressing, and transferring.
-He required extensive assistance with bathing and grooming/personal hygiene.
-He was being seen by a mental health provider (MHP).

Review of Resident #1's November 2024 personal care aide (PCA) weekly task report dated 11/01/24-11/11/24 revealed:
-There was a section for bathing with tasks under the heading including sponge bath and shower/tub assistance.
-Staff documented the resident refused shower/tub assistance on 11/02/24, 11/04/24-11/07/24, and 11/11/24.
-The bathing section of the log was blank from

referral. Resident Care Coordinator will assist and Transportation Director will have all information necessary to schedule the appointment that was referred. Once the appointment is scheduled, the date will be placed in the "Order Log" and followed until the date of appointment is completed. If it is determined to follow physician orders, and process will be the same, and followed by the order log.

Staff Members will understand retrained on the importance of the order log on 12/23/24 and making sure it is followed months. The order log will follow each visit

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D 273	Continued From page 24 11/08/24-11/10/24. -There was a section for skin/hair/feet care with several tasks under the heading including skin care (includes face, hands, feet) and shampoo/hair care. -Staff documented Resident #1 refused skin care on 11/11/24. -Staff documented the resident refused assistance with shampoo/hair care on 11/11/24. -The skin/hair/feet section were not documented on 11/09/24-11/10/24. -There was a section for toileting/incontinence with tasks under the heading including routine toileting. -The toileting section of the logs were not documented from 11/08/24-11/10/24. Review of the Podiatrist visit log dated 09/18/24 revealed: -A podiatrist came to the facility every 60 days. -Resident #1 was not on the list of residents seen by the podiatrist on this visit. -Resident #1 was not on the list of residents who regularly saw podiatry. Review of Resident #1's Telemed visit note with the primary care provider (PCP) dated 11/08/24 revealed: -The resident had altered mental status, a temperature of 100.5 degrees, and had fallen to the floor. -Emergency Medical Services (EMS) was called and Resident #1 refused to be taken to the hospital by EMS. -An order for a urinary analysis to check for urinary tract infection was recommended and to follow up with resident's PCP. Review of Resident #1's PCP Telemed visit note dated 11/11/24 revealed:	D 273	from the time the family resident's the order until it is completed. Administrator, manager, and/or DOS/RCC will monitor the order log reviews.	

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-The resident had altered mental status and had fallen while transferring from the bed to his wheelchair
-This was Resident #1's second fall in three days and he was transferred to the hospital.
-There was an order to notify Resident #1's PCP upon return from the hospital.

Review of Resident #1's Chart Notes from 03/31/23 to 11/12/24 revealed:
-Staff documented Resident #1 refused to see podiatry on 03/31/23, 05/17/23, and 08/07/23.
-Staff documented Resident #1 refused all assistance with ADL's on 08/01/24, 08/08/24, 08/13/24, 08/16/24, 08/21/24, 08/29/24, 09/5/24, 09/10/24, 09/18/24, 09/26/24, 10/02/24, 10/11/24, 10/17/24, 10/29/24, 11/05/24, and 11/07/24.
-Staff documented Resident #1 fell out of his wheelchair on 11/08/24, the resident was not acting his baseline, and the local EMS was called but the resident refused transport to hospital.
-Staff documented Resident #1 fell during transfer from the bed to his wheelchair and hit his left hip and head during the fall on 11/12/24. EMS was called and the resident was transported to the hospital.

Review of Resident #1's hospital discharge summary dated 11/13/24 revealed:
-The resident was admitted to the hospital on 11/12/24 and discharged on 11/13/24.
-The resident was admitted to the hospital with diagnosis of falls, acute kidney injury, and urinary tract infection.
-The resident was discharged from the hospital with medication orders for antibiotics, and orders to receive home health physical therapy.
-An Adult Protective Services (APS) report was made due to concerns for the resident's appearance and hygiene upon arrival to the

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hospital.
-There was nurse's note time dated 11/11/24 at 11:00pm with information as follows:
-The resident's clothes and socks were saturated with urine and had a very foul odor.
-Thick layers of the resident's skin came off the resident's feet upon removal of his socks.
-The resident reported that he was never offered a shower at the facility, and he washed up in the bathroom sink.
-The nurse had high concerns for resident neglect related to hygiene and care.

Review of pictures of Resident #1's feet upon arrival to the hospital dated 11/11/24 at 8:30pm revealed:
-The skin on the top and sides of the resident's right foot was layered, cracked, and peeling.
-The toes on the resident's right foot appeared to be fused together by layers of cracked and peeling skin.
-The toenails on the resident's right foot appeared to be very long and discolored.
-The bottom of the resident's right foot was covered in layers of cracked, peeling skin.
-There were layers of discolored skin covering the bottom portion of the resident's toes fusing them together.
-The bottom and sides of the resident's left foot was covered in layers of cracked peeling skin.
-The toenails on the left foot were thick and overgrown.

Review of Resident #1's chart notes dated from 11/01/24 through 11/23/24 revealed:
-Resident #1 was admitted to the hospital on 11/16/24 due to a fall and kidney injury.
-On 11/18/24 Resident #1 had laboratory work drawn by home health.
-On 11/20/24, staff documented Resident #1 had

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a saturated incontinent brief and pants and refused to allow staff to assist with changing his clothes.
-On 11/23/24, staff documented Resident #1 refused to have the personal care aides (PCA) provide incontinence care.
-A second entry on 11/23/24 revealed staff documented Resident #1 had refused to be provided incontinence care and had been screaming at staff pushing them away when they attempted to provide incontinence care; the resident had urinated on himself.

Interview with Resident #1 on 11/19/24 at 11:57am revealed:
-He had been back from the hospital for a few days.
-His feet felt better since the doctors at the hospital cleaned his feet, but they still hurt.
-He had not seen a foot doctor in a long time. He had seen his normal PCP and had shown her his feet.
-It was hard for him to walk because his feet hurt.
-No staff would help him with his showers; he had to bath himself in the bathroom sink.

Interview with a PCA on 11/19/24 at 12:48pm revealed:
-Staff had attempted to assist Resident #1 with personal care tasks since he returned from the hospital but Resident #1 still refused most care.
-She had seen Resident #1 soaked in urine on more than one occasion since he returned from the hospital, but Resident #1 would refuse assistance to be provided incontinence care.
-If a resident refused assistance with personal care tasks the PCAs had to make three attempts to encourage the resident to allow staff to assist them; if the resident continued to refuse the PCAs were required to report the refusal to a

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medication aide (MA), the Resident Care Coordinator (RCC), or the Operations Manager (OM).
-She had reported the resident's refusals to MAs in the past and the MAs, RCC, or the OM was responsible to report the Resident #1's refusals to his PCP.

Observation of Resident #1 in his room on 11/25/24 at 3:49pm revealed:
-The resident was lying in bed with the covers on top of him.
The resident had on a red shirt that was wet from the naval down. The resident was wearing blue sweatpants that were visibly wet from the waist down and the resident smelled of urine.
-The resident's feet were swollen and red, with dry peeling skin on the tops, sides and bottoms of both feet.
-The resident's toenails on both feet were 1/4 to 1/2 inch past the top of his toes, thick, and a discolored brownish-yellow

Interview with Resident #1 on 11/25/24 at 3:49pm revealed:
-The staff had done nothing about his feet since e returned from the hospital.
-His feet still hurt, and he wished he could get help from the staff with cutting his toenails because it was hard for him to walk.
-He had shown his feet to his PCP last week and the PCP did not say he needed to see a foot doctor about his toes.

Interview with a second PCA on 11/25/24 at 4:00pm revealed:
-He had provided care to Resident #1 in the past, but the resident had constantly refused assistance with personal care tasks from him and the other PCAs.

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-If a resident refused assistance with personal care tasks the PCAs had to make three attempts to encourage the resident to allow staff to assist them; if the resident continued to refuse the PCAs were required to report the refusal to a MA, the RCC, or the OM.
-He had reported Resident #1's refusals to a MA, the RCC, and the OM in the past.

Interview with Resident #1's PCP on 11/26/24 at 10:30am revealed:
-She had been Resident #1's PCP for over ten years.
-Resident #1 would refuse every skin assessment and would refuse to let any staff see his feet.
-She was aware Resident #1 had refused to see the podiatrist in the past but was unaware he had not been regularly seeing podiatry.
-She had never received any documented personal care service refusals from the staff, but staff had verbally informed her in the past of Resident #1's chronic refusals for assistance with personal care tasks "every now and then".
-When she received notification of Resident #1's chronic refusals for care, she gave instructions to staff to continue to encourage Resident #1 to allow staff to assist him with personal care tasks.
-She believed it was a resident's right to refuse care, and the staff could not force a resident to allow the staff to assist him.
-She was unaware of how often Resident #1 was refusing personal care tasks and she was unaware Resident #1 was having issues with his feet until he returned from the hospital.
-She had seen Resident #1's feet during her last visit to the facility on 11/21/24 but had not made a referral for the resident to see a podiatrist

Interview with the Resident #1's MHP on 11/26/24 at 1:35pm revealed:

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-Staff communicated different things about resident through emails.
-She expected the facility staff to communicate with her about resident refusals related to behavior.
-In some instances so she could provide interventions for personal care as part of a residents' mental health care plan.
-If the PCP had concerns related to residents' health care, the PCP documented in computer care notes which were visible to her also.
-Staff had told her Resident #1 was feeling down and refusing to eat.
-She was not aware of multiple refusals of personal care.

Telephone interview with the RCC on 11/26/24 at 2:35pm revealed:
-She was aware Resident #1 refused most assistance with personal care tasks.
-Resident #1 would refuse skin assessments and refuse to let staff touch or see his feet.
-She was aware Resident #1 had refused to see the podiatrist in the past.
-If a resident refused assistance with personal care tasks the PCAs had to make three attempts to encourage the resident to allow staff to assist them; if the resident continued to refuse the PCAs were required to report the refusal to a MA, the RCC, or the OM.
-She had been informed that Resident #1 refused assistance and had verbally reported the refusals to the OM and the resident's PCP in the past.
-Resident #1's PCP informed her to continue to encourage the resident to allow staff to assist him with personal care tasks.
-There were no other interventions implemented by her or the PCP for repeated refusals for care.
-It was the responsibility of the RCC and the OM to inform the resident's PCP of the resident's

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refusals of personal care tasks.
-There was no documentation Resident #1's PCP or MHP had been notified for repeated refusals of personal care, or podiatry care.

Interview with the Operations Manager on 11/26/24 at 5:05pm revealed:
-She was aware Resident #1 refused most assistance with personal care tasks and he had refused skin assessments in the past.
-She was unaware Resident #1 was not seeing the podiatrist when they came to the facility.
-If a resident refused assistance with personal care tasks the PCAs had to make three attempts to encourage the resident to allow staff to assist them; if the resident continued to refuse the PCA's were required to report the refusal to a MA, the RCC, or the OM.
-The staff had reported Resident #1's refusals for assistance in the past but did not report every time.
-She had verbally reported Resident #1's refusals to the resident's PCP in the past but did not report every refusal.
-Resident #1's PCP informed her to continue to encourage the resident to allow staff to assist him with personal care tasks.
-There were no other interventions implemented by her or the PCP for Resident #1.
-It was the OM and RCC's responsibility to ensure the residents' PCP was notified of a resident's refusals for personal care tasks.
-She had not spoken to Resident #1's PCP about referring the resident to podiatry since he returned from the hospital.
-There was no documentation Resident #1's PCP or MHP had been notified for repeated refusals of personal care, or podiatry care.

Interview with the Administrator on 11/26/24 at

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D 273	Continued From page 32 5:30pm revealed: -There was no policy in place for residents who refused care. -She was aware that Resident #1 refused assistance with personal care tasks, but she was unaware of how often or how long Resident #1 had been refusing care. -Her expectation for a resident that refused all care was to talk to them about the importance of letting staff provide the necessary care and then look into discharging the resident for not being able to provide them the proper care if the refusals continued. -Her expectation was that the OM would inform the PCP of chronic refusals and then let her know if the refusals continued. -She did not know that Resident #1 had not seen by podiatry in over one year or that Resident #1 was not on the list to see podiatry. The facility failed to ensure health care referral and follow up for Resident #1 related to refusals of personal care and refusals of podiatry services resulting in the resident hospitalization and the deterioration of the resident's feet related to the residents peeled, cracked toes being fused together with overgrown toenails. This failure placed the resident at substantial risk for physical harm and neglect which constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/14/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 26, 2024.	D 273		

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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 observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents (#4) including administration of continuous oxygen. The findings are: Review of Resident #4's current FL-2 dated 05/02/24 revealed diagnoses included history of right lung aspiration and pneumonia. Review of Resident #4's primary care provider (PCP) visit note dated 04/11/24 revealed an order for 2 liters of continuous oxygen flow. Observation of Resident #4's oxygen concentrator on 11/21/24 at 9:50am revealed: -The oxygen concentrator was off and Resident #4 was not using the oxygen. -Resident #4 did not have portable oxygen tanks located in her room. Review of Resident #4's electronic medication administration records (eMAR) from April 2024 through November 2024 revealed there was no entry for oxygen administration.	D 276	The facility will ensure that the referral and follow up will meet the routine and acute treatment needs of the residents and physician orders are followed by Nursing Care coordinator and or Director will maintain returns in the "order log", designed to track all orders from start to completion. Staff training will conducted and received on the implementation of the order log on 12/23/24 and moving forward, it is to be used by nursing. The order log will be used on orders from the time the facility	12/23/24

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Review of the personal care service (PCS) logs from August 2024, September, and October 2024 revealed there were no entries for facility staff to manage Resident #4's oxygen concentrator

Review of Resident #4's Licensed Health Professional Services (LHPS) assessment dated 10/24/24 revealed:
-Resident #4 had an oxygen concentrator.
-Resident #4's oxygen flow rate was ordered as 2 liters.
-The facility staff was to manage the equipment as per the original PCP order dated 04/11/24 for 2 liters of continuous oxygen flow.

Review of Resident #4's signed hospital discharge summary from 11/06/24 revealed:
-The resident was admitted on 10/27/24.
-The resident had diagnoses of chronic obstructive pulmonary disease (COPD) with mild exacerbation, chronic hypoxic respiratory failure, and hypoxia.
-The resident was to continue to be monitored and was discharged on 11/06/24 with an order for 5 liters of continuous oxygen.

Review of Resident #4's primary care provider (PCP) visit note dated 11/07/24 revealed:
-The resident was being seen due to a recent hospital visit with diagnoses of COPD with mild exacerbation, chronic hypoxic respiratory failure, and hypoxia.
-There was an order for 2 liters of continuous oxygen therapy.
-Resident #4 was to be monitored and for staff to encourage oxygen therapy of 2 liters of continuous oxygen beyond her refusals.

Review of Resident #4's PCP triage note dated

recent's mc order until it is completed.

Administrator, manager, and I or designee will monitor mc order logs by nursing.

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11/25/24 revealed:
-The PCP addressed Resident #4's refusals of continuous oxygen for refusals to be documented and the PCP to be notified by the facility staff.
-There was an order for 2 liters of continuous oxygen therapy, for saturation of peripheral oxygen levels to be checked by staff every 12 hours, and for the provider to be notified for saturation of peripheral oxygen levels below 90%.

Observation of Resident #4's oxygen concentrator on 11/22/24 at 1:20pm revealed the oxygen concentrator was off and Resident #4 was not using the oxygen.

Observation of Resident #4's oxygen concentrator on 11/25/24 at 9:45am revealed the oxygen concentrator was off and Resident #4 was not using the oxygen.

Interview with Resident #4 on 11/25/24 at 3:20pm revealed:
-She was not aware that the PCP ordered her to be administered 2 liters of continuous oxygen.
-She did not use the oxygen in her room because she believed it was "toxic."
-The oxygen concentrator was always turned off.
-The personal care aides (PCA) and the medication aides (MA) have never advised her to wear her oxygen and had not attempted to turn on her oxygen concentrator.
-She did not have any complaints of shortness of breath.
-She walked to the dining room for each meal and outside to smoke without her oxygen and did not experience any shortness of breath.
-She was not aware if she had portable oxygen tanks available, but she would not wear them anyway.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 36 Observation of Resident #4's oxygen concentrator on 11/25/24 at 3:20pm revealed the oxygen concentrator was off and Resident #4 was not using the oxygen. Observation of Resident #4's oxygen saturation, checked by the MA on 11/25/24 at 3:27pm revealed an oxygen level of 93% for Resident #4. Interview with a PCA on 11/25/24 at 4:00pm revealed: -He was aware Resident #4 had an order for continuous oxygen. -He had not looked at Resident #4's oxygen concentrator to see how many liters of oxygen it was set on and knew it was off, but Resident #4 usually refused to wear her oxygen. -The PCA noticed Resident #4 did not wear her oxygen in her room or in the hallway and was told by management to honor the resident's right to refuse personal care including oxygen. -Resident #4 had been short-of-breath when she came down the hallway and went to smoke outside. -The Resident Care Coordinator (RCC) and the Operations Manager (OM) were responsible to review PCP orders and the hospital discharge summary orders. Interview with a MA on 11/25/24 at 3:30pm revealed: -She was not aware of the 2 liters of continuous oxygen orders from the 11/07/24 PCP visit notes or from the hospital discharge summary notes dated 11/06/24. -She was aware there was not an entry on Resident #4's eMAR for oxygen. -She did not check Resident #4's oxygen concentrator to see how many liters the concentrator was set.	D 276		

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-She did not know Resident #4's concentrator was off but Resident #4 refused to wear her oxygen.
-Resident #4 had been short-of-breath when she came down the hallway and went to smoke outside.
-Resident #4 did not have portable oxygen tanks in her room but portable oxygen tanks were available in the facility hallway closet.
-The RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders.

Interview with a second MA on 11/26/24 at 3:15pm revealed:
-She was not aware Resident #4 had an order for continuous oxygen, but Resident #4 refused to wear her oxygen.
-She had not looked at Resident #4's oxygen concentrator to see how many liters of oxygen it was set on and to see that it was off.
-She was not aware of the 2 liters of continuous oxygen orders from the 11/07/24 PCP visit notes or from the hospital discharge summary notes dated 11/06/24.
-Resident #4 did not have portable oxygen tanks in her room but portable oxygen tanks were available in the facility hallway closet.
-She was aware there was not an entry on Resident #4's eMAR for oxygen.
-The RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders.

Interview with Resident #4's PCP on 11/26/24 at 10:30am revealed:
-Resident #4 was ordered oxygen 2 liters continuously on 11/07/24 to decrease the worsening of her COPD, chronic hypoxic respiratory failure.

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-It was necessary for Resident #4 to have oxygen at 2 liters because of the COPD diagnosis.
-Resident #4 had not complained of shortness of breath.
-She had addressed the refusals on a 11/25/24 triage note for staff to encourage the resident to continue the oxygen continuously even when Resident #4 refused to wear the oxygen.
-She expected the facility staff to follow her orders for Resident #4's continuous oxygen to prevent possible increased COPD exacerbation issues such as shortness of breath and fatigue.

Interview with the RCC on 11/26/24 at 2:35pm revealed:
-The RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders.
-She was not aware of the 2 liters of continuous oxygen orders from the 11/07/24 PCP visit notes or from the hospital discharge summary notes dated 11/06/24.
-She was not aware of the 2 liters of continuous oxygen orders from the 11/25/24 PCP triage notes with the saturation of peripheral oxygen levels to be checked by staff every 12 hours.
-She thought Resident #4 was on as needed (PRN) oxygen when in her room but Resident #4 refused to wear her oxygen.
-She was aware there was not an entry on Resident #4's eMAR for oxygen, but there should be a PRN entry for oxygen on the eMAR.

Interview with the OM on 11/26/24 at 5:05pm revealed:
-The MAs, the RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders.
-She was not aware of the 2 liters of continuous oxygen orders from the 11/07/24 PCP visit notes

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or from the hospital discharge summary notes dated 11/06/24 and she must have overlooked that information.
-She was not aware of the 2 liters of continuous oxygen orders from the 11/25/24 PCP triage notes with the saturation of peripheral oxygen levels to be checked by staff every 12 hours.
-The PCAs and MAs should check Resident #4's oxygen concentrator to ensure it was on and set at 2 liters even when Resident #4 refused the oxygen.

Interview with the Manager on 11/26/24 at 11:15am revealed:
-The RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders to implement orders.
-The PCAs and MAs were responsible for checking Resident #4's oxygen concentrator to ensure the machine was on.
-She did not know the PCAs and the MAs were not aware of Resident #4's current orders for 2 liters of continuous oxygen.
-She did not know the RCC and the OM were not aware of the Resident #4's continuous oxygen order.
-She was not aware the RCC and the OM had not reviewed the PCP visit notes dated 11/07/24 or the hospital discharge summary notes dated 11/06/24 for Resident #4's order of continuous oxygen.
-She expected the RCC and the OM to review and implement orders from PCP visit notes and from discharge summary report orders.

Interview with the Administrator on 11/26/24 at 5:30pm revealed:
-The RCC and the OM were responsible to review PCP orders and the hospital discharge summary orders to implement orders.

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-The PCAs and MAs were responsible for checking Resident #4's oxygen concentrator to ensure the machine was on even if Resident #4 previously refused to wear the oxygen.
-She did not know the PCAs and the MAs were not aware of Resident #4's current orders for 2 liters of continuous oxygen.
-She did not know the RCC and the OM were not aware of the Resident #4's continuous oxygen order.
-She was not aware the RCC and the OM had not reviewed the PCP visit notes dated 11/07/24 or the hospital discharge summary notes dated 11/06/24 for Resident #4's order of continuous oxygen
-She expected the RCC and the OM to review and implement orders from PCP visit notes and from discharge summary report orders.

D 338 10A NCAC 13F .0909 Resident Rights — D 338

10A NCAC 13F .0909 Resident Rights
An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (#3) was free of exploitation as evidenced by the resident's debit card being used by a staff (Staff A) who made unauthorized purchases on the debit card, and multiple residents were free of verbal abuse as evidenced by residents being yelled at by Staff A causing the

Facility provides specific 12/23/24
additional staff training
in certain instances with
residents including, but not
limited to providing items for
residents without Administrator
or Manager Approval. All employees
are required to sign and follow
this practice. This document is

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residents to feel nervous, unsafe and embarrassed.

The findings are:

Review of Staff A's personnel record revealed:
-Staff A was hired as a personal care aide (PCA) on 08/25/23
-There was documentation of Resident Rights training dated 08/25/23.
-There was documentation of a Criminal Background Check dated 08/25/23.
-There was documentation of a Health Care Personnel Registry (HCPR) check dated 07/24/24.
-There was no documentation of a HCPR check being completed when Staff A was hired on 08/25/23.

Review of Resident #3's PCP dated 09/26/24 revealed:
-Diagnoses included bulging disc, degenerative disc disease, fibromyalgia, anxiety, and chronic pain syndrome.

Interview with Resident #3 on 11/25/24 at 3:25pm revealed:
-She reported a recent incident where she gave Staff A her debit card to buy her some things from the grocery store.
-This was not the first time she had given her debit card to Staff A to buy things for her at the store.
-Staff A had offered to take her debit card last month to buy her things at the store.
-She had $300.00 in her account when she gave Staff A her debit card but when she received it back from Staff A there was only $7.00 left in her account.
-When she checked her bank statement, she

hired "Agreement Between Employer and Employee." In addition, all staff will be required to report to Specialty Management if they feel any fellow employee is not following facility policies or practices, or in any way violates resident rights. This document is titled "Employee Responsibility to Report to Management."

Both of these documents were in place at the facility to be signed by all employees. However, due to turnover by certain employees, most employees were not been followed as required by our company. The facility will retrain all employees and communicate the importance

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found there were two separate charges on her debit card, one for $110.00 and a separate online charge for #127.00 that she did not authorize.
-When she confronted Staff A about the money within the last 2 weeks, Staff A got angry, so she told another staff about the incident.
-Staff A had asked her for money in the past and when she gave money to Staff A, she had told her not to tell anyone and that Staff A would pay her back.
-Staff A had paid her back after she confronted Staff A about it.

Telephone interview with Staff A on 11/26/24 at 3:15pm revealed:
-She had been suspended from working at the facility because a resident was telling lies about her.
-She wanted to do something nice for a resident (#3) and had decided to make some food for the resident.
-The resident had offered to pay for part of the food and the resident had given her, her debit card to buy things at the store.
-She had gone to the store with the resident's card but when she swiped the card it only had two dollars ($2) in the account.
-When she gave the card back to the resident, the resident accused her of taking her money.

Interview with the Manager on 11/22/24 at 4:22pm revealed:
-Staff A had been identified as part of an incident involving a staff member taking a resident's debit card and possibly used for unauthorized purchases.
-A 24-hour Health Care Personnel Registry report had been sent as of 11/20/24.
-Staff A had been identified and had been suspended from working as of 11/15/24.

Of the staff members and nurses employed with more documents. In addition, training will take place regarding resident rights and all employees will review the resident rights documents. Administrator and key nurse management will participate in the review training of all employees on more than one facility process.

More extensive new employee and ongoing training will be provided on resident and safety topics. Additional training will be ongoing regarding resident rights and employees responsibility to report any perceived

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2 Interview with a resident on 11/25/24 revealed at 3:25pm revealed:
-She had witnessed Staff A yelling at other residents saying, "I'm going to quit my job because of you."
-She had witnessed Staff A get angry and throw a chair down the hallway of the women's hall yelling "this doesn't belong here!"
-It made her feel angry when she witnessed the PCA, Staff A, treating the other resident's that way.

Interview with another resident on 11/19/24 at 12.11pm revealed:
-Staff A would yell and scream at her and other residents.
-Staff A would scream at residents in the dining room when they asked for something.
-Staff A would yell at residents and say, "we're not y'all's maids" and "y'all are just going to have to wait until I'm not done." when she or other residents asked for things.
-Staff A would curse and yell at resident's saying, "I'm going to quit my job because of you residents!".
-She and other residents called Staff A "the warden" because Staff A would yell at residents if they did not "act right"
-She felt upset, angry, and hurt when Staff A would yell at her.

Interview with a third resident on 11/20/24 at 1:00pm revealed:
-Staff A was always screaming and yelling at the residents.
-Staff A would yell at residents and say, "I've had it with y'all" and "You're not going to hit me because I'll hit you back".
-When Staff A would scream and curse at her or

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other residents, the screaming and cursing made the resident tremble and made her feel nervous and unsafe.
-She and other residents had told the MA and OM about Staff A screaming but it had not seemed to change anything.

Interview with a fourth resident on 11/20/24 at 1:25pm revealed:
-Staff A came in her room very loud and angry and would say mean things to her.
-Staff A would come into her room and say, "[you] need to quit wetting yourself".
-Staff A would also yell and say, "I'm going to quit my job because of you residents".
-She "didn't feel too good" when Staff A yelled at her and said mean things.
-She saw Staff A "pick up a chair and throw it down the hall".

Interview with a Personal Care Aid (PCA) on 11/19/24 at 11:38am revealed:
-She was concerned about the way Staff A at the facility was treating the residents.
-Staff A worked as both a PCA and as a medication aide (MA) would come into the facility and scream and curse at the residents.
-Staff A worked third shift and would consistently yell at the residents every day that she was on duty.
-Staff A would scream at residents at three in the morning when the rest of the residents were sleeping if a resident came and asked for something.

Interview with a second PCA on 11/19/24 at 12:48pm revealed:
-Staff A, who worked third shift as both a PCA and MA, would scream and curse at some of the residents

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-She witnessed Staff A screaming and cursing at a resident for asking for her medications.
-She had witnessed Staff A screaming at residents before but she never said anything about it because she liked her job.

Interview with a third PCA on 11/25/24 at 4:00pm revealed:
-He had worked with Staff A who was "very loud and obnoxious" with the residents.
-Staff A would talk to the residents in a "loud and mean sounding" tone
-When residents asked for things Staff A would reply "you need to wait" and "I'm not doing that" to the residents in a mean and loud way.
-He reported what he witnessed to the Resident Care Coordinator (RCC) and the Operations Manager (OM) and they had talked to Staff A about her behavior.
- "A few residents" said to him that they felt nervous or uncomfortable around Staff A.

Interview with the OM on 11/20/24 at 2:52pm revealed:
She had been told that Staff A had been very loud and talking to residents in a loud and mean way
-She had spoken to Staff A about her behavior with the residents.
-Staff A had been suspended the previous week

Interview with the Manager on 11/22/24 at 4:22pm revealed:
-A 24 Hour Health Care Personnel Registry had been sent as of 11/20/24
-Staff A had been identified and had been suspended from working as of 11/15/24.

Telephone interview with Staff A on 11/26/24 at 3:15pm revealed:

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D 336	Continued From page 4A -She had been suspended from working at the facility because a resident was telling lies about her. -She had never been mean to any resident. The facility failed to ensure residents were free from exploitation and were treated with dignity and respect when a staff (Staff A) took a resident's (#3) debit card and used it to make an unauthorized purchase outside of the facility resulting in the resident not having any money left her in account and residents were treated with dignity and respect by being screamed and cursed at by Staff A resulting in residents feeling uncomfortable and unsafe. This failure resulted in the exploitation of one resident (#3) and verbal abuse of other residents which constitutes a Type A1 violation. The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 11/26/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 26TH, 2024.	D 336		
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.	D 358	The facility will ensure that residents' medications are administered to residents as ordered by the physician and meets all rules when narcotics	12/23/24

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This Rule is not met as evidenced by:
Based on observations record review and interviews, the facility failed to administer medications as ordered or 2 of 5 sampled residents (#1, #5) related to medications to treat hypertension and anxiety(#1), and medications to treat pain (#1 and #5).

The findings are:

1. Review of Resident #1's current FL2 dated 08/21/24 revealed
-Diagnosis included hypertension and gait abnormality.
-The resident was intermittently disoriented, and semi-ambulatory

a. Review of Resident #1's current FL-2 dated 08/21/24 revealed there was an order for metoprolol tartrate (used to treat hypertension) 50mg take one and one-half (75mg) once daily.

Review of Resident #1's Chart Notes on 11/13/24 revealed staff documented the resident fell during transfer from the bed to his wheelchair and hit his left hip and head during the fall on 11/12/24. EMS was called and the resident was transported to the hospital.

Review of Resident #1's hospital discharge summary dated 11/13/24 revealed:
-The resident was admitted to the hospital on 11/12/24.
-The resident was discharged with an order to decrease metoprolol tartrate from 75mg daily to 25mg twice daily.

Review of Resident #1's electronic medication administration record (eMAR) for November 2024

We received and followed known in Quickmar and MC order LOS. Resident care coordinator / designee will enter all orders that are given from physicians during new orders from outside physicians for residents on routine order LOS, may be decided to receive orders from Start Re-admission. After logging into the order for resident, the designee will follow through with next steps in the process and verifying all in Quickmar correctly with full completed and will sign off completion when all steps have been completed.

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revealed:
-There was an entry for 75mg once daily scheduled for administration from 6:00am to 10:00am.
-Metoprolol tartrate 75mg was discontinued on 11/13/24.
-There was entry for metoprolol tartrate 25mg twice daily scheduled for administration at 6:00am and 6:00pm daily.
-Metoprolol tartrate 75mg was documented as administered from 11/01/24 to 11/11/24.
-Resident #1 was documented as in the hospital on 11/12/24 and 11/13/24.
-Metoprolol tartrate 25mg was documented as administered twice daily at 6:00am and 6:00pm from 11/15/24 -11/21/24 and 6:00am on 11/22/24.

Observation of medication on hand for administration to Resident #1 on 11/22/24 at 4:16pm revealed:
-There was a bubble medication card of metoprolol tartrate 50mg tablets with one and a half tablets [totaling 75mg] in each bubble dispensed on 10/31/24 for 29 doses.
-The medication card had eight doses of 75mg remaining on the card reflecting 21 of 29 doses administered since 10/31/24.
-There was a second bubble medication card labeled metoprolol tartrate 25mg with 30 doses dispensed on 11/13/24 labeled with instructions for one tablet twice a day.
-There were no metoprolol tartrate 25mg administered from the bubble medication card dispensed for 30 doses on 11/13/24.

Interview with the Operations Manager (OM) on 11/22/24 at 4:53pm revealed:
-Resident #1 was discharged from the hospital on 11/13/24 with orders to decrease his metoprolol tartrate from 75mg tablet once daily to 25mg

Provider's Plan of Correction (D 358):

Staff Training will conducted from [illegible] contracted pharmacy; [illegible] training in medication Administration on 12/15/24 and making sure orders are placed and verified correctly in QuickMAR. Also, order log will [illegible] [illegible].

Resident Care Coordinator / and/or designee will monitor the order log daily and making sure pharmacy orders are verified correctly and any medications errors are reported accordingly. The administrator / and/or designee will monitor the order log weekly.

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twice daily
-Resident #1 continued to receive metoprolol tartrate once daily from 11/15/24 to 11/22/24
-Based on the medication on hand for administration, the medication aides (MAs) must have
continued to administer Resident #1 metoprolol tartrate 75mg once daily, and documented metoprolol tartrate 25mg to Resident #1 twice daily from 11/15/24 to 11/21/24.
-Resident #1 had not received metoprolol tartrate 25 mg twice a day (a total of 50mg daily) as ordered from 11/15/24 to 11/22/24.

Interview with the OM on 11/26/24 at 5:15pm revealed:
-She and the Resident Care Coordinator (RCC) were responsible for ensuring medications were administered as ordered.
-She did not have a system in place to routinely audit resident records for correct medication administration.
-Since the RCC was assigned night shift due to MA staff turnover, the OM was primarily responsible for medication administration monitoring.

Interview with the Administrator on 11/26/24 at 11:40am revealed:
-The RCC would be responsible to review the residents' eMARs to ensure medications were administered as ordered
-The RCC was a MA.
-The RCC should inform the OM if medications were missed.
- The RCC along with the OM would be responsible to ensure medication errors were addressed with MAs and corrected.

Telephone interview with a MA on 11/26/24 at

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3:15pm revealed:
-The MAs were supposed to consult the eMAR for medications to be administered for a resident.
-The eMAR displayed medications to be administered for residents starting one hour before, and ending one hour after scheduled time or when documented as administered.
-She thought the RCC or OM were auditing the eMARs for medication administration.

B. Review of Resident #1's discharge summary dated 11/13/24 revealed there was an order for hydrocodone/acetaminophen 5/325 (a controlled medication used to treat mild to moderate pain) twice daily.

Review of Resident #1's previous FL2 dated 08/21/24 revealed:
-Diagnoses included osteoarthritis with chronic pain.
-There was an order for hydrocodone/acetaminophen 5/325 twice daily.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
-The pharmacy provided a controlled substance count sheet (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #1.
-Resident #1 had hydrocodone/acetaminophen 5/325 dispensed routinely from contracted pharmacy.
-Hydrocodone/acetaminophen 5/325 was dispensed for 60 tablets on 08/29/24 and 10/18/24 with instructions for one tablet twice a day.

Review of Resident #1's CSCS for

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hydrocodone/acetaminophen 5/325 dated 08/29/24 revealed:
-On 11/01/24 at 6:00am and 6:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.
-On 11/01/24 at 10:00pm, an additional dose of hydrocodone 5/325 was signed out on the CSCS.
-On 11/05/24 at 5:00am, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.

Review of Resident #1's CSCS for hydrocodone/acetaminophen 5/325 dated 10/18/24 revealed:
-On 11/05/24 at 1:00pm, an additional dose of hydrocodone/acetaminophen 5/325 was signed out on the CSCS.
-On 11/05/24 at 6:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.

Review of Resident #1's November 2024 electronic medication administration record (eMAR) from 11/01/24 to 11/22/24 revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 twice a day and scheduled for administration at 6:00am and 6:00pm.
-On 11/01/24, hydrocodone/acetaminophen 5/325 was documented as administered at 6:00am and 6:00pm.
-On 11/01/24 at 6:00pm, there was no documentation for an additional hydrocodone/acetaminophen 5/325 administered.
-On 11/05/24, hydrocodone/acetaminophen 5/325 was documented as administered at 6:00am and 6:00pm.
-On 11/05/24 at 1:00pm, there was no documentation for an additional hydrocodone/acetaminophen 5/325 administered

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Review of Resident #1's eMAR notes and progress notes revealed there was no documentation for an order to administer an additional dose of hydrocodone/acetaminophen 5/325 on 11/01/24 and 11/05/24.

Review of Resident #1's eMAR notes and primary care provider (PCP) notes revealed there no was documentation Resident #1's PCP was contacted for administering additional doses of hydrocodone/acetaminophen 5/325 on 11/01/24 and 11/05/24.

Observation of medication on hand for administration for Resident #1's hydrocodone/acetaminophen 5/325 on 11/24/24 at 11:05am
revealed there were 27 tablets which matched the quantity remaining on the CSCS dated 10/18/24.

Interview with Resident #1 on 11/25/24 at 3:50pm revealed:
-He had pain and discomfort mainly in his feet.
-He received pain medication routinely every day.
-If he was hurting bad, he would ask for additional pain medication usually he was told he had to wait.
-He did not recall if a MA had given him additional pain medication for the pain in his feet.

Interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm revealed:
-The facility should use the CSCS sent to the facility to assist with accounting for control medication administration along with the eMAR to document administration.
-The contracted pharmacy did not routinely audit CSCS compared to residents' eMARs unless the facility requested assistance in reconciling a

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particular controlled medication.

Interview with a lead personal care aide (PCA) on 11/25/24 at 4:05pm revealed.
-He had worked at the facility for a long time.
-He routinely worked day shift when most residents received medications.
-No resident had told him controlled medications were missed or they had received an additional dose of controlled medication: the residents usually spoke to him openly about most everything (good and bad).

Interview with Resident #1's PCP on 11/26/24 at 10:30am revealed:
-The facility should be administering medications as ordered.
-She saw Resident #1 on scheduled visit but Resident #1 was not very cooperative with examinations.
-Resident #1 never complained to her regarding any issue with pain medication.

Interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm revealed:
-The RCC was supposed to review the CSCS for completeness daily.
-The eMAR systems provided a print out for medications not administered.
-The Operations Manager (OM) assisted her with medication administration monitoring now that the RCC had been moved to third shift due to MA staff turnover.
-She did not have a system in place to routinely audit CSCS compared to eMAR for medication administration.
-She did not know residents were receiving medications without orders.

Interview with the OM on 11/26/24 at 5:15pm

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revealed:
-She and the RCC were responsible for ensuring medications were administered as ordered.
-She did not have a system in place to routinely audit resident records for correct medication administration.
-Since the RCC was assigned night shift due to MA staff turnover, the OM was primarily responsible for medication administration monitoring.
She did not know residents were administered medications without an order.

Interview with the Administrator on 11/26/24 at 11:40am revealed:
-The Resident Care Coordinator (RCC) would be responsible to review CSCS and the residents' eMARs to ensure controlled medications were administered as ordered
-The RCC was a MA
-The RCC should inform the Operation Manager (OM) if medications were missed.
- The RCC along with the OM would be responsible to ensure medication errors were addressed with MAs and corrected
-The RCC nor the OM had informed her there were medications, including any controlled medications, administered that were not ordered.

Telephone interview with a MA on 11/26/24 at 3:15pm revealed:
-The MAs were supposed to consult the eMAR for medications to be administered for a resident, remove controlled medications from the bubble pack, sign out the medication on the CSCS to document preparation for administration, administer medications, and then document administration on the eMAR by clicking accept.
Control medications were counted between shifts by the oncoming and outgoing MAs to

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ensure the quantity on hand matched the CSCS.
-The MAs did not audit eMARs compared to the CSCS, only checked to see if count on CSCS matched on hand quantity when starting or ending a shift.
The eMAR displayed medications to be administered for residents starting one hour before and ending one hour after scheduled time or when documented as administered.
She thought the RCC or OM were auditing the eMARs and maybe the CSCS for medication administration.

Review of Resident #1's current hospital FL2 dated 11/13/24 revealed there was an order for lorazepam 0.5mg (a controlled medication used to treat anxiety) twice a day.

Review of Resident #1's previous FL2 dated 08/21/24 revealed there was an order for lorazepam 0.5mg twice a day.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
-The pharmacy provides a controlled substance count sheet (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #1.
-Resident #1 had lorazepam 0.5mg dispensed routinely from contracted pharmacy.
-Lorazepam 0.5mg was dispensed for 56 tablets on 10/04/24 with instructions for one tablet twice a day and 56 tablets on 10/31/24 with instructions for one tablet twice a day.

Review of Resident #1's CSCS for lorazepam 0.5mg dated 10/04/24 revealed

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-On 10/28/24 at 1:00pm and 6:00pm, lorazepam 0.5mg was signed out on the CSCS.
-On 10/28/24 at 8:00am, an additional dose of lorazepam 0.5mg was signed out on the CSCS.

Review of Resident #1's October 2024 eMAR revealed:
-Lorazepam 0.5mg twice a day was listed and scheduled for administration at 1:00pm and 6:00pm daily.
-On 10/28/24, lorazepam 0.5mg was documented as administered at 1:00pm and 6:00pm.
-On 10/28/24 at 8:00am, there was no documentation for an additional dose of lorazepam 0.5mg administered.

Review of Resident #1 CSCS for lorazepam 0.5mg dated 10/04/24 revealed:
-On 11/01/24 at 1:00pm and 6:00pm, lorazepam 0.5mg was signed out on the CSCS.
-On 11/01/24 at 10:00pm, an extra dose of lorazepam 0.5mg signed out on the CSCS.

Review of Resident #1 CSCS for lorazepam 0.5mg dated 10/31/24 revealed:
-On 11/14/24 at 1:00pm and 6:00pm, lorazepam 0.5mg was signed out on the CSCS.
-On 11/14/24 at 6:00am, an extra dose of lorazepam 0.5mg was signed out on the CSCS.

Review of Resident #1's November 2024 eMAR from 11/01/24 to 11/23/24 revealed
-Lorazepam 0.5mg twice a day was listed and scheduled for administration at 1:00pm and 6:00pm daily.
-On 11/01/24, lorazepam 0.5mg was documented as administered at 1:00pm and 6:00pm.
-On 11/01/24 at 8:00am, there was no documentation for an additional dose of lorazepam 0.5mg administered but signed out as

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administered on the CSCS dated 10/04/24.
-On 11/14/24, lorazepam 0.5mg was documented as administered at 1:00pm and 6:00pm.
-On 11/14/24 at 6:00am, there was no documentation for an additional dose of lorazepam 0.5mg administered but signed out on the CSCS dated 10/31/24.

Review of Resident #1's eMAR notes and primary care provider (PCP) notes revealed there was documentation for medication orders related to administering the additional dose of lorazepam 0.5mg signed out as administered on the corresponding CSCS on 10/28/24, 11/01/24, and 11/14/24.

Review of Resident #1's medication administration notes revealed there was no documentation available for review on the October 2024 or November 2024 eMARs for lorazepam 0.5mg administered on 10/28/24 at 8:00am, 11/01/24 at 10:00pm and 11/14/24 at 6:00am

Observation of medication on hand for administration for Resident #1's lorazepam 0.5mg on 11/21/24 at 11:05am revealed there were 34 of 58 tablets which matched the quantity remaining on the CSCS dated 10/31/24.

Interview with Resident #1 on 11/25/24 at 3:50pm revealed:
-He usually had more stressed and anxious midday to later in the afternoon.
-He took medication to help keep him calm every day.
-He did not recall a time when he may have received an additional dose of his anxiety medication.

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Interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm revealed:
-The facility should use the CSCS sent to the facility to assist with accounting for control medication administration along with the eMAR to document administration.
-The contracted pharmacy did not routinely audit CSCS compared to residents' eMARs unless the facility requested assistance in reconciling a particular controlled medication.

Interview with Resident #1's PCP on 11/26/24 at 10:30am revealed:
-She saw Resident #1 on scheduled visit but Resident #1 was not very cooperative with examinations.
-Resident #1 never complained to her regarding any issue with his anxiety medication.
-The facility should be administering medications as ordered.

Interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm revealed.
-The RCC was supposed to review the CSCS for completeness daily.
-The eMAR systems provided a print out for medications not administered.
-The Operations Manager (OM) assisted her with medication administration monitoring now that the RCC had been moved to third shift due to MA staff turnover.
-She did not have a system in place to routinely audit CSCS compared to eMAR for medication administration.
-She did not know residents were receiving medications without orders.

Interview with the OM on 11/26/24 at 5:15pm revealed:

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D 358	Continued from page 59 -She and the RCC were responsible for ensuring medications were administered as ordered. -She did not have a system in place to routinely audit resident records for correct medication administration. -Since the RCC was assigned night shift due to MA staff turnover, the OM was primarily responsible for medication administration monitoring. -She did not know residents were administered medications without an order. Interview with the Administrator on 11/26/24 at 11:40am revealed: -The Resident Care Coordinator (RCC) would be responsible to review CSCS and the residents' eMARs to ensure controlled medications were administered as ordered -The RCC was a MA. -The RCC should inform the Operation Manager (OM) if medications were missed. -The RCC along with the OM would be responsible to ensure medication errors were addressed with MAs and corrected. -The RCC nor the OM had informed her there were medications, including any controlled medications, not administered as ordered. Telephone interview with a MA on 11/26/24 at 3:15pm revealed -The MAs were supposed to consult the eMAR for medications to be administered for a resident, remove controlled medications from the bubble pack, sign out the medication on the CSCS to document preparation for administration, administer medications, and then document administration on the eMAR by clicking accept. -Control medications were counted between shifts by the oncoming and outgoing MAs to ensure the quantity on hand matched the CSCS.	D 358		

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The MAs did not audit eMARs compared to the CSCS, only checked to see if count on CSCS matched on hand quantity when starting or ending a shift.
-The eMAR displayed medications to be administered for residents starting one hour before and ending one hour after scheduled time or when documented as administered.
-She thought the RCC or OM were auditing the eMARs and maybe the CSCS for medication administration.

2. Review of Resident #5's current hospital FL2 dated 11/11/24 revealed
-Diagnoses included chest pain and bipolar disorder.
-There was an order for hydrocodone/acetaminophen 5/325 (a controlled medication used to treat mild to moderate pain) 3 times a day

Review of Resident #5's previous FL2 dated 03/02/24 and signed physician's orders dated 10/10/24 revealed orders for hydrocodone/acetaminophen 5/325 three times a day

Interview with the contracted pharmacy's Nurse for the facility on 11/22/24 at 2:30pm revealed,
-The pharmacy dispersed Resident #5's medications.
-The pharmacy provided a controlled substance count sheet (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-Resident #5 had hydrocodone/acetaminophen 5/325 dispensed routinely from the contracted pharmacy
-Hydrocodone/acetaminophen 5/325 was dispensed for 90 tablets with instructions for one

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PINEBROOK RESIDENTIAL CENTER II	304 HARRISON AVENUE YADKINVILLE, NC 27055

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tablet three a day on 09/13/24, 10/12/24, and 11/07/24.

Review of Resident #1 CSCS for hydrocodone/acetaminophen 5/325 dated 09/13/24 revealed:
-On 10/31/24 at 6:00am, 12:00pm, and 6:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.
-On 10/31/24 at 6:00am, an additional dose of hydrocodone/acetaminophen 5/325 was signed out on the CSCS by a second medication aide (MA).

Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 3 times a day scheduled for administration at 6:00am, 1:00pm and 6:00pm daily.
-On 10/31/24 at 6:00am hydrocodone/acetaminophen 5/325 was documented administered on the eMAR.
-On 10/31/24 at 6:00am, there was no documentation for administering the additional dose of hydrocodone/acetaminophen 5/325 signed out on the CSCS dated 09/13/24.
-There was no documentation on the October 2024 eMAR for the additional dose of hydrocodone/acetaminophen 5/325 administered on 10/31/24.

Review of Resident #5's eMAR notes and provider notes revealed there was no documentation Resident #5's had an order for administering an additional dose of hydrocodone/acetaminophen 5/325 on 10/31/24.

Observation on hydrocodone/acetaminophen

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5/325 on hand for administration on 11/21/24 at 3:00pm revealed there were 53 tablets remaining for 60 tablets dispensed on 10/12/24, corresponding to the quantity on the CSCS dated 10/12/24, and 90 of 90 tablets dispensed on 11/07/24.

Interview with Resident #5 on 11/25/24 at 3:05pm revealed:
-He received his pain medication routinely 3 times a day, in the morning, after lunch and after supper.
-He could not recall a time when he missed a dose or may have received extra pain medication.
-The MAs told him when it was time for his medications.

Interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm revealed:
-The facility should use the CSCS sent to the facility to assist with accounting for control medication administration along with the eMAR to document administration.
-The contracted pharmacy did not routinely audit CSCS compared to residents' eMARs unless the facility requested assistance in reconciling a particular controlled medication.

Interview with Resident #5's primary care provider (PCP) on 11/26/24 at 10:30am revealed:
-She saw Resident #5 on routine visits to the facility.
-Resident #5 never complained to her regarding any issue with his pain medication.
-The facility should be administering medications as ordered.

Interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm revealed:
-The RCC was supposed to review the CSCS for

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completeness daily.
-The eMAR systems provided a print out for medications not administered.
-The Operations Manager (OM) assisted her with medication administration monitoring now that the RCC had been moved to third shift due to MA staff turnover.
-She did not have a system in place to routinely audit CSCS compared to eMAR for medication administration.
-She did not know residents were receiving medications without orders.

Interview with the OM on 11/26/24 at 5:15pm revealed:
-She and the RCC were responsible for ensuring medications were administered as ordered.
-She did not have a system in place to routinely audit resident records for correct medication administration.
-Since the RCC was assigned night shift due to MA staff turnover, the OM was primarily responsible for medication administration monitoring.
-She did not know residents were administered medications without an order.

Interview with the Administrator on 11/26/24 at 11:40am revealed:
-The RCC would be responsible to review CSCS and the residents' eMARs to ensure controlled medications were administered as ordered.
-The RCC was a MA.
-The RCC should inform the OM if medications were missed.
- The RCC along with the OM would be responsible to ensure medication errors were addressed with MAs and corrected.
-The RCC nor the OM had informed her there were medications, including any controlled

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medications not administered as ordered

Telephone interview with a MA on 11/26/24 at 3:15pm revealed:
-The MAs were supposed to consult the eMAR for medications to be administered for a resident, remove controlled medications from the bubble pack, sign out the medication on the CSCS to document preparation for administration, administer medications, and then document administration on the eMAR by clicking accept.
-Control medications were counted between shifts by the oncoming and outgoing MAs to ensure the quantity on hand matched the CSCS.
-The MAs did not audit eMARs compared to the CSCS, only checked to see if count on CSCS matched on hand quantity when starting or ending a shift.
-The eMAR displayed medications to be administered for residents starting one hour before and ending one hour after scheduled time or when documented as administered.
-She thought the RCC or OM were auditing the eMARs and maybe the CSCS for medication administration.

D 367 10A NCAC 13F .1004(j) Medication Administration — D 367

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;

The nurses will ensure that residents' Medication Administration Record (MARs) is accurately maintained and will include all items needed to be completed on the residents Medication Administration Record (MAR) including, residents name, name of medication 12/13/24

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PRINTED: 12/16/2024
FORM APPROVED

NAME OF PROVIDER OR SUPPLIER: PINEBROOK RESIDENTIAL CENTER II

STREET ADDRESS, CITY, STATE, ZIP CODE: 304 HARRISON AVENUE, YADKINVILLE, NC 27055

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D 367	Continued From page 65 (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure accuracy of the electronic medication administration record (eMAR) and controlled substance count sheets (CSCS) for 4 of 5 sampled residents (#1, #2, #5, and #6) related to documentation of administration of controlled medications for pain (#1, #5 and #6) and anxiety (#1 and #2). The findings are: 1. Review of Resident #1's current hospital FL2 dated 11/13/24 revealed: -Diagnoses included acute kidney injury, urinary tract infection and bipolar disorder. -There was an order for hydrocodone/acetaminophen 5/325 (a controlled substance used to treat mild to moderate pain) twice daily. Review of Resident #1's previous FL2 dated 08/21/24 revealed diagnoses included osteoarthritis-arthritis with chronic pain. 2. Review of Resident #1's signed physician's	D 367	or treatment order, strength and dose, quantity of medication administered, instructions for administering the medication or treatment, reason or justification for the administration of medication or treatments as needed (PRN) and documenting the resulting effect on the resident, date, and time of the administration, documentation of any omission which included refusals of medication, and the reason and name or initials of the person administering the medication and if a signature is used it must match the equivalent to those initials on the controlled substance count sheet. Staff training will address them	

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

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orders dated 10/10/24 revealed there was an order for hydrocodone/acetaminophen 5/325 twice daily.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
-The pharmacy provided a controlled substance count sheets (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #1.
-Resident #1 had hydrocodone/acetaminophen 5/325 dispensed routinely from the contracted pharmacy.
-Hydrocodone/acetaminophen 5/325 was dispensed for 60 tablets on 08/29/24 and 10/18/24 with instructions for one tablet twice a day.

Review of Resident #1 CSCS for hydrocodone/acetaminophen 5/325 dated 08/29/24 revealed:
-Hydrocodone/acetaminophen 5/325 was signed out from 10/03/24 to 11/05/24.
-On 10/26/24 at 8:00am, hydrocodone/acetaminophen 5/325 was documented as signed out.
-On 10/27/24 at 6:00am, hydrocodone/acetaminophen 5/325 was not signed out.

Review of Resident #1's October 2024 electronic medication record (eMAR) compared to the CSCS for hydrocodone/acetaminophen 5/325 dated 08/29/24 revealed:
-There was an entry from 10/26/24 to 10/31/24 for hydrocodone/acetaminophen 5/325 twice a day scheduled for administration at 6:00am and

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Facilities contracted pharmacy. [illegible] training on medication Administration on 12/11/24 and making sure that facilities Medication Administration Record (MAR) and controlled substance count sheet (CSCS) match accordingly to what was given from residents card.

Resident Care Coordinator and or Designee will monitor to make sure what the MAR is stating, and the controlled substance count sheets are equivalent daily and that each shift is counting [illegible] and controlled substance count sheets when end with oncoming shift to make sure all is the same

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6:00pm.
-On 10/26/24 at 8:00am, hydrocodone/acetaminophen 5/325 was documented as refused on the October 2024 eMAR and signed out on the CSCS dated 08/29/24.
-On 10/27/24 at 6:00am, hydrocodone/acetaminophen 5/325 was documented as administered on the eMAR but not signed out on the CSCS dated 08/29/24.

Review of Resident #1 CSCS for hydrocodone/acetaminophen 5/325 dated 10/18/24 revealed:
-Hydrocodone/acetaminophen 5/325 was signed out from 11/05/24 to 11/21/24.
-On 11/07/24 at 8:00pm, hydrocodone/acetaminophen 5/325 was not signed out on the CSCS
-On 11/13/24 at 6:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS

Review of Resident #1's November 2024 eMAR from 11/01/24 to 11/21/24 compared to the CSCS dated 10/18/24 revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 twice a day and scheduled for administration at 6:00am and 8:00pm
-On 11/07/24 at 8:00pm, hydrocodone/acetaminophen 5/325 was documented as administered on the eMAR but not signed out on the CSCS. dated 10/18/24.
-On 11/13/24 at 6:00pm, hydrocodone/acetaminophen 5/325 blank for administration on the eMAR but was signed out on the CSCS dated 10/18/24.

Observation of medication on hand for

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administration for Resident #1's hydrocodone/acetaminophen 5/325 on 11/24/24 at 11:05am
revealed there were 27 tablets which matched the quantity remaining on the CSCS dated 10/18/24.

Interview with Resident #1 on 11/25/24 at 3:50pm revealed.
-He had pain and discomfort mainly in his feet.
-He received pain medication routinely every day.
-If he was hurting bad, he would ask for additional pain medication but usually he was told he had to wait.
-He did not recall if a medication aide (MA) had given him additional pain medication for the pain in his feet.

Interview with Resident #1's primary care provider (PCP) on 11/26/24 at 10:30am revealed:
-The facility should be administering medications as ordered.
-She saw Resident #1 on scheduled visit but Resident #1 was not very cooperative with examinations.
-Resident #1 never complained to her regarding any issue with pain medication.

Refer to the interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm.

Refer to the interview with the Operations Manager (OM) on 11/26/24 at 5:15pm.

Refer to the interview with the Administrator on 11/26/24 at 11.40am.

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Refer to the telephone interview with a medication aide (MA) on 11/26/24 at 3:15pm.

b. Review of Resident #1's current hospital FL2 dated 11/13/24 revealed there was an order for lorazepam 0.5mg (a controlled substance used to treat anxiety) twice a day.

Review of Resident #1's previous FL2 dated 08/21/24 revealed there was an order for lorazepam 0.5mg twice a day.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
-The pharmacy provided a controlled substance count sheets (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #1.
-Resident #1 had lorazepam 0.5mg dispensed routinely from the contracted pharmacy.
-Lorazepam 0.5mg was dispensed for 56 tablets on 10/04/24 with instructions for one tablet twice a day and 58 tablets on 10/31/24 with instructions for one tablet twice a day.

Review of Resident #1's CSCS for lorazepam 0.5mg dated 10/04/24 revealed:
-Lorazepam 0.5mg was signed out as administered from 10/08/24 to 11/07/24.
-On 10/17/24 at 2:00pm, lorazepam 0.5mg was not signed out on the CSCS.
-On 10/24/24 at 2:00pm, lorazepam 0.5mg was not signed out on the CSCS.
-On 11/07/24 at 1:00pm, lorazepam 0.5mg was signed out on the CSCS.

Review of Resident #1's October 2024 eMAR

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compared to the CSCS for lorazepam 0.5mg dated 10/04/24 revealed:
-There was an entry for lorazepam 0.5mg twice a day and scheduled for administration at 1:00pm and 6:00pm daily on the eMAR.
-There were 2 doses of lorazepam 0.5mg not accurately documented for administration from 10/17/24 to 10/24/24.
-On 10/17/24 at 2:00pm, lorazepam 0.5mg was documented as administered on the eMAR but not signed out on the CSCS.
-On 10/24/24 at 2:00pm, lorazepam 0.5mg was documented as administered on the eMAR but not signed out on the CSCS.

Review of Resident #1's November 2024 eMAR from 11/01/24 to 11/22/24 compared to the CSCS for lorazepam 0.5mg dated 10/04/24 revealed:
-There was an entry for lorazepam 0.5mg twice a day and scheduled for administration at 1:00pm and 6:00pm daily on the eMAR.
-There was 1 dose of lorazepam 0.5mg not accurately documented for administration from 11/01/24 to 11/07/24.
-On 11/07/24 at 1:00pm, lorazepam 0.5mg was not documented as administered on the eMAR but was signed out on the CSCS dated 10/04/24.

Observation of medication on hand for administration for Resident #1's lorazepam 0.5mg on 11/21/24 at 11:05am revealed there were 34 of 58 tablets which matched the quantity remaining on the CSCS dated 10/31/24.

Interview with Resident #1 on 11/25/24 at 3:50pm revealed:
-He usually feel more stressed and anxious midday to later in the afternoon.
-He took medication to help keep him calm every

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day).
-He did not recall a time when he may have received an additional dose of his anxiety medication.

Interview with Resident #1's PCP on 11/26/24 at 10:30am revealed:
-She saw Resident #1 on scheduled visit but Resident #1 was not very cooperative with examinations.
-Resident #1 never complained to her regarding any issue with his anxiety medication.
-The facility should be administering medications as ordered.

Refer to the interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm.

Refer to the interview with the Operations Manager (OM) on 11/26/24 at 5:15pm.

Refer to the interview with the Administrator on 11/26/24 at 11:40am.

Refer to the telephone interview with a medication aide (MA) on 11/26/24 at 3:15pm.

2. Review of Resident #2's current FL2 dated 08/02/24 revealed:
-Diagnoses included anxiety and depression.
-There was an order for lorazepam 1mg (controlled substance used to treat anxiety) 3 times a day.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:

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-The pharmacy provided a controlled substance count sheet (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #2
-Resident #2 had lorazepam 1mg dispensed routinely from contracted pharmacy.
-Lorazepam 1mg was dispensed for 24 tablets on 10/19/24 with instructions for one tablet twice a day.
-Resident #2 had order changes faxed to the pharmacy beginning on 10/19/24
-Lorazepam 1mg was dispensed for 21 tablets on 10/24/24 with instructions for one tablet 3 times a day.
-Lorazepam 1mg was dispensed for 84 tablets on 11/01/24 with instructions for one tablet 3 times a day.

Review of Resident #2's CSCS for lorazepam 1mg dated 10/19/24 revealed:
-Lorazepam 1mg was signed out as administered for 10/20/24 to 10/29/24
-On 10/28/24 at 8:00am, lorazepam 1mg was not signed out on the CSCS.

Review of Resident #2's October 2024 electronic medication administration record (eMAR) compared to the CSCS for Lorazepam 1mg dated 10/19/24 revealed:
-There was an entry for lorazepam 1mg twice a day scheduled for administration at 9:00am and 9:00pm daily from 10/19/24 to 10/24/24 on the eMAR.
-On 10/28/24 at 8:00am, lorazepam 1mg was documented as administered on the October 2024 eMAR but not signed out on the CSCS.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Review of Resident #2's CSCS for lorazepam 1mg dated 10/24/24 revealed:
-Lorazepam 1mg was signed out from 10/30/24 to 11/07/24.
-On 11/02/24 at 2:00pm, lorazepam 1mg was signed out on the CSCS.

Review of Resident #2's November 2024 eMAR from 11/01/24 to 11/22/24 compared to the CSCS for lorazepam 1mg dated 10/24/24 revealed:
-There was an entry for lorazepam 1mg three times a day scheduled for administration at 8:00am, 2:00pm and 8:00pm daily on the eMAR.
-On 11/02/24 at 2:00pm, lorazepam 1mg was not documented as administered on the November 2024 eMAR but was signed out on the CSCS.

Interview with Resident #2's primary care provider (PCP) on 11/26/24 at 10:30am revealed:
-She saw Resident #2 on scheduled visit but Resident #1 was not very cooperative with examinations.
-Resident #2 never complained to her regarding any issue with her anxiety medication.
-The facility should be administering medications as ordered.

Interview with Resident #2 on 11/26/24 at 12:00pm revealed she received her anxiety medication as ordered as far as she remembered.

Refer to the interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm.

Refer to the interview with the Operations

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, Manager (OM) on 11/25/24 at 5:15pm.

Refer to the interview with the Administrator on 11/26/24 at 11:40am.

Refer to the telephone interview with a medication aide (MA) on 11/26/24 at 3:15pm.

3. Review of Resident #5's current hospital FL2 dated 11/11/24 revealed:
-Diagnoses included chest pain and bipolar disorder.
-There was an order for hydrocodone/acetaminophen 5/325 (a controlled substance used to treat mild to moderate pain) 3 times a day.

Review of Resident #5's previous FL2 dated 05/02/24 and signed physician's orders dated 10/10/24 revealed orders for hydrocodone/acetaminophen 5/325 three times a day.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
-The pharmacy provided a controlled substance count sheets (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
-The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #5.
-Resident #5 had hydrocodone/acetaminophen 5/325 dispensed routinely from the contracted pharmacy.
-Hydrocodone/acetaminophen 5/325 was dispensed for 90 tablets on 08/15/24, 09/13/24, and 10/12/24 with instructions for one tablet three a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Review of Resident #5's CSCS for hydrocodone/acetaminophen 5/325 dated 08/15/24 revealed:
-Hydrocodone/acetaminophen 5/325 was signed out as administered from 08/25/24 to 09/29/24.
-On 09/12/24 at 2:00pm, hydrocodone/acetaminophen 5/325 was not signed out on the CSCS.
-On 09/17/24 at 2:00pm, hydrocodone/acetaminophen 5/325 was not signed out on the CSCS
-On 09/25/24 at 8:00am, hydrocodone/acetaminophen 5/325 was signed out on the CSCS

Review of Resident #5's September 2024 eMAR compared to the CSCS for hydrocodone/acetaminophen 5/325 dated 08/15/24 revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 3 times as day scheduled for administration at 8:00am, 2:00pm and 8:00pm daily on the eMAR.
-There were 3 doses of hydrocodone/acetaminophen 5/325 not accurately documented for administration from 09/12/24 to 09/25/24 as follows:
-On 09/12/24 at 2:00pm, hydrocodone/acetaminophen 5/325 was documented as administered on the eMAR, but not signed out on the CSCS dated 08/15/24.
-On 09/17/24 at 2:00pm, hydrocodone/acetaminophen 5/325 was documented as administered on the eMAR, but not signed out on the CSCS dated 08/15/24.
-On 09/25/24 at 8:00am, hydrocodone/acetaminophen 5/325 was not documented as administered on the eMAR, but was signed out on the CSCS dated 08/15/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Review of Resident #5's CSCS for hydrocodone/acetaminophen 5/325 dated 09/13/24 revealed:
-Hydrocodone/acetaminophen 5/325 was signed out as administered from 09/30/24 to 11/04/24.
-On 10/13/24 at 8:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.
-On 10/28/24 at 8:00am, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.
-On 11/02/24 at 1:00pm, hydrocodone/acetaminophen 5/325 was signed out on the CSCS.

Review of Resident #5's October 2024 eMAR compared to the CSCS for hydrocodone/acetaminophen 5/325 dated 09/13/24 revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 scheduled for administration at 8:00am, 2:00pm and 8:00pm that changed on 10/25/24 to 6:00am, 1:00pm and 6:00pm daily.
There were 2 doses of hydrocodone/acetaminophen 5/325 not accurately documented for administration from 10/13/24 to 10/28/24 as follows:
-On 10/13/24 at 8:00pm, hydrocodone/acetaminophen 5/325 was not documented as administered on the eMAR but was signed out on the CSCS dated 09/13/24.
-On 10/28/24 at 8:00am, hydrocodone/acetaminophen 5/325 was not documented as administered on the eMAR but was signed out on the CSCS dated 09/13/24

Review of Resident #5's CSCS for hydrocodone/acetaminophen 5/325 dated 10/12/24 revealed:

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-Hydrocodone/acetaminophen 5/325 was signed out as administered from 11/05/24 to 11/21/24.
-On 11/17/24 at 1:00pm, hydrocodone/acetaminophen 5/325 was not signed out on the CSCS dated 10/12/24.

Review of Resident #5's November 2024 eMAR from 11/01/24 to 11/22/24 compared to the CSCSs for hydrocodone/acetaminophen 5/325 dated 09/13/24 and 10/12/24 revealed:
-There was an entry for hydrocodone/acetaminophen 5/325 three times a day scheduled for administration at 6:00am, 1:00pm and 6:00pm daily on the eMAR.
-There were 2 doses of hydrocodone/acetaminophen 5/325 not accurately documented for administration from 11/02/24 to 11/17/24 as follows:
-On 11/02/24 at 1:00pm, hydrocodone/acetaminophen 5/325 was documented as refused and not administered on the eMAR but was signed out on the CSCS dated 09/13/24.
-On 11/17/24 at 1:00pm, hydrocodone/acetaminophen 5/325 was documented as administered on the November eMAR but not signed out on the CSCS dated 10/12/24.

Observation on hydrocodone/acetaminophen 5/325 on hand for administration on 11/21/24 at 3:00pm revealed there were 53 tablets remaining for 60 tablets dispensed on 10/12/24, corresponding to the quantity on the CSCS dated 10/12/24, and 90 of 90 tablets dispensed on 11/07/24.

Interview with Resident #5 on 11/25/24 at 3:05pm revealed:
-He received his pain medication routinely 3 times

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a day, in the morning, after lunch and after supper.
-He could not recall a time when he missed a dose or may have received extra pain medication.
-The MAs told him when it was time for his medications.

Interview with Resident #5's PCP on 11/26/24 at 10:30am revealed:
-She saw Resident #5 on routine visits to the facility.
-Resident #5 never complained to her regarding any issue with his pain medication.
-The facility should be administering medications as ordered.

Refer to the interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm.

Refer to the interview with the Operations Manager (OM) on 11/26/24 at 5:15pm.

Refer to the interview with the Administrator on 11/26/24 at 11:40am.

Refer to the telephone interview with a medication aide (MA) on 11/26/24 at 3:15pm.

4. Review of Resident #6's current FL2 dated 08/21/24 revealed diagnoses included chronic pain syndrome.

Review of Resident #6's physician's orders dated 08/22/24 revealed an order for oxycodone (a controlled substance used to treat mild to moderate pain) 5mg every 6 hours as needed for

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pain control.

Interview with the contracted pharmacy's Nurse for the facility on 11/21/24 at 4:30pm revealed:
- The pharmacy provided a controlled substance count sheets (CSCS) along with controlled medications dispensed to assist the facility for tracking administration of the medication.
- The Nurse had accessed the contracted pharmacy's medication dispensing records for Resident #6.
-Resident #6 had oxycodone 5mg dispensed from the contracted pharmacy.
-Oxycodone 5mg was dispensed for 120 tablets on 09/30/24 with instructions for one tablet every 6 hours as needed for pain control.

Review of Resident #6's CSCS for oxycodone 5mg dated 09/30/24 revealed:
-Oxycodone 5 mg was signed out as administered from 10/01/24 to 11/09/24.
-On 10/20/24 at 6:30am, oxycodone 5mg was signed out on the CSCS.
-On 10/20/24 at 6:00pm oxycodone 5mg was signed out on the CSCS.
-On 10/28/24 at 10:00pm, oxycodone 5mg was signed out on the CSCS.
-On 11/16/24 at 11:00pm oxycodone 5mg was signed out on the CSCS

Review of Resident #6's October 2024 electronic medication administration record (eMAR) compared to the CSCS for oxycodone 5mg dated 09/30/24 revealed.
- There was an entry for oxycodone 5mg every 6 hours as needed for pain with administration scheduled as needed (PRN) on the eMAR.
-There were 2 doses of oxycodone 5mg not accurately documented for administration from 10/20/24 to 10/28/24 as follows:

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-On 10/20/24 at 6:00pm oxycodone 5mg was signed out on the CSCS and not documented as administered, or the effectiveness documented on the October 2024 eMAR.
-On 10/28/24 at 10:00pm, oxycodone 5mg was documented as administered and the effectiveness documented on the October 2024 eMAR but not signed out on the CSCS dated 09/30/24.

Review of Resident #6's November 2024 eMAR from 11/01/24 to 11/22/24 compared to the CSCS for oxycodone 5mg dated 09/30/24 revealed:
-There was an entry for oxycodone 5mg every 6 hours as needed for pain with administration scheduled as needed (PRN) on the eMAR.
-There were 1 doses of oxycodone 5mg not accurately documented for administration from 11/01/24 to 11/22/24 as follows:
-On 11/16/24 at 11:00pm, oxycodone 5mg was signed out on the CSCS, but not documented as administered, or the effectiveness documented on the November 2024 eMAR.

Observation of Resident #6's oxycodone 5mg on hand for administration revealed 42 of 60 tablets dispensed on 09/30/24 were available for administration and matched the quantity remaining on the CSCS dated 09/30/24.

Interview with Resident #6 on 11/25/24 at 3:03pm revealed:
-She received her pain medication when she requested it.
-She did not know how medication aides (MAs) tracked her pain medication's administration. She did not watch any documentation.

Interview with Resident #6's primary care provider

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(PCP) on 11/26/24 at 10:30am revealed:
-She saw Resident #6 on routine visits to the facility.
-Resident #6 never complained to her regarding any issue with pain medication.
-The facility should be administering medications as ordered and documenting correctly so the PCP could review medication usage for effectiveness and therapeutic outcome.

Refer to the interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/26/24 at 4:30pm.

Refer to the interview with the Operations Manager (OM) on 11/26/24 at 5:15pm.

Refer to the interview with the Administrator on 11/26/24 at 11:40am.

Refer to the telephone interview with a medication aide (MA) on 11/26/24 at 3:15pm.

Interview with the contracted pharmacy's Nurse for the facility on 11/25/24 at 3:45pm revealed:
-The facility should use the CSCS sent to the facility to assist with accounting for controlled substance administration along with the eMAR to document administration.
-The contracted pharmacy did not routinely audit CSCS compared to residents' eMARs unless the facility requested assistance in reconciling a particular controlled medication.

Interview with the RCC on 11/26/24 at 4:30pm revealed:
-The RCC was supposed to review the CSCS for

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completeness daily.
-The MAs were supposed to sign controlled substances signed out on the CSCS and documentation of administration on the residents' eMAR when the controlled substances were administered.
-The CSCS and the eMAR should match for controlled substance administration
-The OM assisted her with medication administration monitoring now that the RCC had been moved to third shift due to MA staff turnover.
-She did not have a system in place to routinely audit CSCS compared to eMAR for controlled substance administration.
-She did not know the CSCS sign out compared to the eMAR documentation of administration had missing documentation.

Interview with the OM on 11/26/24 at 5:15pm revealed:
-She and the RCC were responsible for tracking controlled substance administration.
-She monitored shift counts for controlled substances related to the quantity on hand matching the CSCS count for on hand medication.
-She did not have a system in place to routinely audit residents' eMAR compared to the controlled substances signed out on the CSCS for accuracy.
-Since the RCC was assigned night shift due to MA staff turnover, the OM was primarily responsible for medication administration monitoring.
-She did not know there were inaccuracies between the CSCS sign out compared to documentation of administration on the residents' eMARs.

Interview with the Administrator on 11/26/24 at

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D 367	Continued From page 83 11:40am revealed: -The RCC would be responsible to review CSCS and the residents' eMARs to ensure controlled substances were administered as ordered and documentation for administration was correct. -The RCC should inform the OM if the eMARs or CSCS were not accurate. -The RCC along with the OM would be responsible to ensure medication issues were addressed with MAs and corrected. -The RCC nor the OM had informed her there were any inaccurate controlled substances tracking. Telephone interview with a MA on 11/26/24 at 3:15pm revealed: -The MAs were supposed to consult the eMAR for medications to be administered for a resident, remove controlled substances from the bubble packs, sign out the medications on the CSCS to document preparation for administration, administer medications, and document administration on the eMAR by clicking accept. -Controlled substances were counted between shifts by the oncoming and outgoing MAs to ensure the quantity on hand matched the CSCS. -The MAs did not audit eMARs compared to the CSCS, only checked to see if the count on CSCS matched on hand quantity when starting or ending a shift. -She thought the RCC or OM were auditing the eMARs and maybe the CSCS for medication administration.	D 367		

Pinebrook Residential Center II

Adult Care Home Complaint Investigation Plan of Correction

Date Received: December 16, 2024

From: NC Department of Health and Himan Services-DHSR Adult Care Licensure Section

The following violations were identified:

1. Tag D269: 10A NCAC 13F .0901(a) Personal Care and Supervision (A1 Violation)
2. Tag D338: 10A NCAC 13F .0909 Resident Rights (A1 Violation)
3. Tag D273: 10A NCAC 13F .0902(b) Healthcare (A2 Violation)
4. Tag D276: 10A NCAC 13F .0902(c)(3-4) Healthcare (~~A2 Violation~~) (Standard Violation) S.A. 01/10/25
5. Tag D358: 10A NCAC 13F .1004(a) Medication Administration (Standard Violation)
6. Tag D367: 10A NCAC 13F .1004 (j) Medication Administration (Standard Violation)

This plan of correction is prepared and executed as a means to continuously improve the quality of care for our residents and to comply with all applicable state regulatory requirements.

Tag D269: 10A NCAC 13F .0901(a) Personal Care and Supervision:

Facility will modify their practices to increase the intensity of insisting that residents allow staff to perform personal care services. This will be done by increasing the number of different staff who will speak directly and encourage residents to allow staff to perform personal care. Facility will escalate refusals and contact the resident's guardian, Primary Care Physician (PCP), therapist, psychotropic medication doctor, and local DSS as appropriate if residents continue to refuse services. If all encouraging fails and the resident continues to refuse care, the resident will be made aware that a discharge notice may be given if a resident continues to refuse needed care. Management staff will review personal care documentation routinely to ensure staff are following facility practices regarding providing personal care services.

DATE: December 23, 2024

Tag D338: 10A NCAC 13F .0909 Resident Rights:

Facility practices specifically prohibit staff from engaging in certain transactions with residents including but not limited to purchasing items for residents without Administrator or Manager approval. All employees are required to sign and follow this practice. This document is titled "Agreement between Employer and Employee". In addition, all staff are also required to report to specific management if they feel any fellow employee is not following facility policies or practices, or in any way violating resident rights. This document is titled "Employee Responsibility to Report to Management."

Both of these documents were in place at the facility to be signed by all employees. However, based on actions by certain employees, these practices were not being followed as required by our company. The facility will retrain all employees and communicate the importance of these practices and have all employees resign the documents. In addition, retraining will take place regarding Resident Rights and all employees will resign the Resident Rights documentation, Administrator and key corporate management will participate in the regular training of ll employees on these two key facility practices.

More extensive mew employee and ongoing training will be provided at orientation and routinely thereafter. Additional training will b ongoing regarding resident rights and employee's responsibility to report any perceived violations of these facility practices.

DATE: December 23, 2024

Tag D273: 10A NCAC 13F .0902(b) Healthcare:

The facility will ensure that referral and follow up will meet the routine and acute health care needs of the residents and physician orders are followed up. Resident Care Coordinator/and or Designee will write all referrals on "Order Log", designed to track all orders from start to completion. After logging the referral, Resident Care Coordinator/Designee will assure that Transportation Scheduler will have all information necessary to schedule that appointment that was referred. Once the appointment is scheduled, the date will be placed on the "Order Log" and followed until the date of appointment is completed. If it is pertaining to resident physician orders, this process will be the same, and followed by the order log.

Staff Training was conducted and reviewed on the importance of the Order Log on 12/23/24 and making sure it is followed through. The Order Log will follow all orders from the time the facility receives the order until it is completed.

Administrator, Manger, and/or Designee will monitor the Order Log routinely.

DATE: December 23, 2024

Tag D276: 10A NCAC 13F .0902(c)(3-4) Healthcare:

The facility will ensure that the referral and follow up will meet the routine and acute health care needs of the residents and physician orders are followed up. Resident Care Coordinator/and or Designee will write all referrals on the "Order Log", designed to track all orders from start to completion.

Staff Training was conducted and reviewed on the importance of the Order Log on 12/23/24 and making sure it is followed through. The Order Log will follow all orders from the time the facility receives the order until it is completed.

Administrator, Manager, and/or Designee will monitor the Order Log routinely.

DATE: December 23, 2024

Tag D358: 10A NCAC 13F .1004(a) Medication Administration:

The facility will ensure that residents' medications are administered to residents as ordered by the physician and making changes when new orders are received are followed through in QuickMar and the Order Log. Resident Care Coordinator/Designee will write all orders that are given from physicians or any new orders from outside physicians for residents on facilities Order Log, that is designed to track all orders from start to completion. After logging into the order for resident, the designee will follow through with next steps in the process and verifying it is in QuickMar correctly until fully completed and will sign off for completion after all steps have been completed.

Staff training was conducted from facilities contracted pharmacy, Southern Pharmacy on Medication Administration on 12/18/24 and making sure orders are placed and verified correctly in QuickMar. Also, Order log was gone over as well.

Resident Care Coordinator/and or Designee will monitor the Order Log daily and making sure pharmacy orders are verified correctly and any medication errors are reported accordingly. The administrator/and or Designee will monitor the Order Log routinely.

DATE: December 23, 2024

Tag D367: 10A NCAC 13F .1004 (j) Medication Administration:

The facility will ensure that residents' Medication Administrator Record (MAR) is correctly maintained and will include all items that need to be completed on the residents Medication Administration Record (MAR) including residents name, name of the medication or treatment order, strength and dosage or quantity of medication administered, instructions for administering the medication or treatment, reason or justification for the administration of medication or treatments as needed (PRN) and documenting the resulting effect on the resident, date and time of the administration, documentation of any emission which included refusals of medication and the reason, and name or initials of the person administering the medication and if a signature is used it must match the equivalent to there initials on the controlled substance count sheet.

Staff training was conducted from facilities contracted pharmacy, Southern Pharmacy on Medication Administration on 12/18/24 and making sure that facilities Medication Administration Record (MAR) and Controlled Substance Control Sheet (CSCS) match according to what was given from resident's card.

Resident Care Coordinator/and or Designee will monitor to make sure what the MAR is stating and the Controlled Substance Count Sheets are equivalent daily and that each shift is counting the cart and controlled substance count sheets with oncoming shift to make sure all is the same any discretion will reported to Manger immediately.

DATE: December 23, 2024