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MEADOWVIEW TERRACE OF WADESBORO	**123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey December 17-19, 2024.	D 000		
D 050	10A NCAC 13F .0305(e) Physical Environment 10A NCAC 13F .0305 Physical Environment (e) The requirements for bathrooms and toilet rooms are: (1) Minimum bathroom and toilet facilities shall include a toilet and a hand lavatory for each 5 residents and a tub or shower for each 10 residents or portion thereof; (2) Entrance to the bathroom shall not be through a kitchen, another person's bedroom, or another bathroom; (3) Toilets and baths for staff and visitors shall be in accordance with the North Carolina State Building Code, Plumbing Code; (4) Bathrooms and toilets accessible to the physically handicapped shall be provided as required by Volume I-C, North Carolina State Building Code, Accessibility Code; (5) The bathrooms and toilet rooms shall be designed to provide privacy. Bathrooms and toilet rooms with two or more water closets (commodes) shall have privacy partitions or curtains for each water closet. Each tub or shower shall have privacy partitions or curtains; (6) Hand grips shall be installed at all commodes, tubs and showers used by or accessible to residents; (7) Each home shall have at least one bathroom opening off the corridor with: (A) a door of three feet minimum width; (B) a three feet by three feet roll-in shower designed to allow the staff to assist a resident in taking a shower without the staff getting wet; (C) a bathtub accessible on at least two sides; (D) a lavatory; and	D 050		

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D 050	Continued From page 1 (E) a toilet. (8) If the tub and shower are in separate rooms, each room shall have a lavatory and a toilet; (9) Bathrooms and toilet rooms shall be located as conveniently as possible to the residents' bedrooms; (10) Resident toilet rooms and bathrooms shall not be utilized for storage or purposes other than those indicated in Item (4) of this Rule; (11) Toilets and baths shall be well lighted and mechanically ventilated at two cubic feet per minute. The mechanical ventilation requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation; (12) Non-skid surfacing or strips shall be installed in showers and bath areas; and (13) The floors of the bathrooms and toilet rooms shall have water-resistant covering. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure lighting in 6 shared residents' bathrooms were in good repair as evidenced by bathroom vanity lights flashing in short sharp bursts of light causing a strobe light effect. Observations of the shared bathrooms of rooms 201, 205, 223 on 12/18/24 from 3:41pm until 3:50pm revealed: -The bathroom vanity lights constantly flashed when the light switch was turned on. -There was a light in the shower, however it did not provide adequate lighting for the toilet area. Interview with a medication aide (MA) on 12/18/24 at 10:40am revealed: -The lights had been that way since the remodeling was completed March 2023. -There was a total of 6 shared bathrooms that the vanity lights would flash.	D 050		

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-She thought there was a company contracted to fix the lights but was not sure if they had been contacted to come fix them or not.

Interview with a male resident on 12/19/24 at 8:10am revealed:
-The lights had been that way for a while.
-The room across from his had the flashing lights in the bathroom.
-He could see it flashing at night, especially unless the doors were closed.
-It would wake him or keep him awake unless someone shut the door.

Interview with a female resident on 12/18/24 at 4:00pm revealed:
-The lights had been that way since she had been living there.
-"The flashing lights bothered me" and it "has got to go"; "I'm tired of it".
-It was hard for her to see how to brush her teeth or use the bathroom.
-Her family member was there yesterday and knew the lights still had not been fixed.
-Everyone knew about these lights flashing and no one fixed them.

Interview with the Maintenance Director on 12/19/24 at 2:37pm revealed:
-He was aware of the flashing lights in the residents' bathrooms.
-The facility had a contract with a company who was responsible for fixing those.
-He had contacted the company but did not remember the exact date and had not heard back from the company.

Interview with the Maintenance Director on 12/19/24 at 2:33pm revealed:
-He was aware of the flashing lights in the

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residents' bathrooms.
-The facility had a contract with a company who was responsible for fixing the lights that were under warranty from the remodel.
-There were other lights in the bathroom the residents could use instead of the flashing lights.
-He had contacted the contracted company but they had not been out to fix the lights.

Interview with the Regional Maintenance Manager (RMM) on 12/19/24 at 3:03pm revealed:
-He was not aware of the flashing lights in the residents' bathrooms until now.
-He knew the facility had a contract with a company who was responsible for fixing the lights.

Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-She was aware that there were several residents' bathroom vanity lights that were flashing.
-She was concerned the flashing lights could cause problems like headaches or could cause a fall.
-The facility was under contract with a company for the lights and they were under warranty.
-The Maintenance Director was aware and had contacted the contracted company, but they had not been out to fix the lights.
-Since the facility was under contract with the company, the company was responsible to correct the flashing lights.

Requested documentation from the facility regarding the contracted company contacts from emails or texts were not provided by the time of survey exit on 12/19/24.

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D 068	Continued From page 4	D 068		
D 068	10A NCAC 13F .0305(i) Physical Environment 10A NCAC 13F .0305 Physical Environment (i) The requirements for floors are: (1) All floors shall be of smooth, non-skid material and so constructed as to be easily cleanable; (2) Scatter or throw rugs shall not be used; and (3) All floors shall be kept in good repair. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure floors were in good repair as evidenced by missing drain flanges in two spa bathrooms. Observations of the 100-hall spa bathroom at 9:54am and the 200-hall spa bathroom at 10:38am on 12/17/24 revealed: -The 200-hall spa bathroom floor drain had a plastic drain secured with 3 metal Phillips screws. -The cut out ceramic tiles' edges were unfinished and jagged with no sealant, chalking, or flange to join and seal the space between the tile and drain. -There were missing drain flanges between the bathroom drain and floor tile in both spa bathrooms. -The floor drains were not level with the floor tile which posed a potential for tripping. -The raised areas of the tiles and the recess of the drain were raised ¼"- ½". Interview with a personal care aide (PCA) on 12/17/24 at 10:40am revealed: -The tile and the drain in the spa bathrooms had been that way since the remodeling. -When staff noticed something in need of repair, they were supposed to let the maintenance director know.	D 068		

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D 068	Continued From page 5 -She had never reported it to the maintenance director. Observations of the 100-hall spa bathroom at 7:21am and the 200-hall spa bathroom at 7:42am on 12/18/24 revealed the gap between the floor tiles and the drain baskets ranged from ¼" to ¾" with a drop ranging from ¼" to ½". Interview with the Maintenance Director on 12/19/24 at 2:33pm revealed: -He had not realized that the spa bathroom floor drains were left without the flange leaving the gap between the tile and the basket drain. -It had been left that way when the remodeling had been completed which had been about a year ago. -No one had reported it to him. Interview with the Regional Maintenance Manager (RMM) on 12/19/24 at 3:03pm revealed: -He was not aware of the spa bathroom floor drains were not finished when the remodeling had been done. -He realized the importance of the drains being joined to the tile to prevent anyone from tripping over the unfinished edges. Interview with the Administrator on 12/19/24 at 5:17pm revealed: - She was not aware of the spa bathroom floor drains being unfinished. -No one had reported it to her. -She was concerned over the potential for injuries from them not being finished due to the rough edges.	D 068		
D 105	10A NCAC 13F .0311(a) Other Requirements	D 105		

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10A NCAC 13F .0311 Other Requirements
(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the building was maintained in a safe condition related to the kitchen exit door being in disrepair and inoperable to be securely closed and locked, which left the facility vulnerable for anyone to enter and posed a risk for the safety of the residents and staff and to ensure the garbage disposal was in good repair and operating condition.

The findings are:

1. Observation of the facility kitchen on 12/17/24 at 1:20pm revealed:
-The kitchen exit door on the back of the facility was ajar.
-The metal frame in which the door set had rusted out at the bottom on both sides.
-The metal door was not aligned with the frame which left a gap at the top right-hand side of the door.
-Spray foam insulation had been sprayed in the area between the bottom and middle hinges of the door and the frame.
-Spray foam insulation had been sprayed at the left-hand side of the bottom of the door frame and the floor tile where the frame had rusted away.
-Spray foam insulation had been sprayed at the right-hand side of the bottom of the door frame where it met the floor tile.
-The door frame on right-hand bottom side had

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rusted away and spray foam insulation had been used to cover the ceramic tile baseboard where a tile was missing.
-The left-hand top side of the door frame had a ¾" drop from the original position on the wall noted by the paint indentation of the door frame.
-There was a ¾ inch (") opening from the door to the door frame resulting from the door not being able to be closed and secured.

Observation of the facility kitchen door between the kitchen and the residents' dining room on 12/17/24 at 4:30pm revealed:
-The door locking system had a turn lock system from the kitchen to the residents' dining room to allow easy access from the kitchen into the residents' dining room.
-The door locking system from the residents' dining room could only access the kitchen with the use of a key to unlock the door to prevent residents and staff from entering the kitchen without the proper key.

Observation of the facility kitchen on 12/18/24 at 7:10am revealed the key lock direction of the door between the kitchen and the dining room had been changed in order to prevent anyone from entering the facility in the event they had entered into the kitchen through the back exit door that was not able to be closed or locked.

Review of work orders from the Dietary Manager revealed work orders for the kitchen exit door dated 07/11/23 and 08/21/24 which listed the issue as back door will not close all the way and back door will not close - frame is warped.

Interview with a cook on 12/17/24 at 1:15pm revealed:
-She worked in the kitchen with the Dietary

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D 105	Continued From page 8 Manager (DM). -She felt unsafe coming to work in the morning since the back exit door of the kitchen would not close and could not be locked. -The door had been that way for at least 6 months now. Interview with the DM on 12/17/24 at 1:20pm revealed: -She had been telling the Maintenance Director and the Administrator about the kitchen's back exit door for about a year now. -She had used the spray foam insulation to try and close up any holes or cracks to prevent mice, snakes, or any other pests from entering into the facility's kitchen. -She was not concerned about any food being stolen from the facility's kitchen as there were locks on the walk-in cooler and walk in freezer as well as the dry goods storage area. -She was more concerned about the residents and staff members being safe since anyone could walk in through the exit back door of the kitchen and straight into the dining room and from there to anywhere in the facility. Interview with the Maintenance Director (MD) on 12/19/24 at 2:33pm revealed: -He was aware of the poor operating condition of the exit back door of the kitchen. -He and the Administrator had contacted the corporate office, but did not remember the exact date, regarding the need to get the door replaced but had not been given permission or the funds to fix it. -He was concerned about the safety of the residents and staff since that door could not be closed or locked in its current condition. -He had changed the key lock direction of the door between the kitchen and the dining room in	D 105		

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order to prevent anyone from entering the facility in the event they had entered into the kitchen through the back exit door until that door could be repaired or replaced.

Interview with the Regional Maintenance Manager (RMM) on 12/19/24 at 3:03pm revealed:
-He was made aware of the back exit door of the kitchen needed repair during the phone call the MD made to the corporate office on 12/17/24.
-He, the MD, and the other corporate maintenance director started working on fixing the door the next morning on 12/18/24.
-He had told corporate of the needed repairs of the current exit door until the entire door system and frame could be ordered and put into place.
-He had been informed the MD had changed the direction of the key lock on the door between the kitchen and the dining room on 12/17/24 prior to leaving for the day.
-The key lock direction of the door between the kitchen and the dining room had been changed in order to prevent anyone from entering the facility in the event they had entered into the kitchen through the back exit door until that door could be repaired or replaced.
-The door and frame had to be jacked up and secured back into its original position in order to get the door to close and be able to be locked.
-The repair was only a temporary solution until a new door and frame could be ordered and put into place to replace the old door and frame.

Interview with the Administrator on 12/19/24 at 5:15pm revealed:
-She knew the back exit door in the kitchen could not be closed and locked.
-She did not remember how long it had been that way, but it had been a while.
-She and the MD had contacted the corporate

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D 105	Continued From page 10 office but did not remember the exact date but had not been provided with the funding to repair or replace the door. -She was concerned about the safety of the residents and staff since the back exit door in the kitchen could not be closed and locked. 2. Observations of the kitchen on 12/17/24 at 1:30pm revealed: -The splash guard was missing the right half. -There was no strainer available to catch food debris/scraps. -There was no stopper available to prevent food debris/scraps from entering the disposal. -The garbage disposal did not work. -There were particles of food scraps visible located in the non-working disposal. -A foul odor was noted at the sink where the garbage disposal was located. Review of a maintenance work order dated 08/21/24 revealed the "food disposal on the dish machine was not working". Interview with the Dietary Manager (DM) on 12/17/24 at 1:40pm revealed: -The garbage disposal had not worked in "quite some time". -She would have to check the work order for the exact date. -The food particles would go into the disposal, but it would not work to remove the particles. -She had purchased a wet to dry vacuum to try to remove most of the food particles so they would not "give bacteria a place to grow" and her staff would not have to "stick their hands in the disposal to remove the food". -She worried "someone was going to get hurt". -She had reported it to the maintenance director and the Administrator, but nothing was done	D 105		

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because she was "told it was up to corporate".

Interview with the Maintenance Director (MD) on 12/19/24 at 2:33pm revealed:
-He was told that the garbage disposal was not working, but did not remember the exact date.
-He contacted corporate and was told the garbage disposal system was going to be removed before the federal inspection was due.
-The original date for the federal inspection was due at the time of Hurricane Helene, so it was rescheduled.
-The disposal not working could cause problems like contamination from the food being trapped in it.

Interview with the Regional Maintenance Manager (RMM) on 12/19/24 at 3:03pm revealed:
-He was not aware of the garbage disposal not working until now.
-He knew the facility had a federal inspection that was due at the time of Hurricane Helene, so it was rescheduled, and it should have been fixed prior to that date.

Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-The garbage disposal in the kitchen had stopped working a few months ago.
-The DM reported it to the MD and to her.
-She reported issues to the Regional Director of Operations.
-The MD reported issues to the RMM.
-They were told the garbage disposal was going to be removed prior to the federal inspection.
-The federal inspection was due back when Hurricane Helene hit back in September 2024 and was now supposed to be in February 2025.
-She was concerned that the garbage disposal would get "clogged up and bacteria would build

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up".

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10A NCAC 13F .0311(d) Other Requirements

10A NCAC 13F .0311 Other Requirements
(d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.

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

Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 7 of 8 fixtures with water temperatures ranging from 64.2 to 98.4 degrees F.

The findings are:

Review of the facility's census on 12/17/24 revealed there were 50 residents in the facility.

Observation of the 100 hall water temperatures in the facility on 12/17/24 from 8:25am to 10:35am revealed:
-The water temperature in the bathroom sink between rooms 111 and 113 was 93.7 degrees Fahrenheit (F) after allowing the water to run from 8:31am to 8:41am.
-The water temperature in the shower between

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MEADOWVIEW TERRACE OF WADESBORO	**123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170**

(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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rooms 111 and 113 was 92.2 degrees F after allowing the water to run from 8:31am to 8:41am.
-The water temperature in the bathroom sink between rooms 118 and 120 was 64.2 degrees F after allowing the water to run from 8:52am to 9:02am.
-The water temperature in the shower between rooms 118 and 120 was 66.8 degrees F after allowing the water to run from 8:52am to 9:02am.
-The water temperature in the bathroom sink in room 109 was 98.4 degrees F after allowing the water to run from 10:07am to 10:16am.

Second observation of the 100 hall water temperatures in the facility on 12/18/24 from 8:07am to 8:35am revealed:
-The water temperature in the bathroom sink between rooms 111 and 113 was 90.7 degrees F after allowing the water to run from 8:08am to 8:18am.
-The water temperature in the shower between rooms 111 and 113 was 89.4 degrees F after allowing the water to run from 8:08am to 8:18am.
-The water temperature in the bathroom sink between rooms 118 and 120 was 62.2 degrees F after allowing the water to run from 8:21am to 8:31am.
-The water temperature in the shower between rooms 118 and 120 was 99.1 degrees F after allowing the water to run from 8:21am to 8:31am.

Third observation of the 100 hall water temperatures in the facility on 12/19/24 from 1:35pm to 2:00pm revealed the water temperature in the bathroom sink of room 115 was 64.6 degrees F after allowing the water to run from 1:35pm to 2:00pm.

Fourth observation of the 100 hall water temperatures in the facility on 12/19/24 from

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4:40pm to 5:00pm revealed the water temperature in the bathroom sink of room 115 was 64.3 degrees F with the surveyor's thermometer and 64.4 degrees F with the Regional Maintenance Manager's (RMM) thermometer after allowing the water to run from 1:35pm to 2:00pm after the RMM removed the aerator tip from the faucet which allowed a solid stream of water.

Interview with the resident in room 113 on 12/17/24 at 8:41am revealed:
-She lived at the facility for 1 year.
-The water in her bathroom was usually cold.
-The water took a long time to get warm and had been that way since she moved into the facility.
-The water was never warm in the sink when she washed her hands.
-If she wanted to take a shower, the water in the shower had to be turned on for a long time before she could get into the shower.
-There were times she had to wait 30 minutes or longer for the water in her bathroom to start getting warm so she could take a shower.

Interview with the resident in room 120 on 12/17/24 at 9:00am revealed:
-She had lived at the facility for 6 months.
-The water in her bathroom had been cold since she moved into the facility.
-The water in her bathroom took a long time to get warm.
-She often had to wait to get in the shower because the water would not get warm.
-She usually had to turn the water on and wait at least 15-20 minutes for the water to get warm enough in her bathroom for her to get into the shower.

Interview with the resident in room 109 on

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12/17/24 at 10:07am revealed:
-She had lived at the facility for almost 6 years.
-The water in her bathroom was always cold.
-It took a long time for the water in her bathroom to become warm.
-The water in her sink was always cold, so most of the time she used hand sanitizer because the water would not get warm enough for her to wash her hands.
-There were times when the water in the shower would not get warm and she did not shower that day.
-In the evenings, she usually turned on the water in her sink on let the water run for 10-15 minutes and sometimes the water would still not be warm when she wanted to wash her face or brush her dentures.
-The facility had issues with the water temperatures since she lived there.
-She reported the water temperature issues to the Administrator, but there had not been any improvement.

Interview with the resident in room 125 on 12/19/24 at 7:41am revealed:
-She moved into the facility 6 months ago.
-The water in her bathroom was cold.
-She usually let the water in the shower run for 15-20 minutes and sometimes the water would still not be warm.
-A few times she did not take a shower because the water would not get warm.
-She had reported the water temperature issues to the Maintenance Director and the Administrator.
-She was told to let the water run for a while and the water would eventually get warm.

Interview with the resident in room 115 on 12/19/24 at 1:35pm revealed:

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D 113	Continued From page 16 -She lived in the facility for about a year now. -She had returned from the hospital yesterday (12/18/24). -The personal care aide had to wash her hair yesterday in cold water because she could never get the water to get warm. -The water in her bathroom was always cold. -She needed to have her lower legs cleaned in order to remove the "old" cream on them in order to put on some "new" cream but had not been able to get it done because the water would not get warm and cold water would not remove the cream. Interview with a personal care aide (PCA) on 12/18/24 at 3:22pm revealed: -She had worked at the facility for 2 months. -The water in the residents' bathrooms took a long time to get warm. -Some of the residents complained about the water temperatures. -She usually had to turn the water on and let it run for at least 15 minutes before the water got warm enough so she could assist residents with a shower. Interview with a second PCA on 12/19/24 at 9:05am revealed: -She had worked at the facility for 3 months -The water in the residents' bathrooms was cold. -Sometimes the water in the residents' bathrooms had to run 15-20 minutes before it would get warm. -Sometimes she took the residents to the spa room for showers because the water in the residents' rooms took a long time to become warm. -She had not reported the issues with water temperatures to any of the managers because they knew the water in the residents' bathrooms	D 113		

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was cold.

Interview with a medication aide (MA) on 12/18/24 at 8:08am.
-She had worked at the facility for 2 years.
-Residents frequently complained about the water temperatures.
-The water had taken a long time to get warm ever since she started working at the facility.
-She always just turned the water on in the residents' bathrooms and let the water run until the water became warm.
-It was not unusual to have to wait an hour for the water to become warm enough to assist residents with their showers.

Interview with the Maintenance Director on 12/17/24 at 10:38am revealed:
-He started working at the facility in September 2024.
-He checked water temperatures three times weekly and recorded them on a temperature log.
-He thought the water temperature should be between 105 and 115 degrees F.
-It took time for the water to heat up, but the water would eventually get warm.
-He usually let the water run for about 5-10 minutes before he checked the water temperatures.
-Some of the residents complained about the water temperatures but he told the residents to let the water run for a few minutes and the water would get warm.
-He had not had any water temperatures out of range when he checked the water temperatures weekly.
-The facility had not called a plumber for any water temperature issues since he started working at the facility in September 2024.

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Second interview with the Maintenance Director on 12/19/24 at 2:37pm revealed:
-He usually let the water in the residents' bathrooms run for 8-10 minutes or longer when he checked the water temperatures.
-In some of the residents' bathrooms, the water got warm quickly but some of the other rooms took a while for the water to become warm.
-He noticed the water temperatures seemed to fluctuate at different times of the day.
-He reported the issues with the water temperatures to the Administrator and she instructed him to call the RMM.
-He reported water temperatures to the RMM sometime since he started working at the facility in September 2024 but was unsure when.
-The RMM did not advise him to contact a plumber.
-He was unsure when a plumber had last visited the facility.
-He and the RMM inspected the water heater for leaks, flushed the water tank, and adjusted the temperature on the water heater today, 12/19/24.

Review of the facility's October 2024 water temperature logs revealed:
-On 10/01/24, 3 fixtures were checked and temperatures ranged from 107.3 degrees F to 109.4 degrees F.
-On 10/03/24, 3 fixtures were checked and temperatures ranged from 106.8 degrees F to 108.8 degrees F.
-On 10/07/24, 3 fixtures were checked and temperatures ranged from 110.4 degrees F to 111.4 degrees F.
-On 10/09/24, 3 fixtures were checked and temperatures ranged from 108.6 degrees F to 110.4 degrees F.
-On 10/11/24, 3 fixtures were checked and temperatures ranged from 106.9 degrees F to

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108 degrees F.
-On 10/14/24, 3 fixtures were checked and temperatures ranged from 107.4 degrees F to 109.1 degrees F.
-On 10/16/24, 3 fixtures were checked and temperatures ranged from 108.6 degrees F to 111.4 degrees F.
-On 10/18/24, 3 fixtures were checked and temperatures ranged from 109 degrees F to 110 degrees F.
-On 10/21/24, 4 fixtures were checked and temperatures ranged from 110.4 degrees F to 112.3 degrees F.
-On 10/23/24, 3 fixtures were checked and temperatures ranged from 108.8 degrees F to 109.7 degrees F.
-On 10/25/24, 3 fixtures were checked and temperatures ranged from 109.8 degrees F to 110.6 degrees F.
-On 10/28/24, 3 fixtures were checked and temperatures ranged from 108.4 degrees F to 110 degrees F.
-On 10/30/24, 3 fixtures were checked and temperatures ranged from 108.4 degrees F to 109.4 degrees F.

Review of the facility's November 2024 water temperature logs revealed:
-On 11/01/24, 3 fixtures were checked and temperatures ranged from 108.4 degrees F to 110.6 degrees F.
-On 11/04/24, 3 fixtures were checked and temperatures ranged from 107.2 degrees F to 108 degrees F.
-On 11/06/24, 3 fixtures were checked and temperatures ranged from 110.4 degrees F to 111.3 degrees F.
-On 11/08/24, 3 fixtures were checked and temperatures ranged from 108.6 degrees F to 112.4 degrees F.

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-On 11/11/24, 3 fixtures were checked and temperatures ranged from 108.8 degrees F to 109.8 degrees F.
-On 11/13/24, 3 fixtures were checked and temperatures ranged from 108.4 degrees F to 110.6 degrees F.
-On 11/15/24, 3 fixtures were checked and temperatures ranged from 109.1 degrees F to 110.4 degrees F.
-On 11/18/24, 3 fixtures were checked and temperatures ranged from 110.1 degrees F to 110.6 degrees F.
-On 11/20/24, 4 fixtures were checked and temperatures ranged from 109.8 degrees F to 111 degrees F.
-On 11/22/24, 3 fixtures were checked and temperatures ranged from 110.7 degrees F to 111.6 degrees F.
-On 11/25/24, 3 fixtures were checked and temperatures ranged from 110.9 degrees F to 112.4 degrees F.
-On 11/27/24, 3 fixtures were checked and temperatures ranged from 106.4 degrees F to 107.9 degrees F.
-On 11/29/24, 3 fixtures were checked and temperatures ranged from 106 degrees F to 107.6 degrees F.

Review of the facility's December 2024 water temperature logs revealed:
-On 12/02/24, 3 fixtures were checked and temperatures ranged from 108.1 degrees F to 109.3 degrees F.
-On 12/04/24, 3 fixtures were checked and temperatures ranged from 109.6 degrees F to 111.2 degrees F.
-On 12/06/24, 3 fixtures were checked and temperatures ranged from 110 degrees F to 110.6 degrees F.
-On 12/09/24, 3 fixtures were checked and

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temperatures ranged from 108.2 degrees F to 108.4 degrees F.
-On 12/11/24, 3 fixtures were checked and temperatures ranged from 108.7 degrees F to 111.9 degrees F.
-On 12/13/24, 3 fixtures were checked and temperatures ranged from 107.8 degrees F to 108 degrees F.
-On 12/16/24, 3 fixtures were checked and temperatures ranged from 111.1 degrees F to 112.4 degrees F.

Interview with the RMM on 12/19/24 at 3:03pm revealed:
-The water temperature in the residents' bathrooms should be 100-116 degrees F.
-The Maintenance Director should be checking the water temperatures at least weekly and more often if there were issues or water temperatures were out of range.
-The facility had 2 water heaters, one for residents' rooms, and the other for the kitchen and laundry.
-Each of the facility's water heaters had approximately a 100-gallon capacity.
-When he received a report of maintenance issues at a facility, he traveled to the facility as soon as he could get there to assist the Maintenance Director in determining the issue.
-He was first notified the facility was having water temperature issues on 12/18/24
-He had been working with the facility's Maintenance Director today, 12/19/24, to determine why the water temperatures in the facility were cold.
-He thought there may be some shower valves that were not working properly and causing the cold water temperatures.
-He felt the type of water faucets installed in the sinks in the residents' bathrooms also contributed

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to the cold water temperatures.
-Some of the residents had complained to him today, 12/19/24, about the water being cold and taking a long time to become warm.
-He was concerned about the water temperatures in the facility because the water temperature should be a suitable temperature for the residents to take showers and baths.

Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 3:40pm revealed:
-Several residents complained to her about the water temperature in the last couple of months.
-The water temperature issue seemed to be worse in the last 3 months.
-The water in the residents' bathrooms had to run for a long time before it would get warm.
-She reported the concerns about the water temperatures to the Maintenance Director and the Administrator when she noticed the water was not getting warm a couple months ago.
-It was important for the residents to be able to bathe so they could maintain good hygiene.

Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-The facility started having issues with the water temperatures about a month ago.
-The water temperature seemed to be taking a longer time to become warm.
-She reported the water temperature issues to the Regional Director of Operations.
-The Maintenance Director reported the water temperature issues to the RMM.
-The RMM instructed the Maintenance Director on how to adjust the temperature on the water heater.
-There were 2-3 residents who complained about the water temperatures in the last couple of weeks.

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-When the residents complained about the water temperature, she suggested letting the water run for a while to get warm or that the residents take a shower at a different time.
-The water temperature in the facility seemed to fluctuate at different times of the day.
-She did not want the residents to have to take cold showers or wait to take a shower.

Interview with the facility's contracted primary care provider (PCP) on 12/19/24 at 9:15am revealed:
-She was not aware the facility was having issues with the water getting warm.
-The residents should be bathing regularly to maintain cleanliness.
-She was concerned about the residents not taking showers due to cold water because not bathing regularly could cause skin irritation and rashes.

____

The facility failed to ensure water temperatures were maintained between 100 and 116 degrees Fahrenheit (F) as evidenced by 7 of 8 fixtures with water temperatures ranging from 64.2 to 98.4 degrees F. The water temperature of various fixtures in the facility did not rise to over 100 degrees F, after running for several minutes. The water temperatures in the facility caused residents to be unable to bathe and have warm water available for handwashing and personal care tasks. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/24 for this violation.

CORRECTION DATE FOR THE TYPE B

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D 113	Continued From page 24 VIOLATION SHALL NOT EXCEED FEBRUARY 2, 2025.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff who administered medications had successfully passed the written state medication administration examination (Staff C) before administering medication to residents. The findings are: Review of the Facility's Medication Technician (Medication Aide-MA) Training Policy and Procedure dated September 2021 revealed: -The MA must be a Certified Nursing Assistant (CNA) or personal care aide (PCA) with certificate or verification in file. -The facility would validate the state MA test. -The MA would be required to complete 5-hour tests included at the time of the check off if they cannot pass the test or did not pass the skills	D 125		

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portion, they would not be deemed to have completed the check-off.
-The MA would need to be registered, take and pass the MA State test within 60 days of the skills check-off.
-The MAs were required to take and pass the state MA test within 60 days once signed off on the clinical skills check-off form.
-If the MA did not pass the state test within 60 days, they must be immediately removed from the cart.
-Once the MA passed the test, they would be reevaluated by the RN before they could administer medications.

Observation of the 8:00am medication pass on 12/18/24 revealed:
-There were 26 opportunities observed with 2 errors for a 7% error rate
-Staff C administered 8 medications to a resident at 8:15am.
-Staff C gave the resident his inhaler to administer to himself to which he took 2 quick puffs without any pause between the puffs.
-Staff C failed to instruct the resident to rinse his mouth with water and spit it out as per the instructions of the medication label.

Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired 03/27/23.
-There was documentation Staff C completed the medication clinical skills checklist on 04/13/23.
-There was no documentation that Staff C had passed the state medication administration exam.
-On 12/19/24, the facility provided documentation dated 12/18/24 that Staff C had passed the state medication administration test on 07/05/23 which was not within the 60 days after the medication administration clinical skills checklist was

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completed.
-There was no documentation of the Health Care Personnel Registry (HCPR) status prior to Staff C's hire date.
-The HCPR documentation was provided on 12/19/24 and was dated 12/18/24.

Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 3:40pm revealed:
-She was responsible for the medication aide (MA) staff, and they received the 5, 10, 15-hour medication aide training prior to administering medications.
-The facility contracted Registered Nurse (RN) was responsible for ensuring the medication administration clinical skills checklist was completed.
-The Business Office Manager was responsible for the documentation of the MA's training to be placed in the employee files.

Interview with the Business Office Manager (BOM) on 12/19/24 at 4:55pm revealed:
-She was responsible for the employee hire documentation being placed in the employee files.
-The facility had shut down for renovations and then reopened when she started.
-There had not been a system or check list of what was filed or needed to be in each employee's file.
-The facility was also working on a paperless file system (moved towards all electronic files).
-All the employees' paper files had to be scanned into the electronic file system.
-She knew the Health Care Personnel Registry (HCPR) and medication aide state verifications had been in the paper files but when she went to print them out from the electronic files, she was not able to locate them.

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D 125	Continued From page 27 -She completed another HCPR and state MA verification on 12/18/24 to ensure that information would be scanned into the electronic file system from then forward. Interview with the Clinical Nurse Consultant on 12/19/24 at 5:00pm revealed: -The facility contracted Registered Nurse (RN) should have completed another medication administration clinical skills checklist once the MA had taken the state test without passing it to ensure she was "safe" to administer medications to the residents. -Staff C should have been removed from the medication cart until another medication administration clinical skills checklist had been done by the contracted RN and/or until the MA passed the state medication aide test. Interview with the Administrator on 12/19/24 at 5:15pm revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring medication aide staff had received the 5, 10, 15-hour medication aide training prior to administering medications. -The facility contracted Registered Nurse (RN) was responsible for ensuring the medication administration clinical skills checklist was completed. -The Business Office Manager was responsible for the documentation of the MA's training to be placed in the employee files. -She was not aware that Staff C had not taken and passed the state medication aide test within 60 days after the medication administration clinical skills checklist was completed.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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10A NCAC 13F .0407 Other Staff Qualifications
(a) Each staff person at an adult care home shall:
(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to verify 3 of 3 sampled medication aides (Staff A, Staff B and Staff C) who were administering medications had a Health Care Personnel Registry (HCPR) status verification completed prior to or on their hire date.

The findings are:

1. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 03/27/23.
-There was no documentation of the Health Care Personnel Registry (HCPR) status prior to Staff C's hire date.
-The HCPR documentation was provided on 12/19/24 and was dated 12/18/24.

Observation of the 8:00am medication pass on 12/18/24 revealed:
-There were 26 opportunities observed with 2 errors for a 7% error rate
-Staff C administered 8 medications to a resident at 8:15am.
-Staff C gave the resident his inhaler to administer to himself to which he took 2 quick puffs without any pause between the puffs.
-Staff C failed to instruct the resident to rinse his mouth with water and spit it out as per the

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instructions of the medication label.

2. Review of Staff B's, medication aide (MA), personnel record revealed:
-Staff B was hired on 01/23/23.
-There was no documentation of the Health Care Personnel Registry (HCPR) status prior to Staff B's hire date.
-The HCPR documentation was provided on 12/19/24 and was dated 12/18/24.

3. Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired on 04/30/24.
-There was no documentation of the Health Care Personnel Registry (HCPR) status prior to Staff A's hire date.
-The HCPR documentation was provided on 12/19/24 and was dated 12/18/24.

Interview with the Business Office Manager (BOM) on 12/19/24 at 4:55pm revealed:
-She was responsible for the employee hire documentation being placed in the employee files.
-The facility had shut down for renovations and then reopened when she started.
-There had not been a system or check list of what was filed or needed to be in each employee's file.
-The facility was also working on a paperless file system (moved towards all electronic files).
-All the employees' paper files had to be scanned into the electronic file system.
-She knew the Health Care Personnel Registry (HCPR) verifications had been in the paper files but when she went to print them out from the electronic files, she was not able to locate them.
-She completed another HCPR verification on 12/18/24 to ensure that information would be

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D 137	Continued From page 30 scanned into the electronic file system from then forward. Interview with the Administrator on 12/19/24 at 5:15pm revealed the BOM was responsible for the documentation of the MA's training and hire documents to be placed in the employee files and she was not aware that Staff A, Staff B and Staff C did not have their HCPR check in their employee files.	D 137		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were free from contamination related to ice buildup in the walk-in	D 283		

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freezer.

The findings are:

Review of the Food establishment inspection report dated 10/14/2024 revealed:
-The kitchen received a score of 98.5.
-Demerits of 0.5 points were given in rule area 39 which documented to Store food in a clean, dry location, not exposed to contamination.
-Water was dripping onto sausage.

Observation of the walk-in freezer on 12/17/24 at 1:14pm revealed:
-There were black plastic mats used to prevent slips and falls.
-The mats had drainage holes which were supposed to be useful in preventing water from collecting, however there was frozen ice accumulation in the holes of the mats which extended above the top of the mats which left a large exposed thick ice patch.
-The ice build-up on the floor extended up the shelving legs within 1/4" of the bottom shelf where food was stored.
-There were substantially large mounds of ice build-up in the middle of the freezer floor midway to the back of the freezer and between the shelves on each side of the freezer.
-Each mound of ice build-up was approximately a foot long or longer and was six to eight inches deep.
-There was a large amount of ice build-up on the floor under the shelving on the right-hand side of the walk-in freezer.
-The ice build-up under the shelf was approximately four to six inches thick and reached between the rungs on the bottom shelf; there were various items stuck in the ice but unable to discern the types of items due to the

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amount of ice build-up.

Review of work orders from the Dietary Manager revealed work orders for the walk-in freezer dated 01/16/24, 04/07/24, and 08/21/24 which listed the issue as a pipe leaking in the freezer which caused ice to build up on the walk-in freezer floor.

Interview with a cook on 12/17/24 at 1:15pm revealed:
-She worked in the kitchen with the Dietary Manager (DM).
-Whenever there was free time, they cleaned items as they had time.
-The floor to the walk-in freezer had not been cleaned due to the amount of ice build-up.
-The shelves had not been deep cleaned since she had been there; she tried to wipe them down as they needed and weekly before food deliveries, but it was hard to do due to the ice build-up.
-The kitchen staff were afraid to walk into the walk-in freezer for the fear of slipping on the ice build-up.
-The maintenance department and kitchen staff had chipped away ice in the freezer from time to time, but the pipe kept leaking water and froze onto the ice making it bigger and thicker.

Interview with the Dietary Manager (DM) on 11/22/23 at 9:57am revealed:
-The floors in the walk-in freezer were supposed to be swept and mopped every evening by the cook but had not been done due to the ice buildup from the leaking pipe.
-The pipe in the freezer had been leaking for about a year now causing the ice to build up.
-The staff had used hair dryers and hammers to try and break up and remove the ice.
-It was a never-ending cycle since the pipe kept

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leaking and more ice built up.
-She had been working with the current Director of Maintenance (DM) for a long time to get the repairs needed to the freezer completed.

Interview with the Regional Maintenance Manager (RMM) on 11/22/23 at 10:53am revealed:
-He was aware that their freezer needed repair.
-The freezer ha a leaking pipe that had been leaking even before he became the maintenance director.
-He had told corporate of the needed repairs but had not been given the funds or approval to get the work done.

Interview with the Administrator on 12/19/24 at 5:15pm revealed:
-She knew there were issues with the walk-in freezer in the kitchen and that there were parts that needed to be replaced and were ordered.
-The previous Maintenance Director had used de-icer to remove the ice.
-He tried to replace the leaking pipe but said they did not make that size pipe needed to fix it.
-The kitchen staff were chipping the ice and cleaning the walk-in freezer with the maintenance department.
-She had been told about the buildup on the shelves in the walk-in freezer by the DM.
-She was concerned for the safety of the staff having to walk into the walk-in freezer as well as the contamination the ice build-up posed to the food in the freezer.

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

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

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure resident rights were maintained by not responding to reasonable requests for ice due to the facility's ice machine being broken for over 6 months.

The findings are:

Observation of the ice machine in the kitchen on 12/19/24 at 7:58am revealed:
-The ice machine was located in the left corner of the kitchen from the door entrance of the kitchen from the dining room.
-The ice machine was not plugged in, and it did not contain any ice.
-The inside of the ice machine was dry and had dry plastic bags in it.

Review of the ice machine cleaning log located on the side of the ice machine on 12/19/24 at 7:58am revealed the last documented cleaning was noted on 08/04/23.

Review of work orders for the ice machine from the Dietary Manager on 12/19/24 revealed:
-The work order dated 09/23/23 listed the issue being there was no ice in the ice machine, broken.
-The work order dated 03/10/24 listed the issue as the ice machine was making very little ice kept running out of ice and the blue light had not been on for a few days.
-The work order dated 08/21/24 which listed the issue as the ice machine was not working.

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Observation of the walk-in cooler in the kitchen on 12/17/24 at 1:15pm revealed:
-There was a mobile serving cart in the walk-in cooler which held numerous cups of water, milk and tea which were covered with parchment paper.
-There was no ice in the cups on the serving cart.

Observation of the kitchen on 12/17/24 at 1:15pm revealed:
-There were 3 plastic portable cooler in different sizes located near the dish washing sink.
-The smallest of the 3 coolers contained a small amount of ice and some water.
-The other 2 larger coolers were empty.

Interview with a resident on 12/19/24 at 1:45pm revealed:
-The facility had been "chilling" the drinks to make sure they were cold since there was no ice available.
-There have been times when she would get nauseated and needed ice to help relieve the nausea but could not get any ice to help.
-She had asked the personal care aides (PCAs) and the medication aides (MAs) assigned to her hall to get some ice.
-There was some ice at different times and was told that staff had brought it in but that was not often.

Interview with a second resident on 12/19/24 at 4:00pm revealed:
-The ice machine had been broken for over a year that she knew.
-She would love to get ice every day but most days she could not get any or very little.
-She kept a big cup in her room and would ask to get it filled but would be told by staff who were

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passing out the snacks and drinks, they had to "save some for the other residents".
-Iced tea was supposed to have ice in it but very seldom would they have ice in their drinks.
-The staff bought it as far as she knew, she saw them bringing in bags with them when they came to work.

Interview with a medication aide (MA) on 12/19/24 at 2:10pm revealed the kitchen staff made sure they had some ice water on the medication carts when they administer medications.

Interview with Dietary Manager on 12/19/24 at 3:03pm revealed:
-The ice machine had been broken for almost a year.
-She placed several work orders for the freezer.
-Before summer it was temporarily fixed.
-The facility staff had been purchasing ice "on their own" for some time now to make sure the residents were able to have some ice.
-She bought ice as well.
-She contacted a local family-owned restaurant, and they were kind enough to allow the staff to bring a cooler and fill it up from their ice machine.
-The residents wanted and deserved to have ice.
-The Administrator had been trying to get someone to buy an ice machine for the facility but not sure who.

Telephone interview with the county Ombudsman on 12/19/24 at 11:11am revealed:
-She received constant complaints from the residents regarding not having a working ice machine.
-She had been told by the residents that some staff had been buying ice for the residents, but it was not consistent or available daily.

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D 338	Continued From page 37 Interview with the Regional Maintenance Manager (RMM) on 12/19/24 at 3:03pm revealed: -The ice machine needed to be replaced. -There had been some changes in the home office staff and those changes caused a delay in replacing the ice machine. Interview with the Administrator on 12/19/24 at 5:33pm revealed: -The ice machine had been broken for a while. -She had been purchasing ice for the residents but it was not a daily purchase. -The corporate office communicated to her that the ice machine would be replaced, not repaired, but she was not given a date.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#5, #6) observed during the medication pass including a medication used to treat high blood sugar (#5) and a medication used to treat respiratory conditions (#6); and for 1 of 5 sampled residents (#5) for record review for a medication	D 358		

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used to treat high blood pressure, a medication used to treat neurological conditions, and a medication used to treat fungal skin infections.

The findings are:

1. The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 12/18/24.

a. Review of Resident #5's current FL-2 dated 05/22/24 revealed diagnoses included atrial fibrillation, atherosclerotic heart disease, type 2 diabetes mellitus, hypertension, peripheral vascular disease, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease.

Review of Resident #1's physician's order dated 11/08/24 revealed there was an order for Lantus insulin 10 units subcutaneously daily (Lantus is a long-acting injectable medication used to control blood sugar levels According to the manufacturer, the Lantus insulin pen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles prior to administration).

Observation of the 8:00am medication pass on 12/18/24 from 7:10am to 7:45am revealed:
-The medication aide (MA) donned gloves and dialed Resident #1's Lantus insulin pen to 10 units.
-The MA did not perform a 2-unit air shot prior to dialing the Lantus insulin pen to 10 units to ensure no air bubbles were present and insulin was flowing from the pen.
-The MA cleaned an area on Resident #1's left abdomen with an alcohol pad.
-The MA injected Lantus 10 units on the left side

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of Resident #1's abdomen at 7:40am.
-The MA held the pen in place for a few seconds before removing the pen from Resident #1's abdomen.

Review of Resident #1's December 2024 electronic medication administration (eMAR) revealed:
-There was an entry for Lantus insulin pen, inject 10 units subcutaneously once daily scheduled for 9:00am.
-Lantus insulin pen was documented as administered at 9:00am from 12/01/24 to 12/18/24.

Interview with Resident #1 on 12/19/24 at 7:41am revealed:
-She had diabetes and took Lantus insulin once a day.
-She usually ate breakfast every morning at 8:00am.
-She usually received Lantus insulin before breakfast, but occasionally she received Lantus after breakfast.
-Sometimes the staff was busy, and she took her medications whenever the staff had time to administer them.

Interview with the MA on 12/18/24 at 2:21pm revealed:
-She started working at the facility as a MA 2 years ago.
-She received training on insulin pens with a nurse when she first started working at the facility.
-MAs did some online training on medication administration periodically.
-She was aware she was supposed to prime the insulin pen with a 2-unit air shot before administering the dose prescribed.

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-Priming the insulin pen helped to ensure there were no air bubbles.
-She forgot to prime the insulin pen this morning, 12/18/24, because she was in a hurry.
-She administered Resident #1's Lantus insulin pen at 7:40am because Resident #1 usually preferred to take Lantus before breakfast.

Interview with the Resident Care Coordinator (RCC) on 12/18/24 at 4:36pm revealed:
-MAs received training on insulin pens with a nurse before completing their skills validation.
-MAs completed online training on diabetes and insulin administration periodically.
-MAs should administer medications an hour before or an hour after the time on the eMAR.
-The MA should have primed Resident #1's Lantus pen to ensure there were no air bubbles in the pen.
-The MA should have administered the medication at the time on the eMAR.
-If Resident #1's Lantus was administered too early, her blood sugar could drop before she ate breakfast.

Interview with the facility's clinical nurse consultant (CNC) on 12/18/24 at 2:31pm revealed:
-She was a registered nurse (RN) and started working for the company in May 2024.
-She completed training and skills validations for new MAs.
-She completed training on how to administer insulin pens with MAs prior to completing their medication skills validation.
-MAs should prime the insulin pens because if the pen was not primed, the resident may not get the full dose of the medication.
-MAs should follow the instructions on the eMAR regarding how and when to administer

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medications.
-If the MAs administered Resident #1's insulin too early prior to breakfast, her blood sugar could become too low.

Interview with the Administrator on 12/18/24 at 4:55pm revealed:
-MAs had an hour before the time on the eMAR and an hour after to administer medications to residents.
-MAs completed annual online training on insulin and medication administration.
-MAs had training on insulin with the RN before working on the medication cart.
-The MA should have primed Resident #1's insulin pen before administering the insulin.
-The MA should have administered Resident #1's Lantus at the time the medication was scheduled on the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/24 at 4:44pm revealed:
-Medications should be administered either an hour before or an hour after the time scheduled on the eMAR.
-A 2-unit air shot should be performed before an insulin pen was administered to ensure the resident was receiving the correct dose of insulin and the pen was working properly.

Interview with Resident #1's primary care provider (PCP) on 12/19/24 at 9:15am revealed:
-MAs should be priming the insulin pens with an air shot prior to administering the prescribed dose to ensure the resident was getting the correct dose of insulin.
-Medications should be administered at the time scheduled on the eMAR.
-Resident #1 should be getting the insulin before

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meals and the time on Resident #5's eMAR should be changed to before breakfast.

b. Review of the facility's technique for administering inhalant medications policy dated September 2021 revealed:
-The staff member should instruct the residents to exhale completely, close their lips around the mouthpiece, and breath in deeply while depressing the inhalant canister.
-The staff member should instruct the resident to hold their breath for as long as comfortable before exhaling.
-If more than one inhalation of the same product is prescribed, follow physician's orders between inhalations.
-Follow any special directions indicated by the pharmacy or prescribing physician, such as having the residents rinse their mouth out with water or mouthwash.

Review of Resident #6's current FL2 dated 03/06/24 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, seizures, lumbar stenosis with neurogenic claudication, urinary retention, and anemia.

Review of Resident #6's primary care provider (PCP) order report dated 11/07/24 revealed there was an order for Breyna aerosol inhaler 160-4.5mcg inhale 2 puffs in the morning and inhale 2 puffs in the evening, rinse mouth with water and spit after use (Breyna aerosol inhaler is a medication used to treat shortness of breath caused by respiratory conditions).

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:

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-There was an entry for Breyna aerosol inhaler 160-4.5mcg inhale 2 puffs every morning and every evening, rinse mouth with water and spit after use scheduled for 8:00am and 8:00pm.
-Breyna aerosol inhaler was documented as administered at 8:00am from 12/01/24 to 12/18/24 and at 8:00pm from 12/01/24 to 12/17/24.

Observation of the 8:00am medication pass on 12/18/24 from 7:10am to 7:45am revealed:
-The medication aide (MA) handed Resident #6's Breyna inhaler to Resident #6 and did not give Resident #6 any instructions to exhale, breathe in, or hold his breath.
-At 7:16am, Resident #6 pressed the canister of the inhaler two times without exhaling, inhaling, holding his breath, or waiting in between puffs.
-Resident #6 handed the MA his Breyna inhaler and she placed the inhaler in the medication cart.
-The MA did not give Resident #6 water or prompt Resident #6 to rinse his mouth with water after using the Breyna inhaler.

Interview with Resident #6 on 12/18/24 revealed:
-The facility staff administered an inhaler to him twice a day.
-The facility staff had not instructed him on how to breathe with his inhaler, he usually inhaled 2 puffs of the inhaler and gave the inhaler back to the MA.
-None of the facility staff instructed him to wait in between puffs.
-He had not been instructed to rinse his mouth and spit after using the inhaler.
-He was not aware of the risk of developing thrush if he did not rinse his mouth after the inhaler (Thrush is a fungal infection of the mouth).

Interview with the MA on 12/18/24 at 2:15pm

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revealed:
-She started working at the facility 1 year ago.
-She could not recall having any training on how to administer inhalers since she started working at the facility.
-She was not aware that she should give the residents instructions on how to breathe when administering inhalers.
-She was not aware Resident #6 should wait a minute in between puffs of the inhaler.
-She saw the instructions about Resident #6 needing to rinse and spit after using Breyna inhaler, but Resident #6 usually refused so she did not ask him to rinse his mouth during the medication pass on 12/18/24.

Interview with the Resident Care Coordinator (RCC) on 12/18/24 at 4:36pm revealed:
-MAs should follow instructions on the eMAR when administering medications.
-The MA should have prompted Resident #6 on how to breathe while administering his inhaler.
-The MA should have prompted Resident #6 to wait a minute in between puffs of the inhaler.
-If the eMAR said for Resident #6 to rinse his mouth, the MA should have given him water to rinse his mouth.

Interview with the clinical nurse consultant (CNC) on 12/18/24 at 2:31pm:
-She was a registered nurse (RN) and started working for the company in May 2024.
-She completed training on how to administer inhalers with MAs prior to completing their medication skills validation.
-The MA should have asked Resident #6 to take a deep breath in before administering the first puff of the inhaler, then waited 30 seconds to 1 minute before the second puff of the inhaler.
-If there were instructions on the eMAR for

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Resident #6 to rinse his mouth and spit, the MA should have prompted Resident #6 to rinse his mouth.

Interview with the Administrator on 12/18/24 at 4:55pm revealed:
-MAs received training on how to administer inhalers before they started working on the medication cart.
-MAs should follow instructions on the eMAR when administering medications.
-The MA should have instructed Resident #6 on how to properly use his inhaler.
-The MA should have asked Resident #6 to rinse his mouth after using the inhaler.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/24 at 4:44pm revealed:
-It was important for MAs to instruct residents on how to use an inhaler to ensure the inhaler was being used correctly.
-The MA should have encouraged Resident #6 to take a deep breath to allow the medication to properly fill the lungs.
-There should be at least 1 minute in between each puff of the Breyna inhaler.
-A potential side effect of Breyna inhaler was thrush, so the mouth should always be rinsed after use.

Interview with Resident #6's PCP on 12/19/24 at 9:15am revealed:
-The MA should have given Resident #6 instructions on inhaling fully when inhaling puffs of the Breyna inhaler.
-There was a potential for thrush if Resident #6 did not rinse his mouth after using the inhaler.

2. Review of Resident #5's current FL-2 dated

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05/22/24 revealed diagnoses included atrial fibrillation, atherosclerotic heart disease, type 2 diabetes mellitus, hypertension, peripheral vascular disease, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease.

a. Review of the facility's blood pressure and/or pulse readings required for medication administration policy dated September 2021 revealed:
-Medication aides (MA) are allowed to take blood pressure readings to determine the need for medications.
-Abnormal vital signs should be reported immediately to the Resident Care Coordinator (RCC) and resident's physician.

Review of Resident #5's physician's order dated 07/10/24 revealed there was an order for Metoprolol Tartrate 25mg take ½ tablet (12.5mg) twice daily, hold if blood pressure was less than 110/80 (Metoprolol Tartrate is a medication used to treat high blood pressure or heart failure).

Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Tartrate 25mg take ½ tablet (12.5mg) twice daily for hypertension, hold if blood pressure less than 110/80.
-On 10/02/24 at 9:00am, Resident #5's blood pressure was documented as 107/58 and Metoprolol Tartrate 12.5mg was administered.
-On 10/04/24 at 9:00pm, Resident #5's blood pressure was documented as 100/54 and Metoprolol Tartrate 12.5mg was administered.
-On 10/09/24 at 9:00am, Resident #5's blood pressure was documented as 109/66 and

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D 358	Continued From page 47 Metoprolol Tartrate 12.5mg was administered. -On 10/16/24 at 9:00am, Resident #5's blood pressure was documented as 104/55 and Metoprolol Tartrate 12.5mg was administered. -On 10/17/24 at 9:00am, Resident #5's blood pressure was documented as 104/56 and Metoprolol Tartrate 12.5mg was administered. -On 10/24/24 at 9:00am, Resident #5's blood pressure was documented as 104/69 and Metoprolol Tartrate 12.5mg was administered. -On 10/26/24 at 9:00am, Resident #5's blood pressure was documented as 101/55 and Metoprolol Tartrate 12.5mg was administered. Review of Resident #5's November 2024 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg take ½ tablet (12.5mg) twice daily for hypertension, hold if blood pressure less than 110/80. -On 11/01/24 at 9:00am, Resident #5's blood pressure was documented as 102/58 and Metoprolol Tartrate 12.5mg was administered. -On 11/25/24 at 9:00pm, Resident #5's blood pressure was documented as 108/54 and Metoprolol Tartrate 12.5mg was administered. -On 11/28/24 at 9:00am, Resident #5's blood pressure was documented as 102/56 and Metoprolol Tartrate 12.5mg was administered. Interview with Resident #5 on 12/19/24 at 9:00am revealed: -The facility staff took her blood pressure a couple of times each day. -Sometimes she had low blood pressure readings. -When her blood pressure was low, she usually just waited before she did anything strenuous. -She was not aware of any times when her blood pressure medication was held.	D 358		

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Interview with a medication aide (MA) on 12/19/24 at 1:30pm revealed:
-If a resident had an order to check their blood pressure, she checked the blood pressure before administering any medications to the resident.
-Resident #5 had an order to hold her Metoprolol Tartrate if her blood pressure was less than 110/80.
-She worked on 10/24/24 and 10/26/24 on the 7:00am to 3:00pm shift.
-She was unsure why she administered Resident #5's Metoprolol Tartrate when her blood pressure was less than 110/80.
-She should not have administered the medication and reported Resident #5's low blood pressure to the RCC or primary care provider (PCP).

Interview with the RCC on 12/19/24 at 3:40pm revealed:
-MAs should check residents' blood pressures before giving medications if blood pressure parameters were ordered.
-MAs should not have administered Resident #5's Metoprolol Tartrate if her blood pressure was less than 110/80.
-Resident #5 could have low blood pressure or weakness if she was administered the medication when the medication should have been held.

Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-MAs should be following instructions on the eMAR when administering medications.
-If blood pressure parameters were ordered, MAs should check the resident's blood pressure before administering medications.
-MAs should not have administered Resident #5's Metoprolol Tartrate if her blood pressure was

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lower than the parameters on the eMAR.
-Resident #5's blood pressure could become too low if she was administered Metoprolol Tartrate when her blood pressure was low, and the medication should have been held.

Interview with Resident #5's PCP on 12/19/24 at 9:15am revealed:
-Resident #5 was taking Metoprolol Tartrate because she had a history of high blood pressure and congestive heart failure.
-When there were parameters on the eMAR for blood pressure readings, the facility staff should follow those parameters.
-When Resident #5 had blood pressure readings lower than 110/80, Metoprolol Tartrate should have been held.
-She was not aware Resident #5 had blood pressure readings less than 110/80.
-If Resident #5 was administered Metoprolol Tartrate when her blood pressure was less than 110/80, she was at risk for low blood pressure, dizziness, and falls.

b. Review of Resident #5's current FL-2 dated 05/22/24 revealed there was an order for Ingrezza 40mg at bedtime (Ingrezza is used to treat tardive dyskinesia, a neurological condition causing involuntary facial and body movement).

Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Ingrezza 40mg, take 1 capsule at bedtime scheduled for 9:00am.
-Ingrezza 40mg was documented as administered at 9:00am on 27 of 31 days from 10/01/24 to 10/31/24.
-Ingrezza 40mg was documented as not admintered at 9:00am on 10/01/24, 10/27/24,

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D 358	Continued From page 50 10/28/24, and 10/29/24 due to Resident #5 being out of the facility. Review of Resident #5's November 2024 eMAR revealed: -There was an entry for Ingrezza 40mg, take 1 capsule at bedtime scheduled for 9:00am. -Ingrezza 40mg was documented as administered at 9:00am on 25 of 30 days from 11/01/24 to 11/30/24. -Ingrezza 40mg was documented as not administered at 9:00am on 11/11/14, 11/12/24, 11/13/24, 11/14/24, and 11/15/24 due to Resident #5 being out of the facility. Review of Resident #5's December 2024 eMAR revealed: -There was an entry for Ingrezza 40mg, take 1 capsule at bedtime scheduled for 9:00am. -Ingrezza 40mg was documented as administered at 9:00am daily from 12/01/24 to 12/18/24. Interview with Resident #5 on 12/19/24 at 9:00am revealed: -She took Ingrezza for tardive dyskinesia. -She was taking Ingrezza at night at one time, but she felt like the medicine worked better when she took it in the morning. -She asked the staff if she could take Ingrezza in the morning instead of at night, and the staff started administering Ingrezza in the morning. Interview with a medication aide (MA) on 12/19/24 at 1:30pm revealed: -She always matched the medication to the eMAR when she administered medications. -Resident #5 took Ingrezza in the morning with her 9:00am medications. -She did not notice the instructions on the eMAR	D 358		

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said to administer the medication at bedtime.
-She was unsure why Ingrezza 40mg was scheduled for 9:00am when the instructions said bedtime.
-She notified the Resident Care Coordinator (RCC) when she saw issues with medications on the eMAR.

Interview with the RCC on 12/19/24 at 3:40pm revealed:
-MAs should read instructions on the eMAR and follow the instructions for each medication.
-Resident #5 used to take Ingrezza at bedtime but preferred to take the medication in the morning.
-She thought Resident #5's primary care provider (PCP) changed the time on the order and that was why the medication was now scheduled at 9:00am on the eMAR.
-She could change the times of medications on the eMAR or the pharmacy could change the times medication were administered.
-She preferred that the pharmacy make changes to medications and times on the eMAR.
-MAs should report any issues with the eMAR to her and she would notify the pharmacy or PCP.

Interview with the Administrator on 12/19/24 revealed:
-MAs should read the eMAR and follow the instructions on the eMAR when administering medications.
-The medications should be administered as ordered on the instructions given by the PCP.
-If MAs noticed that medication instructions did not match the time the medication was to be administered, the MAs should report it to the RCC or contact the residents' PCP.

Telephone interview with a pharmacist at the

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facilty's contracted pharmacy on 12/19/24 at 4:44pm revealed:
-If the facility noticed a medication was scheduled at an incorrect time on the eMAR, the facility should contact the pharmacy immediately.
-If the issue was noticed after hours, the facility staff could leave a voicemail.
-Ingrezza was often scheduled in the evening because the medication could cause drowsiness.
-Some people who took Ingrezza may not experience drowsiness and side effects varied for each person.
-It was important for MAs to read the instructions on the eMAR and notify the pharmacy of any issues.

Interview with Resident #5's PCP on 12/19/24 at 9:15am revealed:
-Ingrezza was often taken at night because the medication could cause sedation.
-She was unsure if the time was changed on Resident #5's Ingrezza.
-MAs should follow the instructions for medication administration on the eMAR.

c. Review of Resident #5's primary care provider's (PCP) order dated 06/27/24 revealed there was an order for Nystatin powder 100,000 units/gram apply topically to abdominal folds every shift for fungal rash.

Review of Resident #5's PCP order dated 11/23/24 revealed:
-There was an order to discontinue the scheduled dose of Nystatin powder units/gram apply topically to abdominal folds every shift for fungal rash.
-There was an order for Nystatin powder 100,000 units/gram apply a small amount to skin three times a day as needed for redness under

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D 358	Continued From page 53 abdominal folds and groin area. Review of Resident #5's November 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Nystatin powder 100,000 units/gram apply topically to abdominal folds every shift for fungal rash scheduled for 1st shift, 2nd shift, and 3rd shift. -Nystatin powder was documented as administered on 1st shift on 26 of 30 opportunities from 11/01/24 to 11/30/24. -Nystatin powder was documented as administered on 2nd shift on 25 of 30 opportunities from 11/01/24 to 11/30/24. -Nystatin powder was documented as administered on 3rd shift on 25 of 30 opportunities from 11/01/24 to 11/30/24. -There was an entry for Nystatin powder 100,000 units/gram apply a small amount to skin three times a day as needed for redness under abdominal folds and groin area. -There was no documentation of Nystatin powder being administered as needed from 11/23/24 to 11/30/24. Review of Resident #5's December 2024 eMAR revealed: -There was an entry for Nystatin powder 100,000 units/gram apply topically to abdominal folds every shift for fungal rash scheduled for 1st shift, 2nd shift, and 3rd shift. -Nystatin powder was documented as administered on 1st shift daily from 12/01/24 to 12/18/24. -Nystatin powder was documented as administered on 2nd shift daily from 12/01/24 to 12/17/24. -Nystatin powder was documented as administered on 3rd shift daily from 12/01/24 to	D 358		

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12/17/24.
-There was an entry for Nystatin powder 100,000 units/gram apply a small amount to skin three times a day as needed for redness under abdominal folds and groin area.
-There was no documentation of Nystatin powder being administered as needed from 12/01/24 to 12/18/24.

Interview with Resident #5 on 12/19/24 at 7:41am revealed:
-She sometimes had redness and irritation under her abdominal folds.
-The facility applied a medicated powder to those areas when she had irritation.
-She currently did not have any irritation in those areas, the rash was healed.
-Sometimes the facility staff administered the powder 2-3 times a day.
-If she needed the powder for skin irritation, she could ask the staff for the medication.

Interview with a medication aide (MA) on 12/19/24 at 1:30pm revealed:
-When new medication orders for residents were received from the PCP, the Resident Care Coordinator (RCC) was responsible for ensuring the orders were sent to the pharmacy.
-If the RCC was not at the facility, the MAs sometimes sent new orders to the pharmacy.
-The facility's contracted pharmacy entered new orders in the eMAR system.
-Resident #5 had a scheduled Nystatin order and a PRN Nystatin order on the eMAR for Nystatin (PRN is a medical abbreviation for as needed).
-She was not aware Resident #5's scheduled dose of Nystatin was discontinued by her PCP.

Interview with the RCC on 12/19/24 at 3:40pm revealed:

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D 358	Continued From page 55 -She usually sent new medication orders to the facility's contracted pharmacy. -Sometimes MAs sent new medication orders to the pharmacy. -Resident #5's PCP usually sent all new orders to pharmacy. -The order to discontinue the scheduled dose of Nystatin must have been overlooked. -She was unsure why the order was not discontinued on Resident #5's eMAR. Interview with the Administrator on 12/19/24 at 5:17pm revealed: -The RCC or MAs sent residents' new medication orders to the pharmacy. -The RCC or Administrator approved new orders on the eMAR system. -When an order was approved in the eMAR system, the MAs could then administer the medication on the order. -The RCC audited the eMARs and medication carts 1-2 times per week. -She was unsure how the order for Resident #5's scheduled Nystatin dose was overlooked. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/24 at 4:44pm revealed: -The pharmacy entered the residents' medication orders in the eMAR system. -A representative from the facility had to approve the orders so the MAs could administer the medication as ordered. -She was unsure why Resident #5's scheduled dose of Nystatin was still on the eMAR. Interview with Resident #5's PCP on 12/19/24 at 1:43pm revealed: -Resident #5 had an order for Nystatin powder to be applied 3 times daily due to a fungal rash	D 358		

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around her abdominal folds.
-Resident #5's rash was now healed, so she changed the Nystatin order to as needed and the scheduled dose should have been stopped.

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

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 2 of 6 sampled residents (#5, #6) related to a medication used to lower blood sugar (#5), and a medication used for arthritis pain (#6).

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The findings are:

1. Review of Resident #5's current FL-2 dated 05/22/24 revealed diagnoses included atrial fibrillation, atherosclerotic heart disease, type 2 diabetes mellitus, hypertension, peripheral vascular disease, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease.

Review of Resident #5's primary care provider's (PCP) order dated 09/05/24 revealed an order for Humalog Kwikpen inject sliding scale prior to meals 150-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=8 units,451-500+12 units, greater than 500=14 units and notify provider (Humalog Kwikpen is a rapid-acting insulin used to control blood sugar levels).

Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed:
-There was an entry to check blood glucose (BG) three times daily before meals at 7:30am, 11:30am, and 5:00pm.
-There was an entry for Humalog Kwikpen inject insulin subcutaneously per sliding scale prior to meals 150-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=8 units,451-500+12 units, greater than 500=14 units and notify provider scheduled for 8:00am, 2:00pm, and 8:00pm.
-Humalog Kwikpen was documented as administered or held appropriately on 86 of 93 opportunities from 10/01/24 to 10/31/24.

Review of Resident #5's November 2024 eMAR revealed:

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D 367	Continued From page 58 -There was an entry to check BG three times daily before meals at 7:30am, 11:30am, and 5:00pm. -There was an entry for Humalog Kwikpen inject insulin subcutaneously per sliding scale prior to meals 150-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=8 units,451-500+12 units, greater than 500=14 units and notify provider scheduled for 8:00am, 2:00pm, and 8:00pm. -Humalog Kwikpen was documented as administered or held appropriately on 76 of 90 opportunities from 11/01/24 to 11/30/24. Review of Resident #5's December 2024 eMAR revealed: -There was an entry to check BG three times daily before meals at 7:30am, 11:30am, and 5:00pm. -There was an entry for Humalog Kwikpen inject insulin subcutaneously per sliding scale prior to meals 150-200=0 units, 201-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=8 units, 401-450=8 units,451-500+12 units, greater than 500=14 units and notify provider scheduled for 8:00am, 2:00pm, and 8:00pm. -Humalog Kwikpen was documented as administered or held appropriately on 52 of 52 opportunities from 12/01/24 to 12/18/24. Interview with Resident #5 on 12/19/24 at 7:41am revealed: -She had a continuous blood glucose monitoring system to check her BG. -The facility staff always checked her BG prior to administering her insulin. -She usually got her Humalog insulin before each meal, there were only 1 or 2 times since she was admitted to the facility in June 2024 that she received her insulin after she ate her meal.	D 367		

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-She was on a sliding scale of Humalog and if her BG was higher than 200, she normally received Humalog around 7:30am-8:00am each morning, around 12:00pm for the lunchtime dose, and around 5:30pm for the evening dose.
-She did not receive any insulin at 8:00pm.

Interview with the Dietary Manager (DM) on 12/18/24 at 7:08am revealed:
-The facility had 2 seatings for each meal.
-The first seating for breakfast was at 7:30am and the second seating was at 8:00am.
-The first seating for lunch was at 11:30am and the second seating was at 12:00pm.
-The first seating for dinner was at 5:30pm and the second seating was at 6:00pm
-Resident #5 always ate all 3 meals at the second seating.

Interview with a medication aide (MA) on 12/19/24 at 1:30pm revealed:
-When administering medications, she always followed the directions on the eMAR.
-BG should be checked before administering insulin.
-Resident #5 had a continuous blood glucose monitoring system and she used a device to obtain Resident #5's BG before administering her insulin.
-Resident #5 had an order for Humalog Kwikpen before meals.
-She usually checked Resident #5's BG before meals and administered her insulin immediately after checking her BG.
-She did not notice Resident #5's Humalog Kwikpen was scheduled for 8:00am, 2:00pm, and 8:00pm.
-She noticed the eMAR would prompt to check Resident #5's BG before meals then there would be another prompt later to administer Humalog

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Kwikpen.
-She always administered Resident #5's Humalog insulin immediately after checking Resident #5's BG before meals.
-If she noticed any issues with the eMAR and directions, she notified the Resident Care Coordinator (RCC).

Interview with the RCC on 12/19/24 at 3:40pm revealed:
-MAs should always follow the directions on the eMAR.
-She was not aware Resident #5's Humalog Kwikpen was scheduled at 2:00pm and 8:00pm instead of before lunch and dinner.
-The times on the eMAR should be changed to times before Resident #5's mealtimes.
-Resident #5's BG could become irregular if her insulin was not administered at the correct times.
-MAs should check the times medications were administered and notify her if there were any issues.

Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-MAs should administer medications according to the directions on the eMAR.
-If MAs saw any issues with orders on the eMAR, they should report the issue to the RCC.
-If the instructions for Resident #5's insulin were to administer before meals, the times on the eMAR should match the instructions.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/24 at 4:44pm revealed:
-MAs should be following the instructions on the eMAR.
-When the times on a medication do not match the order, the pharmacy should be contacted so

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the order times could be corrected.
-If Resident #5's insulin was not scheduled at the correct time, there was a potential for the medication to be administered after a meal and be less effective at controlling her blood sugar.

Interview with Resident #5's PCP on 12/19/24 at 9:15am revealed:
-Resident #5 should be receiving Humalog Kwikpen before meals.
-The times on Resident #5's eMAR should be changed to reflect the accurate time.
-Resident #5 had diabetes and should receive insulin at the times ordered to regulate her blood sugar.

2. Review of the facility's discontinue medication order policy dated September 2021 revealed:
-All discontinued medication orders should be processed according to the company's policies and procedures.
-An order is never filed in the chart until it has been reviewed by the care coordinator.
-When an order to discontinue an order from the prescribing provider is received, the medication staff receiving the order will remove the medication from the medication cart.

Review of Resident #6's current FL2 dated 03/06/24 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, seizures, lumbar stenosis with neurogenic claudication, urinary retention, and anemia.

Review of Resident #6's primary care provider's (PCP) order dated 10/25/24 revealed there was an order for Diclofenac Sodium 1% gel apply 2 grams topically to affected area three times daily (neck) (Diclofenac gel is a topical medication

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D 367	Continued From page 62 used to treat arthritis pain). Review of Resident #6's PCP order dated 12/05/24 revealed there was an order to discontinue Diclofenac. Observation of the 8:00am medication pass on 12/18/24 from 7:10am to 7:45am revealed: -The medication aide (MA) applied Lidocaine 4% cream to the cervical area of Resident #6's neck (Lidocaine 4% cream is a topical medication used to treat pain) at 7:18am. -The MA did not administer Diclofenac Sodium 1% gel during the 8:00am medication pass observation. Observation of Resident #6's medications on hand on 12/18/24 at 3:30pm revealed there was a tube of Diclofenac Sodium 1% gel dispensed from the facility's contracted pharmacy on 10/25/24. Review of Resident #6's December 2024 electronic medication administration (eMAR) revealed: -There was an entry for Diclofenac Sodium 1% gel apply 2 grams topically to affected area three times daily (neck) scheduled for 8:00am, 2:00pm, and 8:00pm. -Diclofenac Sodium 1% gel was documented as administered at 8:00am from 12/01/24 to 12/18/24. -Diclofenac Sodium 1% gel as documented as administered at 2:00pm and 8:00pm from 12/01/24 to 12/17/24. Interview with the MA on 12/18/24 at 2:15pm revealed -She administered Resident #6's Diclofenac Sodium 1% gel after Resident #6 returned to his	D 367		

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room after breakfast this morning,12/18/24.
-The Resident Care Coordinator (RCC) usually handled all the residents' new medication orders.
-If a medication was discontinued, the RCC usually took the medication off the residents' eMAR.
-She was not aware Resident #6's Diclofenac Sodium 1% gel was discontinued by his PCP.

Interview with Resident #6 on 12/18/24 at 3:15pm revealed:
-He had pain in his neck almost daily due to previous back surgery.
-His PCP prescribed Lidocaine cream for his neck pain, which seemed to help the pain.
-He was using Diclofenac gel for a while, but his PCP stopped the Diclofenac a couple of weeks ago and started Lidocaine cream.
-The MA applied 1 cream to his neck this morning before breakfast, 12/18/24, and it was Lidocaine cream.
-He did not have any other creams or topical medications administered to his neck this morning, 12/08/24, after the Lidocaine cream was applied.

Interview with the RCC on 12/18/24 at 4:36pm revealed:
-She usually sent residents' new medication orders to the pharmacy.
-Resident #6's PCP usually sent all new medication orders to the pharmacy.
-The pharmacy entered medication orders in the eMAR system.
-She could make changes to the eMAR but preferred for the pharmacy to make changes to the eMAR.
-She was unsure why Resident #6's Diclofenac Sodium gel was still on the eMAR if the order was discontinued.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW TERRACE OF WADESBORO	123 ANSON HIGH SCHOOL ROAD WADESBORO, NC 28170

(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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Interview with the Administrator on 12/19/24 at 5:17pm revealed:
-The RCC or MAs send residents' new medication orders to the pharmacy.
-The RCC or Administrator approved new orders on the eMAR system.
-The RCC audited the eMARs and medication carts 1-2 times per week.
-She was unsure why Diclofenac Sodium was still on Resident #6's eMAR if the order was discontinued.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/19/24 at 4:44pm revealed:
-The pharmacy entered new medication orders in the facility's eMAR system.
-The pharmacy received the order to discontinue Resident #6's Diclofenac Sodium on 12/18/24 and removed the medication from Resident #6's eMAR.

Interview with Resident #6's PCP on 12/19/24 at 9:15am revealed:
-She discontinued Resident #6's Diclofenac Sodium gel on 12/05/24.
-Diclofenac Sodium should be taken off Resident #6's eMAR since the medication was discontinued.