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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240044	A. BUILDING: _____ B. WING _____	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SHELBURN	16 SHELBURN CT DURHAM, NC 27712

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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on 11/22/24.	C 000		12/15/24
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, B, and C) were tested upon hire for Tuberculosis (TB) disease in compliance with the TB control measures adopted by the commission for Health Services. The findings are: 1. Review of Staff A's, Personal Care Aide (PCA), personnel record revealed: -Her date of hire was 10/23/24. -There was a negative TB skin test that was read on 06/19/24. -There was no documentation that a second TB skin test had been completed.	C 140	To ensure the proper Tuberculosis requirement is satisfied. The Enclave will develop a new monitoring protocol to ensure that all staff members have met the 2 - step TB skin test requirement. The Enclave monitoring protocol will ensure that all staff members will have satisfied the requirement prior to hire. The Enclave will only hire staff members that present the proper Tuberculosis testing paperwork. The House Supervisor will request a 2 -step TB skin test from the potential employee on the date of the interview of the potential staff member. If the staff member has not met the second test requirement, the potential staff member will have ten days after the date of hire. The House Supervisor will request the second Tuberculosis test, in accordance with the rule If the test is not completed within 10 days of hire, the staff member will be taken off the work schedule. Once all requirements are fulfilled, and confirmed by the House Supervisor, the staff member will be put back on the work schedule. All employee documents including all tuberculosis test will be scanned and uploaded onto The Enclave's online folder. This will aid the Administrator with the monthly staff audits and act as an added safeguard against lost physical paper documents. The House Supervisor will be trained on the proper procedure. Notes: If there is not a House Supervisor, the Administrator will assume this duty until a suitable candidate is available. An audit of employee files will be completed by the Administrator every 90 days to ensure all staff requirements are met. The House Supervisor will be reporting staff requirements at our weekly meetings addressed	

Reviewed and Acknowledged Keisha Banks 02/18/2025

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C 140	Continued From page 1 Interview with Staff A on 11/22/24 at 4:38pm revealed: -She had a two TB skin tests completed in June and August 2024. -She did not have a TB skin test completed when she was hired at the facility. Telephone interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring two TB skin tests were completed for staff. -Staff A submitted a TB skin test result upon hire, but a second TB skin test was not completed upon hire. -Staff A should have had a 2-step TB skin test completed. 2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -Her date of hire was 10/21/24. -There was no documentation a 2-step TB skin test had been completed. Attempted telephone interview with Staff B on 11/22/24 at 4:50pm was unsuccessful. Telephone interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring two TB skin tests were completed for staff. -Staff B did not submit any negative TB skin tests completed within the previous 12 months, and she did not have a TB skin test completed upon hire. -Staff B should have had two TB skin tests completed. 3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed: -Her date of hire was 11/02/24.	C 140	Staff Member A completed second TB test 12/5/24 Staff member B- completed 1st step 11/27/24 & 12/13/24 Staff member C was terminated before a test could be completed	

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C 140	Continued From page 2 -There was no documentation a TB skin test had been completed. Interview with Staff C on 11/22/24 at 4:41pm revealed: -She needed to get her TB skin test completed. -She was told by the Administrator that she needed to get a TB skin test completed when she was hired, but she had not been able to get one. -She had a TB skin test completed almost a year ago, but she was not sure of the date. Telephone interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring two TB skin tests were completed for staff. -Staff C did not submit any negative TB skin tests completed within the previous 12 months, and she did not have a TB skin test completed upon hire. -Staff C should have had a two TB skin tests.	C 140	To ensure the North Carolina Health Care Personnel Registry requirement is met, The Enclave House Supervisor will complete the Health Care Personnel Registry after each interview of a potential staff member. All employee documents including the Health Personnel Registry will be scanned and uploaded onto The Enclave's online folder. This will aid the Administrator with the monthly staff audits and act as an added safeguard against lost physical paper documents. The House Supervisor will be trained on the proper procedure.	12/17/ 24 and will be addressed monthly on an ongoing basis.
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family 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 record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (staff B) had no substantiated findings listed on the North Carolina Health Care personnel Registry (HCPR) prior to hire.	C 145	Notes - If there is not a House Supervisor to perform an interview and complete the on-boarding process, the Administrator will assume this duty until a suitable candidate is available. There was an audit done on all staffing files12/17 /24 to ensure that all correct qualifications were up to date. An audit of all staff files will be performed every 90 days. The Administrator will oversee each audit every 90 days.	

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C 145	Continued From page 3 The findings are: Review of Staff B's, Personal Care Aide (PCA), personnel record revealed: -Staff B;s date of hire was 10/21/24. -There was no documentation a HCPR check was completed prior hire. Attempted telephone interview with Staff B on 11/22/24 at 4:50pm was unsuccessful. Telephone interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring HCPR checks were completed for staff prior to hire. -He completed a HCPR check for Staff B and thought the documentation was in her personnel record.	C 145		
C 166	10A NCAC 13G .0503(a) Medication Administration Competency Evaluati 10A NCAC 13G .0503 Medication Administration Competency Evaluation (a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills validation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration;	C 166		

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C 166	Continued From page 4 (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) rules pertaining to medication administration in adult care facilities; and (10)the facility's medication administration policy and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 staff (Staff C) who administered medications had completed the clinical skills validation portion of the competency evaluation prior to administration of medications. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 11/02/24 as a medication aide (MA)/Supervisor-in-Charge (SIC). -There was documentation Staff C passed the medication aide written exam on 12/21/17 and completed the 5 hour medication training on 11/02/24. -There was no documentation a medication administration competency validation clinical skills checklist had been completed.	C 166	Policy : The Enclave shall ensure that a competency evaluation for medication administration consisting of a written examination and a clinical skills validation. The evaluation is to determine competency in the following areas: (1)medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) rules pertaining to medication administration in adult care facilities; and (10) The Enclave medication administration policy and procedures. Procedure: The Enclave will present a written examination on the first day of staff orientation. The staff are to complete the clinical skill validation by the second day of orientation. At the time of hire, the House Supervisor is to check the Medication Aide Registry. To ensure that the potential staff member has passed the NC Medication Aide Test A House Supervisor is to oversee the first week after the skills validation. No staff is to pass medications before they complete their competency evaluation. Notes: An audit of all employee files will be completed by the House Supervisor every 90 days to ensure all staff requirements are met. If there is not a House Supervisor, the Administrator will assume this duty until a suitable candidate is available. The staff member C was terminated before a competency evaluation was completed The new policy went into effect 12/17/24	12/17/24

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C 166	Continued From page 5 Review of a resident's November 2024 electronic medication administration records (eMARs) from 11/01/24 through 11/22/24 revealed Staff C administered medications on 19 days from 11/01/24 through 11/22/24. Interview with Staff C on 11/22/24 revealed: -She administered medications to residents in the facility. -She had medication training when she was hired, but she did not remember if a medication administration competency validation clinical skills checklist had been completed. Telephone interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring staff completed the medication administration competency validation clinical skills checklist. -He knew Staff C did not have her medication administration competency validation clinical skills checklist completed. -He thought MAs had 60 days from the date of hire to have the medication administration competency validation clinical skills checklist checklist completed.	C 166		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing	C 171		

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C 171	Continued From page 6 in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) had a Licensed Health Professional Support (LHPS) competency validation completed prior to performing LHPS tasks of transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that required physical assistance. The findings are: Review of 2 residents' LHPS reviews revealed there was documentation the 2 residents had LHPS tasks of transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that required assistance. Review of 2 residents' care plans revealed they required total assistance with ambulation and transfers. Based on record reviews and interviews, it was determined the 2 residents were not interviewable. 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -Staff A was hired on 10/23/24. -There was no documentation Staff A had a	C 171	To ensure the safety of the residents' and the competency of all staff of The Enclave. All oncoming and existing staff will participate in the mandatory Licensed Health Professional Support Task training. The training will be the appropriate support tasks equal to the residents that reside within the community. Each new and existing staff member will need to complete this training before they can provide care to a resident that has a task that is listed in the Subparagraphs (a) (1) through (a)(28) of the NC Rules and Regulation for Adult Care Licensure . The administrator is responsible for scheduling the licensed health professional. Resident Coordinator will advise the Administrator one week (7 days) before a resident move into the Community that has a personal care task. The Administrator will audit employee files to ensure all staff members have completed the Professional Support Tasks appropriate to the resident. Timeline to implement : 12/17/24 Staff A had completed their Licensed Health Professional Support tasks training 12/17/24 Staff C was terminated before the training	12/17/24

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C 171	Continued From page 7 completed competency validation for LHPS tasks. Interview with Staff A on 11/22/21 at 4:38pm revealed: -She assisted residents with transfers and with ambulation using assistive devices. -She had not been checked off by a nurse for competency validation for LHPS tasks. Refer to the interview with the Administrator on 11/22/24 at 4:55pm. 2. Review of Staff C's, personal care aide (PCA), personnel record revealed: -Staff C was hired on 11/02/24. -There was no documentation Staff C had a completed competency validation for LHPS tasks. Interview with Staff C on 11/22/21 at 4:38pm revealed: -She assisted residents with transfers and with ambulation using assistive devices. -She did not remember if she had been checked off by a nurse for competency validation for LHPS tasks. Refer to the interview with the Administrator on 11/22/24 at 4:55pm. _____ Interview with the Administrator on 11/22/24 at 4:55pm revealed: -He was responsible for ensuring LHPS competency validations were completed for staff. -He knew staff did not have a LHPS competency validation completed for LHPS tasks. -He thought staff had 60 days from hire to have the LHPS competency validation completed.	C 171		

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C 330	Continued From page 8	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) related to an anti-anxiety medication. The findings are: Review of Resident #2's current FL2 dated 09/23/24 revealed: -Diagnoses included dementia with behavior disturbance. -There was an order for lorazepam (used to treat anxiety) 0.5mg as needed no more than 6 times daily. Review of Resident #2's physician's orders dated 10/18/24 revealed an order for lorazepam 0.5mg 2 tablets 3 times daily. Review of Resident #2's After Visit Summary dated 10/30/24 revealed recommendations for a gradual taper of lorazepam 0.5mg 1 tablet 3 times daily for 1 week, 1 tablet twice daily for one week with 1 tablet of 0.5mg as needed, 1 tablet at	C 330	Plan of Correction: The proper medication administration of each resident is the responsibility of the Resident Coordinator. The Resident Coordinator has completed the proper EMAR training to ensure that all medications are administered as per the doctor's orders. All medication aide staff have also completed EMAR training and will administer the medication as ordered. All orders will be checked by the Resident Coordinator before they are placed or submitted on the EMAR. Notifications are sent to the RC with any medications that are missed or late for each resident. Training was completed 11/25/2024. All orders are now faxed to the Community fax line. All the healthcare modalities have been notified of our fax number and also our pharmacies fax number. The prescribers are to fax The Enclave and the contracted pharmacy. Notes: The Resident Coordinator will check the fax daily. This is to ensure all orders are correct. If orders need clarification of any kind, before the order is put in the EMAR or the resident is administered their medication; the resident coordinator will contact the physician within 24 hours to ensure that each resident is receiving the proper medication. Monthly audits of the EMAR and medication cart will be performed in conjunction with the Contracted Pharmacy's Quarterly (90 day) Review. All resident admission and readmissions will need to provide medication orders 24 hours prior to being admitted into The Enclave. The Resident Coordinator will ensure that all medication orders are correct, and if needed can be clarified before the admission or readmission of a resident.	Resident admission / readmission procedure - 11/31/24 Resident orders corrected- 11/31/24

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C 330	Continued From page 9 bedtime for 2 weeks with 1 tablet of 0.5mg as needed. Review of Resident #2's physician's orders dated 11/04/24 revealed: -There was an order to discontinue lorazepam 1mg 3 times daily with a tapered schedule. -The tapered schedule was lorazepam 0.5mg 3 times daily for 7 days, then lorazepam 0.5mg 2 times daily for 7 days, then lorazepam 0.5mg at daily at bedtime for 21 days. Review of Resident #2's electronic medication administration record (eMAR) for November 2024 from 11/01/24 through 11/22/24 revealed: -There was an entry for lorazepam 0.5mg 2 tablets 3 times daily scheduled for administration at 8:00am with a discontinue date of 10/31/24; There was documentation lorazepam was administered on 11/01/24. -There was a second entry for lorazepam 0.5mg 1 tablet 3 times daily for 7 days scheduled for administration at 8:00am, 2:00pm, and 8:00pm; there was no documentation lorazepam was administered 3 times daily for 7 days. -There was a third entry for lorazepam 0.5mg 1 tablet 2 times daily for 7 days scheduled for administration at 8:00am and 8:00pm; there was no documentation lorazepam was administered 2 times daily for 7 days. -There was a fourth entry for lorazepam 0.5mg 1 tablet daily at bedtime scheduled for 8:00pm; there was no documentation lorazepam was administered daily at bedtime. -There was documentation for the bedtime administration that lorazepam was suspended from 11/21/24 through 12/06/24 with documentation: "I will get a discontinue order for this resident. She does not need this." -There was a fifth entry for lorazepam 0.5mg 1	C 330	Notes - A review of resident medication is addressed every week at the Manger weekly meeting.	

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C 330	Continued From page 10 tablet 3 times daily scheduled for administration as needed; there was documentation 1 dose of lorazepam was administered once on 11/03/24 and 11/04/24 and 2 doses were documented as administered on 11/05/24 and 11/06/24. Observation of Resident #2's medications available for administration on 11/22/24 at 12:07pm revealed: -Lorazepam 0.5mg 1 tablet up to 3 times daily as needed was dispensed to the facility on 10/31/24 with a quantity of 90 tablets. -It could not be determined how many tablets of lorazepam were remaining as they were dispensed in a bottle container. -Lorazepam had been dispensed by a non-contracted pharmacy. Interview with a representative from the facility's contracted pharmacy on 11/22/24 at 2:14pm revealed: -Resident #2 had an order dated 10/31/24 for lorazepam 0.5mg 1 tablet 3 times daily as needed; -There was an order dated 11/12/24 for lorazepam 0.5mg 1 tablet 3 times daily for 7 days. -There was an order dated 11/19/24 for lorazepam 0.5mg 1 tablet 2 times daily for 7 days. -There was an order dated 11/26/24 for 1 tablet daily at bedtime. -Lorazepam was profiled by the pharmacy so that it could be entered onto Resident #2's eMAR, but it was not dispensed by the pharmacy. Interview with the Supervisor-in-Charge (SIC) on 11/22/24 at 12:08pm revealed: -Resident #2 was not supposed to be administered lorazepam. -When she administered lorazepam to Resident #2, she slept at the breakfast table and all	C 330		

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C 330	Continued From page 11	C 330		

throughout the day.
-She did not call Resident #2's primary care provider (PCP) to let her know that lorazepam was making Resident #2 drowsy throughout the day and that she was no longer administering the medication.
-She thought the Resident Care Coordinator (RCC) contacted Resident #2's PCP to let her know how Resident #2 was responding to the lorazepam.
-She thought the RCC entered the note on the eMAR to hold Resident #2's lorazepam.

Interview with the RCC on 11/22/24 at 2:39pm revealed:
-She contacted Resident #2's PCP regarding Resident #2 being lethargic after being administered lorazepam when it was first ordered, but she did not remember the date of the contact.
-The PCP wrote an order to taper the lorazepam for Resident #2.
-The MAs held the lorazepam because Resident #2 continued to be lethargic.
-She followed up with Resident #2's PCP but she did not remember when, and she did not get an order to discontinue lorazepam.
-Resident #2's family member was supposed to be getting an order to discontinue the lorazepam.

Interview with Resident #2's PCP on 11/22/24 at 12:10pm revealed:
-She wrote an order for a taper of lorazepam for Resident #2 due to the facility reported that Resident #2 was somnolent with administration.
-She did not know that the facility had stopped administering Resident #2's lorazepam without tapering.
-She expected the facility to follow the tapering schedule as ordered and would have expected the facility to communicate with her regarding not

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	240044	A. BUILDING: _____ B. WING _____	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SHELBURN	16 SHELBURN CT DURHAM, NC 27712

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C 330	Continued From page 12 administering Resident #2's lorazepam. -Discontinuing lorazepam abruptly could have caused Resident #2 to have withdrawals and seizures. Telephone interview with the Administrator on 11/22/24 at 3:13pm revealed: -Resident #2 became lethargic after being administered lorazepam. -MAs should have contacted the RCC who should have contacted Resident #2's PCP for instructions. -He did not know that Resident #2's lorazepam was not being administered according to the taper orders. -He expected Resident #2's medications to be administered as ordered. Based on observations, record reviews, and interviews, it was determined that Resident #2 was not interviewable. Attempted telephone interview with Resident #2's family member on 11/22/24 at 2:24pm was unsuccessful.	C 330		
C 381	10A NCAC 13G .1009(b) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 381	The Resident Coordinator will review all medications, and documentations daily . This is to ensure all orders are correct. If orders need clarification or reviewed of any kind, before the order is put in the EMAR or the resident is administered their medication; the resident coordinator will contact the physician within 24 hours to ensure that each resident is receiving the proper medication. Monthly audits of the EMAR and medication cart will be performed in conjunction with the Contracted Pharmacy's Quarterly (90 day) Review. After a pharmacy review is performed the Resident Coordinator will communicate any recommendations from the Pharmacist to the resident's primary care physician, as soon as possible. The physician must acknowledge the recommendation and sign the recommendation form left by the Pharmacist .	11/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	240044	A. BUILDING: _____ B. WING _____	11/22/2024

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C 381	Continued From page 13 facility failed to ensure action was taken in response to the quarterly pharmacy review recommendation for 1 of 3 sampled residents (#1) related to laboratory tests for sodium levels. The findings are: Review of Resident #1's current FL2 dated 09/30/24 revealed diagnoses included hypernatremia, syncope, anemia, dementia in Alzheimer's disease, and osteoarthritis. Review of Resident #1's pharmacy review dated 11/05/24 revealed: -There was documentation Resident #1 had laboratory testing on 09/19/24 and his sodium level was elevated at 159. (A normal blood sodium level is between 135 and 145 milliequivalents per liter.) -There was documentation Resident #1 had laboratory testing on 09/20/24 and his sodium level was elevated at 156. -There was a recommendation to follow up with Resident #1's sodium level. -There was no documentation Resident #1's primary care provider (PCP) reviewed or responded to the recommendation. Interview with the Resident Care Coordinator (RCC) on 11/22/24 at 2:39pm revealed: -She was responsible for reviewing the residents' quarterly pharmacy reviews and ensuring the residents' PCPs reviewed recommendations for follow-up. -She had not reviewed Resident #1's pharmacy review dated 11/05/24 and had not followed up with Resident #1's PCP regarding the recommendation to follow-up on Resident #1's increased sodium level.	C 381	All resident medication and documentation was reviewed by their health professional on their next visit to ensure compliance Resident 1- 11/25/24	

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C 381	Continued From page 14 Telephone interview with the Administrator on 11/22/24 at 3:13pm revealed: -The RCC was responsible for reviewing the quarterly pharmacy reviews and following up with the provider regarding any recommendations. -He did not know there was a recommendation to follow up regarding Resident #1's sodium level or that Resident #1's primary care provider (PCP) had not been made aware. Attempted telephone interview with a nurse from Resident #1's hospice provider's office on 11/22/24 at 11:42am was unsuccessful.	C 381		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care	C 453		

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	240044	A. BUILDING: _____ B. WING _____	11/22/2024

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C 453	Continued From page 15 planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed and used only with a written order from a physician for 2 of 2 residents (#1 and #3) who had half bed rails. The findings are: Review of the facility's undated physical restraint policy revealed: -The physician must prescribe a physical restraint to a resident. -There would be a written care plan for the use of a physical restraint developed within 1 days of the	C 453	The Enclave does not use physical restraints within the community .	11/31/24

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C 453	Continued From page 16 device being ordered and prior to use on the resident. -The resident would be evaluated every 30 days to validate the use of the restraint. 1. Review of Resident #1's current FL2 dated 09/30/24 revealed: -Diagnoses included hypernatremia, syncope, anemia, dementia in Alzheimer's disease, and osteoarthritis. -There was no documentation regarding orientation. -There was not an order for a bed rail. Review of Resident #1's physician's orders and assessments revealed there was not an order for a bed rail and no assessment for the use of a restraint. Review of Resident #1's care plan dated 10/02/24 revealed: -Resident #1 required total assistance with all activities of daily living. -Resident #1 used a wheelchair and a hoyer lift. -There was no documentation of the use of a bed rail for Resident #1. Observation of Resident #1 on 11/22/24 at various times between 9:30am and 5:15pm revealed: -Resident #1 was lying in a hospital bed in his room. -The hospital bed had 2 half rails attached, one on each side of the bed, which were raised to the up position. -Resident #1 was able to feed himself when the head of his bed was raised. Based on observations, interview, and record review, it was determined Resident #1 was not	C 453	Residents 1 and 3 had their bed rails were removed 11/22/24, with an order from their Hospice	

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	240044	A. BUILDING: _____ B. WING _____	11/22/2024

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C 453	Continued From page 17 interviewable. Interview with a personal care aide (PCA) on 11/22/24 at 10:20am revealed: -Resident #1 needed his bed rails because he tried to get out of bed. -Resident #1 would fall out of bed if he did not have his bed rails. -Resident #1 was able to use his bed rails to assist with care. -Resident #1 was not able to raise or lower the bed rails by himself. -She thought Resident #1 would be able to extricate himself if he became entangled in the bed rails. Attempted telephone interview with a nurse from Resident #1's hospice provider's office on 11/22/24 at 11:42am was unsuccessful. Refer to the interview with a medication aide (MA) on 11/22/24 at 10:21am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/22/24 at 2:39pm. Refer to the interview with the Administrator on 11/22/24 at 3:13pm. 2. Review of Resident #3's current FL2 dated 10/07/24 revealed: -Diagnoses included dementia, osteoarthritis, and spinal stenosis. -Resident #3 was constantly disoriented and semi-ambulatory. -There was not an order for a bed rail. Review of Resident #3's physician's orders and assessments revealed there was not an order for a bed rail and no assessment for the use of a	C 453		

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C 453	Continued From page 18	C 453		

restraint.

Review of Resident #3's care plan dated 10/4/24 revealed:
-Resident #3 required extensive assistance with toileting and total assistance with all other activities of daily living.
-Resident #3 used a wheelchair.
-There was no documentation of the use of a bed rail for Resident #3.

Observation of Resident #3 on 11/22/24 at various times between 9:30am and 5:15pm revealed:
-Resident #3 was lying in a hospital bed in her room.
-The hospital bed had 2 half rails attached, one on each side of the bed, which were raised to the up position.
-Staff were providing feeding assistance to Resident #3.

Based on observations, interview, and record review, it was determined Resident #3 was not interviewable.

Interview with a personal care aide (PCA) on 11/22/24 at 10:20am revealed:
-Resident #3's bed rails were always up unless she was providing personal care.
-Resident #3 was not able to raise or lower the bed rails by herself.
-She thought Resident #3 would be able to extricate herself if she became entangled in the bed rails.
-Resident #3 did not use her bed rail for repositioning or to assist with mobility during care.

Attempted telephone interview with a nurse from Resident #3's hospice provider's office on

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C 453	Continued From page 19 11/22/24 at 11:42am was unsuccessful. Refer to interview with a medication aide (MA) on 11/22/24 at 10:21am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/22/24 at 2:39pm. Refer to the interview with the Administrator on 11/22/24 at 3:13pm. _____ Interview with a MA on 11/22/24 at 10:21am revealed: -The bed rails on the hospital beds had been in place on the residents' hospital beds since she started working at the facility at the beginning of November 2024. -The bed rails were always in the up position on both sides of the hospital beds. -The bed rails were not a restraint. -The residents should have an order for the bed rails. Interview with the RCC on 11/22/241 at 2:29pm revealed: -She assumed that since the bed rails came with the hospital bed for the residents, that they were okay to use. -The residents did not really need the bed rails; they were just in place because they came with the bed. -She did not know that an assessment and physician's orders for the bed rail were needed prior to using. -Neither resident was able to raise or lower the bed rails. -Neither resident moved around in the bed that much. -She thought the residents would be able to free themselves if they became entangled in the	C 453		

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C 453	Continued From page 20 bedrails. Interview with the Administrator on 11/22/24 at 3:13pm revealed: -He thought the bed rails were okay to use on the hospital bed because they came with the bed. -He did not know there should have been an assessment and a physician's order prior to the residents using the bed rails. -The residents usually stayed in one place in the bed and were not able to get out of bed by themselves. -He thought the residents could put the bed rails up and down by themselves and would be able to free themselves if they became entangled in the bed rails.	C 453		