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	HAL050016	A. BUILDING: _____ B. WING _____	01/30/2025

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey 01/28/25 through 01/30/25.	D 000	D273 - All resident records were audited. Any orders discovered were clarified or followed up on per instructions.	2/24/25
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure health care referral and follow up was completed for 2 of 5 sampled residents (#1 and #3) related to a referral for a speech therapy evaluation and notification of choking incidents (#1) and Prothrombin Time/International Normalized Ratio (PT/INR) labs were completed and results faxed to the primary care provider (PCP) (#3). The findings are: 1. Review of Resident #1's current FL2 dated 06/24/24 revealed diagnoses included dementia and gastro-esophageal reflux disease (GERD). Review of Resident #1's Care Plan dated 06/18/24 revealed he needed supervision while eating. a. Review of Resident #1's record revealed there was an order for a speech therapy evaluation dated 10/18/24 due to a choking incident.	D 273	All incident reports are reviewed by Administrator, or her designee and PCP is notified when injuries are present. Staff training on First Aid / CPR conducted. Ensured all labs were completed and PCP notified of results as ordered PCP notified of any missed labs or orders.	1/30/25 and on-going 2/20/25 1/30/25 and on-going

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE COO (X6) DATE 3/5/25

LSB Reviewed and acknowledged 03/06/25

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D 273	Continued From page 1 Review of Resident #1's Incident Report dated 09/16/24 revealed: -Resident #1 choked while eating dinner. -The Heimlich maneuver was performed. -He had no complaints of pain afterwards and continued to eat. -There was documentation the primary care provider's (PCP) reviewed the incident report on 10/12/24. Interview with the Director at the local home health provider on 01/28/25 at 4:36pm revealed: -The facility was responsible for sending the order for speech therapy, along with the resident face sheet, a diagnosis and the PCP visit note. -There was no documentation a referral was ever received for Resident #1 to have a speech therapy evaluation. -If the facility submitted a request for a referral and any required information was missing, they would contact the facility. -There was no documentation they requested information to complete a speech therapy evaluation for Resident #1. Interview with the facility Manager on 01/29/25 at 9:10am revealed: -The Resident Care Coordinator (RCC) was responsible for ensuring referrals were complete. -She was the RCC when the speech therapy referral was made on 10/18/24. -The PCP was responsible for sending the order and all supporting documentation to the home health provider. -About a month after the initial order was written she reminded the PCP to submit the information to home health and then she "just forgot about it". -She failed to have the referral completed because she usually did not file orders in a resident record until the orders were finalized,	D 273	D310 - All dietary staff were re-trained on pureed and easy to chew diets. Prethickened liquids have been purchased for use c meals and med passes. All diets were updated in QuickMAR. List was posted for dietary staff. New list to be posted c any diet changes. Administrator, or her designee will conduct dietary audits until substantial compliance on-going and then monthly.	2/3/25 of 2/7/25 1/30/25 and on-going 2/27/25 and on-going 2/3/25 and

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D 273	Continued From page 2 and because she filed the order in Resident #1's record there was nothing to remind her to follow up. Interview with the PCP on 01/29/25 at 11:49 revealed: -She ordered the speech therapy evaluation after a choking incident. -She did not know there was any problem with the speech therapy order and today (1/29/25) was the first she ever heard that there was a problem obtaining a speech therapy evaluation for Resident #1. -The RCC was responsible for sending orders to the home health provider. -If the RCC needed any supporting documentation to complete the referral she should have asked. -If the speech therapy evaluation was completed whe she initially ordered it, Resident #1 may have ben referred for further testing and continued choking could have been prevented. b.Review of Resident #1's Incident Report dated 01/02/25 revealed: -Resident #1 choked in his room on a chocolate covered peanut candy and was sent to the local emergency department (ED) for evaluation. -There was no documentation the primary care provider (PCP) was notified of the incident and there were no initials to indicate the PCP reviewed the incident report. Interviews with a medication aide (MA) on 01/29/25 at 9:57am and 11:30am revealed: -She responded to the choking incident on 01/02/25. -She performed the Heimlich maneuver on Resident #1 and dislodged a chocolate covered peanut candy.	D 273	D358 - Administrator, or her designee will review MAR's for exceptions and will follow-up as appropriate c pharmacy or provider. weekly. Medication staff were retrained on handling of resident refusals.	2/3/25 and on going 2/6/25

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-She sent Resident #1 to the ED for evaluation.
-Because she sent Resident #1 to the ED and he was receiving medical attention she thought she did not need to contact the PCP.
-Resident #1 choked at least one time a week and if he started turning red in the face and started to pass out she had to perform the Heimlich, which she had to do monthly.
-The Resident Care Coordinator (RCC) was aware of the choking frequency and would have been the person responsible for contacting the PCP

Interview with a second MA on 01/29/25 at 10:28am revealed:
-Resident #1 choked daily.
-Resident #1 choked easily and was known to choke while eating or after swallowing his saliva.
-Sometimes he was able to clear his throat after a choking incident and sometimes staff had to intervene with a "pat on the back" or the use of the Heimlich maneuver.
-The PCP was not contacted after Resident #1 experienced a choking episode unless something "worse " happened such as if he passed out, had to be sent to the hospital or fell out of the dining room chair due to the choking incident.
-She told the facility Manager each time Resident #1 choked.
-She would not contact the PCP; that was the responsibility of the facility Manager or the RCC's responsibility.

Interviews with the facility Manager on 01/29/25 at 9:10am and 10:54am revealed:
-She did not think the PCP needed to be contacted about the choking incident on 01/02/25 because he was sent to the ED.
-The PCP was informed about choking incidents the next time she came to the facility.

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D 273	Continued From page 4 Interview with the Owner on 01/29/25 at 10:54am revealed: -She was a registered nurse (RN). -The facility Manager or RCC was responsible for contacting the PCP about choking incidents. Interview with Resident #1's PCP on 01/29/25 at 11:49am revealed: -She was aware Resident #1 had a history of choking but was not made aware of the frequency. -She expected the facility to send Resident #1 to the ED if he had a choking incident requiring the Heimlich maneuver and then call her or the on-call triage number. -She was informed of the 01/02/25 choking incident when she was at the facility the week of 01/06/25 and she usually documented she reviewed the incident report by signing her initials. c. Review of Resident #1's Incident Report dated 01/24/25 revealed: -Resident #1 choked at the dinner table. -Resident was "assisted" by staff and continued to eat. -There was no documentation the Heimlich maneuver was performed. -There was documentation the primary care provider (PCP) was notified on 01/27/25 of the incident but no time was documented. -There were no initials to indicate the PCP reviewed the incident report. Interview with a personal care aide (PCA) on 01/28/25 at 5:20pm revealed: -She responded to Resident #1's choking incident on 01/24/25. -Resident #1 choked on mashed potatoes with gravy, and she had to perform the Heimlich	D 273		

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maneuver to dislodge it.
-He choked easily, even when drinking water.
-The medication aide (MA) was responsible for contacting the PCP.

Interview with a medication aide (MA) on 01/29/25 at 3:33pm revealed:
-She completed Resident #1's incident report dated 01/24/25.
-It was reported to her that the PCA had to do abdominal thrusts and was able to dislodge the food.
-Resident #1 coughed "all the time" while eating.

Interview with the PCP on 01/29/25 at 11:49am revealed:
-She was not aware Resident #1 choked weekly.
-She was not aware of a choking incident requiring the Heimlich maneuver on 01/24/25.
-She expected the facility to send Resident #1 to the ED if he had a choking incident requiring the Heimlich maneuver.

Interview with the facility Manager on 01/29/25 at 9:10am and 10:54am revealed she reviewed Resident #1's 01/24/25 incident report on 01/28/25 and put it in the folder for the PCP to review the next time she came to the facility.

Interview with the Owner on 01/29/25 at 10:54am revealed:
-She was a registered nurse (RN).
-If a resident was having trouble swallowing and became "strangled" or coughed she would not expect an incident report to be completed but she would expect the PCP to be informed.

Based on observations, interviews, and record review it was determined Resident #1 was his own responsible person and was not

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D 273	Continued From page 6 interviewable. 2. Review of Resident #3's current FL2 dated 01/25/25 revealed diagnoses included chronic atrial fibrillation, essential hypertension, occlusion and stenosis of carotid artery, chronic kidney disease stage 3, abdominal aortic aneurysm, and unspecified dementia. a. Review of Resident #3's physician order dated 11/01/24 revealed: -Start warfarin 2mg daily (used as a blood thinner). -Check Prothrombin Time/International Normalized Ratio (PT/INR is a blood test used to assess the clotting ability of the blood) Monday (11/04/25) with home health and then on Mondays and Thursdays results faxed to physician. Review of Resident #3's record revealed there were no PT/INR tests completed on 11/07/24 (Thursday), 11/11/24 (Monday), 11/14/24 (Thursday), 11/18/24 (Monday), 11/21/24 (Thursday), and 11/25/24 (Monday). Review of Resident #3's physician's order dated 11/25/24 revealed PT/INR ordered through a medical laboratory service. Review of Resident #3's PT/INR result dated 11/28/24 revealed: -The PT was 14.6. -The INR was 1.31. Review of Resident #3's primary care provider (PCP) teletriage note dated 12/09/24 revealed: -Warfarin refill requested. -"What was the most recent PT/INR?" -A prescription for a 30-day emergency supply of	D 273		

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D 273	Continued From page 7 warfarin was sent to the facility's contracted pharmacy. Review of Resident #3's PT/INR result dated 12/13/24 revealed: -The PT was 12.2. -The INR was 1.10. Review of Resident #3's record revealed there were results for completed blood counts (a blood test that analyzes the number and characteristics of blood cells to assess overall health and identify a range of conditions) on 12/20/24 and 12/24/24 but there were no results for PT/INRs. Review of Resident #3's physician order dated 01/06/25 revealed: -Discontinue weekly complete blood counts. -Start weekly INR (sent to local laboratory service). Review of Resident #3's PT/INR result dated 01/10/25 revealed: -The PT was 13.9. -The INR was 1.25. Review of Resident #3's physician order dated 01/12/25 revealed: -There was an order for warfarin 2mg on Mondays, Wednesdays, and Fridays. -There was an order for warfarin 1mg on Tuesdays, Thursdays, Saturdays, and Sundays. -PT/INR in one week on 01/21/25. Review of Resident #3's record revealed there was no PT/INR test completed on 01/21/25. Review of Resident #3's record revealed there were results for completed blood counts on 01/16/25 and 01/23/25.	D 273		

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D 273	Continued From page 8 Review of Resident #3's physician order dated 01/27/25 revealed: -There was an order for warfarin 2mg one tablet daily on Monday, Wednesday, Friday, and Sunday -There was an order for warfarin 1mg once daily on Tuesday, Thursday, and Saturday. Review of Resident #3's PT/INR result dated 01/28/25 revealed: -The PT was 13.3. -The INR was 1.19. Telephone interview with Resident #3's physician on 01/29/25 at 11:33am revealed: -She ordered PT/INR's lab tests for Resident #3 and they "did not happen." -It was difficult to manage warfarin at a therapeutic level without PT/INR results. -Resident #3 was at an increased risk for stroke when the INR level was less than 2-3. -Resident #3 was at risk of gastrointestinal bleeding with warfarin administration and INR levels not being monitored to ensure the INR was not over 3. -She recently ordered PT/INR's to be completed weekly and they had not been completed "consistently." -She sent orders directly to a lab service on three separate occasions and the orders had not been completed. -She had been on leave from 12/16/24 to 01/04/25. -She spoke with the facility Manager when she returned from leave at the beginning of January 2025 and made the facility Manager aware the PT/INRs were not being completed. -She ordered a PT/INR for the week after 01/09/25 and it did not get completed.	D 273		

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D 273	Continued From page 9 -The facility Manager told her she was speaking with the laboratory service personnel about why they were still obtaining complete blood count labs and not PT/INRs. -The lab service was the only resource the facility had to collect laboratory tests for residents. Telephone interview with Resident #3's laboratory service on 01/30/25 at 10:02am revealed: -They had a preexisting order for weekly complete blood counts for Resident #3 prior to 11/04/24. -She did not see that they had received the order on 11/04/24 for PT/INRs. -They received an order on 01/21/25 to discontinue the weekly complete blood counts and do weekly PT/INRs instead. -The lab service was local and available to come into the facility on Mondays, Wednesdays, and Fridays. Interview with the facility Manager on 01/29/25 at 2:58pm revealed: -She was new to her position and had been the facility Manager "about two months." -Resident #3's physician sent orders to a lab service to collect PT/INRs for Resident #3 prior to 12/16/24. -Since the physician had arranged for the PT/INRs to be completed by the lab service, she did not feel the need to follow-up to ensure Resident #3's PT/INRs were completed. -The lab service automatically sent laboratory results to the physician. -She did not know warfarin had to be closely monitored with the PT/INR blood test. -She had no prior experience with warfarin management. -She was "oblivious" to all the steps she needed to take to monitor warfarin.	D 273		

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D 273	Continued From page 10 -She had access to Resident #3's triage service to communicate with a primary care provider (PCP) about missed labs, obtain new lab orders, discontinue lab orders, or to seek assistance with problems with the lab service. -She did not communicate the continuing missed PT/INR labs to Resident #3's physician or triage service after she learned from Resident #3's physician at the beginning of January the importance to obtain PT/INR's weekly. Interview with the Administrator on 01/30/25 at 10:47am revealed: -Warfarin tracking should have been initiated on 11/01/24 by the facility Manager. -The facility Manager was new to her position and had not been trained on warfarin tracking when the issues with Resident #3's PT/INR labs arose. -The facility policy was to track the PT/INR ordered lab dates, the PT/INR level results, and the warfarin dose changes on the warfarin tracking form. -The PT/INR labs should be completed as ordered. -The staff should have reached out to the physician with problems obtaining the PT/INR labs. Based on observations, interviews, and record review it was determined Resident #3 was not interviewable. b. Review of Resident #3's physician order dated 11/01/24 revealed start warfarin (used to prevent blood clots) 2mg daily. Review of Resident #3's primary care provider (PCP) order dated 12/09/24 revealed warfarin 2mg one tablet daily.	D 273		

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D 273	Continued From page 11 Review of Resident #3's physician order dated 01/12/25 revealed: -There was an order for warfarin 2mg once daily on Monday, Wednesday, and Friday. -There was an order for warfarin 1mg once daily on Tuesday, Thursday, Saturday, and Sunday. Review of Resident #3's physician order dated 01/27/25 revealed: -There was an order for warfarin 2mg once daily on Monday, Wednesday, Friday, and Sunday. -There was an order for warfarin 1mg once daily on Tuesday, Thursday, and Saturday. Review of Resident #3's December 2024 eMAR revealed: -There was an entry for warfarin 2mg daily scheduled at 8:00am. -The warfarin 2mg was documented as administered 28 occurrences out of 31 opportunities from 12/01/24-12/31/24. -On 12/08/24, 12/09/24, and 12/10/24, the warfarin was documented as not administered due to awaiting pharmacy delivery. Review of Resident #3's January 2024 eMAR revealed: -There was an entry for warfarin 2mg daily scheduled at 8:00am with a date written of 12/09/24 and stop date of 01/13/25. -The warfarin 2mg was documented as administered 9 occurrences out of 13 opportunities from 01/01/25 to 01/13/25. -On 01/10/25, 01/11/25, 01/12/25, and 01/13/25, the warfarin was documented as not administered due to awaiting pharmacy delivery. -There was an entry for warfarin 2mg one tablet on Monday, Wednesday, and Friday scheduled at 8:00am with a date of 01/13/25 and stop date of 01/21/25.	D 273		

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D 273	Continued From page 12 -The warfarin 2mg one tablet on Monday, Wednesday, and Friday was documented as administered 2 occurrences out of 3 opportunities. -On 01/15/25, the warfarin 2mg was documented as not administered due to awaiting pharmacy delivery. -There was an entry for warfarin 2mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled at 8:00am with a date of 01/21/25. -The warfarin 2mg one tablet daily on Monday, Wednesday, Friday, and Sunday was documented as administered 3 occurrences out of 4 opportunities from 01/22/25 to 01/28/25. -On 01/22/25, the warfarin was documented as not administered with no reason documented. -There was an entry for warfarin 1mg one tablet on Tuesday, Thursday, Saturday, and Sunday scheduled at 8:00am with a date of 01/13/25 and a stop date of 01/21/25. -The warfarin 1mg one tablet on Tuesday, Thursday, Saturday, and Sunday was documented as administered 3 occurrences out of 6 opportunities from 01/14/25 to 01/23/25. -On 01/14/25, 01/16/25, and 01/23/25, the warfarin was documented as not administered due to awaiting pharmacy delivery. -There was an entry for warfarin 1mg once daily on Tuesday, Thursday, and Saturday scheduled at 8:00am with a date of 01/21/25. -The warfarin 1mg one tablet on Tuesday, Thursday, and Saturday was documented as administered as ordered for 2 occurrences out of 2 opportunities. Observation of Resident #3's available medications on 01/29/25 at 11:10am revealed: -There was one bubble pack of warfarin 2mg tablets with label directions for one tablet on	D 273		

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Mondays, Wednesdays, and Fridays with a dispense date of 01/13/25.
-There was one bubble pack of warfarin 1mg tablets with label directions for one tablet on Tuesday, Thursday, Saturday, and Sunday with a dispense date of 01/13/25.

Telephone interview with a representative from the facility's contracted pharmacy on 01/29/25 at 9:50am revealed:
-The pharmacy dispensed 30 tablets of warfarin 2mg one tablet daily on 11/04/24 and 12/09/24.
-There were no refills on the warfarin prescriptions dated 11/04/24 and 12/09/24.
-The pharmacy dispensed 12 tablets of warfarin 2mg one tablet on Monday, Wednesday, and Friday on 01/13/25.
-The pharmacy dispensed 16 tablets of warfarin 1mg one tablet on Tuesday, Thursday, Saturday, and Sunday on 01/13/25.
-The pharmacy dispensed 16 tablets of warfarin 2mg one tablet on Monday, Wednesday, Friday, and Sunday on 01/28/25.
-The pharmacy dispensed 12 tablets of warfarin 1mg one tablet on Tuesday, Thursday, and Saturday on 01/28/25.

Interview with a medication aide (MA) on 01/29/25 at 11:15am revealed:
-On 01/13/25, 01/14/25, and on 01/23/25, she documented she did not administer Resident #3's warfarin due to awaiting pharmacy delivery.
-She did not administer the warfarin because there was no warfarin available to administer.
-If an order was needed to refill a medication, she would notify the Resident Care Coordinator and the facility Manager to let them know the medication required an order for the pharmacy to refill it.
-The RCC and facility Manager were responsible

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for communicating with Prescribers to obtain orders.
-The RCC and facility Manager were responsible for communication missed doses of medications to Prescribers.

Interview with a second MA on 01/29/25 at 3:40pm revealed:
-She documented waiting on pharmacy to delivery when a medication displayed as reordered in the eMAR history but was not available to administer.
-She notified the facility Manager when a medication was not available to administer.
-It was the responsibility of the RCC and the facility Manager to check on reordered medications which had not arrived from the pharmacy.

Telephone interview with Resident #3's PCP on 01/29/25 at 11:33am revealed:
-Resident #3 was ordered warfarin to treat atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).
-The warfarin was ordered to prevent blood clots which could form due to atrial fibrillation.
-Resident #3's therapeutic INR range was 2-3.
-She was not aware Resident #3 had missed three doses of warfarin in December 2024 and 10 doses of warfarin in January 2025.
-The missed doses of warfarin explained why Resident #3's PT/INR's were "not coming up" to a therapeutic level.
-Missed doses of warfarin meant Resident #3 was at an increased risk of stroke.

Interview with the RCC on 01/30/25 at 8:30am revealed:
-He became the RCC at the facility on 01/06/25.
-The MAs did not let him know Resident #3's

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D 273	Continued From page 15 warfarin was not available to administer. -The MAs "probably" reported to the facility Manager the warfarin was not available to administer. -He did not report the missed doses of warfarin to Resident #3's PCP. Interview with the facility Manager on 01/29/25 at 2:58pm revealed: -She became aware Resident #3 was out of warfarin on 12/09/24 and needed an order to refill it. -She contacted the PCP's triage service for an emergency refill of the warfarin on 12/09/24. -She had not understood at the time the "seriousness" of not having the warfarin for Resident #3. -The RCC was responsible for notifying Resident #3's PCP of the missed doses of warfarin. -She did not let the PCP know Resident #3 missed three doses of warfarin in December and missed 10 doses of warfarin in January. Interview with the Administrator on 01/30/25 at 10:47am revealed: -Resident #3 should have received the warfarin as it was ordered. -Warfarin tracking should have been initiated on 11/01/24 by the facility Manager. -The facility Manager was new to her position and had not been trained on warfarin tracking. Based on observations, interviews, and record review it was determined Resident #3 was not interviewable. _____ The facility failed to ensure a speech therapy evaluation was completed on a resident who choked frequently and required the Heimlich maneuver, and failed to notify the PCP about the	D 273		

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D 273	Continued From page 16 frequency of choking episodes (Resident #1) and failed to ensure PT/INR labs were completed and failed to inform the PCP warfarin was unavailable for administration (Resident #3). These failures put Resident #1 at risk of aspiration due to another choking episode and put Resident #3 at increased risk of a stroke and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 28, 2025. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 01, 2025.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to serve therapeutic diets as ordered to 2 of 5 sampled residents (#1, #4) related to a pureed diet (#1 & #4) and nectar thickened liquids (#4). The findings are: 1.Review of Resident #1's current FL2 dated	D 310		

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D 310	Continued From page 17 06/24/24 revealed diagnoses included dementia and gastro-esophageal reflux disease (GERD). Review of Resident #1's record revealed there was an order for a pureed diet dated 10/18/24. Review of the resident diet orders posted in the kitchen revealed Resident #1 was documented as receiving a pureed diet. Review of the facility's lunch menu for 01/28/25 revealed the meal consisted of beef chopped steak, buttered noodles, cooked carrots, a dinner roll, and vanilla pudding. Review of the facility's puree menu for 01/28/25 revealed all items on the regular menu should be served but would be pureed. Observation of Resident #1's lunch meal service on 01/28/25 revealed: -The meal was served in a small dining room, separate from the main dining room. -There was one or two staff in the dining room at all times. -Resident #1 was served beef steak, egg noodles, carrots and pudding. -Resident #1 did not receive a dinner roll. -The beef steak and the egg noodles were pureed together. -The pureed steak and noodles were thick enough to be eaten with a fork; not a creamy pureed consistency. -The carrots were very soft and appeared to be mashed well but did not have the appearance of being pureed in a food processor. -Resident #1 was served tea, water and milk with his meal. -Resident #1 ate 100% of his meal.	D 310		

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D 310	Continued From page 18 Interview with a personal care aide (PCA) on 01/28/25 at 1:10pm and 5:20pm revealed: -Resident #1's food was usually soft and pureed but he still choked frequently. -The pureed food was normally thick but still easy to chew. -She had to perform the Heimlich maneuver on Resident on 01/24/25 in the evening because he was eating too fast and choked on mashed potatoes. Interview with a medication aide (MA) on 01/29/25 at 9:57am revealed: -The puree food was usually thick, depending upon which cook prepared it. -Sometimes the puree food was dry and needed fluid added to it. -Resident #1 was never left alone during mealtimes because he choked frequently. Interview with the facility Manager on 01/28/25 at 1:32pm and 01/29/25 at 9:10am revealed: -She was in training to be the Administrator. -The Dietary Coordinator (DC) was responsible for ensuring the therapeutic diet menus were followed and pureed foods were fixed properly. -The Business Office Manager (BOM) was training the DC on all aspects of the kitchen because she had previously worked in the kitchen. -Resident #1 was on a pureed diet because he ate very fast and crammed too much food in his mouth. Telephone interview with Resident #1's primary care provider (PCP) on 01/29/25 at 11:49am revealed: -Resident #1 was ordered a pureed diet because he has a history of choking due to cramming too much food in his mouth at one time before he	D 310		

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D 310	Continued From page 19 attempts to swallow. -Pureed food should be smooth and creamy like mashed potatoes or pudding, not thick enough to eat with a fork. -Resident #1 choked, needed the Heimlich maneuver, and aspirated on 01/02/25 and was admitted to the hospital with aspiration pneumonia where a computed tomography (CT) exam identified a possible narrowing of the esophagus which could cause him to choke easily. -Being served thick pureed food may cause Resident #1 to choke and aspirate again. Interview with a cook on 01/28/25 at 1:00pm revealed: -He pureed the food items served for lunch. -He did not know pureed food should be creamy and not thick. -He mashed the carrots with a fork because they were very soft. -He did not know all pureed food should be prepared in a food processor. -He mixed the beef and noodles together because he did not know they should be served separately. -He did not prepare a pureed dinner roll but sometimes he used bread to thicken meats. -He thought he knew how to puree food so he did not look at the recipes to see how pureed food should be prepared. -He had worked at the facility on and off for 10 years and was trained how to prepare pureed food when he was first hired. -He did not remember anyone doing a formal class on how to prepare pureed food, just to put everything in the food processor but he did not remember much else. -Pureed diets had not been served at the facility for a long time until just recently when two	D 310		

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D 310	Continued From page 20 residents were ordered pureed diets. Interview with the DC on 01/28/25 at 9:50am and 1:00pm revealed: -She had worked at the facility as a dietary aide off and on for years but just recently started as the DC a few months ago. -She did not know to refer to the therapeutic menu to prepare pureed foods. -She and the cook pureed the food on the regular menu. -Sometimes bread was used to get the pureed food to the correct consistency. -She had prior knowledge about preparing therapeutic diets but had not received any training on since she returned to the facility. -Residents who received a pureed diet were served in the small dining room that had more supervision so they could be monitored closely. Interview with the BOM on 01/29/25 at 9:40am revealed: -She was responsible for some of the training of the DC. -Since the DC worked at the facility previously and had experience from other facilities she did not do any training related to menu reading or consistency preparation. 2. Review of Resident #4's current FL2 dated 02/07/24 revealed diagnoses included traumatic subdural hematoma of brain, aphasia, dysarthria, dementia without behaviors, acute respiratory without hypoxia, hemiplegia, right sided weakness, cardiovascular disease, and hearing loss. Review of Resident #4's physician's order dated 12/13/24 revealed regular pureed diet with nectar thickened liquids.	D 310		

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D 310	Continued From page 21 Review of the resident diet orders posted in the kitchen revealed Resident #4 was documented as receiving a pureed diet with nectar thickened liquids. Review of the facility's lunch menu for 01/28/25 revealed the meal consisted of beef chopped steak, buttered noodles, cooked carrots, a dinner roll, and vanilla pudding. Review of the facility's puree menu for 01/28/25 revealed all items on the regular menu should be served but would be pureed. Observation of the 12:00pm medication pass on 01/28/25 at 12:21pm revealed: -Resident #4 was administered four oral medications that were crushed and added into small amount chocolate pudding by a medication aide (MA). -As Resident #4 swallowed the pudding with the crushed medications, she coughed and then sneezed. -The MA put a small cup of unthickened water to Resident #4's lips and asked her to take a sip. -Resident #4 took a small sip of the unthickened water and coughed again. Interview with the MA on 01/28/25 at 12:23pm revealed: -Resident #4 was only supposed to receive nectar-thickened liquids. -She routinely gave Resident #4 "a little bit" of regular water with her medications. -The nurse who trained her told her she could give Resident #4 a little unthickened water when she administered medications to Resident #4. -Resident #4 did not usually have any trouble swallowing crushed medications if the	D 310		

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D 310	Continued From page 22 medications were in pudding. Observation of Resident #4's beverages on 01/28/25 at 12:30pm revealed: -They were on the serving tray in the kitchen ready to be delivered to the dining room. -Resident #4's water and tea were in 6 ounce cups. -They appeared to be slightly thickened but not nectar consistency. Review of the facility's beverage thickener revealed: -The thickener was dispensed in individual packets. -The directions on the packet instructed to use one packet for every four ounces of liquid to achieve nectar thickened consistency. Interview with the Dietary Coordinator (DC) on 01/28/25 at 12:30pm revealed: -She used one packet of thickener to thicken one glass of liquid. -She poured too much liquid in the glass and should have used more thickener to get it to nectar thickened. -She had been thickening liquids for many years and had been trained how to thicken liquids properly. -The surveyor requested Resident #4's liquids be thickened to the proper consistency before taking them to the dining room. Observation of Resident #2's lunch meal service on 01/28/25 at 12:43pm revealed: -The meal was served in a small dining room, separate from the main dining room. -There was one or two staff in the dining room at all times. -Resident #4 was served beef steak, egg	D 310		

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noodles, carrots and pudding.
-Resident #4 did not receive a dinner roll.
-The beef steak and the egg noodles were pureed together.
-The pureed steak and noodles were thick enough to be eaten with a fork; not a creamy pureed consistency.
-The carrots were very soft and appeared to be mashed well but did not have the appearance of being pureed in a food processor.
-Resident #4 was served nectar thick tea, nectar thick water and a pre-thickened nutritional supplement.

Review of the facility's lunch menu for 01/28/25 revealed the meal consisted of beef chopped steak, buttered noodles, cooked carrots, a dinner roll, and vanilla pudding.

Review of the facility's puree menu for 01/28/25 revealed all items on the regular menu should be served but would be pureed.

Observation of Resident #2's dinner meal service on 01/28/25 at 5:45pm revealed:
-The meal was served in a small dining room, separate from the main dining room.
-There was one or two staff in the dining room at all times.
-Resident #4 was served ice cream for dessert.

Review of the supper meal menu for 01/28/25 revealed the puree menu should receive pureed fruit for dessert.

Interview with a cook on 01/28/25 at 1:00pm revealed:
-He pureed the food items served for lunch.
-He did not know pureed food should be creamy and not thick.

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D 310	Continued From page 24 -He mashed the carrots with a fork because they were very soft. -He did not know all pureed food should be prepared in a food processor. -He mixed the beef and noodles together because he did not know they should be served separately. -He did not prepare a pureed dinner roll but sometimes he used bread to thicken meats. -He thought he knew how to puree food so he did not look at the recipes to see how pureed food should be prepared. -He had worked at the facility on and off for 10 years and was trained how to prepare pureed food when he was first hired. -He did not remember anyone doing a formal class on how to prepare pureed food, just to put everything in the food processor but he did not remember much else. -Pureed diets had not been served at the facility for a long time until just recently when two residents were ordered pureed diets. Interview with the DC on 01/28/25 at 9:50am and 1:00pm and 01/29/25 at 8:30am revealed: -She had worked at the facility as a dietary aide off and on for years but just recently started as the DC a few months ago. -She did not know to refer to the therapeutic menu to prepare pureed foods. -She and the cook pureed the food on the regular menu. -Sometimes bread was used to get the pureed food to the correct consistency. -She had prior knowledge about preparing therapeutic diets but had not received any training on since she returned to the facility. -Residents who received a pureed diet were served in the small dining room that had more supervision so they could be monitored closely.	D 310		

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D 310	Continued From page 25 -The BOM had helped train her on ordering foods but not on menu reading or food consistencies. -She knew that a resident who received thickened liquids should not be served ice cream because it melted in the mouth and became a thin liquid. -She made the decision the previous evening to substitute ice cream for the fruit because they did not have enough bowls for fruit. -She did not think about looking at the menu or think about thickened liquids because she was stressed. -She could not remember if she told the dietary aide to puree fruit for Resident #4. Interview with the dietary aide on 01/28/25 at 5:57pm revealed: -He served ice cream in individual frozen containers instead of the fruit that was on the menu because the kitchen did not have enough fruit bowls to serve pureed fruit. -The DC made the decision to substitute ice cream for the pureed fruit. -He did not know that a resident who received thickened liquids should not be served ice cream because it melted in the mouth and became a thin liquid. -He thought thickened liquids only applied to beverages and did not know that it applied to some foods. -He had worked at the facility most recently for the past 3-4 months. -He was trained on diet consistencies when he worked at the facility 5 or 6 years ago. -He had not received any training since he returned to the facility. Interview with a personal care aide (PCA) on 01/28/25 at 1:10pm and 5:20pm revealed: -Resident #4's food was usually soft and pureed and liquids were thickened in the kitchen.	D 310		

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D 310	Continued From page 26 -The pureed food was normally thick but still easy to chew. Interview with a medication aide (MA) on 01/29/25 at 9:57am revealed: -The puree food was usually thick, depending upon which cook prepared it. -Sometimes the puree food was dry and needed fluid added to it. Interview with the facility Manager on 01/28/25 at 1:32pm and 01/29/25 at 9:10am revealed: -She was in training to be the Administrator. -The DC was responsible for ensuring the therapeutic diet menus were followed and pureed foods were fixed properly. -The Business Office Manager (BOM) was training the DC on all aspects of the kitchen because she had previously worked in the kitchen. -Resident #1 was on a pureed diet because he ate very fast and crammed too much food in his mouth. Interview with the BOM on 01/29/25 at 9:40am revealed: -She was responsible for some of the training of the DC. -Since the DC worked at the facility previously and had experience from other facilities she did not do any training related to menu reading or consistency preparation. Telephone interview with Resident #4's primary care provider (PCP) on 01/29/25 at 11:49am revealed: -Resident #4 was ordered a puree diet with nectar thickened liquids due to coughing and choking at meals. -Resident #4 had a stroke causing dysphagia	D 310		

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D 310	Continued From page 27 (difficulty swallowing). -Resident #4 was at risk for aspiration of liquids into her lungs when she did not receive nectar thickened liquids. -Pureed food should be smooth and creamy like mashed potatoes or pudding, not thick enough to eat with a fork. -Being served thick pureed food may cause Resident #4 to choke. Interview with the facility Manager on 01/28/25 at 12:52pm revealed: -Resident #4 should receive her medications crushed and mixed in pudding. -Resident #4's medications should be crushed smooth and placed in pudding. -The MAs should just give the medications in the pudding and not give anything to drink afterwards. -All of the staff knew Resident #4 was supposed to receive nectar thickened liquids. Interview with the Administrator on 01/30/25 at 10:47am revealed: -The MAs should crush Resident #4's medications to a fine powder and mix the medications in pudding or applesauce. -The MAs should give nectar thick liquids to Resident #4 with her medications if she needed something to drink after receiving the crushed medications in pudding. _____ The facility failed to ensure a pureed diet was served to Resident #1 who had a history of multiple choking episodes and needing the Heimlich maneuver and failed to serve a pureed diet with nectar thickened liquids to Resident #4 who had dysphagia due to a stroke and coughed after receiving unthickened liquids with her medications. This failure put Resident #1 at substantial risk of aspirating due to a history of	D 310		

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D 310	Continued From page 28 multiple choking episode and put Resident #4 at substantial risk of aspiration and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 28, 2025. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 01, 2025.	D 310		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1 and #3) related to a medication used to treat infection (#1) and a medication used to prevent blood clots (#3). The findings are: Review of the facility's medication administration	D 358		

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policy and procedure manual dated 2019 revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders.

1. Review of Resident #3's current FL2 dated 01/25/25 revealed diagnoses included chronic atrial fibrillation, essential hypertension, occlusion and stenosis of carotid artery, chronic kidney disease stage 3, abdominal aortic aneurysm, and unspecified dementia.

Review of Resident #3's physician order dated 11/01/24 revealed start warfarin (used to prevent blood clots) 2mg daily.

Review of Resident #3's primary care provider (PCP) order dated 12/09/24 revealed warfarin 2mg one tablet daily.

Review of Resident #3's physician order dated 01/12/25 revealed:
-There was an order for warfarin 2mg once daily on Monday, Wednesday, and Friday.
-There was an order for warfarin 1mg once daily on Tuesday, Thursday, Saturday, and Sunday.

Review of Resident #3's physician order dated 01/27/25 revealed:
-There was an order for warfarin 2mg once daily on Monday, Wednesday, Friday, and Sunday.
-There was an order for warfarin 1mg once daily on Tuesday, Thursday, and Saturday.

Review of Resident #3's December 2024 eMAR revealed:
-There was an entry for warfarin 2mg daily scheduled at 8:00am.
-The warfarin 2mg was documented as

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administered 28 occurrences out of 31 opportunities from 12/01/24-12/31/24.
-On 12/08/24, 12/09/24, and 12/10/24, the warfarin was documented as not administered due to awaiting pharmacy delivery.

Review of Resident #3's January 2024 eMAR revealed:
-There was an entry for warfarin 2mg daily scheduled at 8:00am with a date written of 12/09/24 and stop date of 01/13/25.
-The warfarin 2mg was documented as administered 9 occurrences out of 13 opportunities from 01/01/25 to 01/13/25.
-On 01/10/25, 01/11/25, 01/12/25, and 01/13/25, the warfarin was documented as not administered due to awaiting pharmacy delivery.
-There was an entry for warfarin 2mg one tablet on Monday, Wednesday, and Friday scheduled at 8:00am with a date of 01/13/25 and stop date of 01/21/25.
-The warfarin 2mg one tablet on Monday, Wednesday, and Friday was documented as administered 2 occurrences out of 3 opportunities.
-On 01/15/25, the warfarin 2mg was documented as not administered due to awaiting pharmacy delivery.
-There was an entry for warfarin 2mg one tablet daily on Monday, Wednesday, Friday, and Sunday scheduled at 8:00am with a date of 01/21/25.
-The warfarin 2mg one tablet daily on Monday, Wednesday, Friday, and Sunday was documented as administered 3 occurrences out of 4 opportunities from 01/22/25 to 01/28/25.
-On 01/22/25, the warfarin was documented as not administered with no reason documented.
-There was an entry for warfarin 1mg one tablet on Tuesday, Thursday, Saturday, and Sunday

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D 358	Continued From page 31 scheduled at 8:00am with a date of 01/13/25 and a stop date of 01/21/25. -The warfarin 1mg one tablet on Tuesday, Thursday, Saturday, and Sunday was documented as administered 3 occurrences out of 6 opportunities from 01/14/25 to 01/23/25. -On 01/14/25, 01/16/25, and 01/23/25, the warfarin was documented as not administered due to awaiting pharmacy delivery. -There was an entry for warfarin 1mg once daily on Tuesday, Thursday, and Saturday scheduled at 8:00am with a date of 01/21/25. -The warfarin 1mg one tablet on Tuesday, Thursday, and Saturday was documented as administered as ordered for 2 occurrences out of 2 opportunities. Observation of Resident #3's available medications on 01/29/25 at 11:10am revealed: -There was one bubble pack of warfarin 2mg tablets with label directions for one tablet on Mondays, Wednesdays, and Fridays with a dispense date of 01/13/25. -There was one bubble pack of warfarin 1mg tablets with label directions for one tablet on Tuesday, Thursday, Saturday, and Sunday with a dispense date of 01/13/25. Telephone interview with a representative from the facility's contracted pharmacy on 01/29/25 at 9:50am revealed: -The pharmacy dispensed 30 tablets of warfarin 2mg one tablet daily on 11/04/24 and 12/09/24. -There were no refills on the warfarin prescriptions dated 11/04/24 and 12/09/24. -The pharmacy dispensed 12 tablets of warfarin 2mg one tablet on Monday, Wednesday, and Friday on 01/13/25. -The pharmacy dispensed 16 tablets of warfarin 1mg one tablet on Tuesday, Thursday, Saturday,	D 358		

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D 358	Continued From page 32 and Sunday on 01/13/25. -The pharmacy dispensed 16 tablets of warfarin 2mg one tablet on Monday, Wednesday, Friday, and Sunday on 01/28/25. -The pharmacy dispensed 12 tablets of warfarin 1mg one tablet on Tuesday, Thursday, and Saturday on 01/28/25. Interview with a medication aide (MA) on 01/29/25 at 11:15am revealed: -On 01/13/25, 01/14/25, and on 01/23/25, she documented she did not administer Resident #3's warfarin due to awaiting pharmacy delivery. -She did not administer the warfarin because there was no warfarin available to administer. -When a medication was not available to administer, she would check the eMAR reorder history to display the last date the medication was demanded from the pharmacy. -If the medication had not been reordered, she would reorder it. -If the history showed the medication had already been demanded from the pharmacy, she would ask the Resident Care Coordinator (RCC) and the facility Manager when the medication was supposed to arrive. -If an order was needed to refill a medication, she would notify the Resident Care Coordinator and the facility Manager to let them know the medication required an order for the pharmacy to refill it. -The RCC and facility Manager were responsible for communicating with Prescribers to obtain orders. -The RCC and facility Manager were responsible for communication missed doses of medications to Prescribers. -She did not know how long it took for medications to arrive from the facility's contracted pharmacy.	D 358		

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D 358	Continued From page 33 -She had never had to use the backup pharmacy so she did not know what the process was to obtain medications from the backup pharmacy. Interview with a second MA on 01/29/25 at 3:40pm revealed: -She documented waiting on pharmacy to delivery when a medication displayed as reordered in the eMAR history but was not available to administer. -She would check the eMAR to see if the medication was flagged which meant the RCC or facility Manager needed to approve the medication in the eMAR. -If the medication was not approved, it meant they were still waiting on the medication to be delivered from the pharmacy. -She notified the facility Manager when a medication was not available to administer. -It was the responsibility of the RCC and the facility Manager to check on reordered medications which had not arrived from the pharmacy. Telephone interview with Resident #3's physician on 01/29/25 at 11:33am revealed: -Resident #3 was ordered warfarin to treat atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). -The warfarin was ordered to prevent blood clots which could form due to atrial fibrillation. -Resident #3's therapeutic INR range was 2-3. -She was not aware Resident #3 had missed three doses of warfarin in December 2024 and 10 doses of warfarin in January 2025. -The missed doses of warfarin explained why Resident #3's PT/INR's were "not coming up" to a therapeutic level. -Missed doses of warfarin meant Resident #3 was at an increased risk of stroke.	D 358		

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D 358	Continued From page 34 Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/30/25 at 9:16am revealed warfarin stayed active in the body for up to 72 hours, but there was no way to know without a PT/INR test how therapeutic the levels were in that 72 hours. Interview with the RCC on 01/30/25 at 8:30am revealed: -He became the RCC at the facility on 01/06/25. -He worked in the facility as a MA on the 11pm to 7am prior to taking the position as the RCC. -The MAs did not let him know Resident #3's warfarin was not available to administer. -The MAs "probably" reported to the facility Manager, the warfarin was not available to administer. -He completed a medication cart audit on 01/13/25, but it did not include checking to see if all the residents medications were available according the eMAR entries and physician orders. -The MAs were supposed to reorder medications on the last dose prior to the blue strip on the bubble pack. -Reordering this way allowed a full week for a medication to be filled and delivered before the medication ran out. -When medications were delivered, he or the facility Manager, were responsible for marking the medications as received in the eMAR. -The pharmacy did not deliver the medications, but utilized a delivery service to deliver the medications to the facility. -Then the eMAR added those to the eMAR to alert the MA's to administer the medication. -Once he or the facility Manager checked in the medications delivered by the pharmacy, they took the medications to the MAs and they went	D 358		

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D 358	Continued From page 35 through the medications and placed the medications in the medication carts. -They could pick up medications at the local backup pharmacy when they needed a medication "quickly." Interview with the facility Manager on 01/29/25 at 2:58pm revealed: -She did not know Resident #3 was out of warfarin on 12/08/24. -The MAs just "automatically" tried to reorder the warfarin through the eMAR application on 12/08/24 when they did not have the warfarin to administer. -The MAs thought by reordering the warfarin through the eMAR application the facility's contracted pharmacy would just send it. -The warfarin order written 11/01/24 was written without refills. -When the MAs requested the reorder the facility's contracted pharmacy sent a notification asking for a prescription to refill the warfarin for Resident #3. -She became aware Resident #3 was out of warfarin on 12/09/24 and needed an order to refill it. -She did not know a PT/INR test was needed to monitor warfarin drug levels. -She contacted the primary care provider (PCP) triage service for an emergency refill of the warfarin on 12/09/24. -Medications ordered by 3:00pm from the facility's contracted pharmacy are shipped and arrive next day. -Medications ordered after 3:00pm from the facility's contracted pharmacy arrive two days later. -They were able to obtain medications from a local backup pharmacy. -The backup pharmacy could have been used to	D 358		

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obtain the warfarin for Resident #3.
-She had not understood at the time the "seriousness" of not having the warfarin for Resident #3.
-She did not know what she needed to know about warfarin and the "seriousness"of the warfarin for Resident #3 at the time these errors occurred.

Interview with the Administrator on 01/30/25 at 10:47am revealed:
-Resident #3 should have received the warfarin as it was ordered.
-Warfarin tracking should have been initiated on 11/01/24 by the facility Manager.
-The facility Manager was new to her position and had not been trained yet on warfarin tracking.
-The facility policy was to track the PT/INR ordered lab dates, the PT/INR level results, and the warfarin dose changes on the warfarin tracking form.
-The RCC or facility Manager should have reached out to the prescriber and obtained an order to refill the warfarin at the backup pharmacy.
-The RCC was responsible for doing medication cart audits monthly and following up with the facility Manager if missing medications were identified.
-The RCC and facility Manager could utilize medication administration variance reports and medication exception reports to find out if medications were not being administered as ordered.

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

2. Review of Resident #1's current FL2 dated

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D 358	Continued From page 37 06/24/24 revealed diagnoses included dementia and gastro-esophageal reflux disease (GERD). Review of Resident #1's hospital discharge summary dated 01/04/25 revealed: -He was admitted to the hospital on 01/02/25 due to a choking episode resulting in aspiration pneumonia. -There was an order for amoxicillin (an antibiotic) 875mg-potassium clavulanate 125mg 1 tablet two times daily for 7 days. -There was an order for a probiotic (used for gut health while taking antibiotics) daily for 10 days. Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed: -There was no entry for 875mg-potassium clavulanate 125mg 1 tablet two times daily for 7 days. -There was no entry for a probiotic daily for 10 days. Telephone interview with a pharmacist at the facility's contract pharmacy on 01/28/25 at 3:33pm revealed: -A copy of Resident #1's 01/04/25 hospital discharge summary was not received from the facility so they were not informed of the antibiotic and probiotic orders. -The pharmacy was responsible for entering medications into the eMAR system but since they did not receive the orders the antibiotic and probiotic were not entered nor dispensed to the facility. Interview with the Administrator on 01/28/25 at 3:52 revealed antibiotics ordered after hospital admissions were usually obtained from the local back-up pharmacy.	D 358		

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D 358	Continued From page 38 Telephone interview with the facility's local back-up pharmacy on 01/28/25 at 3:54pm revealed: -Amoxicillin 875mg-potassium clavulanate 125mg two times daily for seven days was filled on 01/04/25 after the order was received from the hospital. -The medication was never picked up by the facility. -A probiotic was an over-the-counter product, so they did not fill a prescription for it specifically. Interview with a Medication Aide (MA) on 01/28/25 at 5:15pm revealed she did not remember administering an antibiotic or probiotic to Resident #1 after he returned from the hospital on 01/04/25. Interview with the facility Manager on 01/28/25 at 4:04pm and 01/29/25 at 9:10am revealed: -She was the acting Resident Care Coordinator (RCC) on 01/04/25 and was responsible for reviewing the hospital discharge summary when Resident #1 returned from the hospital. -She remembered reviewing the discharge summary, but she must have missed the orders for the antibiotic and probiotic, so they were never picked up from the pharmacy and therefore they were not administered. Telephone interview with Resident #1's primary care provider (PCP) on 01/29/25 at 11:49am revealed: -She expected the RCC to review all hospital discharge summaries. -She reviewed the hospital discharge summary but did not remember if he was ordered an antibiotic and probiotic. -Ordering antibiotics after a choking and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL050016	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSTAR ASSISTED LIVING	95 MORNINGSTAR LANE SYLVA, NC 28779

(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 358	Continued From page 39 aspiration event was not considered beneficial by all practitioners and therefore, she was not concerned that he did not receive them. -She was concerned that the RCC did not review the discharge summary carefully enough to recognize that Resident #1 was ordered an antibiotic, and she considered that a significant system failure. -The RCC should have contacted her about the hospital discharge orders and she would have written an order to discontinue them. Based on observation and record review it was determined Resident #1 was not interviewable. _____ The facility failed to administer warfarin as ordered to Resident #3, increasing the resident's risk of stroke if the warfarin level was not within a therapeutic range or gastrointestinal bleeding if the warfarin level was above the therapeutic range. This failure put Resident #3 at substantial risk for harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 28, 2025. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 01, 2025.	D 358		