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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey with a complaint investigation from 02/18/25 to 02/21/25 and 02/24/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#1) was tested for tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: Review of Resident #1's current FL2 dated 01/23/25 revealed diagnoses included atrial fibrillation, asthma, emphysema, vitamin b12 deficiency, breast cancer, oxygen dependence, sleep apnea, depression, and hypertension.	D 234		

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Review of Resident #1's Resident Register revealed she was admitted to the facility on 03/13/23.

Review of Resident #1's record revealed:
-There was one TB skin test documented as administered on 03/09/23 and read as negative on 03/12/23.
-There was not a second TB skin test available for review.

Interview with Resident #1 on 02/18/25 at 5:20pm revealed she did not recall whether she received another TB skin test after she was admitted to the facility.

Interview with the facility's licensed practical nurse (LPN) on 02/21/25 at 9:41am revealed:
-Each resident was required to have a first step TB skin test completed and read prior to admission.
-The Resident Care Director (RCD) was responsible for ensuring the second step was administered after the resident was admitted.
-She did not see a second step TB skin test in Resident #1's record.
-She did not know how the facility audited the resident records to ensure the TB skin tests were completed.

Interview with the Administrator on 02/24/25 at 4:50pm revealed:
-Each resident was to have a first step TB skin test completed prior to admission.
-The RCD was responsible for making sure the second step TB skin test was completed after admission.

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 2 of 5 sampled residents (#4 and #5) who resided in the special care unit (SCU) related to a resident who had a history of aggression and wandering into other residents' rooms (#4); and a resident who had a history of falls with injuries (#5). The findings are: 1. Review of the facility's Abuse, Neglect, and Exploitation-Prevention, Reporting, and Investigations policy dated 05/04/16 revealed: -Every reasonable effort within its control was taken to prevent the abuse, neglect, and exploitation of residents. -Team Members must not engage in, nor permit anyone else to engage in, abuse, neglect, or exploitation of any resident. -Team members of the community were mandated reporters and had a duty to report known or suspected abuse, neglect, and/or	D 270		

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exploitation to local, state, federal, and/or provincial authorities in accordance with applicable law and regulation.
-In addition, team members who knew of or suspected abuse, neglect, or exploitation of any resident must immediately notify the Executive Director/designee, to ensure appropriate action was timely taken for the safety of the resident and those potentially impacted.
-Resident to Resident altercations were treated as abuse.
-Abuse: the infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish.
-Physical abuse: the willful infliction of bodily injury or physical harm upon any resident. Physical abuse includes hitting, slapping, pinching, kicking, and any form of corporal punishment.
-Sexual abuse: any form of nonconsensual sexual contact, including but not limited to inappropriate touching, sexual harassment, sexual coercion, sexually explicit photographing, or sexual assault.
-Resident to Resident Altercation: action by one resident against another resident that had the potential to physically or psychologically injure/harm another resident.

Review of Resident #4's current FL-2 dated 11/07/24 revealed:
-Diagnoses included Alzheimer's disease, dementia, hyperprolactinemia, and type 2 diabetes.
-He was intermittently disoriented.

Review of Resident #4's FL-2 completed upon admission and dated 07/16/24 revealed:
-He was constantly disoriented.
-He had a history of being injurious to others.

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-He had wandering behaviors.
-He was ambulatory.

Review of Resident #4's Resident Register revealed an admission date of 07/18/24.

Review of Resident #4's service plan dated 07/18/24 revealed:
-The focus was disruptive behaviors, which included exhibiting sexually inappropriate actions and being combative or aggressive.
-The goal initiated for Resident #4 on 07/18/24 was to accept the assistance of empathetic caregivers who were sensitive to the resident's needs, knew his preferences and routines, gave choices, and encouraged independence through the next review date.
-The interventions created on 07/18/24 were to encourage and engage the resident to participate in his care.
-Observe the resident for changes in his mood to help determine external causes for his behaviors and report these changes.
-Intervene as necessary to protect the rights and belongings of others.
-Provide consistency in care to promote comfort with his activities of daily living (ADLs).
-Maintain consistency with the timing of his ADLs, caregivers, and his routine as much as possible
-Remove the resident from the situation and assist him to an alternate location.
-Attempt to engage the resident in a 1:1 activity.

Review of Resident #4's mental health provider's (MHP) after-visit summary for July 2024 revealed:
-On 07/22/24, Resident #4 was seen for an initial evaluation.
-He was admitted to the special care unit (SCU) from an assisted living facility (ALF) due to elopement attempts and cognitive decline.

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-Resident #4's medications had recently been titrated to a level where there had been no recent behaviors before admission to the SCU.
-He was accepted to the facility with the contingency that the resident's medications stay the same even though a family member was requesting a reduction of his medications.
-Resident #4 had intermittent anxious behaviors in the evening and was sometimes triggered.
-Overall, staff reported Resident #4's behaviors were stable.

Review of Resident #4's personal care aide (PCA) daily reports for July 2024 revealed Resident #4 had episodes of being physically/verbally aggressive, rummaging through common areas or other residents' belongings, entering other residents' rooms uninvited and pacing anxiously, undressing in public, climbing into bed with other residents, and constantly seeking close contact with others.

Review of Resident #4's MHP after-visit summary dated 08/01/24 revealed:
-Resident #4 was seen for an acute visit.
-Staff reported Resident #4 had an increase in behavior over the last two weeks, including throwing himself on the floor during crying episodes, wandering into other residents' rooms, being hyper-sexual towards staff, and refusing personal care.
-Staff reported these behaviors often occurred during the second shift and throughout the night.
-Staff were requesting a review of medications.
-Her telephone conversation with Resident #4's family member revealed the resident had a history of wandering at night and being very friendly with other female residents at the previous ALF.
-Staff were concerned with Resident 4's

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D 270	Continued From page 6 wandering and assertive behaviors. Telephone interview with Resident #4's MHP on 02/21/25 at 10:37am revealed she did not recall what she was told about Resident #4's behavior that made her document he was being hypersexual towards staff, but she vaguely recalled something about the resident groping others. Review of Resident #4's PCA daily report for August 2024 from 08/01/24-08/06/24 revealed Resident #4 had episodes of rummaging through common areas or other residents' belongings, constantly seeking close contact with others, and urinating/defecating in a common area. a. Review of Resident #4's occurrence report dated 08/07/24 at 3:50am revealed: -Resident #4 was found in a female resident's room and had removed the female resident's incontinent brief. -Resident #4 was transported by emergency medical services (EMS) to the hospital at 4:35am. -The Administrator, the Primary Care Provider (PCP), and the family were notified. Review of Resident #4's incident and accident report dated 08/07/24 at 4:00am revealed Resident #4 was transferred to the hospital due to combative behavior towards staff. Review of Resident #4's EMS report dated 08/07/24 revealed: -Upon arrival at the facility at 4:49pm, Resident #4 was standing in the hallway of the facility. -The staff stated that they found Resident #4 hiding in the bathroom of another resident's room after the female resident called the staff in there because Resident #4 was trying to pull her pants	D 270		

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off.
-The staff stated the resident had dementia and became combative.
-Staff stated when they were trying to direct Resident #4 back to his room, he became combative by punching the staff and cussing them out.
-The staff stated that during the struggle the resident obtained a contusion to the back of the head.
-Resident #4 was transported to a local hospital to be evaluated.

Telephone interview with a PCA on 02/19/25 at 7:56pm revealed:
-Resident #4 had been going in and out of all the resident rooms on 08/07/24.
-A [named] female resident's bed alarm was going off and this resident never pulled her call bell.
-When she went into the resident's room, the resident's incontinent brief was lying on the floor and the resident's cover was pulled down to her feet.
-She saw something moving in the resident's bathroom, and when she looked, Resident #4 was in the bathroom, like he was hiding.
-She directed the resident out of the room, and he went into another female resident's room.
-She called for staff to assist her with Resident #4 because the resident became combative.

Second telephone interview with the same PCA on 02/24/25 at 8:35am revealed:
-The [named] resident's incontinent brief was dry when she found it lying on the floor on 08/07/24.
-She did not think the [named] resident would or could pull her covers to the foot of the bed.
-She did not think the [named] resident removed her incontinent brief on 08/07/24 because she

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D 270	Continued From page 8 had never done it before. Telephone interview with a Supervisor on 02/20/25 at 10:55am revealed: -Resident #4 was always walking up and down the hallway. -She recalled "about a year ago", she was told Resident #4 was in a female resident's room. -She was not told the resident's incontinent brief had been removed. -If she had been told the female resident's incontinent brief had been removed, she would have sent Resident #4 to the hospital for behaviors. -Resident #4 may have done something he was not supposed to, like hitting, touching, or anything physical. -She was usually not in the SCU during the 3rd shift because she was in the Assisted Living (AL) section of the facility. -She had good staff working in the SCU and she had no reason to go to the SCU unless there was a problem. Telephone interview with a medication aide (MA) on 02/24/25 at 11:19am revealed: -She had seen Resident #4 in the [named] resident's room either sitting on her bed or in her wheelchair. -The resident was always covered up and asleep when she observed this. Telephone interview with Resident #4's MHP on 02/20/25 at 4:39pm revealed: -She was not notified of the incident with Resident #4 being in a female resident's room and that resident's incontinent brief had been removed. -She could not say for sure, but with his diagnoses and medications, she did not think Resident #4 was physically able to sexually	D 270		

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assault another resident, but that did not mean the resident could not fondle or do other things.

Interview with the Special Care Coordinator (SCC) on 02/24/25 at 12:40pm revealed:
-When she started working at the facility, she read Resident #4's service plan to learn about the resident.
-She was not aware of an incident in August 2024 where Resident #4 was found in another resident's room.
-If she had known about the August 2024 incident, she would have implemented a plan to have a chair in the hallway where a staff member would be watching the hallways at all times.

Interview with the Senior Resident Care Director (RCD) on 02/24/25 at 2:50pm revealed:
-She was not aware of the incident in August 2024 when Resident #4 was found to be in another resident's room.
-Resident #4's service plan should have been updated after the incident.
-Increased supervision of Resident #4 would have been put in place after the incident, which may have prevented future occurrences.

Interview with the Administrator on 02/24/25 at 4:52pm revealed:
-He was not aware of the incident in August 2024 related to a female resident and her incontinent brief being removed and Resident #4 being in her room.
-Interventions should have been put in place immediately following the incident.

Review of Resident #4's service plan dated 08/09/24 revealed:
-The focus was physical aggression.
-The goal initiated on 08/09/24 was to have

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Resident #4's needs met to help reduce any physically aggressive behavioral expressions.
-The interventions were to anticipate the residents' needs: food, thirst, toileting, comfort level, body positioning, pain medications, meaning and purpose, self-expression, security and affection, identity, recent changes to his environment, appetite and routine, lack of sleep, change of medication, level of alertness and symptoms of illness.
-The intervention was to observe for and immediately report any signs and symptoms of Resident #4 posing a danger to himself or others.

Review of Resident #4's MHP after-visit summary dated 08/12/24 revealed:
-Staff reported Resident #4 was up late at night.
-Staff reported the resident was resistant to care at times and continued to be slightly aggressive towards other women, more on the obsessive side no physical aggression, and staff requested as-needed (prn) medication to help with this.
-Ativan, Benadryl, and Haldol (ABH) gel (compounded topical gel containing a mixture of Ativan, Benadryl, and Haldol that was often used to manage certain behavioral issues like agitation or anxiety) apply 1ml topically three times daily PRN for acute agitation was ordered.

Review of Resident #4's August 2024 electronic medication administration record (eMAR) from 08/12/24-08/31/24 revealed:
-There was an entry for ABH gel 2/25/2ml, give 1ml three times every 8 hours as needed for agitation.
-There was no documentation ABH gel 2/25/2ml was administered from 08/12/24-08/31/24.

Review of Resident #4's PCP after-visit summary dated 08/15/24 revealed:

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-Resident #4 was being seen for a follow-up after a hospital visit.
-Resident #4 was sent to the hospital after becoming agitated and striking a staff member.
-Resident #4's medications were adjusted during the hospitalization including Donepezil (used to treat Alzheimer's disease), Melatonin (used to improve sleep), Zyprexa (used to regulate mood), and Zoloft (used to regulate mood).
-Resident #4 was to follow up with his MHP.

Review of Resident #4's PCA daily report for August 2024 from 08/14/24-08/20/24 revealed Resident #4 was rummaging through common areas or other residents' belongings and he was undressing in public.

Review of Resident #4's progress notes for August 2024 from 08/07/24-08/31/24 revealed:
-On 08/07/24 at 9:52am, Resident #4 was physically/verbally aggressive, which was a new behavior.
-Resident #4 was redirected out of another resident's room and hit a care manager.
-Resident #4 was sent to the hospital.
-On 08/15/24 at 3:41pm, Resident #4 was aggressive and combative; he pushed and shoved care managers.
-On 08/20/24, the previous RCD would meet with the family for suggestions on interventions and behaviors.

Review of Resident #4's PCA daily report for September 2024 revealed Resident #4 had episodes of physically/verbally aggressive behavior, pacing anxiously, and he wanted to be in control of others or the environment.

Review of Resident #4's progress notes for September 2024 revealed:

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-On 09/03/24, the interdisciplinary team (IDT) met and there were no concerns at that time.
-On 09/05/24, Resident #4 constantly walked the halls but was easily redirected during the day. When the sun went down, Resident #4 became agitated and aggressive.
-The MHP assessed the resident and added Zoloft (a medication used to treat anxiety) and the resident tolerated the medication well.
-On 09/08/24, the previous Senior Resident Care Director (RCD), spoke to Resident #4's family member and the family member was happy with the resident's care and had no concerns.

Review of Resident #4's MHP after-visit summary dated 09/30/24 revealed:
-Resident #4 continued to have episodes of agitation and resistance to care.
-Resident #4 had several hospitalizations due to altered mental status and falls related to severe dementia.

Review of Resident #4's PCP after-visit summary dated 09/26/24 revealed staff denied any new concerns.

Review of Resident #4's PCA daily report for October 2024 revealed Resident #4 had episodes of being physically/verbally aggressive, wanting to be in control of others or the environment, rummaging through common areas or other residents' belongings, undressing in public, pacing anxiously, and hearing or seeing things that others did not.

Review of Resident #4's progress notes for October 2024 revealed:
-On 10/29/24, Resident #4 was continuously walking up and down the halls and going into other resident rooms without permission.

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D 270	Continued From page 13 -Staff redirected Resident #4 to his room so he could lie down. Review of Resident #4's MHP after-visit summary dated 10/14/24 revealed staff reported with the medication adjustment; Resident #4 was doing well; there were no behavioral concerns. Review of Resident #4's PCA daily report for November 2024 revealed Resident #4 exhibited behaviors of pacing anxiously, physically/verbally aggressive behaviors, wanting to be in control of others or the environment, constantly seeking close physical contact with others, pacing anxiously, exit seeking, and entering other residents' rooms uninvited, rummaging through common areas or other residents' belongings, urinating or defecating in the common area, and undressing in public. Review of Resident #4's progress notes from 11/01/24-01/05/25 revealed there were no progress notes for November 2024. Review of Resident #4's MHP after-visit summary dated 11/03/24 revealed: -Resident #4 had a fall on 11/03/24 and was hospitalized. -During the hospitalization, medication adjustments were made on 11/04/24. Review of Resident #4's MHP after-visit summary dated 11/11/24 revealed: -Staff reported with the medication changes made on 11/04/24, Resident #4 had been frequently wandering around the unit and would enter other residents' rooms to get their belongings. -Due to these behaviors staff needed to closely monitor the resident and attempt to redirect his	D 270		

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actions.
-Despite efforts to engage Resident #4 in activities, he would often lose interest quickly and resume wandering.

b. Telephone interview with a PCA on 02/24/25 at 10:00am revealed:
-Resident #4's behaviors that she had seen included him being naked from the waist down and attempting to urinate on other residents.
-This happened with two different [named] residents on two different occasions; she thought it was in December 2024.
-She reported the behavior to the SCC.

Telephone interview with a MA on 02/24/25 at 11:19am revealed:
-She had seen Resident #4 in the hallway, where he would remove his incontinent brief, and would be naked from the waist down, but she did not recall when this happened.
-Resident #4 would become aggressive when the staff tried to get the resident to put clothing on when this occurred.

Interview with the SCC on 02/24/25 at 12:40pm revealed:
-She reviewed the PCA daily reports first thing in the morning.
-If something happened during normal business hours the PCAs would usually tell her directly.
-She did not recall anyone telling her Resident #4 had attempted to urinate on other residents in the common area.

Interview with the Senior RCD on 02/24/25 at 2:50pm revealed:
-She was not aware of any incidents where Resident #4 was observed attempting to urinate on other residents.

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-Had she known about the incident, she would have questioned if the resident was a right fit for the community.
-She was concerned about how many other residents could be affected by Resident #4's behavior that they were not aware of.

Interview with the Administrator on 02/24/25 at 4:52pm revealed he did not recall being told Resident #4 had attempted to urinate on other residents.

Review of Resident #4's MHP after-visit summary dated 11/22/24 revealed staff reported with the medication changes on 11/11/24, Resident #4 was doing well with no behavioral concerns.

Review of Resident #4's PCA daily reports for December 2024 revealed Resident #4 had episodes of pacing anxiously, undressing in public, sexually expressive (verbally or physically),
rummaging through common areas or other residents' belongings, being physically/verbally aggressive, and entering other residents' rooms uninvited.

Review of Resident #4's progress notes for December 2024 revealed on 12/29/24, Resident #4 had episodes of agitation related to other residents, and staff administered ABH gel as needed.

Review of Resident #4's MHP after-visit summary dated 12/16/24 and 01/15/25 revealed staff reported Resident #4 was doing well with no behavioral concerns.

Review of Resident #4's PCA daily reports for January 2025 revealed Resident #4 was

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rummaging through common areas or other residents' belongings, pacing anxiously, and was physically/verbally aggressive.

Review of Resident #4's PCP after-visit summary dated 01/02/25 revealed:
-Resident #4 was seen for a routine monthly visit.
-Due to diagnoses of dementia, Resident #4 required specialized care in a secure environment.
-He needed around-the-clock supervision, a personalized service plan, structured routines, and activities that promoted cognitive and physical well-being.
-Resident #4 also needed additional security measures as he was prone to wandering.
-There were no reports of behaviors or non-compliance with medications and staff denied acute concerns.

Review of Resident #4's progress notes for January 2025 revealed on 01/05/25, Resident #4's ABH was administered at 8:25am.

c. Review of another resident's incident and accident report dated 01/29/25 revealed at 7:30pm, staff reported the female resident was struck in the face by another resident (Resident #4).

Review of Resident #4's hospital after-visit summary dated 01/30/25 revealed:
-Resident #4 was seen for aggressive behavior.
-Resident #4 was prescribed antibiotics for a urinary tract infection.
-If the resident had behavioral disturbances, contact the provider regarding medication to help with the behavioral disturbances.

Review of Resident #4's progress note dated

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D 270	Continued From page 17 01/29/25 revealed Resident #4 had disruptive behaviors, the service plan was updated, 24/7 sitters were added, and the power of attorney (POA)/family member was notified. Interview with the SCC on 02/19/25 at 10:48am revealed: -Sitters were put in place from 7:00am-7:00pm for Resident #4 on 01/30/25. -She did not know why the progress note dated 01/29/25 had 24/7 sitters documented. Telephone interview with a PCA on 02/20/25 at 8:13pm revealed: -She worked on 01/29/25, when the incident between Resident #4 and the [named] female resident occurred. -The female resident was lying on the couch in the common area and Resident #4 was walking around in the dining room and common area. -Resident #4 stopped at the couch and hit the female resident three times with a closed fist on her forehead. -The staff reacted immediately; she grabbed Resident #4 and sat him in a chair. -Resident #4 would wander into other residents' rooms. -She was not aware of any interventions that had been put in place for Resident #4 after the incident on 01/29/25. Telephone interview with another PCA on 02/20/25 at 8:05pm revealed: -After dinner on 01/29/25, the staff had laid a [named] female resident on the couch in the common area. -Resident #4 stopped at the end of the couch and just started hitting the female resident. -Resident #4 hit the female resident three times with a closed fist on her forehead area.	D 270		

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-The female resident grabbed Resident #4's arm and tried to push him away.
-The PCA was able to "grab" Resident #4 and sit him down.
-Resident #4 was still upset as he was by rocking back and forth and rubbing his hand, and fist; it took him a while to calm down.
-She was not aware of any previous behaviors between Resident #4 and the female resident but she did not start working until November 2024.

Telephone interview with Resident #4's family member on 02/21/25 at 8:57am revealed:
-She received a call from the Administrator in January 2025, who informed her there was an incident where Resident #4 hit another resident because he wanted to sit where the other resident was sitting, and because of the incident Resident #4 needed a sitter during his wake hours, from 8:00am-8:00pm.
-She was shocked it had happened.
-She was not told of any other behaviors with Resident #4 from the time of admission until he hit the resident on 01/29/25.
-As far as she knew, Resident #4 was not sleeping during the day, he did not even take daytime naps.
-Resident #4 had been prescribed medication to help him sleep at night and as far as she knew it was working fine.
-When she received the telephone call on 01/30/25, it was the first time she heard Resident #4 was not sleeping at night.
-The MHP provider changed Resident #4's medications to improve his sleeping at night.

Review of Resident #4's PCP after-visit summary visit dated 02/04/25 revealed:
-Resident #4 was being seen secondary to a hospital visit for aggressive behaviors.

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-Resident #4 had agitation due to dementia.
-Resident #4 had an order for ABH gel every eight hours as needed.
-Resident #4 would continue to be seen along with the MHP.

Telephone interview with Resident #4's PCP on 02/20/25 at 9:24am revealed she was notified Resident #4 had hit someone in the face and was sent to the hospital for aggression; she did not provide the date she was notified.

Telephone interview with Resident #4's MHP on 02/20/25 at 4:39pm revealed:
-She did not specifically recall being told Resident #4 hit another resident in January 2025.
-On 01/31/25, she had a note for medication orders only.
-In her note on 01/31/25, she documented Resident #4 had been restless and resistant to care over the past month.
-Resident #4 started a mood stabilizer on 01/31/25 but that was because another mood stabilizer had been discontinued due to cost.

Interview with the SCC on 02/24/25 at 12:40pm revealed:
-The intervention put in place for the occurrence where Resident #4 hit another resident, was for the resident to have a sitter from 8:00am-8:00pm.
-The new intervention should have been updated in Resident #4's service plan.
-A sitter was placed with Resident #4 during the day because Resident #4 wandered during the day, whereas at night there were usually 4-5 residents up that needed to be watched.

Telephone interview with a representative from the private duty sitter agency on 02/19/25 at 10:07am revealed:

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-A sitter had been placed with Resident #4 on 01/31/25 from 3:00pm-8:00pm.
-On 02/01/25, a sitter was placed with Resident #4 from 8:00am-8:00pm and was scheduled for 7-days a week.

Interview with the Administrator on 02/20/25 at 4:10pm and on 02/24/25 at 4:52pm revealed:
-There was an incident where a [named] resident was lying on the couch and Resident #4 tried to move her feet and when she would not move her feet he struck her in the head.
-Sitters were put in place immediately from 8:00am-8:00pm.
-There had been no previous incidents between Resident #4 and the female resident that he was aware of.
-After talking with the staff, the decision was made to put the hours in place for Resident #4 to have sitters from 8:00am-8:00pm, especially since this incident occurred in the common area and while other residents were up.

c. Review of the time-stamped electronic recording from a [named] female resident's room dated 02/09/25 revealed:
-At 10:32pm, Resident #4 entered the female resident's room and closed the door behind him.
-Between 10:33pm-10:34pm, Resident #4 stood at the foot of the female resident's bed, looking toward the female resident, and walked toward the electronic recording device, which was on a table against the wall opposite the bedroom door; Resident #4 was then out of view.
-Between 10:40pm-10:43pm, Resident #4 walked back into view of the electronic recording device.
-Between 10:46pm-10:49pm, Resident #4 picked up the electronic recording device and maneuvered the electronic recording device in his hands.

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D 270	Continued From page 21 -At 10:54pm, the electronic recording device stopped recording. Review of the local law enforcement officer's investigation report dated 02/10/25 revealed: -The officer was dispatched to the facility due to a resident-to-resident assault. -There was an electronic recording device in a [named] female resident's bedroom which recorded Resident #4 entering the female resident's bedroom. -The female resident was assaulted by Resident #4 on 01/29/25. -Today, 02/10/25, the electronic recording device, placed in the room by the resident's family, was discovered disconnected. -The female resident's family member reviewed the electronic recording and discovered Resident #4 had entered the female resident's bedroom and disconnected the electronic recording device. -The family member advised him that when the private sitter pulled the female resident's covers back, she found the female resident's incontinent brief and pajama bottoms pulled down just above her pubic area. -He arrived at the facility and was met by the RCD. -The RCD advised him that EMS had been called to transport the female resident to the hospital and had requested a SANE kit (a kit used to gather and preserve physical evidence following an instance or allegation of sexual assault) to be completed. -He reviewed the electronic recording of the incident dated 02/09/25. -He spoke with the private sitter and viewed pictures of how the resident was found on the morning of 02/10/25 and a picture of the camera being disabled. -The private sitter advised him that she had called	D 270		

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a family member, and the family member checked the electronic recording device and informed her Resident #4 had entered the female resident's room and disabled the electronic recording device.
-The private sitter stated that the female resident's incontinent brief was pulled further down in the back, just below the buttocks.
-Forensics was called to process the room due to possible sexual assault and seized the bedding and pajamas.
-The family members informed him that the female resident stated "sexual assault" three times while in the emergency department (ED).

Review of a PCA's written statement dated 02/10/25 revealed:
-On 02/09/25, she cared for Resident #4, provided personal care around 10:00pm, gave him a snack around 11:00pm, and put him to bed around 11:15pm.
-When she checked on Resident #4 at 1:15am, he was out of bed wandering the halls; he would not go back to bed.
-Resident #4 continued to wander until 4:00am and then he went back to bed.

Telephone interview with this PCA on 02/20/25 at 8:05pm revealed:
-When she came into work on 02/09/25, Resident #4 was asleep.
-Resident #4's sitter reported the resident had been asleep all day and would probably be awake all night.
-The private duty sitter left after 8:00pm, but before 10:00pm.
-She changed Resident #4's incontinent brief around 7:30pm.
-Resident #4 wanted a snack after he slept all day, so he went to the common area and had a

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snack.
-Resident #4 was slumping over the table and looked tired, so she walked him back to his room.
-She saw Resident #4 in his room a little bit before 10:00pm.
-Resident #4 came out of his room between 10:30pm-10:40pm and just started wandering from the hallway to the common area.
-A PCA asked her to assist with another resident's care, so she was out of the common area.
-When she went back into the common area, she was in the kitchen area with another resident.
-If Resident #4 went into the female resident's room she would not have been able to see him from where she was.
-She went into Resident #4's room around 5:30am and the resident was awake.
-At 6:30am, Resident #4 was lying down but was not asleep.

Interview with the RCD on 02/19/25 at 10:18am revealed:
-On 02/10/25 at 8:30am, she received a text message from the Administrator requesting her to check on a [named] female resident.
-The Administrator stated he received a text message from the female resident's family member and wanted to have a meeting.
-The Administrator did not know why the family wanted a meeting, so the Administrator asked her to check on the female resident.
-The private duty sitter reported that the camera in the female resident's room was unplugged this morning, 02/10/25, the resident was lying diagonally in the bed, and her incontinent brief and pajama bottoms were pulled down.
-The private duty sitter contacted the female resident's family member and informed the family member that the camera was unplugged.

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-The family member looked at the video and identified the last person in the room was Resident #4.

Interview with the Administrator on 02/18/25 at 2:43pm revealed:
-He was informed by the RCD that the female resident's private duty sitter reported she found the camera in the resident's room unplugged, and the resident's incontinent brief and pajama bottoms were pulled down.
-The private duty sitter verbalized that the female resident was sexually assaulted.
-The RCD sent the female resident to the hospital due to a decline in her condition.
-The facility requested a rape kit be done at the hospital due to the accusations made by the private duty sitter.

Interview with the Administrator on 02/20/25 at 4:10pm revealed:
-There was no evidence that a sexual assault occurred between the female resident and Resident #4 on the night shift of 02/09/25.
-Management asked for a rape kit to be done on the female resident.

Telephone interview with the private duty sitter for the female resident on 02/20/25 at 8:32am revealed:
-She asked the female resident questions on the morning of 02/10/25.
-She asked, "Was she OK?", and the female resident responded "No".
-She asked, "Did her body hurt?", and the female resident responded "No".
-She asked, "Did someone come into your room?", and the female resident responded "Yes".
-She asked, "Did a man come into your room?",

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and the female resident responded "Yes"
-She asked, "Did the man touch your body?", and the female resident responded "Yes".
-The female resident's family members arrived at 11:00am and asked the female resident the same questions.
-The female resident responded the same for all questions except one.
-When the female resident was asked "Did the man touch your body", the female resident did not respond, she became tearful.

Interview with two family members of the female resident on 02/20/25 at 11:00am revealed:
-On 02/10/25, the private duty sitter called a family member to ask what happened to the electronic recording device, because it had been disabled.
-The family member did not disable the electronic recording device, so he checked the video.
-The family member saw Resident #4 in the female resident's room.

Second interview with a family member of the female resident on 02/20/25 at 12:36pm revealed:
-She was present with the female resident in the ED.
-She, the nurse, and the doctors were discussing the assault and having the sexual assault examination done in the room with the female resident when the female resident said "SANE" and "sexual assault".
-She asked the female resident if Resident #4 did anything to her, and she responded "yes".
-She asked the female resident did Resident #4 pull your pants down, and she responded "yes".
-She asked the female resident did Resident #4 put anything inside of you, and she responded "no".
-The female resident said "sexual assault" two

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more times.
-The female resident had been non-verbal until the discussion about the sexual assault exam.
-She asked the female resident if she wanted to have the sexual assault exam done and the female resident agreed.

Telephone interview with the law enforcement officer on 02/24/25 at 11:29am revealed:
-He was dispatched to the facility because of an incident with a resident.
-After arriving at the facility, he spoke with a family member and was informed that the private duty sitter noticed the female resident's pants were pulled down and there was a possibility that "something inappropriate happened" with Resident #4.
-The family member showed him the video of the incident from the electronic recording device.
-He learned Resident #4 had been in the female resident's room and Resident #4 had private sitters twelve hours a day.

Interview with the SCC on 02/19/25 at 10:48am revealed:
-The staff informed her Resident #4 had entered the female resident's room around 10:30pm and disabled the electronic recording device.
-She asked the female resident, "did anyone come into your room", and she responded "yes, yes, yes" and "no, no, no".
-She asked the female resident, "did Resident #4 come into your room", she responded "yes, yes, yes" and "no, no, no".

Telephone interview with a Supervisor on 02/20/25 at 10:15am revealed:
-She found Resident #4 in the female resident's room before, but she could not remember the dates.

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-Resident #4 was sitting in the chair or standing at the foot of the female resident's bed.
-Sometime in 2024, when she was providing care to the female resident, the female resident said Resident #4's name several times in a row.

Interview with the Administrator on 02/18/25 at 2:49pm revealed based on Resident #4's behaviors of going in and out of resident rooms, a 24-hour sitter had been put in place for the resident.

Interview with the Administrator on 02/20/25 at 4:10pm revealed when the incident occurred between Resident #4 and the female resident, it was based solely on allegations from others, but he still put 24-hour sitters in place.

Review of Resident #4's progress notes revealed:
-On 02/10/25, the SCC contacted Resident #4's family to discuss placing 24/7 sitters.
-On 02/11/25, 24/7 sitters were placed with Resident #4 due to the resident infringing on resident rights while going into resident rooms.
-On 02/13/25, Resident #4's service plan was updated due to recent disruptive behavior.

Review of Resident #4's service plan revealed:
-On 02/13/25, a new intervention was to validate the resident by speaking in a calm manner and to divert his attention by using relationship-based redirection.
-On 02/18/25, a new intervention was implemented to have 24/7 sitters and to encourage the resident to not have disruptive behaviors.

Interview with Resident #4's private duty sitter on 02/18/25 at 2:49pm revealed:
-She had worked various shifts with Resident #4.

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-Resident #4 usually slept in the mornings.
-Resident #4 was up and active "all night."
-She had been trying to keep Resident #4 in his room because of the allegations and other residents were nervous around him.
-A staff member (she did not recall who) told her she did not think Resident #4 was capable of "that" referring to the allegation but told her to keep a close eye on Resident #4.
-She did not answer what the allegations were.

Telephone interview with a representative from the private duty sitter agency on 02/19/25 at 10:07am revealed on 02/10/25, a sitter was placed with Resident #4 twenty-four hours per day due to confusion and wandering all night.

Telephone interview with Resident #4's MHP on 02/20/25 at 4:39pm revealed:
-She was not notified Resident #4 had disabled a female resident's electronic recording device.
-On 02/13/25, she received a notification requesting she reach out to Resident #4's family member regarding medications and wandering.
-When she reached out to Resident #4's family member, she was told the family member was having to pay for sitters due to the resident's wandering.
-Resident #4's medication dosage for a mood stabilizer was increased on 02/13/25.
-She recalled specifically during her visit on 02/13/25, telling staff to use the ABH gel up to three times a day to help with agitation and if it was working, she could change the ABH gel to a scheduled medication.

Interview with the SCC on 02/24/25 at 12:40pm revealed:
-After the incident on 02/09/25, the changes that were implemented included having a staff person

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in the hallway, in the common area, and the third staff member would be doing resident care or activities.
-Prior to 02/10/25, there were no staff members assigned to watch the hallway.
-Because of Resident #4's disruptive behaviors, the staff did more frequent "looks" to keep an eye on him.
-On nice days staff members would take him outside, and activities at night were implemented because of him.

Interview with the Administrator on 02/24/25 at 4:52pm revealed:
-He did not recall being told by staff and/or family members that Resident #4 had ever been in the female's room before the incident on the night shift of 02/09/25.
-As soon as he was notified of the alleged incident on the night shift of 02/09/25, sitters were put in place 24 hours per day for Resident #4.

Observation of Resident #4's room on 02/18/25 at 8:57am revealed:
-Resident #4 was lying on his bed with his eyes closed.
-There was a sitter in his room.

Interview with the sitter on 02/18/25 at 8:57am revealed:
-He was a private duty sitter for Resident #4 and worked from 7:00am to 4:00pm.
-Resident #4 had taken his medication this morning and was sleeping.
-Resident #4 had private duty sitters 24 hours a day, 7 days a week.

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Interview with a PCA on 02/19/25 at 11:14am revealed:
-If the staff saw a resident go into another

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resident's room, staff tried to redirect the resident with a snack, water, or the television.
-The only thing she had been told about Resident #4 was to keep an eye on him because he wandered.

Interview with a second PCA on 02/19/25 at 4:39pm revealed:
-She had only been working at the facility for "about" four weeks.
-She checked on Resident #4 every two hours to make sure his incontinent brief was dry and to see if his private duty sitter needed any assistance.

Telephone interview with a third PCA on 02/20/25 at 8:05pm revealed:
-When Resident #4 woke up, he wandered the halls and common areas.
-He went into other residents' rooms.
-Resident #4 was known to hide and when he was found it would be somewhere the lights were out, and the door was closed.
-She recalled going into a female resident's room in December 2024 and when she was changing the resident's incontinent brief, she saw the bathroom door move and when she looked Resident #4 was in the bathroom.
-Staff could not do much with Resident #4 because he was violent.
-If Resident #4 was wandering, staff were told to not do anything, but to let him wander.

Telephone interview with a fourth PCA on 02/20/25 at 10:42pm revealed:
-Resident #4's behaviors included fighting, slapping, and kicking.
-Resident #4 resisted care.
-If Resident #4 went into another resident's room and the resident did not want him in there, it could

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cause Resident #4 to have behaviors.
-Resident #4 had a right to do whatever he wanted to, but if it could cause danger to someone else, staff intervened.
-If he entered a resident's room and the resident started hollering "get out" staff could not leave Resident #4 in the room because it may escalate to more; Resident #4 would become combative when he was told to leave the room.
-She did not always document Resident #4"s behaviors.

Telephone interview with a fifth PCA on 02/24/25 at 10:00am revealed:
-She observed Resident #4 smack a [named] female resident in the dining room.
-Resident #4 would antagonize other residents by standing over other residents and staring at them.
-Resident #4 was constantly in and out of other resident rooms, specifically three [named] residents.
-She was told to "just let Resident #4 do his thing."
-If Resident #4 was in another resident's room, he was easy to redirect.
-There were not enough staff to catch Resident #4 going into other residents' rooms all the time.
-Usually at mealtimes or doing rounds, someone would say, where is Resident #4, and they would look for him and he would be in another resident's room.
-There were not enough staff in the SCU to watch Resident #4 all the time.

Interview with a MA on 02/18/25 at 5:08pm revealed:
-Resident #4 wandered at night, mostly from 8:00pm on, but not every night.
-Staff were not directed to do anything with Resident #4.

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-Staff "just" let him wander as long as he was not bothering anyone.
-She was not aware of Resident #4 going into any other residents' rooms.

Telephone interview with another MA on 02/24/25 at 9:17am revealed:
-She was usually in the SCU from 2:00pm-6:00pm and then she went to the AL unit and only went back to the SCU if the PCAs called and needed something.
-Resident #4 usually wandered around and went in and out of other residents' rooms.
-There were residents who complained about Resident #4 going in/out of their rooms.
-She had not been told Resident #4 had been hiding in any resident rooms.
-She had not seen Resident #4 have any inappropriate behaviors.
-Residents who wandered were usually relocated back to their rooms.

Telephone interview with Resident #4's family member on 02/21/25 at 8:57am revealed:
-She discussed at length with the admissions staff and a registered nurse (RN) what Resident #4's behavioral history was.
-The RN interviewed Resident #4 and felt he was overmedicated.
-Resident #4 did fine the first 6 months at the facility, as far as she knew.
-She had not been notified Resident #4 had any behaviors that required him to be sent to the hospital until he hit another resident in January 2025.
-She had been told if there was ever a problem with Resident #4, the facility would take care of staffing for him, but now, she was having to pay for a sitter.
-Staff told her other residents were up at night

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and were going in and out of other resident rooms, and she did not know why the staff were singling out Resident #4.
-She was told when Resident #4 got up at night, staff redirected him.
-Resident #4 always wanted to get up and walk around.
-She was not aware Resident #4 had been up wandering all night until the facility requested a 24-hour sitter on 02/10/25.

Interview with the SCC on 02/19/25 at 10:48am revealed:
-When she started working at the facility, she was told Resident #4 wandered.
-Resident #4 had wandered into other residents' rooms.
-Only one resident's family had complained about Resident #4's wandering.
-When she started working at the facility, she was told Resident #4 wandered.
-Resident #4's wandering fluctuated between day and night.
-Resident #4's baseline was that he wandered.

Interview with the SCC on 02/24/25 at 12:40pm revealed:
-She was not aware of any other residents complaining about Resident #4 going into their rooms.
-She asked the Administrator in November 2024/December 2024, if the PCAs could do activities at night for residents who wandered.
-She thought if the residents who wandered had something to do, it would provide more supervision for the residents, and giving the residents something to do would decrease the wandering behaviors.
-Resident #4 would do an activity, but it depended on the day.

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-Residents were allowed to wander in the common areas but not allowed to go into other resident rooms.
-Occurrence reports were used to notify the family and PCP of any occurrence with the resident.
-In the facility's computer system, the PCA completed the "risk connect" which immediately flagged the incident for the SCC, the nurses, and the Administrator.
-Her responsibility was to make sure the nurses were aware of the incident and the service plan was updated with interventions based on the incident.
-Any change in the baseline for the resident would be reported to all staff.

Interview with the senior RCD on 02/24/25 at 2:50pm revealed:
-Interdisciplinary team meetings (IDT) were held weekly to discuss changes in a resident.
-Behaviors were discussed at the IDT meetings.
-Incident reports were discussed, so as a team, interventions could be put in place.
-New interventions were put into the tablet so the PCAs could see the new intervention as soon as the PCA signed in for their shift.
-The intervention implemented should match what the incident was.
-She expected a new intervention to be implemented after every change in behavior.
-If an issue could not be resolved during IDT, they would reach out to corporate for support as the company had a behavioral specialist that they could brainstorm with to put interventions in place.
-She did not know if the behavioral specialist had been contacted about Resident #4, but it had been discussed after Resident #4 hit another resident on the head on 01/29/25.

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D 270	Continued From page 35 Interview with the Administrator on 02/19/25 at 5:25pm revealed: -How often a resident was checked on depended on the service plan and tasks for that resident. -The staff were trained on their tasks and assignments for each resident. -When they used their electronic tablet and clicked on the resident's name, it showed everything that needed to be done for the resident. -The SCC was responsible for checking every day to make sure the tasks were done, not only by looking at the computer but also by observing the residents. -The SCC was responsible for telling staff about any new interventions that were implemented. -Any circumstance with Resident #4 that needed an intervention would be put into the system for the staff to see. Interview with the Administrator on 02/20/25 at 4:10pm revealed: -Safety was his number one concern. -He had spoken to Resident #4's family member about his concerns for the resident's safety. -He wanted Resident #4's MHP to see him. -He did not want Resident #4 to have 24-hour sitters long term. 2. Review of the facility's fall policy dated 08/02/22 revealed: -A "near miss" was an episode where a resident lost their balance and would have fallen, if not for a team member intervening; this was considered a fall. -A fall without injury was still a fall. -Unless there was evidence to suggest otherwise, when a resident was found on the floor, a fall was considered to have occurred; the facility was	D 270		

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obligated to complete an investigation and put interventions in place to prevent another fall.
-Ensure a focus on a safe environment and reduce the likelihood of injury from a fall.
-Evaluate the effectiveness of interventions through the care planning process and make changes, as necessary to prevent falls.
-All falls must be documented in the electronic record.
-The team member who was first on site after the fall was to document the event in the "Risk Connect" system.
-The service plan was reviewed and updated with new interventions, if applicable.
-Depending on state requirements, a fall may need to be reported to the state licensing agency.
-For resident falls, the event must be documented in their system.

Review of Resident #5's current FL-2 dated 08/20/24 revealed:
-Diagnoses included dementia in other diagnoses with mood disturbances, congestive heart failure (CHF), spinal stenosis of the lumbar/sacral region, lower back pain, syncope, and major depressive disorder.
-She was intermittently confused.
-She was semi-ambulatory.
-She was incontinent of bowel and bladder.

Review of Resident #5's service plan dated 11/22/24 revealed:
-The focus was fall risk factors.
-The goal initiated on 05/13/23, was to be free from injuries from falls.
-The intervention created on 05/13/23 was to observe and report any changes in gait or balance.
-The intervention created on 05/25/23 was to have therapy evaluate for adaptive devices, and

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re-evaluate as needed to ensure use of the least restrictive device.
-The intervention created on 05/29/23 was to encourage, remind, and assist Resident #5 with using the bathroom at frequent intervals.
-The interventions created on 07/24/23 were to provide a safe environment by providing an assistive device in good repair, ensure the call device was in reach, and to remove potential hazards when possible.
-Evaluate and assess for physical, cognitive and environmental factors that could contribute to a fall such as poor lighting, uneven, slippery, cluttered floor surfaces, improper footwear, and failure to use an assistive device.
-Educate Resident #5 and the caregivers of potential fall hazards.
-The interventions created on 04/05/24 were to evaluate her environment at the time and location of the fall and attempt to identify any factors that may have contributed to the fall such as uneven surfaces, her bed not in the lowest position, poor lighting, improper footwear, not using her assistive device, and frequently used items were out of reach; remind her to use her assistive device, walker and wheelchair, and remind her to take her time.

Review of Resident #5's electronic progress notes from 05/04/24 to 01/14/25 revealed there was documentation that Resident #5 had 16 falls, including 8 with injuries.

a. Review of Resident #5's incident/accident reports revealed there was no report dated 05/23/24 available for review.

Review of Resident #5's electronic progress notes dated 05/23/24 revealed:
-She fell, busted her lip and was sent to the

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emergency department (ED); she returned with 2 sutures.
-On 05/28/24, the interdisciplinary team (IDT) met and discussed care concerns including the fall on 05/23/24.

Review of Resident #5's service plan dated 11/22/24 revealed the service plan was not updated after the fall on 05/23/24.

b. Review of a Resident #5's incident/accident report dated 06/07/24 at 8:25am revealed:
-She was found in the hallway scooting on her bottom; she was bleeding from the back of her head.
-Emergency Medical Services (EMS) was notified and Resident #5 was transferred to the ED.
-The Administrator completed the report on 06/07/24.

Review of an ED summary dated 06/07/24 revealed:
-Resident #5 was seen for a fall with a laceration to the right scalp.
-Resident #5 was a recurrent ED visitor for falls.
-Two staples were placed in the head laceration and Resident #5 was discharged back to the facility.

Review of Resident #5's electronic progress notes dated 06/07/24 revealed:
-She had an unwitnessed fall in the hallway, sustaining a laceration to the back of her head, was sent to the ED and returned with 2 staples in her head.
-On 06/11/24, the IDT met, and reviewed Resident #5's service plan related to her fall on 06/07/24.

Review of Resident #5's updated service plan

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dated 06/13/24 revealed to encourage her to sit in the common area and attend activities during the day to minimize her risk of trying to walk on her own in her room.

c. Review of Resident #5's incident/accident reports revealed there was no report dated 06/24/24 available for review.

Review of Resident #5's electronic progress note dated 06/24/24 revealed she had a witnessed fall in the common area, sustaining an abrasion to her right knee.

Review of the service plan dated 11/22/24 revealed there were no interventions implemented after the fall on 06/24/24.

d. Review of Resident #5's incident/accident reports revealed there was no report dated 07/13/24 available for review.

Review of Resident #5's electronic progress note dated 07/13/24 revealed:
-She was seen by the hospice nurse related to a fall; she sustained a bruise and small knot to her left upper forehead.
-On 07/14/24, the service plan was reviewed with no updates needed.
-On 07/16/24, the IDT met and discussed the small cut on her forehead; there was no documentation related to falls being discussed during the IDT meeting.

Review of Resident #5's updated service plan revealed:
-On 07/26/24, during her awake hours, especially before meals, bring her to the common area to sit on the couch.
-On 08/01/24, ensure she was placed safely in

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bed away from the edge of the bed.

Review of Resident #5's hospice progress note dated 08/16/24 revealed:
-A personal care aide (PCA) witnessed Resident #5 trying to stand up by herself; she fell and bumped her head.
-Resident #5 has a bump on the left side of the back of her head.
-Resident #5 denied any headaches or nausea.
-Resident #5's Power of Attorney (POA) verbalized Resident #5 forgets she cannot get up by herself.

Attempted telephone interview with the hospice nurse on 02/21/25 at 9:09am was unsuccessful.

e. Review of Resident #5's incident/accident reports revealed there was no report dated 08/16/24 available for review.

Review of Resident #5's electronic progress note dated 08/16/24 revealed:
-On 08/16/24, she stood up from the dining room chair, fell and hit her head; she had a knot on the left side of her head and she complained of soreness to the area.
-Her Power of Attorney (POA) did not want her sent to the ED; the hospice nurse was called and assessed her.

Review of the service plan dated 11/22/24 revealed there were no interventions implemented after the fall on 08/16/24.

Review of Resident #5's incident/accident reports revealed there was no report dated 11/07/24 available for review.

Review of Resident #5's electronic progress note

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D 270	Continued From page 41 dated 11/07/24 revealed: -She was found on the floor in her room lying on her back; she sustained an abrasion on her right eye in 2 areas, wounds cleaned. -On 12/03/24, the IDT met and determined the resident was stable on hospice. -There was no documentation related to fall during the IDT meeting. Review of Resident #5's updated service plan revealed: -On 11/12/24, the PCAs were to check on her 2 to 4 times per shift, evaluate and monitor for three days post fall, observe and report changes in vital signs, in condition, pain, skin discolorations, swelling, difficulty moving an extremity, change in mental status like confusion, sleepiness and agitation, and assist and encourage her to use her assistive devices and ensure the wheels were locked when attempting to transfer. -On 11/20/24, encourage and assist her to attend activities. Review of Resident #5's hospice note dated 11/07/24 revealed the hospice nurse was notified that Resident #5 had a fall and had two red marks above her eye. Attempted telephone interview with the hospice nurse on 02/21/25 at 9:09am was unsuccessful. g. Review of an incident/accident report dated 01/13/25 at 5:30pm revealed: -Resident #5 had a witnessed fall and hit her head. -EMS was notified and she was transferred to the ED. -The Administrator completed the report on 01/14/25.	D 270		

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Review of Resident #5's electronic progress note dated 01/13/25 revealed:
-On 01/13/25, Resident #5 was found on the floor in front of the door with a laceration over her right eye.
-She was sent to the ED and returned the same day with 1 stitch above right her eye.

Review of Resident #5's hospital ED visit note dated 01/13/25 revealed:
-She had an unwitnessed fall.
-She sustained a laceration above the right eyebrow, which was closed with 1 suture, with skin abrasions noted around the laceration and edema around the right eye.

Review of the service plan dated 11/22/24 revealed there were no interventions implemented after the fall on 01/13/25.

Review of Resident #5's hospice note dated 01/13/25 revealed:
-The hospice nurse was notified that Resident #5 had fallen, hit her head just above her left eye, and she was bleeding
-The hospice nurse received a second call before arriving at the facility and was informed Resident #5 was being transferred to the ED.

Attempted telephone interview with the hospice nurse on 02/21/25 at 9:09am was unsuccessful.

h. Review of Resident #5's incident/accident reports revealed there was no report dated 01/14/25 available for review.

Review of Resident #5's electronic progress notes dated 01/14/25 revealed:
She had an unwitnessed fall; the resident hit her head with an abrasion on her head above her left

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D 270	Continued From page 43 eye; her service plan was reviewed with no updates. -On 01/15/25, staff attempted to keep her in the common area while she was awake to increase supervision due to recent falls with head injuries. Review of the service plan dated 11/22/24 revealed there were no interventions implemented after the fall on 01/14/25. _____ Telephone interview with the Supervisor of the hospice agency on 02/21/25 at 9:09am revealed: -The facility staff should notify hospice each time Resident #5 had a fall. -The hospice nurse would assess Resident #5 and the hospice nurse would notify the doctor if needed. -The hospice nurse documented all visits with Resident #5. Interview with the Administrator on 02/19/25 at 5:15pm revealed: -Each PCAs assignment was on the electronic tablet. -The PCAs had access to their assigned residents' service plans and tasks to be done for each shift. -Supervision of the residents was based on the service plan. -There was no frequency of time the PCAs had to check on the residents; it was based on the tasks entered onto the service plan. -Interventions for residents who were at high risk for falls were entered into the service plan by the SCC. -The SCC would place the task onto the electronic tablet, speak to the PCA about the task that was added, and communicate with all staff through the communication board within the facility's electronic system.	D 270		

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-The SCC could review reports to ensure the interventions were done.

Interview with a PCA on 02/19/25 at 11:13am revealed:
-She had found Resident #5 on the floor.
-Resident #5 would forget she could not walk by herself because she had dementia.
-She would tell the Supervisor when she found a resident on the floor.
-She was not told anything to do for Resident #5 than to "watch her".

Interview with a medication aide (MA) on 02/21/25 at 12:15pm revealed:
-When a resident fell, the MA only got involved if the resident had to be sent out of the facility.
-Otherwise, the Supervisor would assess the resident.
-If the Supervisor was not in the facility, it would be the MA's responsibility to assess the resident.
-She would call the nurse on call and let them know a resident had fallen.
-Once fall precautions were put in place, the PCA would implement them.

Telephone interview with a second MA on 02/24/25 at 8:35am revealed:
-If there was an unwitnessed fall, the resident would be sent to the ED; if the resident was receiving hospice, they would be called to see if the resident should be sent out.
-The MA and/or PCA would notify EMS, the Primary Care Provider (PCP) and the family, when residents were sent to the ED.
-The PCA would document in the progress notes and on Risk Connect the events of the fall.
-An occurrence report (an internal document completed by the PCAs about the fall) would be completed and faxed to the PCP.

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-The staff had been instructed to "keep an eye on the residents with falls" and "to watch them closer".
-She was instructed to increase checks on Resident #5 from every 2 hours to 1 hour because Resident #5 was falling a lot from her bed; she did not recall who told her or when she was told.
-Each time Resident #5 fell or was found on the floor, the staff would document on the progress notes.

Telephone interview with a third MA on 02/24/25 at 9:17am revealed:
-When a resident had a witnessed or unwitnessed fall, the staff called EMS.
-The MA did not recall what documentation was completed for a fall.
-Residents in the Special Care Unit (SCU) could have a fall and the MA on second shift would not know about it; the PCA would report the fall to the Supervisor, and they would handle everything.
-The Supervisor in the SCU would call EMS and notify the family and the PCP.
-Residents with frequent falls could be placed in wheelchairs, but the supervision was the same.

Interview with a fifth MA on 02/24/25 at 11:43pm revealed:
-She knew Resident #5 had fallen twice over the past 3 months.
-The MAs did not do the incident reports; the PCAs checked vital signs and completed the incident reports, occurrence reports, and notified the family and the PCP.
-The PCAs did not have to report a fall to the MA, so Resident #5 may have had more falls than she was aware of.

Interview with the SCC on 02/24/25 at 12:39pm

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revealed:
-The staff had been instructed to place Resident #5 in the bed when she appeared drowsy, and while in bed she would be checked on every 1 to 2 hours.
-All interventions put in place for Resident #5 would be in the service plan.
-The PCAs had access to the service plan when they signed into their tablets.
-When a resident fell and was on hospice, the staff would call hospice first; if the resident was not on hospice, they were to call the nurse to assess the resident.
-If the resident fell and hit their head, the resident would be sent to the ED, and the nurse would assess the resident upon return from the ED.
-The PCA would complete an occurrence report, report the incident to her and she would give the statement to the Administrator.
-The PCA's immediate Supervisor would enter the information into the electronic system, fax the occurrence report to the PCP, and contact the family.
-The nurses could review the information in the electronic system.
-The information entered in the electronic system was similar to the information on the occurrence report.
-Her responsibility was to ensure measures were put in place related to the fall and the service plan was updated.
-She was responsible for entering the interventions into the service plan.
-Interventions for Resident #5 included placing her in bed when she was drowsy; however, the staff would honor her request if she did not want to lay down, then she would stay in the common area.

Interview with the senior RCD on 02/24/25 at

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D 270	Continued From page 47 2:37pm revealed: -When the PCA found a resident on the floor, they would notify their Supervisor, complete an occurrence report, and fax the report to the PCP. -If the resident was on hospice, the PCA should notify the hospice nurse. -Residents were automatically sent out of the facility if there was an obvious injury such as a laceration, broken bones, or change in their mental state. -The IDT met weekly, discussed the falls, and would come up with interventions to put into place related to the falls. -The SCC would update the service plan and communicate with the staff what interventions had been put into place. -The entries on the service plan were dated and timed stamped with the name of the person who added the interventions. -The service plan should be updated after each fall. -If the interventions put in place were not working in 30 to 60 days, then new interventions would be added. Interview with the Administrator on 02/24/25 at 5:24pm revealed: -When a resident was found on the floor the staff would assess the resident. -If the resident exhibited pain or hit their head, the staff would call 911. -The staff were not to move the residents. -The information regarding the fall would be entered into the electronic system and management would be able to see there was a fall and read the comments in the progress notes. -Interventions would be implemented at the weekly interdisciplinary meeting and the interventions would be added to the service plan by the SCC.	D 270		

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D 270	Continued From page 48 -Interventions were individualized for each fall. -Each fall should have an intervention added to the service plan. _____ The facility failed to ensure supervision was provided according to each resident's assessed needs and current symptoms, including a resident (#4), who had a diagnosis of Alzheimer's disease and was intermittently disoriented and had history of physically aggressive behaviors, wandering in other resident's rooms, and was seen hitting a female resident when she was lying on a couch. Resident #4 then entered the same female resident's room and when the private sitter came on shift the next morning, she found the female resident's incontinent brief and pajama bottoms pulled down; and a resident (#5) who had 16 documented falls from 05/05/24 to 01/14/25, including 8 with injuries, requiring multiple ED visits for stapling and suturing of lacerations, with ineffective fall interventions to protect the resident from falls and injury. The facility's failure resulted in serious physical harm and injury, and mental anguish to the resident, which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/19/25. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 26, 2025.	D 270		
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.	D 273		

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

Based on record reviews and interviews, the facility failed to ensure physician notification for 2 of 5 sampled residents (#1,#4) related to medication refusals (#1) and weight loss (#4).

The findings are:

1. Review of the facility's nutrition and weight management program dated 01/09/19 revealed:
-Residents were weighed at the time of admission and then monthly, or if there was a significant change in condition, to evaluate trends, or in accordance with the healthcare provider's orders.
-All weights were recorded in the resident's electronic health record.
-When a possible weight gain or loss issue was identified, the personal care aide (PCA) used the facility's communication system to notify the nurse.
-The nurse validated the observation by examining the resident.
-If the nurse determined that the resident was unexpectedly gaining or losing weight, the nurse would complete an assessment and document the results in the progress note.
-The nurse would notify the health care provider, family member, and the interdisciplinary team (IDT) about the weight gain/loss.
-The nurse would determine the potential root causes of the weight gain/loss and develop targeted interventions.
-The nurse would review and revise the care plan as needed.
-The nurse would educate and train the facility

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D 273	Continued From page 50 staff on any new treatments and interventions. Review of Resident #4's current FL-2 dated 11/07/24 revealed diagnoses included Alzheimer's disease, dementia, hyperprolactinemia, and type 2 diabetes. Review of Resident #4's service plan dated 07/18/24 revealed there was an intervention to observe and report if the resident had any of the following adverse reactions to antipsychotic medications including weight loss. Review of Resident #4's weights and vitals summary form revealed: -On 08/20/24, Resident #4's weight was 185.6 pounds (lbs), sitting. -On 09/04/24, Resident #4's weight was 179.8 lbs, sitting. -On 09/19/24, Resident #4's weight was 174.4 lbs, sitting. -On 10/06/24, Resident #4's weight was 174.6 lbs, sitting. -On 11/05/24, Resident #4's weight was 167.0 lbs, sitting. -On 12/09/24, Resident #4's weight was 151.6 lbs, sitting. -On 01/16/25, Resident #4's weight was 152.0 lbs, sitting. -On 02/01/25, Resident #4's weight was 150.0 lbs, sitting. -On 02/06/25, Resident #4's weight was 150.0 lbs, sitting. -On 02/13/25, Resident #4's weight was 154.0 lbs, sitting. Observation of Resident #4's weight on 02/21/25 at 1:22pm revealed Resident #4's weight was 161.2 lbs, standing.	D 273		

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Interview with a personal care aide (PCA) on 02/21/25 at 1:22pm revealed Resident #4 was usually weighed sitting but that scale was not working.

Based on Resident #4's documented weights, he had a weight loss of 35 lbs from 08/20/24 to 02/01/25 which was a 19% weight loss in six months and he had a 9% weight loss from 11/05/24 to 12/09/24.

Review of Resident #4's physician's order form dated 11/12/24 revealed:
-Resident #4's family member had requested a nutritional supplement be ordered for Resident #4 to help him with his weight due to weight loss.
-An order was written as a verbal order by the nurse on 11/12/24, for a nutritional supplement twice daily due to weight loss.
-The verbal order was signed by the primary care provider (PCP) on 11/14/24.

Telephone interview with a PCA on 02/20/25 at 8:05pm revealed:
-Resident #4's clothes were too big.
-She had noticed Resident #4 had lost weight, but not that much.

Telephone interview with Resident #4's family member on 02/21/25 at 8:57am revealed:
-She was concerned Resident #4 was losing weight and requested the nutritional supplement.
-Resident #4 had dropped 20 lbs-30 lbs.

Interview with a medication aide (MA) on 02/21/25 at 11:47am revealed:
-Resident #4 appeared to have lost weight.
-The Special Care Coordinator (SCC) was responsible for ensuring weights were obtained monthly and the documented weights were

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BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

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D 273	Continued From page 52 reviewed by the nursing staff. Interview with the SCC on 02/24/25 at 12:40pm revealed: -The PCAs were responsible for weighing the residents, she entered the weights in the computer and the nurses were responsible for reviewing them. -She noticed last week (week of 02/17/25) that Resident #4 looked like he had lost weight, but she looked at his recent weights and they seemed okay. Telephone interview with Resident #4's PCP on 02/20/25 at 9:24am revealed: -She had not been notified of Resident #4's weight loss by facility staff. -She expected staff to monitor the resident's weight loss trend and notify her. Telephone interview with Resident #4's mental health (MHP) on 02/20/25 at 4:39pm revealed: -She expected to be notified if Resident #4 had weight loss. -She would want to know why the resident had lost weight, was the resident sleeping all day, or was he missing meals because he was too sedated. -She would need to know Resident #4 had weight loss so she would know how to address it. Interview with the Senior Resident Care Director (RCD) on 02/24/25 at 2:50pm revealed: -The PCAs weighed the residents, and the nurses should be reviewing the weights. -If a resident had more than a 5 lb weight loss in a month, she would ask the PCAs to reweigh the resident and confirm the weight loss and then notify the PCP. -She did not recall if she had notified Resident	D 273		

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#4's PCP of weight loss or not.
-She was concerned Resident #4 had weight loss.

Interview with the Administrator on 02/24/25 at 4:52pm revealed:
-The PCAs were responsible for weighing the residents and entering the information in the computer system.
-The nurses would then be able to review the weights and notify the PCP of a significant weight loss.
-A significant weight loss was a 5% change in one month.
-His concern would be the resident's health and if the resident was losing weight, an intervention needed to be put in place.

Based on observations, record reviews, and interviews, Resident #4 was not interviewable.

2. Review of Resident #1's current FL2 dated 01/23/25 revealed:
-Diagnoses included emphysema, asthma, and sleep apnea.
-There was an order for fluticasone propionate nasal spray (used to treat allergy symptoms) 50mcg one spray both nostrils twice a day.

Review of Resident #1's January 2025 electronic medication administration record (eMAR) from 01/23/25 to 01/31/25 revealed:
-There was an entry for fluticasone propionate nasal spray 50mcg 1 spray both nostrils twice a day for allergy symptoms with scheduled administration times of 7:00am-9:00am and 7:00pm to 9:00pm.
-There were six refusals of fluticasone propionate nasal spray documented at the 7:00am to 7:00pm administration time.

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D 273	Continued From page 54 -There were five refusals of fluticasone propionate nasal spray documented at the 7:00pm to 7:00am administration time. Review of Resident #1's February 2025 eMAR from 02/01/25 to 02/18/25 revealed: -There was an entry for fluticasone propionate nasal spray 50mcg 1 spray both nostrils twice a day for allergy symptoms with scheduled administration times of 7:00am-9:00am and 7:00pm to 9:00pm. -There were sixteen refusals of fluticasone propionate nasal spray documented at the 7:00am to 7:00pm administration time. -There were eleven refusals of fluticasone propionate nasal spray documented at the 7:00pm to 9:00pm administration time. Review of Resident #1's record revealed no documentation the primary care provider (PCP) had been notified of the medication refusals. Interview with Resident #1 on 02/18/25 at 5:20pm revealed: -She had nasal spray that the staff brought to her, but she did not like it. -The nasal spray did not really work for her, and she refused it almost every day. -She could not recall the last time she used the nasal spray. Interview with a medication aide (MA) on 02/21/25 at 1:00pm revealed: -Resident #1 frequently refused her nasal spray. -She sent an alert to the nurse via the electronic charting system that Resident #1 was refusing her nasal spray back in January 2025. -The nurse was supposed to review the alerts and notify the PCP.	D 273		

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D 273	Continued From page 55 Interview with the senior Resident Care Director (RCD) on 02/21/25 at 12:55pm revealed: -She was not aware Resident #1 was refusing her nasal spray. -She did not know if she had received an alert via the electronic charting system that Resident #1 was refusing her medications. -The MAs were supposed to let her know so she could let the PCP know. Interview with a nurse from Resident #1's PCPs office on 02/21/25 at 12:40pm revealed: -Resident #1 was last seen in the office on 02/04/25. -During the visit, Resident #1's orders were reviewed. -The PCP's office had not reviewed Resident #1's eMAR. -The PCP's office had not been notified of Resident #1's multiple refusals of fluticasone propionate. -It was important for the facility to report medication refusals, so they had a correct reconciliation of Resident #1's medications. -The PCP may have wanted to try an alternate medication for Resident #1 if he was aware of the multiple refusals. Interview with the senior RCD on 02/21/25 at 1:55pm revealed: -There was a report that should be pulled to look at the medication refusals. -The MAs should let her know verbally that medications were being refused. -After one refusal, the MAs should tell her so the PCP could be notified. Interview with the Administrator on 02/24/25 at 4:50pm revealed: -He was very concerned Resident #1 had so	D 273		

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D 273	Continued From page 56 many medication refusals and the PCP had not been notified. -The residents were on specific medications for a reason. -If a resident refused medications two or three times, the family and the PCP needed to be called so changes could be implemented. -The MAs needed to report refusals daily to the RCD. -The RCD was responsible for pulling a daily report that showed medication refusals and following-up as indicated. _____ The facility failed to ensure physician notification for Resident #4, who had a diagnosis of Alzheimer's Disease and resided on a special care unit. The resident's care plan included an intervention to report if the resident had any adverse reactions to antipsychotic medications which included weight loss. The resident had lost 35 pounds from 08/20/24 to 02/01/25 and had a 9% weight loss from 11/05/24 to 12/09/24, which was not reported to the resident's provider. This failure was detrimental to the safety, health, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 12, 2025. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 10, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

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following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to implement physician's orders for 1 of 5 sampled residents (#1) for compression socks and oxygen.

The findings are:

Review of Resident #1's current FL2 dated 01/23/25 revealed diagnoses of atrial fibrillation, asthma, emphysema, hypertension, hyperlipidemia, and depression.

a. Review of Resident #1's current FL2 dated 01/23/25 revealed there was an order for compression socks.

Review of Resident #1's January 2025 from 01/23/25 to 01/31/25, and February 2025 from 02/01/25 to 02/18/25 electronic medication administration record (eMAR) revealed there was no entry for compression socks.

Observation of Resident #1 on 02/18/25 at 8:55am revealed:
-Resident #1 was sitting on the side of her bed with her legs on the floor.
-Resident #1 did not have any swelling to her legs.
-Resident #1 did not have compression socks on.

Interview with Resident #1 on 02/18/25 at 8:55am

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revealed:
-Sometimes her legs got very swollen.
-She went to the hospital last month because she had too much fluid and her legs were swollen.
-She had compression socks but did not have them on because she was going to take a shower.
-The facility did not provide compression socks; her family member had to purchase them.
-The staff did not apply the compression socks.
-She put them on herself in the morning and knew she was supposed to take them off in the evening.

Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 10:20am revealed:
-Resident #1 had a current order for compression socks.
-The order did not include directions for the use of the compression socks.
-The pharmacy did not enter orders for the facility; the facility entered the orders.
-The pharmacy did not add orders to the eMAR.

Interview with a medication aide (MA) on 02/21/25 at 8:00am revealed she was not aware Resident #1 had an order for compression socks.

Interview with another MA on 02/21/25 at 8:10am revealed:
-Resident #1 had swelling in her legs sometimes.
-Resident #1 did not have any swelling in her legs now.
-Resident #1 had an order to wear compression socks.
-Resident #1's service plan indicated to apply compression socks in the morning but not when to remove them.
-Resident #1 put her compression socks on

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D 276	Continued From page 59 herself. Interview with the facility's licensed health professional support (LHPS) nurse on 02/19/25 at 6:00pm revealed: -When she completed an LHPS assessment, she looked at the resident's eMAR and talked to staff to find out what tasks the residents had. -She was not aware Resident #1 had an order for compression socks. -Compression socks were used to prevent edema. -She did not note any edema when she completed Resident #1's LHPS assessment. -She thought compression socks should be on the eMAR so they could be monitored. Interview with the facility's Licensed Practical Nurse (LPN) on 02/21/25 at 9:41am revealed: -Resident #1 had edema to her lower legs off and on. -She did not see an order for Resident #1 to have compression socks. -If she had an order for compression socks, it would be added to the service plan and a new focus would be added so the personal care aide (PCA) and the MA knew when to apply them and remove them. -She was not sure if compression socks should be documented on the eMAR because the MAs did not assess. Interview with the senior Resident Care Director (RCD) on 02/21/25 at 1:54pm revealed: -Resident #1 had an order for compression socks. -Compression socks were entered on the service plan for the PCAs. -There was not a system in place to monitor the PCAs to make sure compression socks were on.	D 276		

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D 276	Continued From page 60 -She was concerned Resident #1 could have edema that no one was aware of and would need to be sent to the hospital. -When she worked on a medication cart, she did not have time to apply compression socks. Interview with the Administrator on 02/24/25 at 4:50pm revealed: -Compression socks would be a task the lead PCA would add to the care plan. -The PCAs applied and removed compression socks. Refer to the interview with the Administrator on 02/24/25 at 4:50pm. b. Review of Resident #1's current FL2 dated 01/23/25 revealed there was an order for oxygen 2L/minute at bedtime. Review of Resident #1's January 2025 from 01/23/25 to 01/31/25 and February 2025 from 02/01/25 to 02/18/25 eMAR revealed there was no entry for oxygen. Observation of Resident #1 on 02/18/25 at 8:55am revealed: -Resident #1 was sitting on the side of her bed. -There was an oxygen concentrator in her room. -She was not short of breath. Interview with Resident #1 on 02/18/25 at 8:55am revealed: -She did not use her oxygen continuously. -She used her oxygen when she needed it, at night, and sometimes during the day. -She got short of breath when she moved around. -The staff were aware she had frequent episodes of shortness of breath.	D 276		

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D 276	Continued From page 61 Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 10:20am revealed: -Resident #1 had an order for oxygen 2L/min at bedtime. -The pharmacy did not enter orders for the facility; the facility entered their own orders. -Oxygen did not get entered onto the eMAR. Telephone interview with a nurse from Resident #1's PCP's office on 02/21/25 revealed: -Resident #1 had an order for oxygen at night. -Resident #1 had end stage emphysema and was frequently short of breath. -Resident #1 should wear her oxygen at bedtime. Interview with a MA on 02/21/25 at 8:00am revealed: -Resident #1 used oxygen at night. -If she noticed a problem with Resident #1 being short of breath or unable to breathe, she would let the nurse know. Interview with the facility's LPN on 02/21/25 at 9:41am revealed: -Resident #1 had an order for oxygen. -She did not know if oxygen was something that should be on the eMAR. -Oxygen was on the service plan for the PCAs to check off that it was on. Interview with the senior RCD on 02/21/25 at 1:54pm revealed: -Resident #1 had an order for oxygen. -Oxygen use would go on the service plan for the PCAs to apply. -There was not a system in place to monitor the PCAs to make sure oxygen was being used as ordered. -She was concerned that Resident #1 could have	D 276		

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D 276	Continued From page 62 shortness of breath that no one was aware of and would need to be sent to the hospital. Interview with the Administrator on 02/24/25 at 4:50pm revealed: -Oxygen would be a task the lead PCA would add to the service plan. -The PCAs assisted with applying oxygen. -The PCAs were trained to identify if oxygen was on or not on and reported via clinical reports in the electronic record. -The LPN would follow up as needed. Refer to the interview with the Administrator on 02/24/25 at 4:50pm. _____ Interview with the Administrator on 02/24/25 at 4:50pm revealed: -The care coordinators were responsible for adding tasks to a resident's care plan. -The PCAs would see any new tasks added to the service plan on the electronic device they used daily. -PCAs were trained to report changes to the LPN for follow-up.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to serve therapeutic	D 310		

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diets as ordered for 2 of 2 sampled residents (#4 and #7), who had an order for a nutritional supplement (#4) and an order for a regular diet and thin liquids (#7).

The findings are:

Review of Resident #7's current FL2 dated 11/16/22 revealed:
-Diagnoses included Alzheimer's disease, atrial fibrillation, osteoporosis, chronic diarrhea, and scoliosis.
-There was no diet listed.

Review of the facility's therapeutic diet list dated 02/18/25 revealed Resident #7 was to be served a pureed diet with nectar thickened liquids.

Review of the facility's therapeutic diet extensions for a pureed diet for the lunch meal service used for guidance on Tuesday, 02/18/25 revealed Resident #7 was to be served pureed chicken and rice, pureed kale, chocolate pudding, nectar thickened water, nectar thickened milk, and nectar thickened tea.

Observation of the lunch meal service on 02/18/25 from 12:10pm-12:45pm revealed:
-At 12:10pm, Resident #7 was served her lunch meal.
-The meal consisted of 4 pureed items, three were green in color and the fourth item was brown.
-She was served a cup of tea with ice, water with ice, and milk; the beverages were not thickened.
-The resident looked at the meal and stated, "This is liquid, I cannot eat this."
-She later stated this looks like chicken [expletive].
-She did not eat any of the pureed items.

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-She continuously looked at other residents' meals and her meal as if she was confused.
-At 12:31pm, Resident #7 was given a small bowl, of soup with green beans, small, diced potatoes, and carrots.
-She ate 100% of the soup.
-She drank 100% of her tea.

Interview with a personal care aide (PCA) on 02/21/25 at 10:01am revealed:
-She served food in the Special Care Unit (SCU).
-The cart came in from the kitchen with the meals prepared and ready to serve.
-Resident #7 was on a regular diet with thin liquids.
-Resident #7 only ate regular foods.
-She only served Resident #7 a regular diet with thin liquids.
-She was not made aware Resident #7's diet had been changed to a pureed diet with nectar thickened liquids.

Interview with Resident #7 on 02/18/25 at 5:08pm revealed:
-She always got a regular meal and regular drinks.
-She had never had a meal like her lunch today, 02/18/25, and could not eat it.
-She did not have any swallowing problems and did not cough after eating and/or drinking.
-She did not understand why she had to eat in her room.
-She had not done anything, and they told her she had to leave the dining room and go to her room.
-She did not understand "what was going on".

Observation of the SCU on 02/18/25 at 5:26 p.m. revealed the Special Care Coordinator (SCC) was in the hallway and was heard telling another staff member that Resident #7 was upset over

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her meal and did not want to comply with her diet order.

Review of the facility's therapeutic diet extensions for a pureed diet for the dinner meal service used for guidance on Tuesday, 02/18/25 revealed Resident #7 was to be served pureed Mediterranean vegetable soup, pureed dinner roll, pureed chocolate ice cream, nectar thickened water, nectar thickened milk, and nectar thickened tea.

Observation of Resident #7's dinner meal on 02/18/25 at 5:08pm revealed:
-She was eating in her room.
-She was served a cheeseburger and potato chips.
-She had eaten ½ of the cheeseburger.
-She was served a cup of tea with ice, water with ice, and milk; the beverages were not thickened.

Second interview with Resident #7 on 02/18/25 at 5:08pm revealed:
-She ate all of her dinner.
-She did not have any problems with eating her dinner.

Review of Resident #7's diet order dated 02/19/25 revealed an order for a regular diet with thin liquids.

Interview with Resident #7 on 02/21/25 at 10:17am revealed:
-She had been served a regular diet with thin liquids since she lived at the facility.
-She did not know why her diet was changed from a regular diet to a pureed diet.
-This week she had been served different diets and staff could not tell her why.

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Interview with a dietary aide (DA) on 02/21/25 at 10:31am revealed:
-The kitchen staff had a diet list that they followed when they plated the residents' meals.
-She used a tablet to see the diets, supplements, and thickened liquids for the residents.
-Dietary staff were responsible for ensuring the diet list was correct.
-The nursing staff notified dietary staff when a resident's diet order changed.
-Resident #7's diet changed a few weeks ago to a pureed diet with nectar thickened liquids when she returned to the facility from the hospital.
-Nursing notified the dietary staff on 02/19/25 Resident #7's diet changed to a regular diet with thin liquids.

Interview with the Dietary Manager (DM) on 02/21/25 at 10:40am revealed:
-Nursing and the DM were responsible for ensuring the dietary staff had correct diet orders.
-Staff used a computer system to enter all diet orders and dietary staff would see the alert when they signed into the computer system.
-Nursing entered all diet orders into the computer system.
-Staff on the SCU were responsible for looking at the tablet to make sure they were serving the correct meals to the residents.
-On 02/19/25, Resident #7's diet upgraded to a regular diet with thin liquids.
-Resident #7 was previously ordered a pureed diet with nectar thickened liquids.
-She could not recall when Resident #7's diet downgraded to a pureed diet with nectar thickened liquids.

Interview with Resident #7's responsible party on 02/21/25 at 12:51pm revealed:
-Resident #7 was on a regular diet with thin

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liquids since December 2022 with no restrictions.
-Two weeks ago, Resident #7 went to the hospital and returned to the facility with a pureed diet with nectar thickened liquids.
-The facility could not provide her with paperwork showing why Resident #7's diet had been changed to a pureed diet with nectar thickened liquids.
-She contacted the SCC on 02/03/25 to upgrade the diet.
-The diet was not changed.
-She called the Speech Therapist (ST) on 02/17/25 to have an evaluation to upgrade the resident's diet.
-The ST did not have any evidence Resident #7 was having swallowing issues.
-Resident #7 did not like the pureed diet and was resistant to it.
-On 02/19/25, during the dinner meal service, Resident #7 took another tray in the SCU and ate the food because she did not want the pureed meal she was served.
-The diet change caused Resident #7 to be anxious.

Telephone interview with Resident #7's ST on 02/24/25 at 8:49am revealed:
-The facility contacted her on 02/17/25 to request an evaluation for Resident #7.
-The resident went to the hospital and was placed on a downgraded diet (pureed diet with nectar thickened liquids).
-On 02/19/25, the evaluation was completed for Resident #7 and her diet was upgraded to a regular diet with thin liquids.
-She faxed the updated diet to the facility on 02/19/25.

Interview with the SCC on 02/24/25 at 12:39pm revealed:

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D 310	Continued From page 68 -It was the Resident Care Director's (RCD) responsibility to notify the SCC of Resident #7's diet change. -She was notified Resident #7's diet was downgraded to a pureed diet with nectar thickened liquids. -She could not recall when she was notified of the diet change. Interview with the senior RCD on 02/24/25 at 2:38pm revealed: -On 02/17/25, she realized the diet was incorrect because the resident did not want to eat her food. -ST was contacted on 02/17/25 by the facility to complete an evaluation. -On 02/19/25, a ST evaluation was completed and Resident #7's diet was upgraded to a regular diet with thin liquids. Interview with the Administrator on 02/24/25 at 4:51pm revealed: -The senior RCD was responsible for ensuring Resident #7's diet was entered correctly in the computer system after the resident returned from the hospital. -The senior RCD entered the incorrect diet order to downgrade Resident #7's diet to a pureed diet with nectar thickened liquids. -He was aware Resident #7 was upset due to the diet change from a regular diet to a pureed diet. -On 02/17/25, ST was contacted to complete an evaluation to upgrade the resident's diet to a regular diet. -On 02/19/25, Resident #7's diet was upgraded to a regular diet with thin liquids. -He expected the senior RCD to enter diet orders correctly as ordered by the physician. -He was concerned that if Resident #7 did not eat she would lose weight.	D 310		

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D 310	Continued From page 69 2. Review of Resident #4's current FL-2 dated 11/07/24 revealed diagnoses included Alzheimer's disease, dementia, hyperprolactinemia, and type 2 diabetes. Review of Resident #4's physician's order form dated 11/12/24 revealed: -Resident #4's family member had requested a nutritional supplement be ordered for Resident #4 due to weight loss. -An order was written as a verbal order by the facility's Licensed Practical Nurse (LPN) on 11/12/24, for a nutritional supplement twice daily due to weight loss. -The verbal order was signed by the primary care provider (PCP) on 11/14/24. Review of Resident #4's PCP order dated 02/04/25 revealed an order for a nutritional supplement twice daily. Review of Resident #4's November 2024 electronic medication administration record (eMAR) from 11/12/24-11/30/24 revealed: -There was no entry for a nutritional supplement. -There was no documentation a nutritional supplement was administered. Review of Resident #4's December 2024 eMAR revealed: -There was no entry for a nutritional supplement. -There was no documentation a nutritional supplement was administered. Review of Resident #4's January 2025 eMAR revealed: -There was no entry for a nutritional supplement. -There was no documentation a nutritional supplement was administered.	D 310		

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Review of Resident #4's February 2025 eMAR from 02/01/25-02/21/25 revealed:
-There was an entry for a nutritional supplement twice daily with a scheduled administration time of 9:00am and 3:00pm.
-The nutritional supplement was documented as administered twice daily from 02/05/25-02/20/25.

Observation of Resident #4's nutritional supplement on hand on 02/21/25 at 11:42am revealed there were 14 bottles of the nutritional supplement available to be administered.

Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 3:17pm revealed:
-Resident #4 had an active order for a nutritional supplement twice daily dated 11/12/24.
-On 11/12/24, one case of a nutritional supplement, which was twenty-four containers, was dispensed for a 12-day supply.
-On 02/04/25, a second order was received for Resident #4, (the order was the same) one nutritional supplement twice daily.
-On 02/04/25 and on 02/14/25, one case, twenty-four containers, were dispensed; each dispensing was a 12-day supply.
-The nutritional supplement was not on automatic refill and would need to be reordered as needed.

Telephone interview with Resident #4's family member on 02/21/25 at 8:57am revealed:
-She was concerned Resident #4 was losing weight and requested the order for the nutritional supplement.
-Resident #4 had dropped 20 lbs-30 lbs since he was admitted to the facility.
-The facility was providing Resident #4's nutritional supplement; she had not purchased any.

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D 310	Continued From page 71 Review of Resident #4's weights and vitals summary form revealed: -On 08/20/24, Resident #4's weight was 185.6 pounds (lbs), sitting. -On 09/04/24, Resident #4's weight was 179.8 lbs, sitting. -On 09/19/24, Resident #4's weight was 174.4 lbs, sitting. -On 10/06/24, Resident #4's weight was 174.6 lbs, sitting. -On 11/05/24, Resident #4's weight was 167.0 lbs, sitting. -On 12/09/24, Resident #4's weight was 151.6 lbs, sitting. -On 01/16/25, Resident #4's weight was 152.0 lbs, sitting. -On 02/01/25, Resident #4's weight was 150.0 lbs, sitting. -On 02/06/25, Resident #4's weight was 150.0 lbs, sitting. -On 02/13/25, Resident #4's weight was 154.0 lbs, sitting. Based on Resident #4's documented weights, he had a weight loss of 35 lbs from 08/20/24 to 02/01/25 which was a 19% weight loss in six months and he had a 9% weight loss from 11/05/24 to 12/09/24. Observation of Resident #4's weight on 02/21/25 at 1:22pm revealed Resident #4's weight was 161.2 lbs standing. Interview with a personal care aide (PCA) on 02/21/25 at 1:22pm revealed Resident #4 was usually weighed sitting but that scale was not working. Telephone interview with a medication aide (MA)	D 310		

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on 02/21/25 at 12:15pm revealed:
-She gave Resident #4 a nutritional supplement twice during her shift.
-If a resident had an order for a nutritional supplement there would be an entry on the eMAR and the MA would document when it was given.
-An exception would be documented if it was not provided to the resident and why.

Telephone interview with another MA on 02/24/25 at 9:17am revealed:
-She administered Resident #4's nutritional supplement once during her shift; usually between 2:00pm-6:00pm.
-She did not recall if Resident #4 was administered a nutritional supplement in November 2024, but if it was administered it would be documented on the eMAR.

Interview with the Special Care Coordinator (SCC) on 02/24/25 at 12:40pm revealed:
-The MAs were responsible for administering and documenting nutritional supplements.
-She did not respond when asked about the order for the nutritional supplement in November 2024.

Interview with the senior Resident Care Director (RCD) on 02/24/25 at 2:50pm revealed:
-The nurses were responsible for entering new orders into the eMAR system.
-If Resident #4's order for a nutritional supplement was not entered into the eMAR and was not documented, the nutritional supplement may have not been administered.

Telephone interview with Resident #4's PCP on 02/20/25 at 9:24am revealed:
-She ordered a nutritional supplement for Resident #4 due to the resident's decreased appetite.

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D 310	Continued From page 73 -She was concerned Resident #4 was not being given his nutritional supplement as ordered because the resident would not be getting the protein and calories he needed for his overall health and well-being. Interview with the Administrator on 02/24/25 at 4:52pm revealed: -The nurse would have entered Resident #4's order for the nutritional supplement in the eMAR when it was received in November 2024. -He was concerned the order was received due to the resident's weight loss and the nutritional supplement was not administered as ordered. Based on observations, record reviews, and interviews, Resident #4 was not interviewable.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#5) was protected from harm and her privacy was maintained when the resident was hit by a male resident and the same male resident wandered into the resident's room; and the facility staff did not ensure the resident's bedroom door was locked after being notified by the resident's family member multiple times requesting the	D 338		

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room be locked due other residents who wandered.

The findings are:

1. Review of the facility's abuse policy dated 05/04/16 revealed:
-The community should prevent abuse.
-Team members of the facility should report known or suspected abuse to the local, state, and federal authorities.
-Team members who know of or suspect abuse, of any resident must immediately notify the Administrator or designee to ensure appropriate action is timely taken for the safety of the residents.
-Resident to resident altercations were treated as abuse.
-Abuse is the infliction of injury or intimidation resulting in physical harm, pain or mental anguish.
-Physical abuse is the willful infliction of bodily injury or physical harm upon any resident, including hitting, slapping, pinching, or kicking.
-Sexual abuse was any form of nonconsensual sexual contact, including but not limited to inappropriate touching, sexual harassment, sexual coercion, or sexual assault.
-Resident to resident altercation was action by one resident against another resident that has the potential to physically or psychologically injure or harm another resident.

Review of Resident #5's current FL-2 dated 08/20/24 revealed:
-Diagnoses included dementia in other diagnoses with mood disturbances, major depression disorder, and hypertension.
-She was intermittently confused.
-She ambulated with the assistance of a

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wheelchair.
-She communicated verbally at times.

Review of Resident #5's service plan dated 11/22/24 revealed:
-The focus area was a secure neighborhood and a diagnosis of dementia.
-The goal initiated on 05/13/23 was her safety and security would be maintained through the next review.
-Resident #5's service plan was reviewed on 02/03/24 with no additional goals or interventions added related to the focus of a secure neighborhood.
-There was no intervention to lock Resident #4's door on the service plan.

a. Review of Resident #5's incident/accident report dated 01/29/25 revealed:
-At 7:30pm, staff reported Resident #5 was struck in the face by another resident.
-Hospice was notified, and Resident #5 was assessed by the hospice nurse.
-The report was completed by the Administrator on 01/30/25.

Review of Resident #5's progress note dated 01/30/25 revealed:
-A head to toe assessment was completed by the senior Resident Care Director (RCD).
-Resident #5 had a red abrasion over her right eyebrow; there was no swelling.
-There was no other skin abnormalities noted.
-Resident #5 denied pain or discomfort.
-Hospice was notified and staff was instructed not to send the resident to the emergency department (ED); the hospice nurse would visit.

Review of Resident #5's hospice nurse's visit note dated 01/30/25 revealed:

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D 338	Continued From page 76 -On arrival, Resident #5 was laying in bed with a private duty sitter present. -Resident #5 reported she was hit in the right jaw by another resident. -There was no bruising or swelling noted. -There was a red area noted above the right eyebrow. -Resident #5 responded 'nu-uh' to pain or tenderness. -Resident #5 was able to to state her name, location, month and year. Review of Resident #5's hospice social worker's visit note dated 01/30/25 revealed: -Resident #5 had an altercation with another resident on 01/29/25. -Resident #5 was laying on the couch and was hit in the face by another resident. -Resident #5 had a visible red mark on her forehead. -Resident #5 became anxious when the private duty sitter left the room. Interview with two family members of Resident #5 on 02/20/25 at 11:00am revealed: -On Monday, 01/30/25 at 7:30am, the family was notified that Resident #5 was hit by a male resident on 01/29/25 in the dining room in front of other residents and staff. -On 01/30/25, the family went to the facility to check on Resident #5 and met with the Administrator regarding the incident. -The Administrator stated, "He was not going to comment, he was going to investigate." -The family did not hear from the Administrator about the investigation into the incident on 01/29/25. -The family placed an electronic recording device in Resident #5's room after the incident on 01/29/25.	D 338		

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-The family was told by Special Care Unit (SCU) staff that the male resident had a private duty sitter put in place for 12 hours during the day after the incident on 01/29/25.

Telephone interview with a personal care aide (PCA) on 02/20/25 at 8:05pm revealed:
-After dinner on 01/29/25 the staff laid Resident #5 on the couch in the common area.
-A [named] male resident stopped at the end of the couch and just started hitting Resident #5.
-The male resident hit Resident #5 three times with a closed fist on her forehead area.
-Resident #5 grabbed the male resident's arm and tried to push him away.
-The PCA was able to "grab" the male resident and sit him down.
-She was not aware of any previous behaviors between Resident #5 and the male resident but she did not start working until November 2024.

Telephone interview with another PCA on 02/20/25 at 8:13pm revealed:
-She worked on 01/29/25 when the incident between Resident #5 and the [named] male resident occurred.
-Resident #5 was lying on the couch in the common area and the male resident was walking around in the dining room and common area.
-The male resident stopped at the couch and hit Resident #5 three times with a closed fist on her forehead.
-The staff reacted immediately; she grabbed the male resident and sat him in a chair.
-She asked Resident #5 if she was okay, and she responded, "she was okay".
-She asked Resident #5 if she was hurt, and she responded, "no".
-Another PCA took Resident #5 to her room, and she reported the incident to the medication aide

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BRIGHTON GARDENS OF WINSTON SALEM	2601 REYNOLDA ROAD WINSTON SALEM, NC 27106

(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 338	Continued From page 78 (MA). -There was no Supervisor working on 01/29/25 when the incident occurred. Interview with the Administrator on 02/20/25 at 4:10pm revealed: -On 01/29/25, there was an incident between Resident #5 and a [named] male resident. -It was reported that Resident #5 was lying on the couch in the common area, and the male resident tried to move her feet but she would not move them, so he struck her in the head. -The intervention implemented on 01/30/25 for the male resident was a private duty sitter from 8:00am to 8:00pm. -The sitter was for 12 hours during the day because that was when the incident happened. -There had been no previous incidents between Resident #5 and the male resident. b. Review of the time stamped electronic recording of 02/09/25 revealed: -Between 10:06pm-10:12pm, two staff entered Resident #5's room to provide personal care; they closed the door when they exited the room. -At 10:32pm, a male resident entered Resident #5's room and closed the door behind him. -Between 10:33pm-10:34pm, the male resident stood at the foot of Resident #5's bed, looking toward Resident #5, walked toward the electronic recording device, which was on a table against the wall opposite the bedroom door. -Between 10:40pm-10:43pm, the male resident walked back into view of the electronic recording device toward the chest of drawers, which was against the wall, opposite Resident #5's bed, partially opened a drawer and attempted to close the drawer by "bumping' the drawer with his hip. -He opened a second drawer, looked in the drawer, and closed the drawer.	D 338		

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D 338	Continued From page 79 -He walked to the side of the bed closest to the bedroom door, placed his hand on his hips, and appeared to be looking at something on the table. -At 10:44pm, the male resident walked toward the foot of the bed, then to the chest of drawers, picked up something off the top of the chest of drawers and placed it back, walked to the corner of the room and sat down in a chair next to the table the electronic recording device was sitting on. -Between 10:46pm-10:52pm, the male resident picked up the electronic recording device and maneuvered the electronic recording device in his hands. -Between 10:52pm-10:54pm, the male resident stood up and continued to maneuver the electronic recording device in his hands. -At 10:54pm, the electronic recording device stopped recording. Review of the local law enforcement officer's investigation report dated 02/10/25 revealed: -The officer was dispatched to the facility due to a resident-to-resident assault. -There was an electronic recording device in Resident #5's bedroom which recorded the male resident entering Resident #5's bedroom. -Resident #5 was assaulted by the male resident on 01/29/25; the family placed an electronic recording device in Resident #5's room and hired a private sitter after the incident on 01/29/25. -Today, 02/10/25, the electronic recording device was discovered disconnected. -The family member reviewed the electronic recording and discovered the [name] resident had entered Resident #5's bedroom and disconnected the electronic recording device. -The family member advised him that Resident #5's room was to be locked. -The family member advised him that when the	D 338		

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private sitter pulled Resident #5's covers back, she found Resident #5's incontinent brief and pajama bottoms pulled down just above her pubic area.
-He arrived at the facility and was met by the RCD.
-The RCD advised him that emergency medical services (EMS) had been called to transport Resident #5 to the hospital and had requested a SANE kit (a kit used to gather and preserve physical evidence following an instance or allegation of sexual assault) to be completed.
-Resident #5 was unable to communicate and appeared to be in a comatose state.
-He reviewed the electronic recording of the incident dated 02/09/25.
-He spoke with the private sitter and viewed pictures of how the resident was found on the morning of 02/10/25 and a picture of the camera being disabled.
-The private sitter advised him that she had called a family member, and the family member checked the electronic recording device and informed her the male resident had entered Resident #5's room and disabled the electronic recording device.
-The private sitter stated that Resident #5's incontinent brief was pulled further down in the back, just below the buttocks.
-Forensics was called to process the room due to possible sexual assault and seized the bedding and pajamas.
-It was unknown at this time how often staff were checking on Resident #5; according to the RCD it should have been every 2 hours.
-The family members informed him that Resident #5 stated "sexual assault" three times while in the ED.

Telephone interview with the law enforcement

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officer on 02/24/25 at 11:29am revealed:
-He was dispatched to the facility because of an incident with a resident.
-After arriving at the facility, he spoke with a family member and was informed that the private duty sitter noticed Resident #5's pants were pulled down and there was a possibility that "something inappropriate happened" with another resident.
-The family member showed him the video of the incident from the electronic recording device.
-He learned a male resident had been in Resident #5's room and the male resident had 12 hours a day of private sitters.

Review of the hospice nurse's visit note dated 02/10/25 revealed:
-Upon arrival, Resident #5 was lying in bed.
-Resident #5 was nonverbal and could not answer questions; she grunted.
-Resident #5's face was flushed and afebrile; lungs were clear, diminished with a congested cough.
-The private duty sitter stated Resident #5 ate 25% of her breakfast yesterday, 02/09/25 but refused breakfast that morning.
-She asked Resident #5 if someone had touched her or hurt her, and Resident #5 would grunt.
-There was no visible bruising.
-Resident #5 was sent to the ED.

Review of the hospice social worker's visit note dated 02/10/25 revealed:
-Resident #5 was lying on her side upon arrival, moaning.
-Resident #5 was not herself; she was unable to state her name.
-She asked Resident #5 if anyone hurt her last night; Resident #5 was unable to answer.
-The private duty sitter stated upon arrival that

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morning, 02/10/25, she noticed the camera was unplugged and Resident #5 was halfway across the bed with her pants and incontinent brief halfway down.
-She spoke with Resident #5's family member, who informed her the family wanted Resident #5 sent to the hospital for a rape kit.
-There was no bruising to Resident #5's legs.

Review of Resident #5's local hospital discharge summary dated 02/16/25 revealed:
-Her admission diagnoses was suspected elder abuse, community acquired pneumonia of the right lower lobe, and acute pneumonia.
-Her discharge diagnoses were aspiration pneumonia, suspected sexual assault, and hospice care.
-She presented from an assisted living facility (ALF) due to concern for sexual assault at the facility.
-The family had suspicions and had an electronic recording device placed in her room at the facility
-Prior to this admission, she was found disheveled in her room with her underwear missing on the morning of 02/10/25.
-She had worsened mentation from her baseline on the day of admission and was basically nonverbal.
-A SANE exam was completed in the ED.
-Her urine was noninfectious, but she did have protein, ketones, and blood in her urine.
-She was discharged to the care of hospice on 02/16/25.

Review of Resident #5's progress notes revealed there was no documentation of the incident on 02/10/25.
Review of Resident #5's incident/accident reports revealed there was no report dated 02/10/25 available for review.

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D 338	Continued From page 83 Review of a PCA's written statement dated 02/10/25 revealed: -She worked third shift from 10:30pm to 6:30am. -She made her first round between 11:30pm and 12:00am and every 2 hours afterwards. -She made her last round between 5:00am to 5:30am; Resident #5's ostomy bag was changed, her incontinent brief was dry, her clothes were pulled up and she was covered with her blanket. -After she provided care to Resident #5, she did not see any residents up in the community. Interview with a PCA on 02/19/25 at 11:13am revealed: -She worked third shift on 02/09/25 and cared for Resident #5. -Second shift reported that Resident #5 was checked on between 10:00pm and 10:30pm and that Resident #5 had been changed and was fine. -She checked on Resident #5 for the first time on third shift between 11:00pm and 12:00am. -Resident #5 was awake, lying diagonally in the bed; she had slid down toward the bottom of the bed as if she was trying to get out of bed, and she was not covered up. -She did not notice if Resident #5's incontinent brief was at her waist or not. -She pulled Resident #5 up in the bed, checked her ostomy bag and her incontinent brief; her ostomy bag did not have any air in it and her brief was dry. -Resident #5 was nonverbal when she checked on her. -She checked on Resident #5 for the second time around 2:00pm; Resident #5 was asleep with the covers over her, there was no air in her ostomy bag, and her incontinent brief was dry. -She checked on Resident #5 again at 5:00am; Resident #5 was asleep with the covers over her;	D 338		

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and she noticed Resident #5's ostomy needed to be changed.
-She asked another PCA to assist her with changing Resident #5's ostomy bag.
-Resident #5 was awakened and sat on the side of the bed to change her ostomy bag.
-She positioned Resident #5 back in bed and covered her up.
-She did not notice anything wrong with Resident #5.
-While she and the other PCA were changing Resident #5's ostomy bag, she noticed the electronic recording device was unplugged and laying on top of the table.
-She did not know why the electronic recording device was unplugged.
-She reported to the oncoming shift about the electronic recording device being disabled, but she could not remember who she reported to.
-A male resident wandered in other residents' rooms; there were several residents who wandered in other residents' rooms.
-She did not see anyone enter Resident #5's room on third shift the night of 02/09/25.

Review of another PCA's written statement dated 02/10/25 revealed:
-On 02/09/25 she cared for the [named] male resident, provided personal care around 10:00pm, gave him a snack around 11:00pm and put him to bed around 11:15pm.
-When she checked on the male resident at 1:15am, he was out of bed wandering the halls; he would not go back to bed.
-He continued to wander until 4:00am and then he went back to bed.
-She assisted another PCA with changing Resident #5's ostomy bag at 6:00am, when she noticed the electronic recording device was unplugged.

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D 338	Continued From page 85 Telephone interview with another PCA on 02/20/25 at 8:13pm revealed: -She worked 02/09/25 from 7:00pm to 6:30am. -She worked third shift on 02/09/25, and she assisted with changing Resident #5's ostomy bag the morning of 02/10/25. -Resident #5 could have a conversation, but whoever was speaking with Resident #5 had to be patient because Resident #5's speech was delayed. -At 7:30pm, she checked on the male resident; his sitter reported he had been asleep all day. -The male resident woke up, he was changed, and she ambulated with him to the dining room and gave him a snack; the sitter left at 8:00pm. -The male resident was sitting at the dining room table, laying his head on the table, like he was sleeping. -She walked the male resident back to his room and placed him in bed before 10:00pm. -Between 10:30pm-10:40pm, she saw the male resident come out of his bedroom and was wandering in the commons area and the hallway. -She was in and out of other residents' rooms providing personal care while the male resident wandered; it would take 15 minutes per resident for personal care, except one resident would take 20-30 minutes for personal care. -She was also helping another PCA who was new to the SCU. -At 6:05am, she helped the other PCA change Resident #5's ostomy bag. -Resident #5 woke up to have the ostomy bag change. -She did not notice anything unusual about Resident #5 when she changed the ostomy bag. -She noticed Resident #5's camera had been unplugged, and the cord and camera were laying on top of the table.	D 338		

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-She asked the other PCA why the camera was unplugged but she did not know.
-She reported to the oncoming shift that Resident #5's camera was unplugged.
-She did not see the male resident go into Resident #5's room.
-She knew the male resident had been in the common area in the morning hours; he went to bed around 5:00am.
-She had been told by the Supervisor to let the male resident wander.

Review of a written statement by the Special Care Coordinator (SCC) dated 02/10/25 revealed:
-Resident #5 was resting; she had not been feeling well, so she was less talkative.
-She observed her lying in bed, like she was most mornings.
-The resident's incontinent brief and pants were normal, and her blanket was lying on the bed beside her.

Interview with the Administrator on 02/18/25 at 2:43pm revealed:
-He received a texted message from Resident #5's family member the morning of 02/10/25, requesting a meeting; he did not know why the family requested the meeting.
-He was not in the facility so he notified the RCD to check on Resident #5.

Interview with the RCD on 02/19/25 at 10:18am revealed:
-She received a texted message from the Administrator on 02/10/25 at 8:30am, requesting her to check on Resident #5.
-The Administrator stated he had received a text message from Resident #5's family member who wanted to have a meeting.
-The Administrator did not know why the family

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wanted a meeting, so the Administrator asked her to check on Resident #5.
-Resident #5's private duty sitter was in Resident #5's room when she arrived.
-The private duty sitter reported that the camera in Resident #5's room was unplugged this morning, 02/10/25, Resident #5 was lying diagonally in the bed, and her incontinent brief and pajama bottoms were pulled down.
-The private duty sitter had contacted Resident #5's family member and informed the family member that the camera was unplugged.
-The family member looked at the video and identified the last person in the room was a male resident.
-She requested statements from the third shift staff regarding the happenings on third shift.
-The private duty sitter implied "something had happened" to Resident #5.
-The hospice nurse evaluated Resident #5 and verbalized this was not Resident #5's normal self.
-Resident #5 did not look well and she was non-verbal.
-Resident #5 was "listless" and being treated for the flu.
-She called Resident #5's family member to inform him that Resident #5 was being transferred to the hospital to be evaluated.
-Resident #5's family member wanted to know what happened.
-The family requested to keep Resident #5 at the facility until they arrived, which was an hour to an hour and a half after the telephone call.

Second interview with the Administrator on 02/18/25 at 2:43pm revealed:
-He was informed by the RCD that Resident #5's private duty sitter reported she found the camera in Resident #5's room unplugged, and Resident #5's incontinent brief and pajama bottoms were

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pulled down.
-He did not know how far the incontinent brief and pajama bottoms were pulled down.
-The private duty sitter had a picture of how Resident #5 was found on the morning of 02/10/25, but he had not seen the picture.
-The private duty sitter verbalized that Resident #5 was sexually assaulted.
-Resident #5 was on hospice services, and they were called to assess Resident #5.
-The RCD sent Resident #5 to the hospital due to a decline in her condition; Resident #5 was being treated for the flu.
-The facility requested a rape kit be done at the hospital due to the accusations made by the private duty sitter.
-Resident #5's family member notified the local law enforcement.

Observation of a picture taken the morning of 02/10/25 by the private duty sitter revealed Resident #5's incontinent brief and pajama bottoms where pulled down to her pubic area below her buttock on the left side.

Interview with the Administrator on 02/20/25 at 4:10pm revealed:
-Management spoke with the staff who worked with Resident #5 on third shift on 02/09/25 and obtained written statements.
-There was no evidence of sexual assault.

Telephone interview with the private duty sitter for Resident #5 on 02/19/25 at 3:24pm revealed:
-She sat with Resident #5 from 7:00am to 4:00pm to assist with bathing and dressing for the past 4 weeeks.
-Resident #5 could talk and she could understand her.
-She entered Resident #5's room the morning of

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02/10/25 at 7:00am; Resident #5 was in the bed with the covers pulled over her.
-She pulled the covers back to check Resident #5's incontinent brief and she noticed it and her pajama bottoms were pulled down.
-She took a picture of the way she found Resident #5.
-She noticed the electronic recording device in Resident #5's room was turned off and took a picture of the disconnected device.
-She called and texted the pictures to Resident #5's family member to ask why the electronic recording device was turned off; the family member did not know why the electronic recording device was turned off.
-The family member checked the electronic recording device and identified a male resident had entered Resident #5's room and disconnected the camera electronic recording device.
-She told the SCU staff that Resident #5's electronic recording device was turned off and that Resident #5's pants were pulled down.
-The staff reported there was nothing different about Resident #5; the previous shift did not pull her pants all the way up.
-At 8:49am, the RCD came into the room and wanted to know how she found Resident #5 the morning of 02/10/25; she sent the pictures to the RCD also.
-She dressed Resident #5, transferred her to the chair for breakfast, but after 10 minutes Resident #5 wanted to go back to bed; she was very weak.
-The law enforcement officer arrived at 11:00am.

Telephone interview with the private duty sitter for Resident #5 on 02/20/25 at 8:32am revealed:
-She asked Resident #5 questions on the morning of 02/10/25.
-She asked, "Was she OK?", and Resident #5

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responded "no".
-She asked, "Did her body hurt?", and Resident #5 responded "no".
-She asked, "Did someone come in your room?", and Resident #5 responded "yes".
-She asked, "Did a man come in your room?", and Resident #5 responded "yes"
-She asked, "Did the man touch your body?", and Resident #5 responded "yes".
-Resident #5's family members arrived at 11:00am and asked Resident #5 the same questions.
-Resident #5 responded the same for all questions except one.
-When Resident #5 was asked "did the man touch your body", Resident #5 did not respond, but she became tearful.
-She did not respond to any more questions that morning.
-Resident #5's family member showed her the video of the male resident in Resident #5's room.
-The law enforcement officer arrived about the same time as the family.
-The hospice nurse came to assess Resident #5.
-She sat with Resident #5 on Sunday, 02/09/25, and Resident #5 was her normal self; she was verbal, answered yes and no questions, she was dressed, got up to the chair for meals and she ate well.

Interview with two family members of Resident #5 on 02/20/25 at 11:00am revealed:
-On 02/10/25, the private duty sitter called a family member to ask what happened to the electronic recording device, because it had been disabled.
-The family member did not disable the electronic recording device, so he checked the video.
-The family member saw a male resident in Resident #5's room.

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-The private duty sitter reported to the SCU staff that Resident #5's incontinent briefs and pajama bottoms were pulled down.
-On 02/10/25 at 7:30am, a family member texted the Administrator that she needed to see him for a meeting.
-The Administrator was not in the facility on 02/10/25 and wanted to have a conversation on the phone, but the family member wanted it to be in person.
-The family never had an in person meeting with the Administrator regarding the incident.
-The private duty sitter stated that the RCD came to the room and wanted to know what was wrong with Resident #5.
-The private duty sitter told the RCD what she had found earlier that morning.
-A family member called law enforcement.
-Some family members arrived prior to Resident #5 being sent to the ED.
-Resident #5 was "out cold".
-Resident #5 was in and out of consciousness., and was non-verbal..
-Resident #5 told the POA that the male resident came into Resident #5's room and pulled his pants down in front of her.

Interview with a different family member of Resident #5's on 02/20/25 at 12:36pm revealed:
-The RCD called and stated Resident #5 was very sick and needed to go to the hospital.
-The family member asked that Resident #5 be kept at the facility until they arrived.
-EMS arrived and the law enforcement officer arrived shortly after the family members arrived.
-The family was met in the hallway by the RCD and taken to a private dining room before they could see Resident #5.
-The RCD was informed by the family that the family was made aware of the incident by the

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private duty sitter and not the facility staff.
-The RCD was aware a male resident wandered due to his medical diagnosis; the male resident had a sitter during the day and he roamed the halls at night.
-The RCD reported the SCU was secure and the male resident could not wander outside.
-The RCD stated the male resident would have 24-hour supervision and be removed from the facility.
-The family member saw Resident #5 on the stretcher as she was leaving the facility; Resident #5's mouth was opened, she had a blank stare and appeared gaunt (thin, weak, and grey in color).

Second interview with Resident #5's family member on 02/20/25 at 12:36pm revealed:
-She was present with Resident #5 in the ED.
-She, the nurse, and doctors were discussing the alleged assault and having the sexual assault examination done in the room with Resident #5, when Resident #5 said "SANE" and "sexual assault".
-She asked Resident #5 if the male resident did anything to her, and she responded "yes".
-She asked Resident #5 if the male resident pulled your pants down, and she responded "yes".
-She asked Resident #5 if the male resident put anything inside of her, and she responded "no".
-Resident #5 said "sexual assault" two more times and "DNR" once.
-Resident #5 had been non-verbal until the discussion about the sexual assault exam.
-She asked Resident #5 if she wanted to have the sexual assault exam done and Resident #5 agreed.

Telephone interview with a MA on 02/19/25 at

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7:55pm revealed:
-In August of 2024, the male resident walked down the hall and into Resident #5's room, and he was immediately removed from Resident #5's room.
-She kept the residents' doors locked at night to keep the male resident out of other residents' rooms.
-She had been instructed by the SCC to lock residents' rooms at night because of wandering residents.

Telephone interview with a fourth PCA on 02/24/25 at 9:59am revealed:
-The male resident wandered into residents' rooms.
-The male resident wandered into Resident #5's room.
-The staff would re-direct the male resident when he wandered into Resident #5 room.
-She was told to let the male resident "do his thing" and to make sure he was not antagonizing anyone, but she did not remember who told her and when she was told.

Telephone interview with the hospice social worker on 02/21/25 at 9:09am revealed:
-She visited with Resident #5 on 02/10/25, the morning that an alleged assault had taken place.
-The hospice nurse was also present.
-Resident #5 was not herself, she was unable to answer questions.
-Prior to 02/10/25, Resident #5 would answer questions if she was given time.
-Resident #5 was assessed by the hospice nurse and the RCD sent Resident #5 to the hospital.

Interview with the SCC on 02/19/25 at 10:48am revealed:
-She was notified of the incident with Resident #5

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when she arrived to work on 02/10/25 between 8:30am to 8:45am.
-She checked on Resident #5 between 8:45am to 9:00am on 02/10/25.
-Resident #5 was lying in the bed, diagonally, with her feet in the bottom corner of the mattress toward the door and her head in the opposite corner of the mattress which was how Resident #5 would position herself when she attempted to get out of bed without assistance.
-The private duty sitter showed her the picture she had taken earlier in the morning on 02/10/25.
-The picture showed Resident #5 lying diagonally in the bed as if she had moved her feet to the edge of the bed to get out of bed.
-The picture did not look unusual to her with Resident #5's incontinent brief and pajama bottoms positioned below her waist, because Resident #5 would fidget with her clothes and ostomy bag.
-The staff informed her that a male resident had entered Resident #5's room around 10:30pm and disabled the electronic recording device.
-She asked Resident #5, "did anyone come in your room", and she responded "yes, yes, yes" and "no, no, no".
-She asked Resident #5, "did the male resident come in your room", and she responded "yes, yes, yes" and "no, no, no".
-Resident #5 had the flu and she was not responding as she usually did.
-Before Resident #5 had the flu, she could communicate with the staff.
-Resident #5's family had complained about the male resident entering Resident #5's room, prior to October 2024, when she started work at the facility.

Interview with the SCC on 02/24/25 at 12:39pm revealed:

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-After the incident on 02/09/25, there was a PCA assigned to the hallway on third shift.
-There was no PCA stationed to sit in the hallway prior to the 02/09/25 incident.

Telephone interview with a Supervisor on 02/20/25 at 10:15am revealed:
-She found the male resident in Resident #5's room before but she could not remember the dates.
-The male resident was sitting in the chair or standing at the foot of Resident #5's bed.
-Sometimes, in 2024, she heard Resident #5 say the male resident's name several times in a row, when providing care to Resident #5.

Interview with the Administrator on 02/20/25 at 4:10pm revealed:
-The safety of residents had always been a concern of his.
-The facility's goal was to have behaviors controlled through MHP so families would not have to pay for private duty sitters.

Attempted telephone interview with the Registered Nurse from the facility's contracted hospice agency on 02/20/25 at 4:50pm was unsuccessful.

2. Observation of Resident #5's room on 02/21/25 at 11:29am revealed a sign was attached to the door with the instructions to please keep the door locked.

Review of an electronic message dated 08/06/24 revealed:
-Resident #5's family member texted the previous Special Care Coordinator (SCC) to inform her that Resident #5 had "frequent 'lost' visitors during the night that scare her"; one of the visitors

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was a male resident.
-The family member request that Resident #5's door be locked at night.
-The SCC's texted response was that she could let night shift know the family wanted the door locked.

Review of a second electronic message dated 02/01/25 revealed:
-Resident #5's family member texted the Administrator to inform him that a female resident entered Resident #5's room during the night while Resident #5 was sleeping; the female resident messed with the bed and left with something in her hand.
-This was the first night with the camera, and the family could "only imagine what had transpired over the last 18 months that had not been documented".
-This was why the family requested that Resident #5's door be locked; the family would have an evening sitter starting on Monday to ensure the door was locked when she leaves.
-The family asked to hear from the administrator regarding keeping Resident #5 safe.
-The Administrator texted he would speak to the SCC about "this matter".

Review of a third electronic message dated 02/02/25 revealed:
-Resident #5' s family texted the private sitter that the camera detected a female resident entering the room twice on different nights after dinner over the weekend; the family member recognized the female resident.
-The female resident may have picked up some things.
-The family was trying to get the facility to lock Resident #5's door "without success and it was very frustrating".

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D 338	Continued From page 97 -The private sitter texted response was the door was not locked this morning. Review of the fourth electronic message dated 02/03/25 revealed the private sitter texted Resident #5's family members to inform them that Resident #5's door was not locked this morning. Review of the fifth electronic message dated 02/04/25 revealed the private sitter texted Resident #5's family members, "As always the door was not locked." Review of the local law enforcement officer's investigation report dated 02/10/25 revealed: -The maintenance personnel changed the door lock to Resident #5's room due to learning Resident #5's door handle would not properly lock, and anyone could enter the room. -Resident #5's door was required to be locked when no one was in the room with her. -There were signs on the door stating the door was to remain locked. Interview with two family members of Resident #5 on 02/20/25 at 11:00am revealed: -The family requested that Resident #5's bedroom door be locked; this request was made shortly after Resident #5 was admitted to the facility; she was admitted to the facility on 05/13/2023. -The Administrator told them that Resident #5's bedroom door was not going to be locked, because it was a safety concern. -Most times when the family visited, Resident #5's door would be unlocked. -The private duty sitter told Resident #5's family members, the bedroom door was unlocked each morning when she arrived between 7:00am and 7:30am.	D 338		

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D 338	Continued From page 98 -There was a sign on the door that read "please lock the door." Interview with a different family member of Resident #5 on 02/20/25 at 12:36pm revealed: -He questioned the Resident Care Director (RCD) and wanted to know why the door to Resident #5's room was not locked. -The RCD reported the door lock into Resident #5's room was not working properly. -He was informed the new lock arrived that day, 02/10/25 and someone from maintenance would place the lock on Resident #5's room door. Telephone interview with the law enforcement officer on 02/24/25 at 11:29am revealed: -He learned a male resident had been in Resident #5's room and the door lock was not secure; the door lock was broken. -The door lock was replaced the morning of 02/10/25, while he was in the facility. -There was a sign on the door to keep the door locked. Telephone interview with a medication aide (MA) on 02/19/25 at 7:55pm revealed: -All the room doors could be locked from the outside with a key. -She knew the male resident wandered and she would keep the residents' room doors locked. -The SCC told by the previous SCC about wandering residents and to keep the room doors locked. -She was not given any other instructions related to the male resident who wandered. Telephone interview with a PCA on 02/20/25 at 8:13pm revealed: -Resident #5's bedroom door locked from the inside by pushing a button, and the door was	D 338		

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unlocked from the outside with a key.
-She locked the residents' doors to keep residents that wandered out of the residents' rooms.
-She did not know the bedroom door would automatically unlock when the door was closed after pushing the button on the door handle from the inside.

Interview with a PCA on 02/21/25 at 11:15am revealed:
-The MAs told her to keep the resident rooms unlocked.
-There were residents that wandered in the SCU.
-She did not think residents had the keys to the door locks.
-If a resident wanted their door locked, they could have it locked.

Interview with a MA on 02/24/25 at 8:50am revealed:
-Residents on the SCU could keep their doors locked if they desired.
-The MAs had the master key.
-The lead PCA also had a master key.
-She was not sure if residents or family members had keys to the locks.
-She was not aware if there were any door locks in the SCU that did not work.

Telephone interview with a second MA on 02/24/25 at 9:17am revealed:
-The residents' room doors would lock, but the key did not work well.
-The key had to be "jiggled" to unlock the door.
-The MA was not instructed to lock any resident door.
-The MA would lock the door if the resident requested the door be locked.

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Telephone interview with a second PCA on 02/24/25 at 9:59am revealed:
-Resident #5 had told her family member that the male resident would wander into her room at night.
-There was a sign on Resident #5's door that read "keep the door locked at all times", but the door would be left unlocked at times.
-She had found Resident #5's door unlocked sometimes but could not remember any specific dates.
-She thought the SCC placed the sign on Resident #5's door.
Interview with the Maintenance Director on 02/21/25 at 8:20am revealed:
-All the resident rooms in the SCU had individual locks.
-The family member or the resident has the keys to the door.
-He had a master key as well as the staff in the SCU.
-After the incident that was discovered on 02/10/25 with the male resident, he was told by the Administrator to change the lock on Resident #5's door, and he did it right away; he thought the family requested the lock be changed.
-Residents in the SCU were able to keep their doors locked if they wanted to.

Second interview with the Maintenance Director on 02/21/25 at 11:25am revealed he was not aware Resident #5's door lock was not working prior to the request by the Administrator to change the door lock on 02/10/25.

Interview with the SCC on 02/24/25 at 12:39pm revealed:
-Resident #5's family member had requested Resident #5's bedroom door be locked; the request was made prior to October 2024.

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D 338	Continued From page 101 -She knew there was a sign on Resident #5's bedroom door that read "keep residents' door locked"; the sign had been in place since October 2024. -The family member was informed the staff could not promise Resident #5's door would be locked 100% of the time. -The staff tried hard to keep Resident #5's door locked. -Some nights Resident #5 requested to keep her bedroom door opened. -Resident #5's door would lock from the outside with the key. -She noticed the first week in October 2024, the door could be locked from the inside by pushing the button on the door handle, but when leaving Resident #5's room, if someone pushed the button on the door handle and checked the door handle on the outside of the door, the door appeared locked, but once the door was shut the button on the inside door handle would pop open and the door wound not be locked. -The staff were instructed to use a key to lock Resident #5's bedroom door. -She notified maintenance in October 2024 when she realized it would only lock with a key. -Using the key on the outside was the only way to lock the bedroom door. -Resident #5's door lock was changed but she did not recall when. -Some mornings when she came to work, she would find Resident #5's door unlocked; she would remind the PCAs to keep the door locked. Interview with the senior RCD on 02/24/25 at 2:37pm revealed: -No one had discussed door locks with her. -Residents' doors could be locked. -It was the resident's right to have their room doors locked it the resident wanted them locked.	D 338		

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D 338	Continued From page 102 Interview with the Administrator on 02/20/25 at 6:07pm revealed: -There was not a policy on door locking. -He was responsible for making sure the residents were protected. Interview with the Administrator on 02/24/25 at 5:24pm revealed: -Resident #5's door could be locked from the outside with a key. -Resident #5's family made a request to the previous SCC that Resident #5's bedroom door be locked. -The previous SCC told the family the door could be locked. -If the door was to be locked was implemented, it would be on the service plan. -Resident #5's door lock was changed the morning of 02/10/25. -He did not know why the family wanted the door locked. Attempted telephone interview with the previous SCC on 02/21/25 at 8:36am was unsuccessful. Attempted telephone interview with the previous RCD on 02/21/25 at 8:58am was unsuccessful. _____ The facility failed to ensure Resident #5 was protected from abuse when a male resident, who also resided on the special care unit, hit Resident #5 in the face three times while the resident was lying on the couch in the common area. This same resident, who was known to wander into Resident #5's room and rumble through her personal items, allegedly sexually assaulted Resident #5 when it was observed that the resident entered Resident #5's room and dismantled a video camera Resident #5's family	D 338		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 103 had installed; the private sitter found Resident #5 the next morning with her incontient brief and pajama bottoms pulled down. This failure resulted in the abuse and neglect of Resident #5 which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 for this violation on 02/20/25. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 26, 2025.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify orders for 2 of 6 residents sampled (#4, #6) for compression socks (#4) and an anti-depressant (#6).	D 344		

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D 344	Continued From page 104 The findings are: 1. Review of Resident #6's current FL-2 dated 08/29/24 revealed: -Diagnosis included depression. -There was no order for mirtazapine (used to treat depression) 15mg at bedtime. Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for mirtazapine 15mg at bedtime with a scheduled administration time between 7:00pm and 9:00pm. -There was documentation mirtazapine was administered between 7:00pm and 9:00pm from 12/01/24 to 12/31/24. Review of Resident #6's January 2025 eMAR revealed: -There was an entry for mirtazapine 15mg at bedtime with a scheduled administration time between 7:00pm and 9:00pm. -There was documentation mirtazapine was administered between 7:00pm and 9:00pm from 01/01/25 to 01/31/25. Review of Resident #6's February 2024 eMAR from 02/01/25 to 02/18/25 revealed: -There was an entry for mirtazapine 15mg at bedtime with a scheduled administration time between 7:00pm and 9:00pm. -There was documentation mirtazapine was administered between 7:00pm and 9:00pm from 02/01/25 to 02/18/25. Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 8:30am revealed: -Resident #6 had an order dated 02/10/24 for	D 344		

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mirtazapine 15mg every night.
-The pharmacy had dispensed 30 tablets of mirtazapine 15mg on 11/08/24, 12/10/24, and 01/16/25.
-The pharmacy accepted signed FL-2s as orders.
-The pharmacy did not receive Resident #6's FL-2 dated 08/29/24.
-If the pharmacy had received the FL-2, the medications would have been reconciled.
-If the pharmacy had an active order for a medication that was not listed on the FL-2, the pharmacy would have faxed the FL-2 back to the facility to clarify with the primary care provider (PCP) if the medication was to continue or to be discontinued.

Telephone interview with Resident #6's PCP on 02/20/25 at 9:42am revealed:
-Resident #6 should be taking mirtazapine 15mg at bedtime.
-Resident #6 was started on mirtazapine 15mg in February 2024.
-The facility staff completed the annual FL-2's and placed them in her folder for signature.
-The FL-2s should have the correct medications listed on the FL-2 when it was placed in her folder.

Interview with the Licensed Practical Nurse (LPN) on 02/21/25 at 1:03pm revealed:
-The FL-2s were completed by the Resident Care Director (RCD) or the Nurse.
-She had completed the FL-2s in the past, but she was not responsible for completing them now.
-Medications for the FL-2 were retrieved from the most recent signed physician orders and the eMAR.
-The FL-2 was faxed to the PCP for review; once the PCP signed the FL-2, it was faxed back to the

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facility, the FL-2 would be filed in the resident's chart.
-The FL-2s were not faxed to the pharmacy unless the pharmacy asked for them; the PCP would send all orders to the pharmacy.
-A medication should not be left off of the FL-2, unless the order for a new medication was received the same day as the FL-2 was signed.
-She did not know a medication was left off of Resident #6's current FL-2 dated 08/29/24.
-The PCP should have realized a medication was not on the FL-2 when she reviewed the FL-2 before signing it.
-The nurse completing the FL-2 for the PCP to sign should have reviewed the FL-2 before sending it to the PCP for review.

Interview with the senior RCD on 02/21/25 at 1:56pm revealed:
-The RCD or Nurse completed the annual FL-2s and had the PCP review and sign the FL-2 on her weekly visit or faxed to the PCP's office for signature
-Sometimes, the PCP's office staff would complete the FL-2 and fax it to the facility.
-If the RCD or the Nurse completed the FL-2, they would refer to the order summary sheet directly from the eMAR to complete the FL-2.
-The FL-2s should be faxed to the pharmacy once it was signed by the PCP.
-She did not know a medication had been left off Resident #6's current FL-2 dated 08/29/24.

Interview with the Administrator on 02/24/25 at 5:24pm revealed:
-The RCD or the Nurse was responsible for completing the annual FL-2s.
-The information to be entered on the FL-2 would be obtained from the eMAR.
-The RCD or the Nurse would fax the FL-2 to the

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PCP, the PCP would review, sign, and fax the FL-2 to the facility.
-The signed FL-2 should be reviewed by the RCD or the Nurse when the FL-2 was returned to the facility and compared with the active orders.
2. Review of Resident #4's hospital discharge FL-2 dated 11/07/24 revealed:
-Diagnoses included Alzheimer's disease, dementia, hyperprolactinemia, and type 2 diabetes.
-He was intermittently disoriented.
-He was continent of bowel and bladder.
-He required assistance with bathing and dressing
-The level of care was Special Care Unit (SCU).

Review of Resident #4's physician's order dated 07/22/24 revealed:
-Resident #4 had edema in bilateral legs and feet.
-There was an order to apply compression socks to both legs in the am and remove in the pm.
-This was a second request.
-Leg measurements were documented.

Review of Resident #4's August 2024-February 2025 electronic medication administration record (eMAR) from 02/01/25-02/18/25 revealed there was no entry for compression socks and no documentation compression socks were applied.

Review of Resident #4's personal care aide (PCA) daily report revealed:
-In December 2024, there were 10 days the compression socks were not applied.
-In January 2025, there were 17 days when the compression socks were not applied, and one time the resident refused.
-In February 2025, from 02/01/25-02/18/25, there were 3 days the compression socks were applied, and 15 times the task was blank with no

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D 344	Continued From page 108 exceptions documented for the compression socks. Review of Resident #4's Licensed Health Profession Support (LHPS) review form dated 10/01/24 revealed: -Resident #4 had a new task. -Resident #4 had an order to apply compression socks in the morning and off in the evening. -Resident #4's compression socks were not on. -Resident #4 had trace edema noted. -Recommendations included applying compression socks daily as ordered and to notify the primary care provider (PCP) if the edema continued. Review of Resident #4's LHPS review form dated 001/03/25 revealed: -Resident #4 had an order to apply compression socks in the morning and off in the evening. -Resident #4's compression socks were not on. -Resident #4 had trace edema noted. -Recommendations included applying compression socks daily as ordered and notifying the PCP if the edema continued. Telephone interview with a representative from the facility's contracted pharmacy's on 02/19/25 at 3:17pm revealed: -An order for compression socks with measurements for Resident #4 was received on 07/22/24, and a pair of compression socks was sent to the facility. -On 07/25/24, the facility requested a second pair of compression socks, and they were sent to the facility on 07/25/24. -On 08/27/24, the facility requested a third pair of compression socks, and they were sent to the facility on 08/27/24. -Resident #4's order for compression socks was	D 344		

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still an active order in their system.
-Resident #4's FL-2 dated 11/07/24 was not received at the pharmacy.

Observation of Resident #4 on 02/19/25 at 4:30pm revealed the resident was not wearing compression socks.

Interview with a private duty sitter on 02/19/25 at 4:30pm revealed she had never seen Resident #4 with compression socks on, only regular socks.

Telephone interview with the facility's contracted LHPS nurse on 02/19/25 at 5:07pm revealed:
-Resident #4's compression socks had not been discontinued as far as she knew.
-She expected the staff to apply Resident #4's compression socks as ordered to prevent edema and weeping.

Telephone interview with Resident #4's PCP on 02/20/25 at 9:24am revealed:
-Resident #4 had an active order for compression socks.
-If a resident sat or stood for extended periods of time, the blood could accumulate in the lower legs, which could lead to swelling and discomfort in the legs.
-Ideally, Resident #4 should wear compression socks and elevate his legs daily to prevent swelling.

Based on reviews and interviews there was no documentation the PCP was contacted to clarify the hospital FL-2 dated 11/07/24 regarding the compression socks.

Interview with a PCA on 02/19/25 at 4:39pm revealed Resident #4 did not wear compression

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D 344	Continued From page 110 socks; he only wore regular socks. Telephone interview with a second PCA on 02/20/25 at 8:05pm revealed: -Resident #4 wore regular socks. -The last pair of compression socks Resident #4 had gotten lost in the laundry. -She had not seen Resident #4's compression socks in a couple of weeks. -She told the medication aide (MA) that she could not find Resident #4's compression socks. -When she could not find Resident #4's compression socks, she just put regular socks on him. -If she could not find Resident #4's compression socks, she documented it. Interview with a third PCA on 02/21/25 at 11:35am revealed: -Resident #4 wore compression socks. -The third shift staff were supposed to apply Resident #4's compression socks and first shift PCAs were supposed to check and make sure the compression socks were on. -When she checked if Resident #4 was not wearing compression socks and she could not find the compression socks in his room, she documented they were not applied, and she notified the MA. -She did not recall the last time she saw Resident #4's compression socks. Telephone interview with a fourth PCA on 02/21/25 at 1:08pm revealed: -Resident #4 had an order for compression socks, but she had not been able to find them. -Resident #4 had worn the compression socks "this year" but she did not recall when. -She had let the MA or the Special Care Coordinator (SCC) know when she could not find	D 344		

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Resident #4's compression socks.
-She thought Resident #4's compression socks had been lost in the laundry.

Telephone interview with a fifth PCA on 02/24/25 at 10:00am revealed:
-Resident #4 was supposed to wear compression socks.
-There had been times when she could not locate Resident #4's compression socks.
-She last recalled Resident #4 having compression socks in late January 2025.
-She usually documented when Resident #4 did not have compression socks and/or she would let the SCC know.

Telephone interview with a MA on 02/20/25 at 10:41am revealed:
-Resident #4 had an order at one time for compression socks.
-She had only seen compression socks on Resident #4 three times and that was about four to six months ago.
-The staff member getting Resident #4 up in the mornings would put on his compression socks.
-She did remember telling another staff member that they needed to put Resident #4's compression socks on because she noticed he did not have them on, but later he took them off.
-Compression socks were documented by the PCA.
-Resident #4 got up on the first shift and therefore the compression socks should be put on by the first shift PCA.
-If Resident #4 was removing or refusing the compression socks, whoever saw this would document it.
-When it was documented, a special alert would pop up and the MA, the SCC, or the nurse would see the notification and would let the PCP know.

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D 344	Continued From page 112 Interview with a second MA on 02/21/25 at 11:47am revealed: -In the past, the MAs applied compression socks and documented the application, but now the PCAs were responsible for applying and documenting the compression socks. -No one had let her know Resident #4's compression socks were not available to be applied. -If she had known the PCAs could not find Resident #4's compression socks, she would have ordered a pair from the pharmacy. Telephone interview with a third MA on 02/24/25 at 10:31am revealed Resident #4 did not have an order for compression socks that he was aware of. Telephone interview with Resident #4's family member on 02/21/25 at 8:57am revealed: -She was not aware of Resident #4 having an order for compression socks. -She had only seen Resident #4 in regular socks, but she did not know if the resident had compression socks under his regular socks. Interview with the SCC on 02/24/25 at 12:40pm revealed: -The PCAs were responsible for applying compression socks. -If the PCA could not find the resident's compression socks, they should let the MA know and the MA would let the nurse know. Interview with the Senior Resident Care Director (RCD) on 02/24/25 at 2:50pm revealed: -She was not aware Resident #4 was not wearing compression socks as ordered. -Her concern was the resident could experience	D 344		

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D 344	Continued From page 113 edema, as well as blood clots if the compression socks were not applied as ordered. Interview with the Administrator on 02/24/25 at 4:50pm revealed: -Compression socks would be a task the SCC would add to the resident's care plan. -The PCAs were responsible for applying and removing compression socks. -If Resident #4's compression socks were not available, the PCA should notify their Supervisor and the Supervisor would notify the SCC. -If the compression socks were not available, it should be documented so it could be followed-up on. -If Resident #4's compression socks were missing, "it should not go on for more than one day." Based on observations, record reviews, and interviews, Resident #4 was not interviewable.	D 344		
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	D 358		

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Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 5 of 6 sampled residents (#1, #3, #4, #5, and #6) including a medication for asthma (#1); a blood pressure medication and a vitamin (#3); two medications used for mood stabilization and a medication used for acute behaviors of agitation and anxiety (#4); two medications used for mood stabilization and two blood pressure medications (#5); and a medication for sleep, an inhaler, and a blood thinner (#6).

The findings are:

Review of the medication administration policy dated April 2023 revealed:
-Administration of medications should be done according to the six rights.
-The facility used AM and PM blister packs.
-Staff were to write the start date on the back of the blister pack when the first medication was removed from the blister pack.
-Staff were to pop the pill from the highest number on the pack and enter the date on the side/back of the card.
-Medication cart audits were expected to be checked weekly for expired medications, storage practices, general cleanliness, and organization of carts.

1. Review of Resident #6 current FL-2 dated 08/29/24 revealed diagnoses included cerebral infarction, atrial fibrillation, aortic valve disorder, and hypertension.

a. Review of Resident #6's signed physician order dated 02/14/25 revealed there was an order to administer warfarin (used to prevent blood clots) 4mg every Saturday and Sunday.

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D 358	Continued From page 115 Review of Resident #6's February 2025 from 02/15/25 to 02/23/25 eMAR revealed: -There was an entry for warfarin 4mg every Saturday and Sunday with a scheduled administration time between 4:00pm and 5:00pm. -There was documentation warfarin 4mg was administered on 02/15/25, 02/16/25, 02/22/25, and 02/23/25. Review of Resident #6's international normalized ratios (INR is a blood test that measures the time it takes for blood to clot; the normal INR for someone taking a blood thinner is 2.0-3.0. An elevated INR increased the risk for bleeding, and a low INR increased the risk for blood clots) revealed: -On 12-06-24, the INR was 3.1; continue warfarin 2.5mg every evening. -On 12/16/24, the INR was 1.9; there was an order to increase to warfarin 3mg every evening. -On 12/27/24, the INR was 2.5; continue warfarin 3mg every evening. -On 01/02/25, the INR was 2.5; there was an order to hold warfarin on 01/02/24 and 01/03/24, then resume warfarin 3mg every evening. -On 01/17/25, the INR was 1.5; continue warfarin 3mg every evening. -There were no other INR results available for review. Observation of the medications on hand for Resident #6 revealed: -On 02/21/25, there were 8 of 8 warfarin 4mg tablets available for administration. -On 02/24/25 there were 8 of 8 warfarin 4mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 02/24/25 at	D 358		

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D 358	Continued From page 116 8:30am revealed: -The pharmacy had an order dated 02/14/25 for warfarin 4mg every Saturday and Sunday. -The pharmacy dispensed 8 tablets of warfarin on 02/14/25. Interview with Resident #6 on 02/24/25 at 8:20am revealed: -He took a blood thinner but did not know how often he took it. -He took medications at least twice a day. -He did not refuse his medications. -The cardiac doctor prescribed it because he had a stroke. -He got his blood drawn but did not know how often. Interview with a MA on 02/24/25 at 12:15pm revealed: -She worked Saturday 02/22/25 and Sunday 02/23/25. -She administered medication to Resident #6. -She administered warfarin 4mg to Resident #6 on 02/22/25 and 02/23/25. -She did not know that warfarin 4mg tablets had not been used. -She gave a 3mg tablet and a 1mg tablet that was on the medication cart. Interview with the senior RCD on 02/24/25 at 2:37pm revealed: -The MA may have used a 3mg and a 1mg of warfarin, but she did not know if it was available. -Resident #6's warfarin order changed frequently so any discontinued dosages were kept in case they were needed at a later date. Interview with Resident #6's PCP on 02/24/25 at 12:30pm revealed: -Resident #6 was prescribed warfarin because he	D 358		

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had a history of atrial fibrillation and had an aortic valve replacement.
-When she wrote orders for warfarin, she faxed the orders to the facility and the pharmacy.
-She liked Resident #6's INR to be between 2.5-3.5.
-She noticed that his INR would stay at goal briefly and then would elevate.
-That was a clear indication that he had missed doses or the MAs were confused about the dosing instructions.
-She tried to write the warfarin orders as clear as she possibly could.
-If Resident #6 did not get enough warfarin, his blood would be too thick and he could have a stroke.
-If he took too much warfarin, his risk of bleeding would rise and that would be a concern also.
-She was concerned she did not have accurate records to prescribe the appropriate dose.

Interview with the Administrator on 02/24/25 at 5:24pm revealed he was concerned about Resident #6's healthcare and well-being related.

b. Review of Resident #6 current FL-2 dated 08/29/24 revealed:
-There was an order for melatonin (used to treat insomnia) 5mg at bedtime.
-There was also an order for melatonin 3mg at bedtime, for a total of 8mg of melatonin at bedtime.

Review of Resident #6's February 2025 eMAR from 02/01/25-02/23/25 revealed:
-There was an entry for melatonin 5mg at bedtime for insomnia with a scheduled administration time between 7:00pm and 9:00pm.
-There was documentation melatonin 5mg was administered 21 times out of 23 opportunities

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D 358	Continued From page 118 from 02/01/25 to 02/23/25. -There were 2 exceptions documented; the exception was medication pending delivery. Observation of medications on hand for Resident #6 on 02/18/24 at 3:50pm revealed: -There was a bubble pack with 3 of 30 melatonin 3mg tablets dispensed on 12/28/24 available for administration. -There two bubble packs with 30 of 30 melatonin 3mg tablets dispensed on 01/20/25 and 02/15/25 available for administration. -There was no melatonin 5mg tablets available for administration. Observation of medications on hand for Resident #6 on 02/24/24 at 8:16am revealed: -There was a bubble pack with 26 of 30 melatonin 3mg tablets dispensed on 02/15/25 available for administration. -There was a bubble pack with 30 of 30 melatonin 3mg tablets dispensed on 01/20/25 available for administration. -There was no melatonin 5mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 8:30am revealed: -The pharmacy dispensed 30 tablets of melatonin 3mg tablets on 12/28/24, 01/19/25, and 02/14/25. -The pharmacy had an order dated 08/29/24 for melatonin 5mg at bedtime. -The pharmacy dispensed 30 tablets of melatonin 5mg on 11/02/24, 12/10/24 and 01/15/25. Interview with Resident #6 on 02/24/25 at 8:20am revealed: -He slept well the night before. -He had difficulty falling asleep most nights and	D 358		

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sometimes woke up during the night.
-When he woke up during the night, it was easy for him to go back to sleep.
-He felt tired throughout the day.
-He did not nap during the day.
-He did not know if he took medication for sleep.
-He took medications at least twice a day.
-He did not refuse his medications.

Telephone interview with a medication aide (MA) on 02/24/25 at 10:31am revealed:
-He worked second shift in the assisted living (AL) and administered medications to Resident #6.
-Resident #6 had an order for melatonin 3mg and 5mg tablets to be administered at bedtime.
-He administered the 5mg tablet from 02/18/25 to 02/20/25.
-He thought Resident #6's melatonin was in the facility; he may have borrowed melatonin 5mg from another resident, but could not recall who he would have borrowed the melatonin from.
-If he borrowed the melatonin 5mg, he would not have documented it anywhere.
-He did not remember ordering Resident #5's medications.
-He did not know melatonin 5mg was last ordered on 01/15/25 and was not in the facility on 02/18/25 and had not been ordered or delivered as of 02/24/25.

Interview with a second MA on 02/24/25 at 12:15pm revealed:
-Resident #6 did not have melatonin 5mg to available to administer with the 3mg tablet.
-She gave him two 3mg tablets since the 5mg tablets were not available
-No one instructed her to give two 3mg tablets, she just did it.

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Interview with Resident #6's primary care provider (PCP) on 02/24/25 at 12:30pm revealed:
-Resident #6 used melatonin for sleep.
-She had not been notified that he was not getting the medication as ordered.
-She was concerned the facility was not administering medications as ordered.
-If Resident #6 did not receive his melatonin at night.
-He would disturb his sleep pattern.

Interview with the senior Resident Care Director (RCD) on 02/21/25 at 1:56pm revealed:
-She did not know Resident #6 did not have melatonin 5mg available to administer.
-She was concerned that the MAs were not administering medications as ordered.
-Resident #6 could have difficulty sleeping if he did not receive his medication as ordered.

Interview with the Administrator on 02/24/25 at 5:24pm revealed the MAs falsely documented on Resident #6's eMAR if there was no melatonin 5mg in the facility.

c. Review of Resident #6's signed physician order dated 08/29/24 revealed there was an order for Symbicort (used to treat chronic obstructive pulmonary disease (COPD) 80mcg-4.5mg 2 puffs twice daily.

Review of Resident #6's December 2024 eMAR revealed:
-There was an entry for Symbicort Inhaler 80-45mcg/act 2 puffs twice daily with a scheduled administration time between 7:00am to 9:00am and 7:00pm to 9:00pm.
-There was documentation Symbicort was administered 59 time out of 62 opportunities from 12/01/24 to 12/31/24.

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D 358	Continued From page 121 -There were 3 exceptions documented; the exception was the medication was refused. Review of Resident #6's January 2025 eMAR revealed: -There was an entry for Symbicort Inhaler 80-45mcg/act 2 puffs twice daily with a scheduled administration time between 7:00am to 9:00am and 7:00pm to 9:00pm. -There was documentation Symbicort was administered 58 times out of 62 opportunities from 01/01/25 to 01/31/25. -There were 4 exceptions documented; the exception was the medication was refused. Review of Resident #6's February 2025 eMAR from 02/01/25 to 02/18/25 revealed: -There was an entry for Symbicort Inhaler 80-45mcg/act 2 puffs twice daily with a scheduled administration time between 7:00am to 9:00am and 7:00pm to 9:00pm. -There was documentation Symbicort was administered 35 times our of 36 opportunities from 02/01/25 to 02/18/25. -There was 1 exception documented; the exception was the medication refused. Observation of Resident #6's medications on hand on 02/18/25 at 3:50pm revealed: -There was a Symbicort Inhaler 80-45mcg available for administration with a dispense date of 02/02/25. -There were 116 of 120 Symbicort inhalations remaining. -There was documentation on the box "opened 02/17/25". Telephone interview with a representative for the facility's contracted pharmacy on 02/24/25 at 8:30am revealed:	D 358		

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D 358	Continued From page 122 -The pharmacy had an order dated 08/29/24 for Symbicort inhaler 2 puffs twice daily. -The pharmacy dispensed one inhaler on 08/29/24, 10/03/24, 11/23/24, 01/09/25, and 02/02/25. -There were no inhalers dispensed in September 2024 or December 2024. -Each inhaler contained 120 inhalations and would last 30 days. Interview with Resident #6 on 02/24/25 at 9:00am revealed: -He used an inhaler at least twice a day. -He did not have to ask for the inhaler, the MAs just brought it to him. -He did not refuse his medications. -He was not short of breath right now. -He was able to take a deep breath but coughed a lot. Telephone interview with a MA on 02/24/25 at 10:31am revealed: -He administered Resident #6 the Symbicort inhaler. -Resident #6 did not refuse his inhaler. -Resident #6 did not complain of difficulty breathing. -He did not know why the Symbicort inhaler had not been ordered every month. Interview with a second MA on 02/24/25 at 12:15pm revealed: -She administered Symbicort 2 puffs to Resident #6. -Resident #6 did not refuse the medication. -She did not know why his medication was not ordered monthly -Symbicort was always available to be administered.	D 358		

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D 358	Continued From page 123 Interview with Resident #6's PCP on 02/24/25 at 12:30pm revealed: -Resident #6 was prescribed Symbicort because he had asthma and COPD. -The medication opened his airways and decreased inflammation so he could breathe better. -She was concerned he would have a harder time breathing, would be short of breath, and be at risk for developing pneumonia if he did not take the medication as ordered. -She had not been notified Resident #6 was out of medication. -She put multiple refills on her prescriptions so the facility would not run out of medication. Interview with the Administrator on 02/24/25 at 5:24pm revealed he was concerned about Resident #6's health and well-being related to his inhaler not being administered as ordered. Refer to the interview with a MA on 02/18/25 at 3:52pm. Refer to the interview with a MA on 02/24/25 at 11:43pm. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the licensed practical nurse (LPN) on 02/21/25 at 1:03pm. Refer to the interview with the senior RCD on 02/21/25 at 1:56pm. Refer to the interview with the Administrator on 02/24/25 at 5:24pm. 2. Review of Resident #5's current FL-2 dated	D 358		

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D 358	Continued From page 124 08/20/24 revealed diagnoses included major depressive disorder, dementia in other diagnoses with mood disorder, and hypertension. a. Review of Resident #5's current FL-2 dated 08/20/24 revealed: -There was an order for divalproex (a mood stabilizer) 125mg 1 capsule in the morning. -There was no order for divalproex 125mg 2 capsules at bedtime. Review of Resident #5's signed physician orders dated 01/03/25 revealed: -There was an order for divalproex 1 capsule in the morning. -There was also an order for divalproex 125mg 2 capsules at bedtime. Review of Resident #5's mental health provider (MHP) after-visit notes revealed: -On 11/22/24, Resident #5's family member reported Resident #5 was agitated at times. -Continue current medication divalproex 125mg 2 capsules at bedtime for depression and dementia (original start date was 07/29/23). -On 12/16/24, Resident #5's family member reported Resident #5 was agitated at times. -Continue current medication divalproex 125mg 2 capsules at bedtime for depression and dementia. -On 01/15/25, Resident #5's family member reported Resident #5 was agitated at times. -Continue current medication divalproex 125mg 2 capsules at bedtime for depression and dementia. Review of Resident #5's January 2025 eMAR from 01/03/25 to 01/31/25 revealed: -There was an entry for divalproex 125mg 2 capsules at bedtime with a scheduled	D 358		

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administration time between 7:00pm and 9:00pm.
-There was documentation divalproex was administered nightly 28 of 30 opportunities from 01/03/25 to 01/31/25.
-There were 2 exceptions documented; the exception was medication pending delivery.

Review of Resident #5's February 2025 eMAR from 02/01/25 to 02/14/25 revealed:
-There was an entry for divalproex 125mg 2 capsules at bedtime with a scheduled administration time between 7:00pm and 9:00pm.
-There was documentation divalproex was administered nightly from 02/01/25 to 02/09/25.
-There were exceptions documented from 02/10/25 to 02/14/25; the exception was the resident was in the hospital.

Observation of Resident #5's medication on hand on 02/18/25 at 4:37pm revealed there were no divalproex 125mg 2 capsules at bedtime available for administration.

Interview with a representative from the facility's contracted pharmacy on 02/19/25 at 8:30am revealed:
-The pharmacy had an order dated 02/24/24 for divalproex 125mg every morning.
-The pharmacy dispensed 30 capsules of divalproex 125mg on 12/16/24, 01/09/25, and 01/31/25 to be administered in the morning.
-The pharmacy received an order on 02/24/24 to continue divalproex 125mg 2 capsules at bedtime.
-Resident #5 was not on a bedtime dosage, so the order was faxed to the facility with a note to clarify the order.
-The pharmacy did not receive clarification for divalproex 125mg 2 capsules at bedtime.
-Divalproex 125mg 2 capsules at bedtime had

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never been dispensed from the pharmacy.

Interview with a medication aide (MA) on 02/24/25 at 11:43pm revealed:
-She did not know divalproex 125mg 2 capsules at bedtime had not been dispensed from the pharmacy.
-Maybe she used the medication from the blister pack of divalproex 125mg in the morning to administer the bedtime dosage.

Telephone interview with Resident #5's MHP on 02/21/25 at 10:36am revealed:
-Resident #5 had an order for divalproex 125mg one tablet in the morning and 2 tablets at bedtime.
-She checked Resident #5's eMARs and noticed documentation that Resident #5 was being administered divalproex 125mg two capsules at bedtime.
-She was not aware Resident #5 had not received divalproex 125mg 2 capsules at bedtime as ordered; the original date on this order was 07/29/23.
-Resident #5's current medications were listed on each after visit summary.
-She would write medication orders and leave them at the facility or fax to the pharmacy.
-The current medication list on the after visit summary was not an order but she expected the facility staff to review her summary to ensure all current medications were active.

Interview with the licensed practical nurse (LPN) on 02/21/25 at 1:03pm revealed she was not aware that Resident #5's divalproex 125mg 2 capsules were not dispensed by the pharmacy.

Interview with the senior Resident Care Director (RCD) on 02/21/25 at 1:56pm revealed she did

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not know divalproex 125mg 2 capsules at bedtime had not been dispensed by the pharmacy.

b. Review of Resident #5's FL-2 dated 08/20/24 revealed:
-There was an order for Zyprexa (a mood stabilizer) 2.5mg daily at noon.
-There was also an order for Zyprexa 2.5mg every 12 hours as needed (PRN).

Review of Resident #5's signed physician orders dated 01/03/25 revealed:
-There was an order for Zyprexa 2.5mg daily at noon.
-There was also an order for Zyprexa 2.5mg every 12 hours PRN.

Review of Resident #5's December 2024 eMAR revealed:
-There was an entry for Zyprexa 2.5mg one tablet at noon with a scheduled administration time of 12:00pm.
-There was documentation Zyprexa was administered 29 times out of 31 opportunities 12/01/24 to 12/31/24.
-There were 2 exceptions documented; the exception was the resident spit the medication out.

Review of Resident #5's January 2025 eMAR revealed:
-There was an entry for Zyprexa 2.5mg one tablet at noon with a scheduled administration time of 12:00pm.
-There was documentation Zyprexa was administered 29 times out of 31 opportunities 01/01/25 to 01/31/25.
-There were 2 exceptions documented; the exception was the resident spit the medication

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D 358	Continued From page 128 out. Review of Resident #5's February eMAR from 02/01/25 to 02/14/25 revealed: -There was an entry for Zyprexa 2.5mg one tablet at noon with a scheduled administration time of 12:00pm. -There was documentation Zyprexa was administered 8 times of 14 opportunities from 02/01/25 to 02/14/25. -There were 6 exceptions documented; the exceptions were the resident spit the medication out and resident was hospitalized. Observation of Resident #5's medication on hand on 02/18/25 at 4:37pm revealed there was no Zyprexa 2.5mg available for administration. Interview with a representative from the facility's contracted pharmacy on 02/19/25 at 8:30am revealed: -The pharmacy had an order for Zyprexa 2.5mg twice daily as needed (PRN) -The pharmacy dispensed 60 tablets of Zyprexa 2.5mg to be administered twice daily PRN on 09/04/25, 11/04/25, and 01/09/25. -The pharmacy did not have an order for Zyprexa 2.5mg every afternoon and did not dispense Zyprexa 2.5 mg for a daily scheduled dose. -The pharmacy did not enter orders on the eMAR for the facility: the facility entered all orders into the electronic system. -The pharmacy profiled medication orders based on the electronic and faxed orders received from the Primary Care Provider (PCP) and the facility. Interview with a MA on 02/24/25 at 11:43pm revealed: -She worked in the special care unit (SCU) and administered medications to Resident #5.	D 358		

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-She administered Resident #5 all her medications as ordered.
-She did not know Zyprexa 2.5mg at noon had not been dispensed from the pharmacy.
-Maybe she used the PRN Zyprexa 2.5mg blister pack that was dispensed; if she did, she did not notice the PRN directions on the blister pack.

Telephone interview with the MHP on 02/21/25 at 10:36am revealed:
-Resident #5 had an order for Zyprexa 2.5mg daily at noon and Zyprexa 2.5mg twice daily PRN.
-She checked Resident #5's eMARs and noticed Resident #5 was not administered Zyprexa PRN for any behaviors and saw documentation Zyprexa 2.5mg was being administered daily at noon.
-She did not know Resident #5 did not receive Zyprexa 2.5mg at noon as ordered.

Interview with the LPN on 02/21/25 at 1:03pm revealed she was not aware that Resident #5's Zyprexa 2.5mg was not dispensed by the pharmacy.

Interview with the senior RCD on 02/21/25 at 1:56pm revealed she did not know Zyprexa 2.5mg had not been dispensed by the pharmacy.

Telephone interview with a MA on 02/24/25 at 9:17am revealed:
-If he did not have a medication in the facility to administer, he would notify the SCC and let her know the medications were not on the medication cart.
-The MA may have borrowed the from another resident but could not recall who the medication was borrowed from or when the medication was borrowed.
-The previous SCC told the MA not to document

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when a medication was borrowed.
-The MA would administer Resident #5's bedtime medications before going to the second floor at 6:00pm to administer medications.

Telephone interview with the MHP on 02/21/25 at 10:36am revealed:
-She treated Resident #5 for dementia with behavior disturbances and mood disorder; she visited Resident #5 monthly and as needed.
-She observed Resident #5 refused her medications from the MA during a visit a while back; Resident #5 attempted to bite the MA.
-Resident #5 could have increased behavior and mood instability if she did not receive her medications as ordered.
-Resident #5 had an order for divalproex 125mg one tablet in the morning and 2 tablets at bedtime.
-She faxed Resident #5's orders to the pharmacy and to the facility.

Interview with the Administrator on 02/24/25 at 5:24pm revealed:
-Resident #5 should not be without medication that would assist with her mood and anxiety.
-The RCD or the nurse should have called the pharmacy to see why the medications were not in the facility and available for administration.

c. Review of Resident #5's FL-2 dated 08/20/24 revealed there was an order for Coreg (used to treat high blood pressure) 3.125mg twice daily.

Review of Resident #5's blood pressure (BP) readings from 11/01/24 to 12/10/24 revealed BP readings from 101/60 to 155/87.

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

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-There was an entry for Coreg 3.125mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm.
-There was documentation Coreg was administered 59 times out of 62 opportunities from 12/01/24 to 12/31/24.
-There were 3 exceptions documented; the exception was resident spit the medication out.

Review of Resident #5's January 2025 eMAR revealed:
-There was an entry for Coreg 3.125mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm.
-There was documentation Coreg was administered 14 times out of 14 opportunities from 01/01/25 to 01/07/25.
-There was documentation Coreg was administered 45 times out of 48 opportunities from 01/08/25 to 01/31/25.
-There were 3 exceptions documented; the exceptions were the resident spit the medication out and the resident was hospitalized.

Review of Resident #5's February 2025 eMAR from 02/01/25-02/14/25 revealed:
-There was an entry for Coreg 3.125mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm.
-There was documentation Coreg was administered 18 times out of 28 opportunities from 02/01/25 to 02/14/25.
-There were 10 exceptions documented; the exceptions were the resident spit the medications out and the resident was hospitalized.

Observation of Resident #5's medication on hand

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D 358	Continued From page 132 on 02/18/25 at 4:37pm revealed: -There was a blister pack labeled card 1 of 2 with 21 of 30 Coreg 3.125mg tablets available for administration, and dispensed on 01/08/25. -There was a blister pack labeled card 2 of 2 with 11 of 30 Coreg tablets available for administration, and dispensed on 01/08/25. Telephone interview with a representative from the facility's contracted pharmacy on 02/24/25 at 8:30am revealed: -The pharmacy had an order dated 08/24/24 for Coreg 3.125mg twice daily. -The pharmacy dispensed 60 tablets on 09/20/24, 11/04/24 and 01/08/25. -Sixty tablets would last for 30 days if administered twice daily. -The pharmacy did not dispense any Coreg 3.125mg in December 2024. Based on observations, record reviews and interviews there were 60 tablets of Coreg 3.125mg dispensed on 01/08/25 for Resident #5, 63 tablets were documented as administered from 01/08/25 to 02/14/25 with 32 of the 60 tablets remaining. Telephone interview with a MA on 02/24/25 at 9:17am revealed: -Resident #5's Coreg was always available for administration. -The MA did not know why the medication had not been reordered and dispensed from the pharmacy every 30 days. Interview with a MA on 02/24/25 at 11:43pm revealed: -Resident #5 Coreg was always available for administration. -She did not know why the medications had not	D 358		

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D 358	Continued From page 133 been ordered monthly Interview with Resident #5's primary care provider (PCP) on 02/24/25 at 9:15am revealed Resident #5 was prescribed Coreg for high blood pressure. d. Review or Resident #5's FL-2 dated 08/20/24 revealed there was an order for metoprolol (used to treat high BP) 50mg twice daily. Review of Resident #5's December 2024 eMAR revealed: -There was a entry for metoprolol 50mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm. -There was documentation metoprolol was administered 59 times out of 62 opportunities from 12/01/24 to 12/31/24. -There were 3 exceptions documented; the exception was resident spit the medication out. Review of Resident #5's January 2025 eMAR revealed: -There was an entry for metoprolol 50mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm. -There was documentation metoprolol was administered 14 times out of 14 opportunities from 01/01/25 to 01/07/25. -There was documentation metoprolol was administered 45 times out of 48 opportunities from 01/08/25 to 01/31/25. -There were 3 exceptions documented; the exceptions were the resident spit the medication out and the resident was hospitalized. Review of Resident #5's February 2025 eMAR from 02/01/25 to 02/14/25 revealed:	D 358		

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-There was an entry for metoprolol 50mg twice daily with a scheduled administration time between 11:00am to 1:00pm and 7:00pm to 9:00pm.
-There was documentation metoprolol was administered 18 times out of 28 opportunities from 02/01/25 to 02/14/25.
-There were 10 exceptions documented; the exceptions were the resident spit the medications out and the resident was hospitalized.

Observation of Resident #5's medication on hand on 02/18/25 at 4:37pm revealed:
-There was a blister pack labeled card 1 of 2 with 19 of 30 metoprolol 50mg tablets available for administration with a dispensed dated of 01/08/25.
-There was a blister pack labeled card 2 of 2 with 4 of 30 metoprolol 50mg tablets available for administration with a dispensed date of 01/08/25.
-There were two blister packs with 30 of 30 metoprolol 50mg tablets in each blister pack available for administration dispensed on 02/01/25.

Telephone interview with a representative from the facility's contracted pharmacy on 02/24/25 at 8:30am revealed:
-The pharmacy had an order dated 08/24/24 for metoprolol ER 50mg twice daily.
-The pharmacy dispensed 60 tablets on 09/24/24, 01/08/25, and 02/01/25.
-Sixty tablets would last 30 days if administered twice daily.
-The pharmacy did not dispense metoprolol ER 50mg in December 2024.

Based on observations, record reviews and interviews there were 120 tablets of metoprolol 50mg dispensed since 01/08/25 for Resident #5,

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D 358	Continued From page 135 63 tablets were documented as administered with 83 tablets remaining. Interview with Resident #5's PCP on 02/24/25 at 9:15am revealed: -Resident #5 was prescribed metoprolol for high BP. -She was not aware Resident #5 did not receive her medications as ordered. -She noted some elevated BP readings in Resident #5's record which could have been due to not getting the medications as ordered. -Elevated BPs could result in a stroke or heart attack. -Her biggest concern was the MAs were documenting they administered medications they did not because she might order additional medication thinking Resident #5's BP was not controlled when really it was that she was not administered the medications correctly. -Her expectation was that medications were administered as ordered and to be notified if they were not. Interview with the senior Resident Care Director (RCD) on 02/24/25 at 2:37pm revealed: -Resident #5's BP could go up if she did not receive her BP medications as ordered. -Other medical conditions that could happen were a heart attack or a stroke if her BP got too high. Interview with the Administrator on 02/24/25 at 5:24pm revealed: -Resident #5 was on BP medications to stabilize her BP. -If Resident #5 did not receive her BP medications as ordered her BP may not be stable. Refer to the interview with a MA on 02/18/25 at	D 358		

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D 358	Continued From page 136 3:52pm. Refer to the interview with another MA on 02/24/25 at 11:43pm. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the LPN on 02/21/25 at 1:03pm. Refer to the interview with the senior RCD on 02/21/25 at 1:56pm. Refer to the interview with the Administrator on 02/24/25 at 5:24pm. 3. Review of Resident #4's current FL-2 dated 11/07/24 revealed diagnoses included Alzheimer's disease, dementia, hyperprolactinemia, and type 2 diabetes. Review of Resident #4's personal care aide (PCA) daily report for December 2024 revealed: -There were 4 days Resident #4 had episodes of pacing anxiously. -There was 1 day Resident #4 had an episode of undressing in public. -There was 1 day Resident #4 had an episode of sexually expressive (verbally or physically). -There was 1 day Resident #4 had an episode of rummaging through common areas or other residents' belongings. -There was 1 day Resident #4 had an episode of being physically/verbally aggressive. -There was 1 day Resident #4 had an episode of entering other residents' rooms uninvited. Review of Resident #4's PCA daily report for January 2025 revealed:	D 358		

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-There was 1 day Resident #4 had an episode of pacing anxiously.
-There was 1 day Resident #4 had an episode of rummaging through common areas or other residents' belongings.
-There was 1 day Resident #4 had an episode of being physically/verbally aggressive.

Review of Resident #4's progress notes for December 2024-February 2025 from 02/01/25-02/21/25 revealed:
-There was 1 day Resident #4 had an episode of rummaging through common areas or other residents' belongings.
-There was 1 day Resident #4 had an episode of agitation related to other residents, and staff administered an as needed (PRN) medication used for agitation.
-There was a second day Resident #4's PRN medication used for behaviors was administered.
-On 01/29/25, Resident #4 had disruptive behaviors. The care plan was updated, 24/7 sitters were added, and the POA/family member was notified.
-On 02/11/25, 24/7 sitters were placed with Resident #4 due to the resident infringing on resident rights while entering resident rooms.
-On 02/13/25, Resident #4's care plan was updated due to recent disruptive behavior.

a. Review of Resident #4's FL-2 dated 11/07/24 revealed an order for Divalproex (a mood stabilizer) delayed-release (DR) 250mg take one tablet three times daily.

Review of Resident #4's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Divalproex DR 250mg take one tablet three times daily with a scheduled

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administration time of 9:00am, 3:00pm, and 9:00pm.
-There was documentation Divalproex DR 250mg was administered from 12/01/24-12/31/24 at 9:00am, 3:00pm, and 9:00pm.
-There was no documentation Divalproex DR 250mg was administered at 9:00pm on 12/04/24.

Review of Resident #4's January 2025 eMAR revealed:
-There was an entry for Divalproex DR 250mg take one tablet three times daily with a scheduled administration time of 9:00am, 3:00pm, and 9:00pm.
-There was documentation Divalproex 250mg was administered from 01/01/25-01/31/25 at 9:00am, 3:00pm, and 9:00pm.
-There were 2 exceptions documented, on 01/09/25 at 9:00pm as the resident refused and on 01/30/25 at 3:00pm as the resident was hospitalized.

Review of Resident #4's February 2025 eMAR from 02/01/25-02/18/25 revealed:
-There was an entry for Divalproex DR 250mg take one tablet three times daily with a scheduled administration time of 9:00am, 3:00pm, and 9:00pm.
-There was documentation Divalproex 250mg was administered from 02/01/25-02/17/25 at 9:00am, 3:00pm, and 9:00pm and 02/18/25 at 9:00am.
-There was no documentation the medication was administered at 9:00pm on 02/07/25.

Observation of Resident #4's medications on hand on 02/18/25 at 4:30pm revealed:
-There was a blister pack dispensed on 12/26/24, labeled card 1 of 3 with 4 of 30 Depakote DR 250mg tablets available for administration.

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-There were three blister packs dispensed on 02/15/25, each card contained 30 of 30 Depakote DR 250mg tablets available for administration.
-There were 94 tablets available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 02/21/25 at 8:37am revealed:
-There were 90 tablets of Divalproex DR 250mg dispensed for a 30-day supply each dispensing on 11/29/24, 12/25/24, and 02/14/25.
-Divalproex DR 250mg was not requested for a refill in January 2025.

Based on observations, interviews, and reviews, Resident #4's Divalproex DR 250mg was documented as administered 234 times and there were 94 tablets on hand. There were 270 tablets dispensed leaving 50 more tablets on hand than there should have been.

Telephone interview with a medication aide (MA) on 02/24/25 at 9:17am revealed:
-She had administered Resident #4's Divalproex when she worked.
-She did not know why Resident #4 would have more Divalproex on hand than was documented as administered unless the medication was not being administered.

Interview with the Special Care Coordinator (SCC) on 02/24/25 at 12:40pm revealed:
-She did not know why Resident #4 had more Divalproex on hand than should be based on medication dispensed.
-When she worked as a MA, she administered Resident #4's Divalproex.

Interview with the senior Resident Care Director

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D 358	Continued From page 140 (RCD) on 02/21/25 at 1:56pm revealed: -She was not aware Resident #4's Divalproex had not been refilled monthly. -She was not aware Resident #4's Divalproex had not been administered as ordered. -She was concerned Resident #4's Divalproex was not being administered as ordered because he could have a change in his mood and increased behaviors. Telephone interview with Resident #4's Mental Health Provider (MHP) on 02/20/25 at 4:39pm revealed: -Resident #4 was ordered Divalproex as a mood stabilizer to prevent behaviors. -She was concerned Resident #4's Divalproex had not been administered as ordered because the resident could experience worsening behaviors. Interview with the Administrator on 02/24/25 at 4:52pm revealed: -He was not aware Resident #4's Divalproex had not been administered as ordered. -It was concerning a mood stabilizer was not administered as ordered because the resident would be without the medication that had been prescribed to stabilize his mood. b. Review of Resident #4's physician's order dated 01/31/25 revealed an order for Zyprexa (used as a mood stabilizer) 2.5mg daily at 3:00pm for dementia with agitation. Review of Resident #4's physician's order dated 02/14/25 revealed an order for Zyprexa 5mg daily at 4:00pm for psychotic agitation. Review of Resident #4's February 2025 eMAR from 02/01/25-02/17/25 revealed:	D 358		

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D 358	Continued From page 141 -There was an entry for Zyprexa 2.5mg daily at 3:00pm with a scheduled administration time of 3:00pm. -There was documentation Zyprexa 2.5mg was administered from 02/01/25-02/13/25. -There was a second entry for Zyprexa 5mg with an administration time of 4:00pm. -There was documentation Zyprexa 5mg was administered from 02/14/25-02/17/25. Observation of Resident #4's medications on hand on 02/18/25 at 4:29pm revealed a blister pack of 30 tablets of Zyprexa 5mg dispensed on 02/14/25; no tablets had been punched. Telephone interview with a representative from the facility's contracted pharmacy on 02/19/25 at 3:17pm revealed: -On 01/31/25, 30 tablets of Zyprexa 2.5mg were dispensed for Resident #4. -On 02/19/25, 17 tablets of Zyprexa 2.5mg were processed as returned. -On 02/14/25, 30 tablets of Zyprexa 5mg were dispensed for Resident #4. Telephone interview with a MA on 02/21/25 at 12:15pm revealed: -She did not know why Resident #4's Zyprexa 5mg was documented as administered when the medication was still on the medication cart. -She thought maybe a MA had administered two of Resident #4's Zyprexa 2.5 mg. Telephone interview with another MA on 02/24/25 at 9:17am revealed: -She did not recall whether she had administered Resident #4's Zyprexa or not. -She did not know why she had documented that she administered Resident #4's Zyprexa if the medication had not been punched from the	D 358		

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medication card.

Interview with the senior RCD on 02/21/25 at 1:56pm revealed:
-She was not aware Resident #4's Zyprexa had not been administered as ordered.
-She was concerned Resident #4's Zyprexa was not being administered as ordered because he could have a change in his mood and increased behaviors.

Telephone interview with Resident #4's MHP on 02/20/25 at 4:39pm revealed:
-In her note on 01/31/25, she documented Resident #4 had been restless and resistant to care over the past month.
-Resident #4 started Zyprexa on 01/31/25 but that was because another mood stabilizer had been discontinued due to cost.
-On 02/13/25, she increased Resident #4's Zyprexa from 2.5mg to 5mg daily due to ongoing behaviors and wandering at night.
-She was concerned Resident #4's Zyprexa had not been administered as ordered because the resident could experience worsening behaviors.

Interview with the Administrator on 02/24/25 at 4:52pm revealed:
-He was not aware Resident #4's Zyprexa had not been administered as ordered.
-It was concerning a mood stabilizer was not administered as ordered because the resident would be without the medication that had been prescribed to stabilize his mood.

c. Review of Resident #4's signed physician's order dated 11/22/24 revealed an order for Ativan/Benadryl/Haldol 2mg/25mg/2mg (compounded topical gel containing a mixture of Ativan, Benadryl, and Haldol) often used to

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D 358	Continued From page 143 manage certain behavioral issues like agitation or anxiety) gel, 30 millimeters (ml), apply 1ml three times daily as needed for acute agitation. Review of Resident #4's personal care aide (PCA) daily report for December 2024 revealed: -There were 4 days Resident #4 had episodes of pacing anxiously. -There was 1 day Resident #4 had an episode of undressing in public. -There was 1 day Resident #4 had an episode of sexually expressive (verbally or physically). -There was 1 day Resident #4 had an episode of rummaging through common areas or other residents' belongings. -There was 1 day Resident #4 had an episode of being physically/verbally aggressive. -There was 1 day Resident #4 had an episode of entering other residents' rooms uninvited. Review of Resident #4's December 2024 eMAR revealed: -There was an entry for ABH gel 2/25/2ml, give 1ml three times every 8 hours as needed for agitation. -There was no documentation ABH gel 2/25/2ml was administered from 12/01/24-12/31/24. Review of Resident #4's PCA daily report for January 2025 revealed: -On 01/08/25 between 2:30pm-10:30pm, Resident #4 was rummaging through common areas or other residents' belongings. -On 01/14/25 between 10:30pm-6:30am, Resident #4 was pacing anxiously. -On 01/18/25 between 10:30pm-6:30am, Resident #4 was physically/verbally aggressive. Review of Resident #4's January 2025 eMAR revealed:	D 358		

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-There was an entry for ABH gel 2/25/2ml, give 1ml three times every 8 hours as needed for agitation.
-There was documentation Resident #4's ABH gel 2/25/2ml was administered on 01/05/25 and 01/10/25.
-There was no documentation ABH gel 2/25/2ml was administered on 01/08/24, 01/14/25 or 01/18/25.

Review of Resident #4's progress note dated 02/22/25 revealed Resident #4 was sent to the hospital due to a change in condition.

Telephone interview with a MA on 02/24/25 at 11:19am revealed:
-On 02/22/25 around 5:00am, Resident #4 was being aggressive and would not let staff change his incontinent brief.
-She looked in the computer to see what PRN medication was ordered for Resident #4 and there was an order for the ABH gel but there was none in the medication cart.
-She did not have any PRN medication available to administer to Resident 4 for behaviors.
-She called the SCC who told her to call the facility's Registered Nurse (RN) who was the Resident Care Director (RCD).
-She called the pharmacy and the RCD to let them know something needed to be available when Resident #4 had behaviors.
-Resident #4 had been doing well and then suddenly had an outburst; he was angrier and more upset than usual.

Interview with the SCC on 02/24/25 at 12:40pm revealed:
-If Resident #4 did not have medication on the medication cart, she would direct the MAs to call someone in nursing, since that was the facility's

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protocol.
-She expected the residents' PRN medication to be available.
-She was made aware a couple of nights ago that Resident #4 was having behaviors and there was no PRN medication available.
-She directed the MA to contact the RCD.
-Because Resident #4 had a change in condition and staff were unable to redirect the resident, she told the staff to send Resident #4 to the hospital.

Review of Resident #4's February 2025 eMAR from 02/01/25-02/22/25 revealed:
-There was an entry for ABH gel 2/25/2ml, give 1ml three times every 8 hours as needed for agitation.
-There was no documentation the ABH gel 2/25/2ml was administered from 02/01/25-02/22/25.

Observation of Resident #4's medications on hand on 02/18/25 at 4:30pm revealed there was no ABH gel available to be administered.

Telephone interview with a representative from the facility's contracted pharmacy on 02/24/25 at 2:29pm revealed:
-Resident #4's ABH gel was dispensed on 11/22/24 for 30 syringes and on 01/21/25, 28 syringes were returned to the pharmacy with a note that medication had expired.
-ABH gel was a compounded medication and would expire 30 days from the date the medication was compounded.
-The order dated 11/22/24 had refills that could be filled.
-Resident #4's ABH gel had to be requested for refill.

Telephone interview with Resident #4's MHP on

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D 358	Continued From page 146 02/20/25 at 4:39pm revealed: -She was concerned Resident #4's medications used to prevent behaviors were not being administered correctly, and if the resident then had behaviors, there was no ABH gel available to be administered because it could have helped with the agitation. -She recalled specifically during her visit on 02/13/25, telling staff to use the ABH gel up to three times a day to help with agitation and if it was working, she could change the ABH gel to a scheduled medication. Interview with the senior RCD on 02/24/25 at 2:50pm revealed: -If a medication had expired, the MA should have called the pharmacy to see if there were any refills. -If a hard script was needed, the MA would let the nurse know. -She was concerned Resident #4 did not have a PRN medication available to be administered because sending the resident to the hospital could have possibly been prevented had the staff been proactive and had the medication on hand. Interview with the Administrator on 02/24/25 at 4:52pm revealed: -It was concerning Resident #4 had an order for a PRN medication that was not available when the medication was needed. -He considered medication as a tool that had been given to help Resident #4, and the staff were not utilizing the tool provided, which was not fair to the resident. -Resident #4 was anxious and there was no medication available to help him. Based on observations, record reviews, and interviews, Resident #4 was not interviewable.	D 358		

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D 358	Continued From page 147 Refer to the interview with a MA on 02/18/25 at 3:52pm. Refer to the interview with another MA on 02/24/25 at 11:43pm. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the Licensed Practical Nurse (LPN) on 02/21/25 at 1:03pm. Refer to the interview with the senior RCD on 02/21/25 at 1:56pm. Refer to the interview with the Administrator on 02/24/25 at 5:24pm. 4. Review of Resident #1's current FL2 dated 01/23/25 revealed: -Diagnoses included asthma, oxygen dependence, emphysema, atrial fibrillation, breast cancer, sleep apnea, and depression. -There was an order for ipratropium-albuterol inhalation solution (a medication used to open the airways) 0.5-2.5mg 1 vial orally via nebulizer two times a day. -There was an order for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer every six hours as needed. Review of Resident #1's record revealed there was an order for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer twice a day dated 11/14/2024. Review of Resident #1's December 2024 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 148 -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer two times a day. -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer every six hours as needed. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered two times a day from 12/01/24 to 12/14/24 and from 12/20/24 to 12/31/24. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered as needed on 12/05/24, 12/09/24, 12/10/24, 12/11/24, and 12/14/24. -There was documentation Resident #1 was hospitalized from 12/14/24 to 12/20/24. Review of Resident #1's January 2025 eMAR revealed: -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer two times a day. -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer every six hours as needed. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered two times a day from 01/01/25 to 01/19/25 and from 01/23/25 to 01/31/25. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered as needed on 01/03/25, 01/09/25, 01/10/25, 01/11/25 at 2:31am and 2:08pm, 01/12/25, 01/13/25, 01/14/25, and 01/24/25. -There was documentation Resident #1 was hospitalized from 01/19/25 to 01/23/25.	D 358		

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D 358	Continued From page 149 Review of Resident #1's February 2025 eMAR from 02/01/25 to 02/18/25 revealed: -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer two times a day. -There was an entry for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer every six hours as needed. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered two times a day from 02/01/25 to 02/18/25. -There was documentation ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer was administered as needed on 02/01/25, 02/02/25 at 3:38am and 2:05pm, 02/07/25, 02/10/25 at 1:41am and 4:57pm, 02/11/25, 02/12/25, 02/15/25, and 02/17/25. Observation of Resident #1's medications on hand on 02/18/25 at 3:25pm revealed: -There was a box of 19 vials of ipratropium-albuterol inhalation available for administration with a dispensed date of 07/03/24. -There was no other ipratropium-albuterol inhalation available for administration. Interview with Resident #1 on 02/18/25 at 5:20pm revealed: -She received ipratropium-albuterol inhalation twice a day in the morning and the evening. -She did not keep any medication in her room. -She rarely refused the medication. -She did not know if she ever missed taking the medication; she tried to keep record of it. -She often felt short of breath and the medication helped. -Sometimes she woke up in the middle of the night and felt short of breath and requested the	D 358		

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D 358	Continued From page 150 medication. Telephone interview with a representative with the facility's contracted pharmacy on 02/18/25 at 3:44pm revealed: -Resident #1 had an order for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer two times a day. -Resident #1 had an order for ipratropium-albuterol inhalation solution 0.5-2.5mg 1 vial orally via nebulizer every six hours as needed. -The medication was used to aid in breathing. -Sixty vials of ipratropium-albuterol inhalation solution were dispensed on 07/03/24 and on 07/22/24. -Ninety vials of of ipratropium-albuterol inhalation solution were dispensed on 11/14/24. -There were no other dispensed dates available for ipratropium-albuterol inhalation solution for Resident #1. -The facility requested a refill of ipratropium-albuterol inhalation solution on 02/18/25. Interview with a medication aide (MA) on 02/18/25 at 8:15am: -Resident #1 got breathing treatments once on her shift and as needed when she asked for it. -She had only refused her breathing treatment a couple of times that she knew of. -When Resident #1 refused her breathing treatment, she documented it on the eMAR. -Resident #1 was short of breath frequently and the breathing treatments helped her. Interview with a second MA on 02/21/25 at 8:00am revealed: -Resident #1 had an order for breathing	D 358		

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treatments twice a day.
-Resident #1 did not refuse her medications.
-She did not recall Resident #1 ever being out of the medication.
-When a resident was running out of a medication, she reordered it from the pharmacy using the computer system or calling them.

Interview with a nurse from Resident #1's primary care provider's (PCP) office on 02/21/25 at 12:40pm revealed:
-Resident #1 had end stage COPD and emphysema.
-Resident #1 was prescribed ipratropium-albuterol inhalation for shortness of breath.
-She needed to consult with the PCP because she thought Resident #1 should only be using ipratropium-albuterol inhalation as needed.
-She was concerned that the facility was not ordering medications often enough to administer per the PCP's orders but was not concerned that Resident #1 may not have received the ipratropium-albuterol inhalation twice a day in addition to as needed because of the risk of long term steroid use.

Interview with the licensed practical nurse (LPN) on 02/21/25 at 9:41am revealed:
-Resident #1 had end stage emphysema and was recently hospitalized for fluid overload.
-Resident #1 was frequently short of breath.
-Resident #1 would come out of her room and ask for a breathing treatment.
-The MAs re-ordered medications using the eMAR system.
-The MAs should re-order medications before they ran out.
-There was a system that kept tracking receipts of when medications were received but she could

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D 358	Continued From page 152 not access it. Interview with the Senior Resident Care Director (RCD) on 02/21/25 at 1:54pm revealed: -She was not aware of Resident #1's ipratropium-albuterol inhalation was not being ordered frequently enough to administer as it was ordered. -She was responsible for overseeing the MAs. -The MAs were able to reorder medications using the eMAR system. -MAs could also call the pharmacy if they were out of a medication. -She expected the MAs to come to her if they needed help getting medications for the residents. Interview with the Administrator on 02/24/25 at 4:50pm revealed he was concerned if Resident #1 was not getting her medication as ordered, she would not be able to breathe. Refer to the interview with a MA on 02/18/25 at 3:52pm. Refer to the interview with another MA on 02/24/25 at 11:43pm. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the LPN on 02/21/25 at 1:03pm. Refer to the interview with the senior RCD on 02/21/25 at 1:56pm. Refer to the interview with the Administrator on 02/24/25 at 5:24pm. 5. Review of Resident #3's current FL-2 dated	D 358		

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D 358	Continued From page 153 01/07/25 revealed diagnoses included heart failure, diabetes, and hypertension. a. Review of Resident #3's current FL-2 dated 01/07/25 revealed there was an order for carvedilol (used to treat high blood pressure) 12.5mg twice daily. Review of Resident #3's signed physician orders dated 07/05/24 revealed there was an order for carvedilol 12.5mg twice daily. Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for carvedilol 12.5mg take one tablet two times a day with scheduled administration times from 7:00am to 9:00am and from 7:00pm to 9:00pm. -There was documentation carvedilol was administered twice daily from 7:00am to 9:00am and from 7:00pm to 9:00pm from 12/01/24 to 12/31/24. Review of Resident #3's January 2025 eMAR revealed: -There was an entry for carvedilol 12.5mg take one tablet two times a day with scheduled administration times from 7:00am to 9:00am and from 7:00pm to 9:00pm. -There was documentation carvedilol was administered twice daily from 7:00am to 9:00am and from 7:00pm to 9:00pm from 01/01/25 to 01/31/25. -There were exceptions documented from 01/03/25 to 01/08/25; the exception was Resident #3 was in the hospital. Review of Resident #3's February 2025 eMAR from 02/01/25 to 02/18/25 revealed:	D 358		

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D 358	Continued From page 154 -There was an entry for carvedilol 12.5mg take one tablet two times a day with scheduled administration times from 7:00am to 9:00am and 7:00pm to 9:00pm. -There was documentation carvedilol was administered twice daily from 7:00am to 9:00am and from 7:00pm to 9:00pm from 02/01/25 to 02/17/25. Observation of medication on hand for Resident #3 on 02/19/25 at 10:35am revealed: -There was a bubble pack of carvedilol 12.5mg dispensed on 01/10/25 available for administration. -There were 10 of 60 carvedilol 12.5mg tablets remaining in the bubble pack. Observation of Resident #3's blood pressure on 02/19/25 at 4:57pm revealed Resident #3's blood pressure reading was 136/66. Review of Resident #3's monthly blood pressure checks revealed: -The resident's blood pressure reading on 11/26/24 at 6:30pm was 169/83. -The resident's blood pressure reading on 02/03/25 at 3:51pm was 153/67. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/19/25 at 11:25am revealed: -The pharmacy had an order for carvedilol 12.5mg twice daily dated 07/24/24. -The pharmacy dispensed 60 carvedilol 12.5mg tablets on 10/25/24, 12/13/24, and 01/10/25. Interview with Resident #3 on 02/19/25 at 4:48pm revealed: -She did not know if she took medication for blood pressure.	D 358		

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D 358	Continued From page 155 -She could not recall if staff did not administer the medication. -She took all of the medication given to her. -She remembered staff checking her blood pressure but could not recall how often or what the results were. Interview with medication aide (MA) on 02/19/25 at 4:14pm revealed: -He administered carvedilol to Resident #3 on second shift. -He recalled always having carvedilol available to administer. -Resident #3 did not refuse her medication. -He was not sure why Resident #3's carvedilol had not been ordered since 01/10/25. -He never checked Resident #3's blood pressure. -The MAs on first shift were responsible for monthly blood pressure checks. Interview with another MA on 02/21/25 at 9:47am revealed: -She administered medications on first shift. -She administered carvedilol to Resident #3 and it was always available to administer. Telephone interview with Resident #3's primary care provider (PCP) on 02/20/25 at 4:42pm revealed: -Carvedilol was ordered for lowering blood pressure and heart failure. -She expected all medications to be administered as ordered. -It was concerning when medications were not administered as ordered. -Resident #3 could have fluid retention if she did not use the medication daily. Interview with the senior Resident Care Coordinator (RCD) on 02/21/25 at 2:32pm	D 358		

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revealed:
-She was concerned that the MAs were documenting administration of medication when Resident #3 was not receiving the medication.
-She was concerned that Resident #3's blood pressure would be elevated causing a heart attack or stroke.

b. Review of Resident #3's current FL-2 dated 01/07/25 revealed there was an order for cholecalciferol (used to treat vitamin-d deficiency) 25mcg once daily.

Review of Resident #3's signed physician orders dated 07/05/24 revealed there was an order for cholecalciferol 25mcg daily.

Review of Resident #3's December 2024 eMAR revealed:
-There was an entry for cholecalciferol 25mcg once daily with a scheduled administration time from 7:00am to 9:00am.
-There was documentation cholecalciferol was administered once daily from 7:00am to 9:00am on 12/01/24 to 12/31/24.

Review of Resident #3's January 2025 eMAR revealed:
-There was an entry for cholecalciferol 25mcg once daily with a scheduled administration time from 7:00am to 9:00am.
-There was documentation cholecalciferol was administered once daily from 7:00am to 9:00am on 01/01/2025 to 01/31/25.
-There were exceptions documented from 01/03/25 to 01/08/25; the exception was Resident #3 was in the hospital.

Review of Resident #3's February 2025 eMAR from 02/01/25-02/18/25 revealed:

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-There was an entry for cholecalciferol 25mcg once daily with a scheduled administration time from 7:00am to 9:00am.
-There was documentation cholecalciferol was administered once daily from 7:00am to 9:00am on 02/01/25 to 02/18/25.

Observation of Resident #3's medications on hand on 02/19/25 at 10:35am revealed:
-There was a bubble pack of cholecalciferol 25mcg dispensed on 01/15/25 available for administration.
-There were 5 of 30 cholecalciferol 25mcg tablets remaining in the bubble pack.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/19/25 at 11:25am revealed:
-The pharmacy had an order for cholecalciferol 25mcg once daily dated 07/24/24.
-The pharmacy dispensed 30 cholecalciferol 25mcg tablets on 10/25/24, 12/03/24, and 01/15/25.

Interview with Resident #3 on 02/19/25 at 4:48pm revealed:
-She knew she took vitamin D medication.
-She could not recall if staff did not administer the medication.
-She took all of the medication given to her.

Interview with a MA on 02/19/25 at 4:14pm revealed:
-He administered cholecalciferol to Resident #3 on second shift.
-He recalled always having cholecalciferol available to administer.
-Resident #3 did not refuse her medication.
-He was not sure why Resident #3's cholecalciferol had not been ordered since

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D 358	Continued From page 158 01/15/25. Interview with another MA on 02/21/25 at 9:47am revealed: -She administered medications on first shift. -She administered cholecalciferol to Resident #3 and was always available to administer. Telephone interview with Resident #3's PCP on 02/20/25 at 4:42pm revealed: -Cholecalciferol was ordered for vitamin D deficiency. -She expected all medications to be administered as ordered. -It was concerning when medications were not administered as ordered. Interview with the senior RCD on 02/21/25 at 2:32pm revealed: -She was concerned that the MAs were documenting administration of medication when Resident #3 was not receiving the medication. -She was concerned that Resident #3's vitamin D would be deficient. Refer to the interview with a MA on 02/18/25 at 3:52pm. Refer to the interview with another MA on 02/24/25 at 11:43pm. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the LPN on 02/21/25 at 1:03pm. Refer to the interview with the senior RCD on 02/21/25 at 1:56pm.	D 358		

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D 358	Continued From page 159 Refer to the interview with the Administrator on 02/24/25 at 5:24pm. _____ Interview with a MA on 02/18/25 at 3:52pm revealed: -She re-ordered medications when there were 7 days of medication remaining for the resident. -Some residents had been without their medication for a day or two, but not any longer. -She would call the pharmacy when needed to ensure the medication was delivered. Interview with a MA on 02/24/25 at 11:43pm revealed: -When administering medications she would open the eMAR, pull the medication from the cart, compare the name of the medication to the medication on the eMAR, turn the blister pack of medication over on top of the medication cart until all the medications had been removed from the medication cart. Interview with the Special Care Coordinator (SCC) on 02/24/25 at 12:39pm revealed: -The MAs would notify the RCD or the nurse for any medication problems. -She did not manage the MAs or medication; the RCD and the nurse managed all the medications. Interview with the LPN on 02/21/25 at 1:03pm revealed: -The MAs re-ordered medications by clicking the "reorder" button on the electronic device or calling or faxing the pharmacy. -The MAs were instructed to reorder medications when there was 10 days of medication remaining. -It took between 24-48 hours for the pharmacy to deliver medications to the pharmacy. -If a medication was not on the medication cart, the MAs should look for it on in the medication	D 358		

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room or on another medication cart.
-The RCD and the nurse entered medication orders for the facility; the pharmacy did not enter any medication orders for the facility.
-The MA on third shift would check the medications in and place them on the correct medication cart.
-There was an electronic list of medications waiting to be received from the pharmacy.
-The list should be checked when the medications were delivered to ensure all medications were delivered.
-If a new medication was not delivered by the pharmacy, the MA should notify the RCD or the nurse to inform them that the medication was not delivered.
-The RCD or the nurse would call the pharmacy and check the status of the medication.

Interview with the senior RCD on 02/21/25 at 1:56pm revealed:
-She was responsible for overseeing the MAs.
-Each medication cart was audited weekly by the MAs.
-The MA should compare the medication on the cart to the medication listed on the eMAR.
-The MA should remove discontinued and expired medications from the medication cart.
-If a medication was not on the medication cart it should be ordered from the pharmacy.
-The RCD should complete a monthly medication cart audit.
-The MAs and RCD had not had time to audit medication carts because most shifts have 2 MAs instead of 3 MAs; having 3 MAs would give the staff time to audit the medication carts.
-When a medication order was received by fax, the RCD or the nurse would enter the medication order into the eMAR and fax it to the pharmacy.
-When the medication was delivered to the

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D 358	Continued From page 161 facility, the MA would check "order received" and place the medication on the correct medication cart. -If a medication was missing from the medication cart, the MA should check the manifest sheet to see if the medication was delivered and check all the medication carts to see if the medication was placed on another cart. -If the MA could not find the medication, the MA should call the RCD or the nurse. -The RCD or the nurse would call the pharmacy to see why the medication was not in the facility. -The RCD or the wellness nurse would look at the manifest sent by the pharmacy to ensure the medications were delivered. -They would not check the medication cart to ensure the medications were delivered, because the manifest sheet verified the medications was delivered. Interview with the Administrator on 02/24/25 at 5:24pm revealed: -The RCD or the nurse processed all the medication orders by entering the medication orders into the eMAR and faxing the medication orders to the pharmacy. -The RCD or nurse who faxed the medication order should call the pharmacy to ensure the pharmacy had the order. -The third shift MA would check the medication in upon delivery. -The RCD or nurse should check to see if the medication was delivered by checking to see if the medication was on the medication cart. -If the medication was not on the medication cart, the RCD or nurse should call the pharmacy to see why the medication was not sent. -The RCD or nurse should have called the pharmacy when a medication was not available for administration.	D 358		

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D 358	Continued From page 162 -When the resident did not get the medication as ordered, it would make it harder on the resident. -He was concerned for the health and safety of the residents if they were not administered medications as ordered. -Medication cart audits should be done weekly by the MAs and the RCD monthly. -The MAs should be completing the medication audit form, which should be given to the RCD. -The MA should correct any problems they find during the cart audit. -The RCD should follow up on any issues that were noted on the audit form to see that the MA corrected any issues found. -He was concerned the MAs were documenting medications they had not administered. _____ The facility failed to administer medications as ordered for a resident diagnosed with atrial fibrillation and an aortic valve disorder, who did not receive the prescribed blood thinner which put the resident at risk for developing blood clots and having a possible stroke (#6); a resident, who was not administered PRN medications for agitation resulting in the resident being sent to the hospital each time the resident became agitated (#4); and a resident, who had a diagnosis of asthma and did not receive an inhaler and could have developed issues with breathing and pneumonia (#1). This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 26, 2025.	D 358		

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D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 3 sampled residents (#8, #9, #10) had a physician's order and assessment completed to self-administer medications related to a medication to treat allergies (#8), eye drops (#9), and an antacid (#10). The findings are: Review of the facility's Resident Self-Administration policy dated April 2023 revealed: -There must be a physician's order and a nursing assessment to indicate that a resident could safely administer his/her own medications. -Nothing should be at the resident's bedside unless they could self-administer.	D 375		

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D 375	Continued From page 164 1. Review of Resident #8's current FL2 dated 01/02/25 revealed: -Diagnoses included hypertension, dysphagia, hyperlipidemia, Parkinson's disease, anxiety, iron deficiency anemia, diabetes mellitus type 2, and adult failure to thrive. -There was an order for ipratropium bromide spray (used to treat allergies) 21mcg 2 sprays three times a day. Review of Resident #8's record revealed: -There was an order for Resident #8 to self-administer her ipratropium bromide spray. -There was no self-administration assessment completed for Resident #8. Review of Resident #8's personal service plan dated 01/06/25 revealed Resident #8 was unable to self-administer her medications. Observation on 02/18/25 of Resident #8's room at 8:55am revealed there was a bottle of ipratropium bromide spray in a see-through bottle with a pharmacy label and administration instructions for Resident #8 on the table beside Resident #8's recliner. Interview with Resident #8 on 02/18/25 at 9:00am revealed: -She kept the ipratropium bromide spray in her room on her table. -She used the ipratropium bromide spray three times a day. -She did not know if the facility completed an assessment for self-administering medications. Interview with a personal care aide (PCA) on 02/18/25 at 10:46am revealed: -She had seen the nasal spray in Resident #8's	D 375		

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room.
-Resident #8 had an order to self-administer her nasal spray.

Interview with a medication aide (MA) on 02/18/25 at 5:45pm revealed:
-Resident #8 kept her nasal spray in her room.
-There was an order for Resident #8 to self-administer her nasal spray.
-She did not know if Resident #8 had an assessment done to self-administer medications.

Attempted telephone interview with Resident #8's primary care provider (PCP) on 02/19/25 at 9:30am was unsuccessful.

Refer to the interview with MA on 02/18/25 at 5:45pm.

Refer to interview with the facility's licensed practical nurse (LPN) on 02/21/25 at 9:41am.

Refer to the interview with the Resident Care Director (RCC) on 02/18/25 at 10:53am.

Refer to the interview with the Administrator on 02/24/25 at 4:50pm.

2. Review of Resident #9's current FL2 dated 08/19/24 revealed:
-Diagnoses included presence of intraocular lens and cataract extraction status.
-There was no order for refresh drops.

Review of Resident #9's record revealed:
-There was no assessment for self-administration of medications.
-There was no physician's order to self-administer medications.
-There was no physician's order for refresh eye

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D 375	Continued From page 166 drops. Review of Resident #9's personal service plan dated 11/25/24 revealed: -Resident #9 had impaired cognitive function. -Resident #9 was unable to self-administer her medications. Observation of Resident #9's room on 02/18/25 at 11:20am revealed: -There was a bottle of refresh eye drops on the nightstand next to Resident #9's bed. -There was no pharmacy label on the bottle of refresh eye drops. Interview with Resident #9 on 02/18/25 at 4:25pm revealed: -She used the refresh eye drops a few times a day because she had very dry eyes. -She did not know if there was a physician's order for the refresh eye drops. -No one told her how often to administer the refresh eye drops. -She kept the eye drops on her nightstand so she could use them when she needed them. An attempted telephone interview with a Registered Nurse (RN) from Resident #9's primary care provider (PCP) on 02/19/25 at 11:05am was unsuccessful. Interview with a personal care aide (PCA) on 02/18/25 at 10:46am revealed she had not seen eye drops in Resident #9's room. Interview with the medication aide (MA) on 02/18/25 at 5:45pm revealed: -She had not seen the refresh eye drops in Resident #9's room. -She should have noticed the eye drops in the	D 375		

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D 375	Continued From page 167 room and removed them. Refer to the interview with MA on 02/18/25 at 5:45pm. Refer to interview with the LPN on 02/21/25 at 9:41am. Refer to the interview with the RCD on 02/18/25 at 10:53am. Refer to the interview with the Administrator on 02/24/25 at 4:50pm. 3. Review of Resident #10's current FL2 dated 01/23/25 revealed: -Diagnoses included malignant neoplasm of liver and intrahepatic, chronic pain, and insomnia. -There was no order for an antacid. Review of Resident #10's record revealed: -There was no assessment for self-administration of medications. -There was no physician's order to self-administer medications. -There was no physician's order for the antacid. Observation of Resident #10's room on 02/18/25 at 10:00am revealed: -Resident #10 was asleep in her bed. -There was an almost full bottle of an antacid with the lid removed on Resident #10's bedside table. Interview with Resident #10 on 02/19/25 at 11:28am revealed: -She kept the bottle of antacid at her bedside in case she got indigestion. -She got indigestion occasionally when she ate spicy food. -She liked to have the antacid available when she	D 375		

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needed them.
-She did not know if she had a physician's order for the antacid.
-She had been told before she could not have the antacid at the bedside but she felt like she needed them.

Interview with a personal care aide (PCA) on 02/18/25 at 10:46am revealed she had not seen the antacid in Resident #10's room.

Interview with a medication aide (MA) on 02/18/25 at 5:45pm revealed:
-She had seen the bottle of antacid in Resident #10's room but did not remove it.
-Resident #10 had medication in her room before and she tried to remove it but Resident #10 got angry.
-She should have taken the medication out of the room and if Resident #10 became angry, she should have asked the nurse to help her.

Attempted telephone interview with Resident #10's primary care provider (PCP) on 02/19/25 at 2:00pm was not successful.

Refer to the interview with a personal care aide (PCA) on 02/18/25 at 10:46am.

Refer to the interview with MA on 02/18/25 at 5:45pm.

Refer to interview with the LPN on 02/21/25 at 9:41am.

Refer to the interview with the RCC on 02/18/25 at 10:53am.

Refer to the interview with the Administrator on 02/24/25 at 4:50pm.

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D 375	Continued From page 169 Interview with a PCA on 02/18/25 at 10:46am revealed: -Residents should not have medications in their rooms. -If she saw medications in a resident's room, she should take them out and give them to the MA. Interview with a MA on 02/18/25 at 5:45pm revealed: -Residents should not have medications in their rooms unless they had a physician's order. -If a resident had medications in their room, she should remove the medication. Interview with the Licensed Practical Nurse (LPN) on 02/21/25 at 9:41am revealed: -Before a resident was admitted to the facility, there was an assessment done to determine if they were appropriate to self-administer medications. -If the residents were not appropriate to self-administer their medications, they should not have medications in their rooms. -Oftentimes, family members brought medications for the residents but the residents were aware they should not have medications in their rooms. -If PCA's found medications in resident rooms, they were to alert the MA and the MA should go to the room and remove the medications. -The PCAs and MAs should be looking in resident rooms for medications when they provided care. -Medications left in the resident rooms could cause problems with other medications the resident received, the resident could take too much of the medication, or they could have side effects that staff would not be aware of. Interview with the senior RCD on 02/19/25 at	D 375		

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D 375	Continued From page 170 10:53am revealed: -If a resident wanted to self-administer their own medications, there should be a physician's order and an assessment completed to make sure the resident was appropriate to self-administer. -The PCAs and MAs should be looking for medications in the resident rooms when they made rounds or administered medications. -PCAs should alert the MA or the nurse if medications were found in resident rooms. Interview with the Administrator on 02/24/25 at 4:50pm revealed: -If a resident wanted to self-administer their medications, an evaluation was done by the nurse. -If the resident was appropriate to self-administer medications, a physician's order would be obtained. -All staff were responsible for checking rooms for medications and reporting if medications were found. -For the safety of all the residents, there should not be medications in resident rooms unless an assessment was done and a physician's order to self-administer.	D 375		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.	D 453		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to immediately notify the county Department of Social Services (DSS) and local law enforcement related to 1 of 1 sampled resident (#5) who had three incidents of resident-to-resident physical assault.

The findings are:

Review of the facility's abuse policy dated 05/04/16 revealed:
-The community should prevent abuse.
-Team members of the facility should report known or suspected abuse to the local, state, and federal authorities.
-Team members who knew of or suspected abuse, of any resident must immediately notify the Administrator or designee to ensure appropriate action was timely taken for the safety of the residents.
-Resident to resident altercations were treated as abuse.
-Abuse was the infliction of injury, intimidation resulting in physical harm, pain or mental anguish.
-Physical abuse is the willful infliction of bodily injury or physical harm upon any resident, including hitting, slapping, pinching, or kicking.
-Sexual abuse was any form of nonconsensual sexual contact, including but not limited to inappropriate touching, sexual harassment, sexual coercion, or sexual assault.
-Resident to resident altercation was action by

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one resident against another resident that had the potential to physically or psychologically injure or harm another resident.
-The Administrator or the designee validated that the mandatory report of known or suspected abuse had been made to the applicable authorities in accordance with state and federal requirements.
-The Administrator managed and directed the investigation of all abuse and implemented corrective actions as indicated by the results of the investigation.
-If a written report of the investigation findings was required by law or regulation the Administrator would complete the report and ensure the report was submitted timely.

Review of Resident #5's current FL-2 dated 08/20/24 revealed diagnoses included dementia in other diagnosis with mood disturbance and major depressive disorder.

a. Review of Resident #5's occurrence report dated 10/23/24 revealed:
-A [named] resident walked past Resident #5 who was sitting in a chair.
-Resident #5 bit the [named] resident on his right hand, lifting the skin and trying to rip the skin off his hand.

Review of Resident #5's incident/accident reports revealed there was no report dated 10/23/24 available for review.

Review of Resident #5's electronic progress notes revealed there was no documentation regarding the occurrence dated 10/23/24.

Interview with the Adult Home Specialist (AHS) from the local DSS on 02/24/25 at 2:00pm

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D 453	Continued From page 173 revealed she did not receive an incident report related to a resident-to-resident altercation dated 10/23/24. Telephone interview with the law enforcement officer on 02/24/25 at 11:29am revealed the law enforcement agency did not receive a report of an altercation between Resident #5 and a [named] resident dated 10/23/24. Interview with the Special Care Coordinator (SCC) on 02/24/25 at 12:39pm revealed she did not recall being notified about the incident on 10/23/24. Interview with the senior Resident Care Director (RCD) on 02/24/25 at 2:37pm revealed she did not know about an incident between Resident #5 and the [named] resident on 10/23/24, but if it was considered a resident-to-resident assault then it should have been reported. Interview with the Administrator on 02/20/25 at 4:10pm revealed he was not aware of an incident between Resident #5 and the [named] resident on 10/23/24. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the senior RCD on 02/24/25 at 2:37pm. Refer to the interview with the Administrator on 02/20/25 at 4:10pm. b. Review of Resident #5's incident/accident report dated 01/29/25 revealed: -At 7:30pm, staff reported that Resident #5 was struck in the face by another resident.	D 453		

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-Hospice was notified, and Resident #5 was assessed by the hospice nurse.
-The report was completed by the Administrator on 01/30/25.

Review of Resident #5's progress note dated 01/30/25 revealed:
-A head to toe assessment was completed by the senior RCD.
-Resident #5 had a red abrasion over her right eyebrow; there was no swelling.
-There were no other skin abnormalities noted.
-Resident #5 denied pain or discomfort.
-Hospice was notified and staff were instructed not to send Resident #5 to the emergency department (ED); the hospice nurse would visit.

Telephone interview with the law enforcement officer on 02/24/25 at 11:29am revealed the law enforcement agency did not receive a report of an altercation between Resident #5 and a [named] resident dated 01/29/25.

Interview with the senior RCD on 02/24/25 at 2:37pm revealed she did not know if the incident on 01/29/25 was reported to the law enforcement agency, but it should have been reported.

Interview with the Administrator on 02/20/25 at 4:10pm revealed:
-The first incident between Resident #5 and the [named] resident was on 01/29/25.
-There were no other incidents reported between Resident #5 and the [named] resident prior to 01/29/25.
-He did not notify the local law enforcement agency about the incident on 01/29/25; he did not know he should have notified them.

Refer to the interview with the SCC on 02/24/25

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D 453	Continued From page 175 at 12:39pm. Refer to the interview with the senior RCD on 02/24/25 at 2:37pm. Refer to the interview with the Administrator on 02/20/25 at 4:10pm. c. Interview with the Administrator on 02/18/25 at 2:43pm revealed: -He was informed by the RCD that Resident #5's private duty sitter reported she found the camera in Resident #5's room unplugged, and Resident #5's incontinent brief and pajama bottoms were pulled down. -The private duty sitter had a picture of how Resident #5 was found on the morning of 02/10/25, but he had not seen the picture. -The private duty sitter verbalized that Resident #5 was sexually assaulted. -Resident #5 was on hospice services, and they were called to assess Resident #5. -The RCD sent Resident #5 to the hospital due to a decline in her condition; Resident #5 was being treated for the flu. -The facility requested a rape kit be done at the hospital due to the accusations made by the private duty sitter. -Resident #5's family member notified the local law enforcement. Review of Resident #5 incident/accident reports revealed there was no report dated 02/10/25 available for review. Review of Resident #5's electronic progress notes revealed there was no documentation related to the incident reported on 02/10/25. Interview with the AHS from the local DSS on	D 453		

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D 453	Continued From page 176 02/24/25 at 2:00pm revealed: -She arrived at the facility on the morning of 02/11/25 for another work-related issue when she saw emergency vehicles in the parking lot. -As she was leaving the facility, the RCD said, "you may need to know this" and she proceeded to tell the AHS about the allegations made between Resident #5 and the [named] resident. -She asked to speak to the Administrator, but he was not at the facility. -She did not receive a written incident/accident report regarding the issues discovered with Resident #5 on 02/10/25. Telephone with the law enforcement officer on 02/24/25 at 11:29am revealed the incident regarding Resident #5 and a [named] resident was reported to the agency by Resident #5's family. Interview with the senior RCD on 02/24/25 at 2:37pm revealed she thought the RCD reported the incident from 02/10/25 to the AHS. Interview with the Administrator on 02/20/25 at 4:10pm revealed he did not notify the local law enforcement agency about the incident discovered on 02/10/25 because the family notified them. Refer to the interview with the SCC on 02/24/25 at 12:39pm. Refer to the interview with the senior RCD on 02/24/25 at 2:37pm. Refer to the interview with the Administrator on 02/20/25 at 4:10pm. _____ Interview with the SCC on 02/24/25 at 12:39pm	D 453		

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D 453	Continued From page 177 revealed: -Resident to resident encounters should be reported to management. -The PCA would write a statement and report the occurrence to her; she would give the statement to the Administrator. -The PCA's immediate Supervisor would enter the information into the electronic system and fax the occurrence report to the Primary Care Provider (PCP) and contact the family. -The nurses would have access to the report in the electronic system. -The information in risk connect was similar to the information on the occurrence report. -Her responsibility was to ensure measures were put in place on the resident's care plan. -She did not report incidents to DSS or to the law enforcement; that was not her responsibility. -She did not know who was responsible for notifying DSS or the law enforcement agency. Interview with the senior RCD on 02/24/25 at 2:37pm revealed: -Anyone in management could send an incident report to the AHS a the local DSS. -She did not know who reported incidents to the local law enforcement agency. Interview with the Administrator on 02/20/25 at 4:10pm revealed: -He notified the AHS at the local DSS when reportable incidents occurred. -He was not aware he needed to contact the local law enforcement agency when physical abuse occurred between residents.	D 453		