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	HAL047014	A. BUILDING: _____ B. WING _____	R 03/20/2025

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow up survey, and complaint investigation from 03/18/25 to 03/20/25. The complaint investigation was initiated by Hoke County Department of Social Services on 02/21/25.	D 000	This plan of correction is prepared and executed as a means to continuously improve the quality of care for our residents and to comply with all applicable state regulatory requirements.	
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure oxygen cylinders were stored safely. The findings are: Requested review of the facility's policy and procedures for oxygen tank and equipment use, handling and storage on 03/18/25 revealed the facility did not have a policy for this. Observation of room 30 resident's room on 03/18/25 at 9:19am revealed: -There were 3 unsecured small oxygen cylinders on the resident's floor between the room door and chest of drawers. -There were 5 unsecured medium oxygen cylinders on the resident's floor between the	D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings The facility will maintain an uncluttered, clean, and orderly mannered environment, free of all obstructions and hazards. Upon identification of the deficiency, the Executive Director called the oxygen company and requested oxygen racks for all oxygen not secured safely. All oxygen was placed in secured racks to prevent tipping or damage. Staff will attend in-service training On proper storage of oxygen. The Resident Care Coordinator and/or Designee will conduct weekly inspections of all oxygen storage areas for the next 30 days, followed by monthly checks thereafter.	04/15/2025

Reviewed and Acknowledged 04/29/25 Melissa A. Hoyle

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D 079	Continued From page 1 bathroom door and closet door. -There were no storage racks or crates available for the oxygen cylinders. Observation of room 34 resident's closet on 03/18/25 at 9:23am revealed: -There were 3 medium oxygen cylinders in the resident's closet on the floor surrounded by the residents' clothing. -There were no storage racks or crates available for the oxygen cylinders. Interview with a resident in a room 34 on 03/18/25 at 9:50am revealed: -He and his roommate both used wheelchairs for mobility. -They had to be careful around the oxygen tanks to make sure not to bump into them. -He knew they were flammable, and you should not smoke around them and they could explode if dropped. Interview with a medication aide (MA) on 03/18/25 at 10:30am revealed: -The oxygen tanks had always been stored in the residents' rooms. -There was not a designated storage area for the oxygen cylinders -There were not enough racks or crates for the oxygen cylinders. Interview with the facility's Administrator on 03/20/25 at 10:15am revealed: -She was not aware there were unsecured oxygen tanks in facility until today. -She knew the cylinders were supposed to be secured in racks but was not sure why there were not enough racks to secure all the tanks. -She would contact the oxygen supply company to pick up the unsecured oxygen cylinders	D 079		

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D 079	Continued From page 2 immediately. -She expected all oxygen tanks to be secured in racks and there should be a designated area for storage and not in residents' room. -She was aware of the safety risk and potential danger of unsecured oxygen tanks.	D 079		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the building was maintained in a safe condition related to the front entrance door being in disrepair and inoperable to be securely closed and locked, which left the facility vulnerable for anyone to enter and posed a risk for the safety of the residents and staff. The findings are: Review of FL-2s for current residents residing on the AL unit on 03/20/25 revealed: -There were 38 resident FL-2s that were reviewed. -There were 14 residents' FL-2s with a diagnosis of dementia . -There were 12 residents' FL-2s that indicated intermittent disorientation. -There was 1 resident's FL-2s with a diagnosis of intellectual disability.	D 105	10A NCAC 13F .0311(a) Other Requirements The facility shall ensure that the building and all fire safety, electrical, mechanical and plumbing equipment in the facility is maintained in safe and operating conditions. On 03/20/25 BPSE Gills Security completed the installation of the push bar on the front entrance door to be securely closed and locked. The Maintenance Director and/or Designee will do monthly inspections in the building to ensure all equipment is operating properly. Staff will immediately report any equipment problems to the Maintenance Director or Executive Director.	3/20/25

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D 105	Continued From page 3 -There were 11 residents' FL-2s with no diagnosis of dementia nor any disorientation noted. Observation of the facility front door on 03/18/25 at 8:00am revealed: -The front entrance door of the facility was ajar. -The metal push bar in which the door operated had been removed. -There was no closing, latch mechanism, or lockset mechanism for the front entrance door. -The front entrance door was easily pushed open from the inside and easily pulled open from the outside. -There was an alarm mechanism at the top right-hand corner of the inside of the door, but no sound/alarm was noted when the front entrance door was opened. Observation of the front entrance door on 03/19/25 at 7:00am revealed: -The front entrance door of the facility was ajar. -The front entrance door was unlocked and unalarmed. Interview with a medication aide on 03/18/25 at 1:15pm revealed: -The door had been that way for at least 2 months now. -There was no way to lock the door or secure it. -All the staff used that door as their entrance to and from work. -She was concerned that anyone could walk in at any time day or night without anyone noticing. -She thought it was a safety concern for the residents and staff as well. -There were several residents who resided on the assisted living hall who were confused and could easily leave the facility if they wanted to leave. Interview with the Administrator on 03/20/25 at	D 105		

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D 105	Continued From page 4 11:53am revealed: -She was aware of the front entrance door needed repair. -The previous maintenance director had removed the push bar hardware and not replaced it; she was not sure why he removed the push bar and did not replace it which left the door unable to close and lock. -The facility had a contractor out (not sure of the exact date) to check the front entrance door; they had to order parts to repair it. -She had just contacted the contractor, and he had the parts in and was sending someone as soon as possible to repair the door. Telephone interview with the facility's contractor on 03/20/25 at 1:27pm revealed: -He had spoken with the facility staff, and he had his crew on the way to fix the front door. -The crew should be at the facility within the next 30 minutes to repair the front entrance door.	D 105		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 113	10A NCAC 13F .0311(d) Other Requirements The facility shall ensure that the hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). The Maintenance Director and/or Designee will conduct regular water temperature checks. All results will be documented in the Water Temperature Logbook and reviewed by the Executive Director. Any reading outside of the acceptable range will be reported to the Maintentance Director and Executive Director and will be adjusted immediately.	

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D 113	Continued From page 5 reviews, the facility failed to ensure hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 8 of 9 fixtures with water temperatures ranging from 117.1 to 128.3 degrees F. The findings are: Review of the facility's census on 03/18/25 revealed there were 64 residents in the facility. Observation of the water temperatures on the 2 assisted living (AL) hallways on 03/18/25 from 8:20am to 9:20am revealed: -The hot water temperature in the bathroom sink in room 1 was 128.3 degrees Fahrenheit (F) with visible steam noted in the sink while the water was running. -The hot water temperature in the bathroom sink in room 7 was 120.7 degrees F. -The hot water temperature in the sink in the shower room was 126 degrees F. -The hot water temperature in the right shower stall in the shower room was 123.3 degrees F. -The hot water temperature in the bathroom sink in room 12 was 121.3 degrees F. -The hot water temperature in the bathroom sink in room 29 was 117.4 degrees F. -The hot water temperature in the bathroom sink in room 30 was 117.1 degrees F. Second observation of the water temperatures on the 2 AL hallways on 03/19/25 from 7:12am to 7:48am revealed: -The hot water temperature in the bathroom sink in room 1 was 116.2 degrees F. -The hot water temperature in the bathroom sink in room 7 was 125.6 degrees F. -The hot water temperature in the sink in the	D 113	The Maintentance Director adjusted water Tank and corrected fluctuating water temperature. Water Temperatures are now in range set forth in the rule.	3/19/25

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D 113	Continued From page 6 shower room was 123.6 degrees F. -The hot water temperature in the right shower stall in the shower room was 121.6 degrees F. -The hot water temperature in the bathroom sink in room 12 was 120 degrees F. -The hot water temperature in the bathroom sink in room 30 was 100.2 degrees F. Third observation of the water temperatures on the 2 AL hallways on 03/20/25 from 8:45am to 9:03am revealed: -The hot water temperature in the bathroom sink in room 1 was 120.7 degrees F. -The hot water temperature in the bathroom sink in room 7 was 120.6 degrees F. -The hot water temperature in the sink in the shower room was 121.6 degrees F. -The hot water temperature in the right shower stall in the shower room was 119.5 degrees F. -The hot water temperature in the bathroom sink in room 12 was 119.8 degrees F. Interview with the resident in room 12 at 8:48am revealed: -He was admitted to the facility in June 2024. -He had not noticed the water in his bathroom sink being too hot. -He could adjust the temperature of the water if he thought it was too hot. -He had not been burned by hot water in the facility. Interview with the resident in room 7 at 8:52am revealed: -She had not noticed the water temperature in her bathroom being too hot. -She could adjust the water temperature if needed. -She had not been burned by hot water in the facility.	D 113		

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D 113	Continued From page 7 Interview with a personal care aide (PCA) on 03/18/25 at 8:25am revealed: -Most of the residents who lived in AL needed some type of assistance with bathing. -She had not noticed the water in the facility being too hot. -She adjusted the water temperature before she assisted residents into the shower. -She asked each resident to feel the water temperature with their hand before she assisted the resident into the shower. -She would notify the maintenance staff if she noticed the water seemed too hot. Interview with the maintenance assistant on 03/18/25 at 9:14am revealed: -He started working at the facility approximately 3 weeks ago. -He was responsible for checking the water temperatures in the facility. -He just started checking the water temperatures in the facility in the last few days. -He checked the water temperature in 3 residents' rooms on each hall and the water temperatures in the shower rooms daily. -He recorded the water temperatures on a temperature log. -He did not have any temperature logs for January 2025 or February 2025 because he was not working at the facility and was unsure if the temperatures were being recorded. -He thought the water temperatures in the residents' rooms should be 110-116 degrees F. -He had not had any water temperatures greater than 116 degrees F. -He had to adjust the temperature on the water heater last week because the temperatures were close to 116 degrees F.	D 113		

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D 113	Continued From page 8 Interview with the Maintenance Director on 03/18/25 at 9:17am revealed: -He worked at the facility a few years ago as the Maintenance Director and recently returned to his position a couple of weeks ago. -He was unsure if there were any water temperature logs for the past several months. -The water temperatures in the residents' rooms should not be over 116 degrees F. -He checked the water temperatures when he started working at the facility and some were as high as 125 degrees F, so he adjusted the temperature on the water heaters. -He would adjust the temperature on the water heaters today. -If the water temperatures were elevated, he would report the elevated temperatures to the Administrator. Review of the facility's March 2025 water temperature logs revealed: -On 03/10/25, 12 fixtures were checked from 9:00am to 9:11am and the hot water temperatures ranged from 85 degrees F to 128 degrees F. -There was documentation of the water heater temperatures being adjusted on 03/10/25. -On 03/13/25, 12 fixtures were checked from 8:40am to 9:10am and the hot water temperatures ranged from 86 degrees F to 126 degrees F. -On 03/14/25, 12 fixtures were checked from 8:28am to 8:49am and the hot water temperatures ranged from 105 degrees F to 116 degrees F. -On 03/17/25, 12 fixtures were checked from 8:20am to 8:28am and the hot water temperatures ranged from 98 degrees F to 120 degrees F. -On 03/18/25, 12 fixtures were checked from	D 113		

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D 113	Continued From page 9 8:16am to 8:26am and the hot water temperatures ranged from 106 degrees F to 116 degrees F. Second interview with the maintenance assistant on 03/19/25 at 7:50am revealed: -Each one of the AL hallways had a water heater and he adjusted both yesterday, 03/18/25. -He was unsure the last time a plumber was at the facility. -He had not contacted a plumber since he started working at the facility. -He did not recheck the water temperatures again after he adjusted the temperature on the water heater on 03/18/25. Interview with the Administrator on 03/19/25 at 8:07am revealed: -The maintenance staff was responsible for checking the water temperatures. -The maintenance staff usually checked the water temperatures in 2-3 resident rooms each day. -She was not informed of any elevated water temperatures in the facility. -She would ask the maintenance staff to adjust the water temperatures again today. -She was unsure of the exact range of what the temperatures should be but knew the current temperatures were too hot. -Residents could be burned by hot water if the temperatures were elevated. Second interview with the Administrator on 03/20/25 at 9:05am: -The maintenance assistant adjusted the temperatures on the water heater yesterday, 03/19/25. -The maintenance assistant reported the water temperatures seemed to be fluctuating. -She would ask the maintenance staff to adjust	D 113		

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D 113	Continued From page 10 the temperature again today. -She would contact a plumber or regional maintenance manager for repairs if needed because the temperatures should not be fluctuating like they were currently.	D 113		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff D) had a skills competency validation for Licensed Health Professional Support (LHPS)	D 161	10A NCAC 13F .504(a & b) Competency Eval & Validation For LHPS Tasks The facility will ensure all staff that are designated to assist residents with personal care task, set forth in this rule area, will be evaluated and validated by a licensed health professional to have the knowledge, skills and abilities to demonstrate and perform these tasks. All staff designated to assist residents with personal care tasks will be evaluated and validated by a licensed professional before performing these tasks. The Executive Director and/or Designee audit all staffing charts for compliance in all rule areas. The Executive Director and/or Designee review all new staffing charts for compliance before performing the task.	

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D 161	Continued From page 11 tasks. The findings are: Review of Staff D's personnel record revealed: -Staff D was hired as a personal care aide (PCA) on 01/27/25. -There was no Licensed Health Professional Support (LHPS) skills competency validation available for review. Review of the facility's daily assignment sheet revealed Staff D was scheduled to work as a PCA on 03/18/25 from 10:00pm to 6:00am on one of the facility's assisted living (AL) halls. Telephone interview with Staff D on 03/20/25 at 11:45am revealed: -She was hired as a PCA approximately a month and half ago. -Her responsibilities included cleaning the facility and assisting residents with personal care tasks. -She usually worked third shift at the facility from the hours of 10:00pm to 6:00am. -She assisted residents with toileting, getting in and out of bed, and dressing. -She received 4 days of training on the first shift (6:00am-2:00pm) when she first started working at the facility, then she started working on third shift on her own after her training was completed. -She had not completed a skills validation with a nurse since she started working at the facility. -She came to the facility on 03/18/25 and received a tuberculosis (TB) test but was not informed she needed to have a skills validation. Interview with the Administrator on 03/20/25 at 10:44am revealed: -Staff D did not have an LHPS skills validation. -Staff D was scheduled for a skills validation on	D 161		

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D 161	Continued From page 12 03/18/25 and did not show up for the skills validation. -Staff D did not have her LHPS completed yet because Staff D stated she needed more training. -Staff members should have their LHPS validation completed before performing tasks. -It was important for staff members to have their LHPS validation completed to ensure the staff members performed the tasks correctly. Telephone interview with the facility's contracted registered nurse (RN) consultant on 03/20/25 at 9:10am revealed: -She was employed by the facility's contracted pharmacy. -She started at the facility as the RN consultant in January 2025. -She was responsible for completing staff LHPS skills validations. -She visited the facility at least monthly. -She would visit the facility more often if she was notified there was a need for LHPS validations. -The facility staff were responsible for scheduling their employees for their LHPS skills validations. -The facility provided her with a list of employees who were scheduled for LHPS validations on the days she visited the facility. -If an employee did not come to the facility for their skills validation, she informed the Administrator.	D 161		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and	D 276	10A NCAC 13F .0902 (c) (3-4) Health Care	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 13 (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 record reviews and interviews, the facility failed to ensure implementation of orders for 3 of 5 sampled residents (#2, #3, and #4) who had orders for daily weights (#3), weekly weights (#4), and weekly blood pressure and pulse readings (#2, #4). The findings are: 1. Review of Resident #3's current FL-2 dated 04/17/24 revealed diagnoses included iron deficiency anemia, diabetes mellitus type 2, dementia, delusional disorders, seizures, hypertension, heart failure, chronic kidney disease III, and hydronephrosis. Review of Resident #3's physician's orders revealed: -There was an order dated 12/11/24 to obtain daily weights. -There were parameters to notify the provider if greater than 3 pounds weight gain in 24 hours and if greater than 5 pounds weight gain in 1 week. Review of Resident #3's electronic treatment administration record (eTAR) for January 2025 revealed: -There was an entry for daily weights. -There was an entry for the daily weights to be done between 6:00am and 2:00pm. -There were 12 of 31 daily weights that were not done. Review of Resident #3's eTAR for February 2025	D 276	The facility will ensure that the written procedures, treatments, or orders from a prescribing practitioner or any licensed professional is maintained in the resident's record and that implementation is carried out for all written procedures, treatments, or orders. All orders, and/or treatments will be documented on the order log when received. All orders documented on the order log will have a two staff member check, until completion to ensure compliance. All direct care staff were re-trained on order log procedures and documentation. The Resident Care Coordinator and/or Designee will check the order log daily to ensure all orders or treatment are being implemented. The Resident Care Coordinator and/or Designee will run Exception Report from Quick-Mar Daily to ensure orders and treatments are being completed and documented. The Executive Director will review the order log and exception report weekly for compliance.	

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	HAL047014	A. BUILDING: _____ B. WING _____	R 03/20/2025

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D 276	Continued From page 14 revealed: -There was an entry for daily weights. -There was an entry for the daily weights to be done between 6:00am and 2:00pm. -There were 17 of 28 opportunities for daily weights that were not done. Review of Resident #3's eTAR for March 2025 revealed: -There was an entry for daily weights. -There was an entry for the daily weights to be done between 6:00am and 2:00pm. -There were 15 of 18 opportunities for daily weights that were not done. Interview with a personal care aide (PCA) on 03/19/25 at 12:30pm revealed: -The PCAs usually knew who needed daily or weekly weights or vital signs. -The medication aide would let them know if there was a new or changed order for the residents. Interview with a medication aide (MA) on 03/19/25 at 1:45pm revealed: -The MAs documented the weights but the PCAs usually were the ones who actually weighed the residents. Based on interviews, observations, and record reviews, Resident #3 was not interviewable. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 03/18/25 at 9:22am was unsuccessful. 2. Review of Resident #4's current FL2 dated 03/26/24 revealed diagnoses included anemia, type 2 diabetes mellitus, essential hypertension, chronic kidney disease, benign prostatic hyperplasia, and presence of urogenital implants.	D 276		

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D 276	Continued From page 15 a. Review of Resident #4's primary care provider's (PCP) order dated 09/19/24 revealed there was an order for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50. Review of Resident #4's January 2025 electronic treatment administration record (eTAR) revealed: -There was an entry to check blood pressure and pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50 scheduled for 2:00pm to 10:00pm. -Resident #4's blood pressure and pulse were documented as completed from 2:00pm to 10:00pm on 01/03/25 and 01/10/25. -There was no documentation of Resident #4's blood pressure and pulse on 01/17/25, 01/24/25, and 01/31/25. Review of Resident #4's February 2025 eTAR revealed: -There was an entry to check blood pressure and pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50 scheduled for 2:00pm to 10:00pm. -There were no weekly blood pressure and pulses documented from 02/01/25 to 02/28/25.. Review of Resident #4's March 2025 eTAR revealed: -There was an entry to check blood pressure and pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood	D 276		

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pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50.
-Resident #4's blood pressure and pulse were documented as completed from 2:00pm to 10:00pm on 03/14/25.
-There was no documentation of Resident #4's blood pressure and pulse on 03/07/25.

Interview with Resident #4 on 03/19/25 at 10:38am revealed:
-The facility staff checked his blood pressure and pulse occasionally.
-He was unsure how often the staff was supposed to check his blood pressure and pulse.
-The staff last checked his blood pressure and pulse a few days ago.

Interview with a medication aide (MA) on 03/19/25 at 11:55am revealed:
-When a resident had an order for their blood pressure and pulse to be checked, the MA could see a prompt in the eMAR system.
-She was unsure why Resident #4's blood pressure and pulse checks were not documented.
-She was unsure if Resident #4's blood pressure and pulse checks were completed because she was not working when the blood pressure and pulse checks were scheduled.

Interview with the Administrator on 03/19/25 at 1:12pm revealed:
-If residents had an order for blood pressure and pulse checks, the blood pressure and pulse readings should be documented on the residents' eTAR.
-If a resident's PCP ordered blood pressure and pulse to be checked, the staff should be completing the checks as ordered.
-She was unsure if the staff completed Resident

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D 276	Continued From page 17 #4's blood pressure and pulse check weekly as ordered. -Resident #4's blood pressure and pulse checks may not have been completed if the readings were not documented on the eTAR. -Resident #4's PCP ordered the blood pressure and pulse checks, so the staff should be completing the blood pressure and pulse, documenting the results, and notifying the PCP if needed. Telephone interview with Resident #4's PCP on 03/19/25 at 9:47am revealed: -She ordered Resident #4's blood pressure and pulse to be checked weekly because he had a history of high blood pressure. -She ordered parameters for blood pressure and pulse readings and wanted to be informed if Resident #4's blood pressure or pulses were out of those parameters. -If the blood pressures and pulses were ordered, the facility staff should be checking Resident #4's blood pressure and pulse weekly so she could review the readings. b. Review of Resident #4's primary care provider's (PCP) order dated 11/01/24 revealed: -Resident #4 had weight loss. -There was an order to weigh Resident #4 weekly. Review of Resident #4's January 2025 electronic treatment administration record (eTAR) revealed: -There was an entry for weekly weights scheduled for 6:00am to 2:00pm. -Resident #4's weight was documented as completed from 6:00am to 2:00pm on 01/08/25, 01/15/25, and 01/29/25. -Resident #4's weight was documented as refused on 01/22/25.	D 276		

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D 276	Continued From page 18 Review of Resident #4's February 2025 eTAR revealed: -There was an entry for weekly weights scheduled for 6:00am to 2:00pm. -There were no weekly weights documented from 02/01/25 to 02/28/25. Review of Resident #4's March 2025 eTAR revealed: -There was an entry for weekly weights scheduled for 6:00am to 2:00pm. -There were no weekly weights documented from 03/01/25 to 03/18/25. Interview with Resident #4 on 03/19/25 at 10:38am revealed: -The facility staff checked his weight once or twice a month. -He was unsure how often the staff was supposed to check his weight. -The facility staff last checked his weight 1-2 weeks ago. -He had not lost any weight recently. Interview with a medication aide (MA) on 03/19/25 at 11:55am revealed: -If a resident had an order for weekly weights, the MA saw a prompt on the eTAR to check the residents' weight. -She was not sure why Resident #4's weekly weights were not recorded on some days. -There were different MAs who worked on the hall where Resident #4 lived so she was not sure who was responsible for checking his weights on the days the weights were not documented. Interview with the Administrator on 03/19/25 at 1:12pm revealed: -If Resident #4 had an order for his weight to be	D 276		

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checked, the MAs should be checking his weight weekly.
-Resident #4's weight should be documented on the eTAR.
-It was important for Resident #4's weight to be checked to determine if he was losing weight.
-She was unsure why Resident #4's weights were not recorded on the eTAR.

Telephone interview with Resident #4's PCP on 03/19/25 at 9:47am revealed:
-She ordered weekly weights for Resident #4 because he had some weight loss.
-He was prescribed a medication to stimulate his appetite, and she ordered his weight to be checked to determine if the medication was effective.
-She had noticed Resident #4's weights were not recorded as ordered.
-The facility staff should record Resident #4's weights each week and document the weights on his eTAR.

3. Review of Resident #2's current FL2 dated 04/09/24 revealed diagnoses included anemia, obesity, hyperlipidemia, unspecified visual disturbance, and bilateral primary osteoarthritis of the knee.

Review of Resident #2's primary care provider's (PCP) order dated 01/11/24 revealed there was an order for weekly blood pressure and pulse, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50.

Review of Resident #2's January 2025 electronic treatment administration record (eTAR) revealed:
-There was an entry to check blood pressure and

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D 276	Continued From page 20 pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50 scheduled for 2:00pm to 10:00pm. -Resident #2's blood pressure and pulse were documented as completed from 2:00pm to 10:00pm on 01/15/25 and 01/22/25. -There was no documentation of Resident #2's blood pressure and pulse on 01/01/25, 01/08/25, and 01/29/25. Review of Resident #2's February 2025 eTAR revealed: -There was an entry to check blood pressure and pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50 scheduled for 2:00pm to 10:00pm. -Resident #2's blood pressure and pulse were documented as completed from 2:00pm to 10:00pm on 02/05/25. -There was no documentation of Resident #2's blood pressure and pulse on 02/12/25, 02/19/25, and 02/26/25. Review of Resident #2's March 2025 eTAR revealed: -There was an entry to check blood pressure and pulse weekly, call for systolic blood pressure greater than 200 or less than 90, diastolic blood pressure more than 110 or less than 40, call for pulse of 140 or greater or less than 50 scheduled for 2:00pm to 10:00pm. -Resident #2's blood pressure and pulse were documented as completed from 2:00pm to 10:00pm on 03/12/25. -There was no documentation of Resident #2's blood pressure and pulse on 03/05/25.	D 276		

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D 276	Continued From page 21 Interview with Resident #2 on 03/19/25 at 3:20pm revealed: -The facility staff usually checked her blood pressure and pulse once a month. -The facility staff did not check her blood pressure and pulse each week. -She was unsure if the facility staff should be checking her blood pressure and pulse each week. Interview with a medication aide (MA) on 03/19/25 at 3:15pm revealed: -She was the facility's Activities Director (AD) and filled in as a MA as needed. -When blood pressures and pulses were ordered for a resident, the eMAR system prompted MAs to check the resident's blood pressure and pulse. -She was not sure why Resident #2's blood pressures and pulses were not recorded because she usually did not work on the hall where Resident #2 lived as a MA. -If residents had orders for their blood pressure and pulse to be checked, the MAs should check the blood pressure and pulse and document on the eTAR. Interview with the Administrator on 03/19/25 at 1:12pm revealed: -If residents had an order for blood pressure and pulse checks, the blood pressure and pulse readings should be documented on the residents' eTAR. -If a resident's PCP ordered blood pressure and pulse to be checked, the staff should be completing the checks as ordered. -She was unsure if the staff completed Resident #2's blood pressure and pulse check weekly as ordered. -Resident #2's blood pressure and pulse checks	D 276		

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D 276	Continued From page 22 may not have been completed if the readings were not documented on the eTAR. -Resident #2's PCP ordered the blood pressure and pulse checks, so the staff should be completing the blood pressure and pulse, documenting the results, and notifying the PCP if needed. Telephone interview with Resident #2's PCP on 03/19/25 at 9:47am revealed: -She ordered Resident #2's blood pressure and pulse to be checked because she had a history of high blood pressure and was taking medications for high blood pressure. -She ordered parameters for blood pressure and pulse readings and wanted to be informed if Resident #2's blood pressure or pulses were out of those parameters. -If the blood pressures and pulses were ordered, the staff should be checking Resident #2's blood pressure and pulse weekly so she could review the readings.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the	D 280	10A NCAC 13F .0903 (c) Licensed Health Care Professional Support The facility will ensure that there is an on-site review and evaluation of the residents. health status, care plan, and care provided within 30 days of admission or within 30 days of the date a resident develops the need for the task by a registered nurse, physical therapist, or occupational therapist and continue at least quarterly thereafter.	

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D 280	Continued From page 23 resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 3 of 5 sampled residents (#2, #3, #4) with LHPS tasks of positioning and emptying a urinary catheter bag (#4), transfers (#2), heat therapy (#2, #3), cold therapy (#3), fingerstick blood sugars (#3), and medication by injection (#3). The findings are: 1. Review of Resident #4's current FL2 dated 03/26/24 revealed: -Diagnoses included anemia, type 2 diabetes mellitus, essential hypertension, chronic kidney disease, benign prostatic hyperplasia, and presence of urogenital implants. -Resident #4 had an indwelling urinary catheter. Review of Resident #4's home health agency notes revealed Resident #4's catheter tubing was changed by a home health nurse on 01/15/25, 02/07/25, and 02/24/25. Review of Resident #4's Licensed Health Professional Support (LHPS) evaluation dated	D 280	The Resident Care Coordinator and/or Designee will maintain a spreadsheet with data for all necessary reviewed documentation for residents to ensure that all documentation is completed timely within the rule area that they are under. The contracted pharmacy has been contacted to evaluate and correct any issues with LHPS. The Resident Care Coordinator will review resident diagnosis and treatment on an ongoing basis to determine the need for LHPS. The Executive Director and/or Designee will monitor and review spreadsheets weekly for compliance. The facility will ensure that the preparation and administration of medication, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner, maintained in the residents' record, the rules in this section and the facility's policies and procedures. All orders will be documented on the order log and sent to the pharmacy to be entered the residents' MAR and the medication	

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D 280	Continued From page 24 02/18/25 revealed there were no LHPS tasks identified by the registered nurse (RN) who completed the evaluation. Review of Resident #4's LHPS evaluation completed 07/16/24 revealed: -The date of Resident #4's last evaluation was 06/20/23 -There were no LHPS tasks identified. -The evaluation was not signed by the licensed health professional who completed the evaluation. Interview with Resident #4 on 03/19/25 at 10:38am revealed: -He was independent with ambulation, transfers, bathing, dressing, and grooming. -He had an indwelling urinary catheter for 5-6 years. -He usually emptied the catheter drainage bag himself 3-4 times a day. -He often used a drainage bag that attached to his leg. -The staff had helped him empty the drainage bag before but he usually emptied the bag so it would not get too full. -If he asked for assistance with his catheter from staff, the staff would assist him. -He had home health visits 1-2 times a month, and the home health nurse changed the catheter tubing and drainage bag. -If he had any concerns or problems with his catheter, he notified the facility staff. Interview with a personal care aide (PCA) on 03/19/25 at 11:15am revealed: -Resident #4 was independent with bathing, dressing, grooming, eating, ambulation, and transfers. -Resident #4 had a catheter, but he usually	D 280	sent to the facility. There will be a two-person check for all orders. This consists of seeing that the medication is correctly on the MAR and that the medication is received into the facility and placed in the cart for the residents. Those medications not received through batch to cover monthly administration will be ordered in accordance with the prescribing practitioner. All Veterans Affair Residents will have their medications ordered in accordance with the prescribing practitioner and in a timely manner due to having to be mailed. All Medication Staff and Supervisors will attend in-service in this rule area as well as good practice on the re-ordering of medication. Resident Care Coordinator and /or Designee to run Exception Report and Missed Medication Report from Quick Mar daily to review for compliance with medications being on the cart and following all physician's orders. Executive Director will conduct weekly cart audits to review for compliance with medication.	04/28/2025

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D 280	Continued From page 25 emptied the drainage bag himself. -Resident #4 occasionally asked for assistance with his care, but he was mostly independent. Telephone interview with Resident #4's primary care provider (PCP) on 03/19/25 at 9:47am revealed: -Resident #4 had a urinary catheter. -Resident #4 had his urinary catheter for a few years. -Resident #4 was mostly independent with his care and often emptied his drainage bag. -Resident #4 had home health care to assist with his catheter management. Telephone interview with the facility's contracted RN on 03/20/25 at 9:10am revealed: -She was employed by the facility's contracted pharmacy. -She was responsible for completing LHPS evaluations for residents at the facility. -She started completing LHPS evaluations for the facility in January 2025. -She completed LHPS evaluations for residents quarterly. -The facility staff usually informed her of which residents had LHPS tasks. -The facility staff provided her with a list of LHPS assessments that were due. -She was not aware Resident #4 had a urinary catheter. -When she completed Resident #4's LHPS evaluation on 02/18/25, Resident #4 was sitting in a chair outside of the facility, and she did not see his catheter drainage bag. Refer to interview with the Administrator on 03/19/25 at 11:52am. 2. Review of Resident #2's current FL2 dated	D 280		

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D 280	Continued From page 26 04/09/24 revealed diagnoses included anemia, obesity, hyperlipidemia, unspecified visual disturbance, and bilateral primary osteoarthritis of the knee. Review of Resident #2's primary care provider's (PCP) orders dated 01/29/25 revealed: -There was an order to apply a heating pad to joints for 20 minutes at a time every 4 hours as needed for pain, may keep at bedside and self-apply. -There was an order for knee pads, apply to both knees once daily as needed for knee support, may keep at bedside and self-apply. Review of Resident #2's current care plan dated 07/05/24 revealed: -Resident #2 was ambulatory with aide or devices. -Resident #2's devices needed were walker and wheelchair. -Resident #2 needed extensive assistance with transfers. Review of Resident #2's Licensed Health Professional Support (LHPS) evaluation dated 12/09/24 revealed: -Tasks identified included applying braces and splints, application of prescribed heat therapy, transferring semi-ambulatory or non-ambulatory residents, and ambulation using assistive devices. -The evaluation was not signed by the licensed health professional who completed the evaluation. Review of Resident #2's record revealed there were no other LHPS evaluations available for review.	D 280		

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D 280	Continued From page 27 Interview with Resident #2 on 03/19/25 at 3:20pm revealed: -She needed a staff member to assist her with transfers in and out of bed. -She could walk short distances with a walker but needed stand by assistance. -She used her wheelchair for mobility most of the time and could propel short distances. -She had frequent knee pain. -She had knee pads to provide additional support for her knees if needed but did not use them often. -She had a heating pad with an automatic shut off feature. -She could apply heat independently when she had knee pain. -She used the heating pad almost every night, but she did not put the heating pad in direct contact with her skin. Interview with a personal care aide (PCA) on 03/19/25 at 11:15am revealed: -Resident #2 needed assistance of 1 staff member for transfers. -Resident # 2 needed assistance of 1 person if Resident #2 used her walker. -Resident #2 used her walker to stand for transfers and when ambulating short distances. -Resident #2 used her wheelchair for mobility most of the time and could propel herself. -Resident #2 applied her own heating pad. Telephone interview with the facility's contracted registered nurse (RN) on 03/20/25 at 9:10am revealed: -She was employed by the facility's contracted pharmacy. -She was responsible for completing LHPS evaluations for residents at the facility. -She started completing LHPS evaluations for the	D 280		

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D 280	Continued From page 28 facility in January 2025. -She completed LHPS evaluations for residents quarterly. -She visited the facility at least monthly. -The facility staff gave her a list of LHPS assessments that were due. -She was still in the process of determining which residents needed LHPS evaluations and completing the evaluations -The evaluations should always be signed by the person who completed the assessment. Refer to interview with the Administrator on 03/19/25 at 11:52am. 3. Review of Resident #3's current FL2 dated 04/17/24 revealed: -Diagnoses included iron deficiency anemia, diabetes mellitus type 2, dementia, delusional disorders, seizures, hypertension, heart failure, chronic kidney disease III, and hydronephrosis. -There was an order to apply warm compresses to right wrist three times a day as needed for pain. -There was an order to apply ice pack to left shoulder as needed for pain (leave on a maximum of 20 minutes). -There was an order for fingerstick blood sugar (FSBS) testing to be done three times a day before meals with parameters to notify provider if blood sugar was higher than 400 or less than 60 and give 8 ounces of orange juice and recheck in 15 minutes and if still below 60 notify providers. -There was an order for Lantus insulin 100units/mL to give 20 units subcutaneously twice a day. (used to treat diabetes by helping to keep the blood sugar levels within a safe range) -There was an order for Novolog insulin 100units/mL to give insulin on the sliding scale based on blood sugar as follows: 0 - 150= 0	D 280		

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D 280	Continued From page 29 units, 151 - 200= 3 units, 201 - 250= 5 units, 251 - 300 = 7 units, 301 - 350 = 9 units, 351 - 400 = 11 units. 401 - 450 = 13 units, 450 and above give 15 units and notify provider. (used as a fast acting insulin to help lower blood sugar levels within 10-15 minutes after injection) Review of Resident #3's current care plan dated 01/29/25 revealed: -Resident #3 was ambulatory with supervision. -Resident #3 required medications by injections. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 11/04/24 revealed tasks identified included FSBS, medications by injections and heat therapy application. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 08/18/24 revealed: -Tasks identified included FSBS, and medications by injections. -The evaluation was not signed by the licensed health professional who completed the evaluation. Review of Resident #3's record revealed there were no other LHPS evaluations available for review. Interview with a medication aide (MA) on 03/19/25 at 10:30am revealed: -Resident #3 had fingerstick blood sugars ordered 3 times a day before meals. -Resident #3 had a regular insulin as well as a sliding scale insulin. -She had not applied any heat compresses or cold packs to Resident #3 that she could remember.	D 280		

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D 280	Continued From page 30 Telephone interview with the facility's contracted registered nurse (RN) on 03/20/25 at 9:10am revealed: -She was employed by the facility's contracted pharmacy. -She was responsible for completing LHPS evaluations for residents at the facility. -She started completing LHPS evaluations for the facility in January 2025. -She completed LHPS evaluations for residents quarterly. -She visited the facility at least monthly. -The facility staff gave her a list of LHPS assessments that were due. -She was still in the process of determining which residents needed LHPS evaluations and completing the evaluations -The evaluations should always be signed by the person who completed the assessment. Based on observations, interviews, and record reviews, Resident #3 was not interviewable. Refer to interview with Administrator on 03/19/25 at 11:52am. Interview with the Administrator on 03/19/25 at 11:52am revealed: -Licensed Health Professional Support (LHPS) evaluations were completed quarterly. -The facility's contracted registered nurse (RN) was employed by the facility's contracted pharmacy. -The facility's contracted RN began completing the facility's LHPS evaluations in January 2025. -There was another RN who completed the assessments prior to January 2025 and the RN was no longer employed at the facility. -She was unsure when the previous RN was last	D 280		

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D 280	Continued From page 31 at the facility to complete LHPS evaluations for residents. -The current RN consultant was last at the facility on 03/18/25. -The facility provided the RN consultant with a list of which residents had tasks and residents who were due for an evaluation. -The evaluation should be signed by the nurse who completed the LHPS evaluation. -She was not aware some of the evaluations were not signed. -She was not aware that some of the evaluations were not completed quarterly. -She was unsure why the evaluations were not completed or why some evaluations were not signed by the nurse who completed them	D 280		
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 B VIOLATION Based on record reviews and interviews, the facility failed to administer medications as ordered to 2 of 5 sampled residents (#1, #2) including medications used to treat diabetes, pain, and attention deficit hyperactivity disorder	D 358	10A NCAC 13F .1004(a) Medication Administration	

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D 358	Continued From page 32 (#1) and a medication used to treat seizures (#2). The findings are: 1.Review of Resident #1's current FL-2 dated 09/03/24 revealed diagnoses included vascular dementia, epilepsy, major depressive disorder, anxiety, post trauma stress disorder, and insomnia. a. Review of Resident #1's physician's orders dated 02/06/25 revealed there was an order for Gabapentin tablet 600mg, 1 tablet three times per day scheduled for 7:00am, 1:00pm, and 7:00pm. (Gabapentin is used to treat nerve pain). Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Gabapentin tablet 600mg,1 tablet three times per day scheduled for 7:00am, 1:00pm, and 7:00pm. -Gabapentin tablet 600mg was not documented as administered from 01/01/25 to 01/31/25. -There was an entry in the exceptions that Gabapentin was not on the medication cart. -There were entries in the notes that Gabapentin was on delivery, waiting for medication, or not on the medication cart. -Ibuprofen tablet 600mg, 1 tablet every 8 hours as needed for pain was documented administered and effective from 01/03/25 to 01/31/25. (Ibuprofen is used to treat mild pain). Review of Resident #1's February 2025 eMAR revealed: -There was an entry for Gabapentin tablet 600mg,1 tablet three times per day scheduled for 7:00am, 1:00pm, and 7:00pm. -There were entries Gabapentin tablet 600mg	D 358	The facility will ensure that the preparation and administration of medication, prescription and non-prescription, and treatments by staff are in accordance with orders by a licensed prescribing practitioner, maintained in the residents' record, the rules in this section and the facility's policies and procedures. All orders will be documented on the order log and sent to the pharmacy to be entered into the residents' MAR and the medication sent to the facility. There will be a two-person check for all orders. This consists of seeing that the medication is correctly on the MAR and that the medication is received into the facility and placed in the cart for the residents. Those medications not received through batch to cover monthly administration will be ordered in accordance with the prescribing practitioner. All Veterans Affair Residents will have their medications ordered in accordance with the prescribing practitioner and in a timely manner due to having to be mailed. All Medication Staff and Supervisors will attend in-service in this rule area as well as good practice on the re-ordering of medication. Resident Care Coordinator and /or Designee to run Exception Report and Missed Medication Report from Quick Mar daily to review for compliance with medications being on the cart and following all physician's orders.	04/28/2025

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D 358	Continued From page 33 was not documented as administered from 02/01/25 to 02/06/25. -There were entries in the exceptions that Gabapentin was not on the medication cart. -There were entries in the notes that Gabapentin was on delivery, waiting for medication, or not on the medication cart. Interview with Resident #1 on 03/20/25 at 10:01am revealed: -He was taking Gabapentin for muscle spasms. -When he was out of the Gabapentin in January his legs were jumping uncontrollably, he had muscle spasms and was in serious pain. b. Review of Resident #1's physician's orders dated 02/06/25 revealed: -There was an order for Novolog Flexpen 100unit inject 8 units subcutaneously three times per day with meals, give 15 minutes before food scheduled at 6:00am, 10:30am, 4:30pm. (Novolog is used to treat high blood sugars). -There was an order for Novolog insulin at 6:00am, 10:30am, 4:30pm, and 7:00pm; check blood sugar before meals and at bedtime and inject per sliding scale: 151- 200= 2 units, 201-300= 6 units, 301-400 =8 units, 401- 500= 10 units, 451- 500= 12 units, more than 500= 14 units, give 15 minutes before food. Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Insulin 100unit inject 8 units subcutaneously three times per day with meals, give 15 minutes before food scheduled at 6:45am,10:45am, and 4:45pm. -On 01/01/25, 01/02/25, 01/06/25, and 01/18/25 at 6:45am the blood sugar readings ranged from 142 to 240; 2 to 6 units of Novolog were	D 358	Executive Director will conduct weekly cart audits to review for compliance with medication.	

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D 358	Continued From page 34 documented as administered. - Novolog 8 units insulin was not documented as administered on 01/01/25, 01/02/25, 01/06/25, and 01/18/25 at 6:45am. -On 01/07/25, 01/09/25, 01/10/25, 01/13/25, 01/15/25, and 01/16/25 at 10:45am the blood sugar readings ranged from 162 to 254; 2 to 6 units of Novolog were documented as administered. -Novolog 8 units insulin was not documented as administered on 01/07/25, 01/09/25, 01/10/25, 01/13/25, 01/15/25, and 01/16/25 at 10:45am. -On 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/07/25- 01/13/25, and 01/15/25- 01/17/25 at 4:45pm the blood sugar readings ranged from 185 to 249; 2 to 6 units of Novolog were documented as administered as ordered per sliding scale. -Novolog 8 units insulin was not documented as administered on 01/02/25, 01/03/25, 01/04/25, 01/05/25, 01/07/25- 01/13/25, and 01/15/25- 01/17/25 at the scheduled time of 4:45pm. Review of Resident #1's February 2025 eMAR revealed: -There was an entry for Novolog Insulin 100unit inject 8 units subcutaneously three times per day with meals, give 15 minutes before food scheduled at 6:00am, 10:30am, and 4:30pm. -There were no entry times scheduled 15 minutes before food for Novolog 8 units insulin to be administered. -On 02/05/25, 02/09/25- 02/12/25, 02/14/25- 02/17/25, 02/20/25- 02/28/25- 02/28/25 at 6:00am the blood sugar readings ranged from 86 to 345; 2 to 6 units of Novolog were documented as administered. -On 02//08/25- 02/10/25 at 10:30am the blood sugar readings ranged from 241 to 275; 6 units of Novolog insulin were documented as	D 358		

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D 358	Continued From page 35 administered. Review of Resident #1's March 2025 eMAR revealed: -There was an entry for Novolog Insulin 100unit inject 8 units subcutaneously three times per day with meals, give 15 minutes before food scheduled at 6:00am, 10:30am, and 4:30pm. -There were no entry times scheduled 15 minutes before food for Novolog 8 units insulin to be administered. -On 03/05/25- 03/07/25 at 6:00am the blood sugar readings ranged from 199 to 241; 2 to 6 units of Novolog were documented as administered. Interview with a medication aide (MA) on 03/19/25 at 11:33am revealed: -Resident #1 was scheduled to have 8 units of Novolog insulin along with his sliding scale. -Breakfast was served at 7:00am. -Lunch was served at 11:00am. -Dinner was served at 5:00pm. Interview with a second MA on 03/19/25 at 11:55am revealed: -Resident #1 received his insulin before breakfast, lunch, and dinner. -She did not administer the insulin all the time because his sliding scale determined if he needed to be administered insulin. Interview with the Administrator on 03/19/25 at 1:32pm revealed: -She expected the MAs to administer Resident #1's insulin according to the eMAR and his orders to give with meals. -She was concerned Resident #1 was not administered his insulin as ordered because it could make him sick causing his blood sugar to	D 358		

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D 358	Continued From page 36 drop and possibly hospitalization. Interview with the facility's contracted pharmacy on 03/20/25 at 9:01am revealed the facility should have contacted Resident #1's primary care provider (PCP) to determine if the sliding scale insulin or the scheduled insulin were needed. Attempted telephone interview with the facility's contracted primary care provider (PCP) on 03/18/25 at 9:22am was unsuccessful. Attempted telephone interview with Resident #5's veteran affairs (VA) pharmacy on 03/20/25 at 10:22am was unsuccessful. c. Review of Resident #1's physician's orders dated 02/06/25 revealed there was an order for Clonazepam 0.5mg tablet, 1 tablet every 8 hours scheduled at 6:00am, 2:00pm, and 10:00pm. (Clonazepam is used to treat anxiety). Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Clonazepam tablet 0.5mg, 1 tablet every 8 hours scheduled at 6:00am, 2:00pm, and 10:00pm. -Clonazepam tablet 0.5mg was not documented as administered from 01/26/25 to 01/30/25 at 6:00am, 2:00pm, and 10:00pm. -There were entries in the exceptions that Clonazepam tablet was not on the medication cart. -There were entries in the notes that Clonazepam tablet was on order, waiting for medication, waiting for delivery or not on the medication cart. Review of Resident #1's February 2025 eMAR revealed:	D 358		

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D 358	Continued From page 37 -There was an entry for Clonazepam tablet 0.5mg, 1 tablet every 8 hours scheduled at 6:00am, 2:00pm, and 10:00pm. -Clonazepam tablet was not documented as administered from 02/01/25 to 02/13/25 at 6:00am, 2:00pm, and 10:00pm. -There were entries in the exceptions that Clonazepam tablet was not on the medication cart. -There were entries in the notes that Clonazepam tablet was on order, waiting for medication, waiting for prescription or not on the medication cart. Interview with Resident #1 on 03/20/25 at 10:01am revealed he was prescribed the Clonazepam to relax his muscles. d. Review of Resident #1's physician's orders dated 02/06/25 revealed there was an order for Methylphenidate 20mg tablet, 1 tablet twice per day scheduled at 7:00am and 12:00pm. (Methylphenidate is used to treat attention deficit hyperactivity disorder, ADHD). Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Methylphenidate tablet 20mg, 1 tablet twice per day scheduled at 7:00am and 12:00pm. -Methylphenidate tablet 20mg was not documented as administered from 01/14/25 to 01/22/25 at 7:00am and 12:00pm. -There were entries in the exceptions that Methylphenidate tablet was not on the medication cart. -There were entries in the notes that Methylphenidate tablet was on order, waiting for medication, waiting for delivery or waiting for	D 358		

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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 358	Continued From page 38 medication. Interview with Resident #1 on 03/20/25 at 10:01am revealed: -He was prescribed Methylphenidate for attention deficit hyperactivity disorder (ADD). -He could not focus without the Methylphenidate. -He had to call veteran affairs (VA) to get his refills. -There was a refill form that came with his medications and all the facility needed to do was complete the form and his medications would be set up for automatic refills. -He told the assistant Administrator about the refill form, and she told him to notify the MAs about the form. -He told the medication aides (MAs) about the refill form and was told that it was not the facility's process to request refills. Interview with the Administrator on 03/19/25 at 1:32pm revealed: -The facility should request medication refills within 7 days of the medication being out. -The backup pharmacy should have been called for Resident #1's medication. -She was not aware Resident #1 was out of medication. -The facility should have contacted Resident #1's PCP to notify them the resident was out of medication to determine what they wanted to be done. Attempted telephone interview with Resident #1's VA pharmacy on 03/20/25 at 10:29am was unsuccessful. 2. Review of Resident #3's current FL-2 dated 04/17/24 revealed diagnoses included iron deficiency anemia, diabetes mellitus type 2,	D 358		

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D 358	Continued From page 39 dementia, delusional disorders, seizures, hypertension, heart failure, chronic kidney disease III, and hydronephrosis. Review of Resident #3's physician's orders dated 02/21/25 revealed there was an order for Clonazepam 1mg tablet, 1 tablet in the morning, 1 tablet in the evening and 1 tablet at bedtime. (Clonazepam is used to treat seizures). Review of Resident #3's February 2025 eMAR revealed: -There was an entry for Clonazepam tablet 1mg, 1 tablet three times a day scheduled at 8:00am, 3:00pm, and 8:00pm. -Clonazepam tablet was not documented as administered on 02/01/25 at 3:00pm and 8:00pm. -Clonazepam tablet was not documented as administered from 02/13/25 to 02/20/25. -There was an entry in the exceptions stated that Clonazepam tablet was not on the medication cart. -The entries in the exceptions stated that Clonazepam tablet was 'med not on cart'. -There were entries in the notes that that Clonazepam tablet was 'on order, waiting for delivery, waiting for the prescription, meds not in the building, med not on cart-not given, and waiting for medication'. Review of Resident #3's March 2025 eMAR revealed: -There was an entry for Clonazepam tablet 1mg, 1 tablet three times a day scheduled at 8:00am, 3:00pm, and 8:00pm. -Clonazepam tablet was not documented as administered on 03/08/25 at 2:00pm, on 03/09/25 at 8:00am and 2:00pm, and 03/14/25 at 2:00pm and 8:00pm. -The entries for these dates and times were left	D 358		

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D 358	Continued From page 40 blank without the medication aide's (MA) initials. -There were no entries in the exceptions explaining why the Clonazepam tablet was not administered. Observation of Resident #3's medication on hand on 03/19/25 at 1:38pm revealed: -Resident #3 had 89 Clonazepam 1mg tablets on hand. -The contracted pharmacy had dispensed 90 tablets on 03/17/25. -The first dose of this 90 supply had been administered at 8:00am on 03/19/25. Interview with a MA on 03/19/25 at 1:45pm revealed: -The facility would request medication refills between 7 - 10 days of the medication being out. -If the medication required a new prescription like with controlled medications, the MA would reach out to the provider to get them to send in a prescription to the facility pharmacy. -If the eMAR did not have any initials in the block for administration, the MA may have forgotten to click on the medication or the MA may not have administered the medication. -The facility had a backup pharmacy if a resident needed medication that the contracted pharmacy could not get to the facility for administration. Interview with the Administrator on 03/19/25 at 1:32pm revealed: -The facility should request medication refills within 7 days of the medication being out. -The facility had a backup pharmacy that could have been called for Resident #3's medication. -She was not aware Resident #3 was out of medication. -The facility should contact the resident's primary care provider (PCP) to notify them when a	D 358		

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D 358	Continued From page 41 resident was out of medication to determine what they wanted to be done. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with the facility's contracted (PCP) on 03/18/25 at 9:22am was unsuccessful. The facility failed to ensure medications were administered as ordered for a resident (#1) including medication used to treat nerve pain and diabetes. The resident missed 37 consecutive days (111 doses) of the medication used to treat nerve pain, which caused the resident to have serious pain and caused his legs to jump uncontrollably. The resident missed 7 consecutive days (21 doses) of his scheduled medication used to treat diabetes. The failure of the facility to administer medications as ordered was detrimental to the health, safety 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 04/04/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 4, 2025.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366	10A NCAC 13F .1004(i) Medication Administration	

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D 366	Continued From page 42 staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication staff who administered medications observed a resident (#2) taking their medications. The findings are: Review of the facility's undated medication administration policy revealed staff will provide documentation on the medication administration record after observing the residents taking medications and before administration to another resident. Review of Resident #2's current FL2 dated 04/09/24 revealed diagnoses included anemia, obesity, hyperlipidemia, unspecified visual disturbance, and bilateral primary osteoarthritis of the knee. Review of Resident #2's primary care provider's (PCP) orders dated 01/29/25 revealed: -There was an order for Enteric Coated (EC) Aspirin 81mg one tablet daily (EC Aspirin is a medication used to prevent heart attacks and strokes). -There was an order for Carvedilol 3.125mg one tablet twice a day (Carvedilol is a medication used to lower blood pressure). -There was an order for Furosemide 20mg one tablet daily (Furosemide is a medication used to	D 366	The facility will ensure that the recording of medication on a resident's administration record will be by the medicatior aid who prepared the medication and after observing the residents take all the medication. All Medication Aides attended in-service training on Rule Area 10A NCAC 13F .1004 The Resident Care Director and/or Designee will conduct weekly observation audits of medication administration for 30 days, followed by monthly checks. Resident Care Coordinator to run exception report daily and review. The Executive Director and/or Designee conduct weekly medication cart audits to review usage of medications and compliance of all medication orders.	

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D 366	Continued From page 43	D 366		

treat fluid retention).
-There was an order for Isosorbide Mononitrate ER 60mg one tablet daily (Isosorbide Mononitrate is a medication used to treat chest pain and heart failure).
-There was an order for Multivitamin one tablet every day (Multivitamin is a medication used to treat or prevent vitamin and mineral deficiencies).
-There was an order for Oxybutynin 5mg one tablet twice a day (Oxybutynin is a medication used to treat urinary incontinence).
-There was an order for Pantoprazole 40mg one tablet every day, take on an empty stomach (Pantoprazole is a medication used to treat acid reflux).
-There was an order for Potassium Chloride 10mEq one tablet every day (Potassium Chloride is a medication used to treat or prevent potassium deficiency).
-There was an order for Prevagen 10mg 1 capsule every day (Prevagen is a medication used to supplement the diet and potentially improve memory function).

Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:
-Pantoprazole 40mg was scheduled at 8:00am.
-Pantoprazole was documented as administered at 8:00am from 03/01/25 to 03/19/25.
-EC Aspirin 81mg, Carvedilol 3.125mg, Furosemide 20mg, Isosorbide Mononitrate ER 60mg, Multivitamin, Oxybutynin 5mg, Potassium Chloride 10mEq, and Prevagen 10mg were scheduled for 9:00am.
-EC Aspirin 81mg, Carvedilol 3.125mg, Furosemide 20mg, Isosorbide Mononitrate ER 60mg, Multivitamin, Oxybutynin 5mg, Potassium Chloride 10mEq, and Prevagen 10mg were documented as administered at 9:00am from

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D 366	Continued From page 44 03/01/25 to 03/19/25. Observation of Resident #2 on 03/18/25 at 8:40am revealed: -Resident #2 was in her room. -Resident #2 was sitting in a wheelchair in front of an adjustable overbed table. -There was a cup of water, an empty plastic medication cup, and another plastic medication cup containing 7 capsules and tablets. Second observation of Resident #2 on 03/19/25 at 8:22am revealed: -Resident #2 was in her room. -Resident #2 was sitting in a wheelchair in front of an adjustable overbed table. -There was a cup of water, an empty paper souffle medication cup, and another plastic medication cup containing 7 capsules and tablets. Interview with Resident #2 on 03/18/25 at 8:40am revealed: -The medication aides (MAs) usually left her medications with her each morning. -The MAs left the medications because she did not take all of the medications at the same time. -She took Protonix and Prevagen before she took her other medications. -She was supposed to take Protonix before she ate, so she always took it first. -She had already taken Protonix and Prevagen this morning. -She took the rest of her medications after she ate breakfast. -She had not eaten breakfast yet. Second interview with Resident #2 on 03/19/25 at 8:22am revealed: -The MA had just brought her medications. -The MA put her Prevagen and Protonix in a	D 366		

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D 366	Continued From page 45	D 366		

paper cup and she had just taken both medications.
-She was going to take the rest of her medications after she ate breakfast.
-The staff usually brought her breakfast around 8:45am each morning.

Interview with the MA on 03/19/25 at 11:50am revealed:
-When she administered residents' medications, she followed the instructions on the residents' eMARs.
-When she administered residents' medications, she took the medications in the residents' rooms and observed the residents taking the medications.
-She did not leave the medications in the residents' rooms.
-She explained to residents that she could not leave medications in their room, and she needed to observe them taking the medication.
-She did leave medications in Resident #2's room this morning, but she should not have left them.
-Resident #2 had a certain order in which she preferred to take her medications.
-She did not leave Resident #2's medications in her room on 03/18/25.
-If medications were observed in Resident #2's room on 03/18/25, then Resident #2 must not have taken them all before she left Resident #2's room.
-She did not realize Resident #2 had not taken all her medications before she left Resident #2's room on 03/18/25.
-Medications should not be left in the residents' rooms because another resident could accidentally take the medication.

Interview with the Administrator on 03/18/25 at 1:12pm revealed:

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D 366	Continued From page 46 -The facility did not currently have a Resident Care Coordinator (RCC). -She and another staff member were helping with the RCC responsibilities until the new RCC started next week. -MAs should compare the medication to the eMAR when administering medications. -MAs should observe the residents taking their medications. -Medications should never be left in a resident's room. -MAs could not be sure residents took their medications if they did not observe them. -Anyone could enter the resident's room and take the medications if MAs left medications in the residents' rooms. Interview with Resident #2's PCP on 03/19/25 at 9:47am revealed the staff should follow the facility's policies for medication administration regarding the observation of residents taking their medication.	D 366		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the	D 371	10A NCAC 13F .1004(n) Medication Administration The facility will ensure that all medications are administered in accordance with infection control measures that help prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	

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D 371	Continued From page 47 medication pass on 03/19/25 by 2 of 2 medication aides observed who performed a finger stick blood sugar at the resident's dining room table and who poured medication capsules out of a bottle in to her bare hand, retrieved one capsule and placed it into the medication cup and returned the remainder of the capsules back into the medication bottle. The findings are: Review of the facility's medication policy and procedure (no date) revealed: -Facility staff will administer medications in accordance with infection control measures.. -Infection control practices for washing hands in between each resident during administration would be followed. Review of the facility's infection control / Universal Precautions policy (no date) revealed: -Infection control was one of the most important aspects of environmental safety. -Staff in adult care homes have the responsibility to understand and follow the facility's infection control policies and procedures. -Universal precautions was the procedure followed to keep germs from being spread from one person to another. Review of the Medication Administration 10/15-Hour Training Course for Adult Care Homes Student Manual Section G - Infection Prevention Practices Content Important Infection Control Concepts During Administration of Medication revealed: -Use sanitary technique when pouring or preparing medications into appropriate container. -Do not touch or handle medications but pour medication from the original medication container	D 371	The facility will adhere to the Infection Control Policy set forth by the state in January 2022. All staff were re-trained in the facilities Infection Prevention and Control policy. The objective of this training was to establish basic infection prevention measures Involving bloodborne pathogens. Resident Care Coordinator and/or Designee to observe random medication passes with each medication aid monthly to ensure that proper infection control procedures are being followed. Evaluations to be reviewed by the Executive Director and/or Designee. Infection Prevention and Control training to be completed annually.	05/03/2025

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D 371	Continued From page 48 into a new, appropriate medication container. -Never use your own hands to administer medications and never require resident to have to use his/her own hands to receive medications. -Medications are provided to the resident in clean and appropriate medication containers. Observation of a medication aide (MA) administering medications in assisted living during the 8:00am medication pass on 03/19/25 from 7:46am - 8:00am revealed: -The MA prepared medications for Resident #7 from the "bubble" packs by popping the medication from the card into the medication cup. -The MA removed Resident #7's Linzess bottle from the medication cart and poured several capsules into her bare hand from the bottle before placing one capsule into the medication cup with the other medications. -The MA then poured the remaining capsules from her hand back into the medication bottle. -The MA administered all the medications to Resident #7 and returned to the medication cart to document without performing hand hygiene. Observation of a medication aide (MA) administering medications in the special care unit (SCU) during the 8:00am medication pass on 03/19/25 from 7:15am - 7:30am revealed: -The MA went into the dining room where Resident #3 was seated at the table with 3 other residents. -The MA performed Resident #3's fingerstick blood sugar (FSBS) while the resident was still seated at the dining room table. -The MA returned to the medication cart and used her hands to enter documentation into the computer system after removing her gloves but did not perform hand hygiene. -The MA prepared the insulin pens for Resident	D 371		

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D 371	Continued From page 49 #3 and returned to the dining room table to Resident #3. -Resident #3 requested to have the injection in his abdomen. -The MA informed him they would need to leave the dining room in order to give him his insulin. -The MA directed Resident #3 to another resident's room for privacy and administered Resident #3's insulin into his abdomen. -Resident #3 returned to the dining room and the MA returned to the medication cart to document. -The MA did not perform hand hygiene prior to preparing the insulin for Resident #3 nor after administering his insulin. Observation of the MA on assisted living on 03/19/25 at 9:38am revealed she was administering eye drops without wearing gloves to a resident in the hallway outside of room 20. Interview with a MA on 03/19/25 at 1:45pm revealed: -The MAs were supposed to use the cap of the bottle or a spoon to take out one tablet to give to the resident. -They were not supposed to touch the residents' medications with their bare hands due to infection control. -The MA should wear gloves whenever giving medications like lotions, eye drops, nasal sprays etc. and then remove the gloves and use sanitizer or wash your hands before touching anything else. -Residents could be given pills or capsules in the hall but all other medications should be done in the privacy of their own rooms. -She was nervous when she was being watched giving medications. Interview with the Special Care Unit Coordinator	D 371		

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D 371	Continued From page 50 (SCUC) on 03/19/25 at 12:50pm revealed: -The MAs were trained to use the cap of the bottle of tablets to help in retrieving one tablet to be administered and not contaminate the other tablets in the bottle. -The MA should never pour the tablets from the bottle into her bare hand. -The MA should never place the contaminated tablets from her bare hand back into the bottle. -Touching medications with bare hands could transmit infections or diseases as well as cause a reaction to the MA depending on the type of tablet. Interview with the Administrator on 03/19/25 at 1:15pm revealed: -The MAs were supposed to wash or sanitize their hands between each resident when administering medications. -The MAs should wash or sanitize their hands between residents to prevent cross-contamination. -The MAs should always wear gloves when administering medications like eye drops, nasal sprays, and lotions. -When the MAs remove their gloves, they should use sanitizers or wash their hands. -The MAs should never touch a resident's medication due to contamination not to mention the possibility of what the medication could do to the MA when it came in contact with her skin. -Medications should never be given to a resident in a public area but in the privacy of their own room.	D 371		