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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and a complaint investigation on 06/10/24 through 06/11/24.	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 observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#2) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #2's current FL2 dated 02/13/25 revealed diagnoses included vascular dementia, unspecified disorder of the brain, and heart disease. Review of Resident #2's resident register revealed an admission date of 11/25/24 to the special care unit (SCU).	D 234		

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Review of Resident #2's immunization records revealed:
-There was no documentation of a negative TB skin test.
-There was no documentation of a positive TB skin test.

Interview with the Special Care Unit Coordinator (SCUC) on 06/11/25 at 2:00pm revealed:
-Resident #2's TB skin test was not available for review.
-All residents must have completed TB skin testing prior to admission.
-The Administrator and the Resident Care Coordinator (RCC) were responsible for ensuring TB skin tests were completed upon residents' admissions to the facility.

Interview with the RCC on 06/11/25 at 2:30pm revealed:
-Resident #2's TB skin test was not available for review.
-She did not know why Resident #2's TB skin test was not available for review.
-All residents must have completed TB skin testing prior to admission.
-The Administrator and the SCUC were responsible to ensure TB skin tests were completed upon residents' admissions to the facility for the SCU.

Interview with the Administrator on 06/11/25 at 4:35pm revealed:
-She did not know why Resident #2's TB skin test was not completed and available for review.
-All residents must have a completed skin test prior to admission.
-She was responsible for ensuring TB skin tests were completed upon residents' admissions to the facility and the RCC completed the new

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D 234	Continued From page 2 resident documentation. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.	D 234		
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (Resident #1) had a current FL2 completed annually.	D 235		

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D 235	Continued From page 3 Review of Resident #1's FL2 dated 05/30/23 revealed diagnoses included Mobitz II heart block. Review of Resident #1's Resident Register revealed an admission date of 04/14/22. Review of Resident #1's record revealed Resident #1 did not have an updated FL2 completed since 05/30/23. Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:21pm revealed: -She knew residents must have an FL2 completed annually. -She did not know Resident #1's FL2 was not completed for two years prior to 06/10/25. -She was responsible to ensure residents had an updated FL2 completed annually. Interview with the Administrator on 06/11/25 at 4:40pm revealed: -She knew residents must have an FL2 completed annually. -She did not know Resident #1's FL2 was not completed for two years prior to 06/10/25. -The RCC was responsible to ensure residents had an updated FL2 completed annually.	D 235		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 5 sampled residents with a regular diet order with chopped meat (#4).

The findings are:

Review of Resident #4's current FL-2 dated 04/04/25 revealed:
-Diagnoses included major depressive disorder, anxiety, glaucoma, and hypertension.
-There was no diet listed.

Review of Resident #4's diet order sheet revealed an order for a regular diet with chopped meats.

Review of the facility's therapeutic diet list dated 06/10/25 revealed Resident #4 was to be served a regular diet with chopped meats.

Review of the regular diet with chopped meats menu for the lunch meal service on 06/10/25 revealed Resident #4 was to be served diced hamburger meat with gravy, collard greens, California blend, a dinner roll, and strawberry ice cream.

Observation of Resident #4's lunch meal service on 06/10/25 at 12:15pm revealed:
-Resident #4 was served hamburger steak with gravy; the hamburger steak was not chopped.

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D 309	Continued From page 5 -Resident #4 chopped and ate 100% of the hamburger steak slowly. Review of the regular diet with chopped meats menu for the breakfast meal service on 06/11/25 revealed Resident #4 was to be served bite sized sausage links, eggs, hash brown patty, and milk. Observation of Resident #4's breakfast meal service on 06/11/25 at 8:15am revealed: -Resident #4 was served sausage links; the sausage links were not chopped. -Resident #4 chopped and ate 100% of the sausage links slowly. Interview with Resident #4's on 06/11/25 at 12:36pm revealed: -Her meat was supposed to come from the kitchen chopped up. -Her meats were not served chopped with meals by the kitchen staff. -When her meat was not chopped the resident would cut the meat up herself. Interview with the dietary aide on 06/11/25 at 8:30am revealed: -The cook was responsible for preparing and plating resident's meals. -She served residents meals from the dining cart. -She was not aware Resident #4 was ordered a regular diet with chopped meats. Interview with the cook on 06/11/25 at 8:35am revealed: -He was responsible for plating food items for residents according to their diet orders including chopped meats, but sometimes the correct plates were not served to the residents. -The dietary aides were responsible for serving the plates to residents in the dining room.	D 309		

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-He was not aware Resident #4 was not served chopped meat for the lunch meal on 06/11/25 and for the breakfast meal on 06/10/25.
-He was not aware Resident #4 was ordered a regular diet with chopped meats.

Interview with the Dietary Manager (DM) on 06/11/25 revealed:
-She and the cook were responsible for plating food items for residents according to their diet orders including meats.
-The dietary aides were responsible for serving the plates to the residents during mealtimes.
-She assisted the dietary aide to service resident's meals but sometimes the correct plates were not served to the residents.
-She was not aware Resident #4 was not served chopped meat for the lunch meal on 06/11/25 and for the breakfast meal on 06/10/25.
-She was not aware Resident #4 was on a regular diet with chopped meats until 06/11/25.
-She and the cook should have reviewed the therapeutic diet list to know that Resident #4 was to be served a regular diet with chopped meats.

Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:25pm revealed:
-She was aware Resident #4 was on a regular diet with chopped meat.
-A resident with an order for chopped meats, the meat should be chopped in the kitchen.
-No one had told her Resident #4's meats were not being chopped in the kitchen and she was not aware Resident #4 was not served chopped meat.
-She expected the meals to be served as ordered by a resident's primary care provider (PCP).

Interview with the Administrator on 06/11/25 at 3:02pm revealed:

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D 309	Continued From page 7 -It was the cook's job to ensure the diets were served correctly. -The DM, cook, and the dietary aides should know the resident's diet and if the meal was not served correctly, they should notify either the RCC or her for clarification. -She was not aware Resident #4 was not served chopped meat as ordered by her primary care provider PCP. -She expected the cook and the DM to review the therapeutic diet list and ensure residents diets are served as ordered according to the therapeutic menus. Attempted telephone interview with Resident #4's PCP on 06/11/25 at 4:45pm was unsuccessful.	D 309		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 2 residents (#6) observed during the 8:00am medication pass on 06/11/25 related to a medication to treat elevated cholesterol and a vitamin supplement. The findings are:	D 358		

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The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 8:00am medication pass on 06/11/25.

Review of Resident #6's current FL2 dated 05/22/25 revealed diagnoses included type 2 diabetes, hypertension, and insomnia.

a. Review of Resident #6's current FL2 dated 05/22/25 revealed there was an order for vitamin b complex-folic acid (a medication used to treat or prevent vitamin deficiency) 0.4mg take 1 tablet daily.

Review of Resident #6's signed physician's order dated 06/05/25 revealed there was an order to discontinue vitamin b complex-folic acid 0.4mg take 1 tablet daily.

Observation of the morning medication pass on 06/11/25 at 8:17am revealed:
-The medication aide (MA) prepared 11 oral medications for administration to Resident #6 from medications packaged in bubble cards and a blister card.
-Vitamin b complex-folic acid 0.4mg was packaged with 9 other oral medications in a weekly multiple dose medication blister card.
-The MA administered the 11 prepared oral medications to Resident #6.

Observation of Resident #6's medications on hand on 06/11/25 at 8:15am revealed there were 5 of 7 vitamin b complex-folic acid 0.4mg tablets available for administration in a medication card blister pack with a dispensed date of 06/10/25.

Review of Resident #6's June 2025 electronic

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medication administration record (eMAR) from 06/01/25 to 06/11/25 revealed:
-There was an entry for vitamin b complex-folic acid 0.4mg take 1 tablet daily scheduled for administration at 8:00am.
-There was documentation vitamin b complex-folic acid was administered daily from 06/01/25 to 06/11/25.

Attempted telephone interview with a representative from the facility's contracted pharmacy on 06/11/25 at 4:00pm was unsuccessful.

Telephone interview with Resident #6's primary care provider (PCP) on 06/11/25 at 3:21pm revealed:
-He did not know Resident #6 was administered vitamin b complex-folic acid after he discontinued the medication on 06/05/25.
-Resident #6 should not be administered vitamin b complex-folic acid if he discontinued the medication.
-He expected staff to administer medications as he ordered them.

Interview with the MA on 06/11/25 at 2:40pm revealed:
-She did not know Resident #6's vitamin b complex-folic acid was discontinued on 06/05/25.
-She thought Resident #6's vitamin b complex-folic acid was still an active order when she administered the medication to Resident #6 during the morning medication pass.
-Vitamin b complex-folic acid was still a medication order entry on the eMAR during the morning medication pass on 06/11/25.

Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:21pm revealed:

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-She did not know Resident #6 was administered vitamin b complex-folic acid after the medication order was discontinued during the morning medication pass on 06/11/25.
-She should have checked to see if the vitamin b complex-folic acid order was removed from the eMAR.

Interview with the Administrator on 06/11/25 at 4:40pm revealed she did not know Resident #6 was administered vitamin b complex-folic acid after the medication order was discontinued during the morning medication pass on 06/11/25.

Refer to the interview with the medication aide (MA) on 06/11/25 at 2:41pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:22pm.

Refer to the interview with the Administrator on 06/11/25 at 4:41pm.

b. Review of Resident #6's current FL2 dated 05/22/25 revealed there was an order for cholestyramine (a medication used to lower cholesterol levels in the blood) powder 4 grams, mix 1 packet in a 4-ounce (oz) beverage once daily (take all other medications 1 hour before).

Observation of the morning medication pass on 06/11/25 at 8:17am revealed:
-The medication aide (MA) prepared 11 oral medications for administration to Resident #6 from medications packaged in bubble cards and a blister card.
-The MA administered the 11 prepared oral medications to Resident #6.
-The MA mixed the cholestyramine powder in 4 oz of water and administered cholestyramine to

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Resident #6 immediately after administering the other oral medications.

Observation of Resident #6's medications on hand on 06/11/25 at 8:15am revealed there were 4 cholestyramine powder packets available for administration with a dispensed date of 05/14/25.

Review of Resident #6's June 2025 electronic medication administration record (eMAR) from 06/01/25 to 06/11/25 revealed:
-There was an entry for cholestyramine powder in packet 4 grams, mix 1 packet in 4 oz beverage once daily (take all other medications 1 hour before) scheduled for administration at 9:00am.
-There was documentation cholestyramine powder was administered daily from 06/01/25 to 06/11/25.

Attempted telephone interview with a representative from the facility's contracted pharmacy on 06/11/25 at 4:00pm was unsuccessful.

Telephone interview with Resident #6's primary care provider (PCP) on 06/11/25 at 3:21pm revealed:
-There was potential for decreased absorption of Resident #6's oral medications when the cholestyramine was administered immediately after Resident #6's other oral medications.
-He expected staff to administer medications as he ordered them.

Interview with the MA on 06/11/25 at 2:40pm revealed:
-She did not know Resident #6's cholestyramine must be administered 1 hour after Resident #6's other oral medications.
-She did not know Resident #6's cholestyramine

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D 358	Continued From page 12 administration timing was part of the medication order. Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:21pm revealed: -She did not know Resident #6 was administered cholestyramine immediately after her other oral medications during the morning medication pass on 06/11/25. -She did not know Resident #6's cholestyramine must be administered 1 hour after Resident #6's other oral medications until the MA told her on 06/11/25. Interview with the Administrator on 06/11/25 at 4:40pm revealed: -She did not know Resident #6 was administered cholestyramine immediately after Resident #6's other oral medications during the morning medication pass on 06/11/25. -She knew Resident #6's cholestyramine must be administered 1 hour after Resident #6's other oral medications. Refer to the interview with the medication aide (MA) on 06/11/25 at 2:41pm. Refer to the interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:22pm. Refer to the interview with the Administrator on 06/11/25 at 4:41pm. _____ Interview with the MA on 06/11/25 at 2:41pm revealed: -She followed the medication orders on the eMAR when she administered medications to residents. -She did not know if medication cart audits were completed.	D 358		

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D 358	Continued From page 13 Interview with the Resident Care Coordinator (RCC) on 06/11/25 at 4:22pm revealed: -She expected the MAs to follow the medication orders on the eMAR. -She faxed or sent order changes to the pharmacy. -Medication cart audits were last completed two or three weeks ago in May 2025. -A medication cart audit consisted of printing out provider orders and comparing mediation order entries on the electronic medication administration record (eMAR) to the medications on the medication cart. Interview with the Administrator on 06/11/25 at 4:41pm revealed: -She expected the MAs to pass medications as directed by the provider in a timely manner and to follow the medication orders on the eMAR. -The MAs and the RCC were expected to complete eMAR and medication cart audits. -She did not know how often audits were currently being done or when the last audit was completed. -The MAs and the RCC were responsible to administer medications as ordered.	D 358		