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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on June 18, 2019 through June 21, 2019. | D 000 | | |
| D 079 | 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br>(a) Adult care homes shall<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>This Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure the facility was clean and free of hazards in 3 of 4 common resident spa/bathrooms and a resident bathroom (resident room #10) on the assisted living halls and in 1 of 3 common resident spa bathrooms, 2 shared bathrooms (resident rooms #43 and #45, resident rooms #51 and #53), 2 resident bathrooms (resident rooms #46 and #48), 1 resident room (#45), and the living room in the Special Care Unit (SCU).<br><br>The findings are:<br><br>Observation of the first spa bathroom on the left Hall of the assisted living (AL) side on 06/18/19 at 12:15pm revealed there was a buildup of a white substance on the floor of the spa shower and on the lower tiles of the shower. | D 079 | | |

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| D 079 | Continued From page 1<br><br>Observations of the first spa bathroom on the left Hall of the AL side on 06/18/19 at 12:16pm revealed there was a build up of a brown substance around the base of the faucet and the hot and cold-water knobs on the sink.<br><br>Interview with a housekeeper on 06/20/19 at 10:36am revealed:<br>-She worked on the AL halls as a housekeeper.<br>-She would rinse the showers daily.<br>-She scrubbed the spa bathrooms when they were dirty.<br>-There were only 2 housekeepers working each day one for the AL and one for the special care unit.<br>-She cleaned the resident's bathrooms daily.<br>-There was no documented cleaning schedule to her knowledge.<br><br>Observation of the shared bathroom in resident rooms #23 and #24 on the Right Hall of the AL side on 06/18/19 at 11:50am revealed:<br>-There were two metal brackets on the wall to the right of the sink attached with two screws each and there was no bar attached to the brackets.<br>-There were 2 sharp, protruding edges sticking out on both metal brackets.<br><br>Interview with the Administrator on 06/18/19 at 2:14pm<br>-The maintenance director only came to the facility once a week, normally on Fridays.<br>-They had a maintenance binder that staff documented all needed maintenance repairs for the maintenance director to do.<br>-Repairs had to wait until the maintenance director came weekly to be repaired.<br><br>Interview with the Administrator on 06/18/19 at | D 079 | | |

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| D 079 | Continued From page 2<br><br>2:22pm and 2:37pm revealed:<br>-The housekeeping staff worked from 7:00am to 3:00pm daily.<br>-The housekeeping staff should be cleaning the bathrooms daily, including scrubbing the showers.<br>-She did not know there were metal, protruding brackets on the wall in the shared bathroom between resident rooms #23 and #24.<br>-She would have the brackets removed.<br><br>Interview with a resident in room #23 on 06/20/19 at 10:28am revealed the metal brackets with a missing towel bar on the wall beside the sink had been that way for "months and months".<br><br>A second observation of the shared bathroom in resident rooms #23 and #24 on the Right Hall of the AL side on 06/20/19 at 10:28am revealed the metal brackets had been removed but the 4 screws remained in the wall.<br><br>Observation of the spa bathroom beside resident room #12 on the Right Hall of the AL side on 06/18/19 at 12:10pm revealed:<br>-The shower tile was broken and missing around the metal pipe attached to a plastic turn knob, leaving a hole above the metal pipe with jagged, sharp edges.<br>-There was a thick white coating of soap scum all over the floor and walls of the shower tiles and on the metal grab bars in the shower.<br>-There was a metal bar about 3 feet long attached to the lower right shower wall that had sharp edges.<br>-The shower bench was missing from the metal bar and there was a second metal piece midway below the bar that protruded from the wall about 6 inches with sharp edges. | D 079 | | |

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| D 079 | Continued From page 3<br><br>Observation of the spa bathroom beside resident room #11 on the Right Hall of the AL side on 06/18/19 at 12:18pm revealed:<br>-There was a thick white coating of soap scum all over the floor and walls of the shower tiles and on the metal grab bars in the shower.<br>-The heaviest build up of white soap scum was on the tiles in the corner of the shower.<br><br>Interview with the Administrator on 06/18/19 at 2:37pm revealed:<br>-She did not know the spa bathrooms on the AL halls had a coating of white soap scum.<br>-She did not know there was broken tile around the knob in one of the spa bathrooms on the AL side.<br>-It should be documented in the maintenance binder.<br>-The maintenance person should be doing a walk through when he was at the facility each week.<br>-She did not usually monitor or do a walk through of any of the bathrooms in the facility.<br><br>Interview with a housekeeper on 06/20/19 at 10:36am revealed:<br>-The broken tile in the shower in the spa bathroom on the Right Hall of the AL side had been fixed several times.<br>-She did not know why it kept breaking.<br><br>A second observation of the spa bathroom beside resident room #12 on the Right Hall of the AL side on 06/20/19 at 10:35am revealed:<br>-The shower tile was still broken and missing around the metal pipe attached to the plastic turn knob, leaving a hole above the metal pipe with jagged, sharp edges.<br>-There was still a white coating of soap scum all over the floor and walls of the shower tiles and on the metal grab bars in the shower. | D 079 | | |

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| D 079 | Continued From page 4<br>-The metal bar that was attached to the lower right shower wall had been removed leaving rust marks, small holes, and a metal screw protruding from the wall of the shower.<br>-There was brown debris on the shower floor below the area where the metal bar was removed.<br><br>A second observation of the spa bathroom beside resident room #11 on the Right Hall of the AL side on 06/20/19 at 10:20am revealed:<br>-There was still a white coating of soap scum all over the floor and walls of the shower tiles and on the metal grab bars in the shower.<br>-The was a lighter build up of white soap scum on the tiles in the corner of the shower than observed on 06/18/19.<br><br>Interview with the Administrator on 06/18/19 at 3:55pm revealed:<br>-An estimate for repair of the broken shower towel was obtained on 05/15/19.<br>-The estimate was handled through the corporate office.<br>-Once corporate office got an estimate, it was out of her hands.<br>-She usually waited for corporate to set up and let her know when a repair company was coming to the facility to complete any repairs.<br>-No date had been set up to repair the shower wall to her knowledge.<br><br>Observation of the bathroom in resident room #10 on the Right Hall of the AL side on 06/18/19 at 12:32pm revealed:<br>-The toilet seat was pushed to the left creating a gap between the right side of the seat and the rim of the toilet.<br>-The seat was loose and moved from side to side when touched. | D 079 | | |

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| D 079 | Continued From page 5<br><br>Interview with a resident in room #10 on 06/18/19 at 12:32pm revealed:<br>-The toilet seat was "one-sided" and loose on the right side.<br>-It had "been that way a year".<br><br>Interview with the Administrator on 06/18/19 at 2:37pm revealed she would have the toilet seat repaired in resident room 10.<br><br>Observation of the spa bathroom located next to resident room #43 in the Special Care Unit (SCU) on 06/18/19 at 4:26pm revealed:<br>-There was an area of cracked tile on the end of the privacy wall in front of the toilet that had exposed sharp, jagged edges that measured approximately 4 inches x 2 inches.<br>-There was a thick white layer of soap scum on walls and floor of the shower tiles and on the metal grab bars in the shower.<br><br>Observation of the shared bathroom in resident rooms #43 and #45 in the SCU on 06/18/19 at 4:38pm revealed:<br>-There were two metal brackets with exposed sharp edges on the wall across from the sink.<br>-The metal brackets were attached to the wall with two screws each but there was no bar attached to the brackets.<br><br>Observation of resident room #45 in the SCU on 06/18/19 at 4:47pm revealed:<br>-The cable faceplate next to the first closet was missing its top screw which caused the faceplate to lean approximately 45 degrees to the right.<br>-The housing of the cable was exposed at the top approximately 3 inches.<br><br>Observation of the bathroom in resident room | D 079 | | |

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| D 079 | Continued From page 6<br><br>#46 in the SCU on 06/18/19 at 4:51pm revealed there were two metal towel brackets without the bars on the wall across from the sink that were extended approximately 3 inches from the wall and had exposed sharp edges.<br><br>Observation of the bathroom in resident room #48 in the SCU on 06/18/19 at 4:56pm revealed:<br>-There was an adjustable metal frame raised toilet seat over the toilet in the bathroom.<br>-The metal frame had rusty areas all over.<br>-There was an area of metal frame next to the toilet seat that was rusted completed into two pieces and had exposed rusty metal jagged edges.<br>-There was a toilet paper metal rack located on the wall on the right side of the toilet with 2 exposed metal prongs and no bar.<br><br>Interview with a personal care aide (PCA) on 06/18/19 at 4:57pm revealed:<br>-The raised toilet seat was used by a resident.<br>-She had not noticed the rusted areas on the raised toilet or that part of the frame was rusted in two pieces with exposed edges.<br>-She had not noticed any missing towel racks in any resident's bathrooms.<br>-She did not know anything about the cracked tiles in the spa bathroom next to resident room #43.<br><br>Observation of the living room area in the SCU on 06/18/19 at 5:03pm revealed there was a broken electrical outlet cover on the lower right wall area that was accessible to the residents in the SCU.<br><br>Observation of the shared bathroom in resident rooms #51 and #53 in the SCU on 06/18/19 at 5:08pm revealed:<br>-There were two metal brackets with exposed | D 079 | | |

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| D 079 | Continued From page 7 | D 079 | | |

sharp edges on the wall across from the sink.
-The metal brackets were attached to the wall with two screws each but there was no bar attached to the brackets.
-There was a metal toilet paper rack located on the wall on the right side of the toilet with 2 exposed metal prongs and no bar.

Interview with a housekeeper in the SCU on 06/20/19 at 10:20am revealed:
-She cleaned residents's bathrooms and spa bathrooms everyday.
-The soap scum stains on the shower walls would not come off when she cleaned them.
-She had not seen a rusted raised toilet seat in a resident's bathroom.
-She had not noticed any broken or missing towel or toilet tissue brackets in any of the residents' bathrooms or any cracked electrical outlet covers.
-If she saw anything that needed to be repaired, she reported it the maintenance director.

Interview with the Administrator on 06/18/19 at 6:30pm revealed:
-She had not noticed the broken and missing towel and toilet paper brackets in the residents' bathrooms in the SCU.
-She did not know about the cracked tiles in the spa bathroom.
-No one had reported to her about the rusted raised toilet in a resident's bathroom in the SCU.
-She had not seen the cracked electrical outlet covers or the loose cable faceplate in the SCU.
-She did not walk through to check for these things in the facility.
-Staff were suppose to document any needed repairs on the maintenance repair list in the mainteanance binder.

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| D 079 | Continued From page 8<br><br>Review of the facility maintenance book on 06/19/19 at 5:03pm revealed:<br>-A large 3 ring binder labeled maintenance repair book was kept in the BOM's office.<br>-There was a 7-column form, titled "maintenance repair list" and the columns were for date, location, description of what needed to be repaired, date received, initials, date repaired, and initials.<br>-There was an asterisk noted directive above the columns, the Administrator/ED should initial off each week that repairs were completed.<br>-On 05/17/19, a written repair request for room 19 for tiles in middle floor had water under it. Date repaired and initials were left blank.<br><br>Interview with the Business Office Manager (BOM) on 06/19/19 at 5:11pm revealed:<br>-She is aware of the maintenance director comes weekly, normally on Fridays.<br>-The maintenance book is kept in her office for all staff to have access to make written request or concerns.<br>-When she conducted new hire orientation and apart of the onboarding tour, she reviewed maintenance repair book process and location.<br><br>Interview with the maintenance director on 06/19/19 at 5:03pm revealed:<br>-On 05/20/19, he started working a four-week rotating schedule with five facilities for the company.<br>-He goes to each facility one day each week.<br>-He goes to each facility for two days for one week of the four-week rotating schedule.<br>-The schedule should always follow the four-week rotating schedule unless emergency occurs at another facility.<br>-Going to a location on a non-scheduled day, must be approved by corporate. | D 079 | | |

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| D 079 | Continued From page 9<br>-He is normally scheduled at this facility on Fridays.<br>-The last week that he was at this facility for two consecutive days were the week of 05/17/19.<br>-We have a maintenance book, that is kept in the BOM office for all staff to have access to and make all written repair entry request or concerns for the facility.<br>-Normally when he arrived on Fridays he checked the maintenance book for written request repairs and started on those.<br>-It was hard to keep up with all of the needed repairs since he was only at the facility one day week.<br>-We have all staff meetings monthly and at that time all staff are reminded about the maintenance book, where it is located, how to use it and make repair request.<br>-He works with housekeeping staff in the facility to learn of repairs verbally that are needed.<br>-He is not there all the time to monitor housekeeping, only 1 day a week.<br>-It was hard to keep up with their daily activities since he was not there. | D 079 | | |
| D 105 | 10A NCAC 13F .0311(a) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(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.<br><br>This Rule is not met as evidenced by:<br>The facility failed to assure overall safe maintenance of the gas oven/stove combination as evidence by 9 of 11 missing control knobs that turned on the stove. | D 105 | | |

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| D 105 | Continued From page 10<br><br>The findings are:<br><br>Observation of the stainless-steel gas stove/oven during kitchen tour on 06/19/19 at 11:24am revealed:<br>-There were eleven areas for control knobs to operate the gas stove/oven.<br>-There were nine missing control knobs with exposed nine metal prongs on the front side of the gas stove/oven.<br>-There were only two black and silver controls knobs available to operate the gas stove/oven.<br><br>Interview with dietary manager on 06/19/19 at 11:24am revealed:<br>-She used her bare hands to turn the metal prongs where the control knobs were supposed to be to operate the gas stove/oven.<br>-She guessed on how high to adjust the temperature while cooking the resident meals.<br>-The kitchen staff had expressed that the oven gets hot.<br>-The two control knobs on the left side of the gas stove had been missing for one month.<br>-The four control knobs in the center of the gas stove had been missing for about two months.<br>-The three control knobs for the grill section of the gas stove had been missing for about four years.<br>-"It had been for a while".<br>-She felt they needed better equipment and more upgraded equipment.<br>-The corporate manager was there about one month ago and toured the kitchen.<br>-The corporate manager observed the control knobs missing from the gas stove.<br>-The corporate manager said they would order some control knobs.<br>-She had not heard any updates from corporate regarding the ordered control knobs for the stove | D 105 | | |

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| D 105 | Continued From page 11<br>or oven.<br>-She did not tell the Administrator about the control knobs, because she spoke directly to the corporate manager.<br><br>Interview with a cook on 06/19/19 at 11:37am revealed:<br>-He used special mittens to operate the stove, "It does get really hot" when operating the gas oven/stove.<br>-"I did not notice there were no oven knobs until now...today."<br>-He never spoke with the dietary mananger or Administrator about the missing control knobs on the gas stove or oven.<br>-He did tell the dietary manager that the gas stove gets hot.<br><br>Interview with Administrator on 06/19/19 at 2:36pm revealed:<br>-The stove was old. I'm not surprised that the knobs were missing.<br>-Staff had not told her anything, no one shared with her any concerns regarding the missing control knobs on the gas stove or oven.<br>-"I don't touch the stove, I only go into the kitchen to do food list check off."<br>-Their corporate office approved an estimate for all new kitchen equipment about a week ago. | D 105 | | |
| D 113 | 10A NCAC 13F .0311(d) Other Requirements<br><br>10A NCAC 13F .0311 Other Requirements<br>(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 | D 113 | | |

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| D 113 | Continued From page 12<br>(38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 9 water fixtures including a sink in a resident bathroom and sinks, showers, and a tub in two spa bathrooms on the assisted living hall and 7 of 10 water fixtures including sinks in three resident room bathrooms; sinks and showers in two spa bathrooms in the Special Care Unit (SCU).<br><br>The findings are:<br><br>Observations of the Special Care Unit (SCU) on 06/18/19 between 3:46pm and 5:27pm revealed:<br>-The hot water temperature was 118 degrees Fahrenheit (F) at the sink for the bathroom in resident room #40 at 4:14pm.<br>-The hot water temperature was 120 degrees F at the sink for the shared bathroom between resident room #39 and resident room #41 at 4:15pm.<br>-The hot water temperature was 127.4 degrees F at the sink and 122.4 degrees F at the shower in the spa bathroom located next resident room #43 at 4:26pm and there was visible steam when the water was running.<br>-The hot water temperature was 126.8 degrees F at the sink in resident room #46 at 4:51pm and there was visible steam when the water was | D 113 | | |

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running.
-The hot water temperature was 119 degrees F at the sink and 120 degrees F at the shower in the spa bathroom located across from resident room #60 at 5:27pm and there was visible steam when the water was running.
-The surveyor's thermometer was used for the recordings of these water temperatures in the SCU.

Interview with a resident who lived on the Special Care Unit on 06/18/19 at 4:04pm revealed:
-The water temperature at the bathroom sink got real hot.
-He would snatch his hands away from the water when washing them.

Interview with a personal care aide in the SCU on 06/18/19 at 5:28pm revealed:
-She had not noticed any problems with the water being too hot in the SCU.
-No residents had been burned while bathing or showering in the SCU.
-Staff assisted all residents when they bathed or showered since most residents were not able to manage the water temperatures without assistance.
-If there were any problems with the hot water, staff would write it down in the maintenance book for the maintenance to check.

Interview with a medication aide in the SCU on 06/19/19 at 10:10am revealed:
-She did not know any problems with the hot temperatures in the SCU.
-No residents had complained about the temperature of the water to her.
-She saw the "hot water signs" that were posted on 06/18/19 at the water fixtures.
-No residents bathed without staff assistance in

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the SCU.
-Some residents did go to the bathroom without staff assistance and there were approximately ten residents who wandered in the SCU.
-It was possible if the water temperature was too hot for a resident to burn themselves when they washed their hands after using the bathroom or if they wandered into the bathroom alone.

Interview with housekeeping staff on 06/20/19 at 12:47pm revealed:
-She had worked on the SCU and the AL hall.
-She did not know if the water was too hot in the residents' rooms or bathrooms in the facility.
-She used water from the utility closet and had not heard any complaints for residents or staff about the hot water temperatures.
-She verbally told the maintenance director about the hot water and did not write in the maintenance book.

Observation of the facility's thermometer and the surveyor's thermometer on 06/19/19 at 4:30pm revealed both thermometers were calibrated in an ice water bath to 32.2 degrees.

Observations the Special Care Unit on 06/19/19 between 4:47pm and 5:00pm revealed:
-The hot water temperature was 119.3 degrees F at the shower in the spa bathroom located next resident room #43 at 4:52pm.
-The hot water temperature was 125.7 degrees F at the sink in the spa bathroom located across from resident room #60 at 5:00pm and there was visible steam when the water was running.
-The surveyor's thermometer was used for the recordings of these water temperatures in the SCU.

Observations during the initial facility tour of the

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assisted living (AL) hall on 06/18/19 between 11:10am and 11:43am revealed:
-The hot water temperature at the bathroom sink in resident room #1 was 117.6 degrees Fahrenheit (F) at 11:01am.
-The hot water temperature at the spa bathroom sink was 117.3 degrees F, the spa bathroom shower temperature was 116.7 degrees F, and the spa bathroom tub was 118.2 degrees F at 11:38am.
-The hot water temperature in a second spa bathroom sink was 118.7 degrees F and its shower temperature was 117.8 degrees F at 11:43am.
-There was no steam observed coming from any of the fixtures.
-The surveyor's thermometer was used for the recordings of these water temperatures on the AL hall.

Interview with the resident in resident room #1 on the AL Hall on 06/18/19 at 11:10am revealed she had not noticed the water being hot enough to burn her.

Interview with the Administrator on 06/18/19 at 2:22pm revealed:
-There were separate hot water heaters for each hall in the facility.
-The closer a resident's room was located to one of the hot water heaters, the hot water temperature may be higher in those rooms.
-The maintenance director came to the facility once a week and randomly checked hot water temperatures.
-He had not reported any elevated hot water temperatures to her.
-She did not know about any problems with elevated hot water temperatures in the facility.
-No one had complained to her about the water

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being too hot in the facility.
-Staff documented in a maintenance binder anything the Maintenance Director needed to check or fix.
-Staff did not always tell the Administrator about maintenance problems.
-The maintenance director was the only person who checked water temperatures at the facility.
-There was no other staff trained to check water temperatures in the facility.

Review of the facility's county environmental health inspection report dated 05/14/19 revealed the facility had hot water temperature readings on the back-hall bathrooms (referring to SCU) of 126 degrees F.

Review of the facility's hot water temperature logs revealed:
-Hot water temperatures ranged from 117 degrees F to 118 degrees F in six resident rooms and two spa bathrooms between 10:05am and 10:40am on the assisted living side of the facility on 04/01/19.
-The hot water temperatures were 118 degrees F in six resident rooms and two spa bathrooms between 11:00am and 11:45am in the SCU on 04/01/19.
-The hot water temperatures were 118 degrees F in six resident rooms and two spa bathrooms between 9:05am and 11:00am on the assisted living side of the facility on 04/10/19.
-The hot water temperatures were 118 degrees F in six resident rooms and two spa bathrooms between 11:10am and 11:40am in the SCU on 04/10/19.
-Hot water temperatures ranged from 117 degrees F to 118 degrees F in six resident rooms and two spa bathrooms between 9:30am and 10:40am on the assisted living side of the facility

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| D 113 | Continued From page 17<br>on 04/24/19.<br>-The hot water temperatures were 118 degrees F in six resident rooms and two spa bathrooms between 11:00am and 12:00pm in the SCU on 04/24/19.<br>-Hot water temperatures ranged from 117 degrees F to 118 degrees F in six resident rooms and two spa bathrooms between 10:00am and 10:45am on the assisted living side of the facility on 05/06/19.<br>-The hot water temperatures were 118 degrees F in six resident rooms and two spa bathrooms between 11:12am and 11:45am in the SCU on 05/06/19.<br>-Hot water temperatures ranged from 117 degrees F to 118 degrees F in six resident rooms and two spa bathrooms between 7:08am and 8:00am on the assisted living side of the facility on 06/07/19.<br>-Hot water temperatures ranged from 117 degrees F to 118 degrees F in six resident rooms and two spa bathrooms between 8:20am and 9:20am in the SCU on 06/07/19.<br><br>Interview with the Administrator on 06/18/19 at 4:00pm revealed:<br>-She was made aware of hot water temperatures on 05/14/19 after the county health inspector completed his inspection of the facility.<br>-The back-halls in the county environmental health report referred to the SCU and the front hall was the assisted living unit of the facility.<br>-She called a local plumber and he came on 05/15/19 and found there were no mixing valves on the hot water heaters.<br>-She got an estimate for the cost of fixing the hot water heaters and sent it to corporate office on 05/15/19.<br>-She usually gave corporate office thirty days before she followed up on the estimates for | D 113 | | |

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repairs.
-She had not followed up with the corporate office prior to 06/18/19.
-She had not provided any instructions to the staff or posted any "hot water" signs to caution the residents about the elevated water temperatures prior to 06/18/19.
-She had posted "hot water" signs at all water fixtures after she had spoken with the survey team about the hot water temperatures earlier on 06/18/19.

Interview with the maintenance director on 06/19/19 at 4:45pm revealed:
-He was supposed to check the hot water temperature in the facility once a week when he came to the facility.
-He documented the water temperature readings on the facility's hot water temperature log.
-He last checked the hot water temperatures approximately two weeks and there was no problem with any water temperatures in the facility.
-There were no other staff who were trained to check the water temperatures in the facility.
-The hot water temperatures were first reported as being too hot at the facility on the last county environmental health inspection completed sometime in May 2019.
-He was not instructed by the Administrator to adjust the thermostats on hot water heaters or to post any signs to warn the residents or staff of possible hot water temperature after the health inspection.
-The Administrator had contacted a plumbing company after the county health inspection in May 2019 and received an estimate for needed mixing and check valves to regulate the water temperatures for the facility's hot water heaters.
-He did not know if the mixing and check valves

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| D 113 | Continued From page 19<br>had been ordered yet.<br>-The Administrator contacted the corporate office to authorize those kinds of repairs.<br><br>Interview with the Administrator on 06/19/19 at 8:30am revealed:<br>-She was responsible to follow-up with the corporate office for the hot water repairs, but she had forgotten.<br>-She did not think to post any "hot water" signs when she learned about the water being too hot in the Special Unit in May 2019.<br>-She had "hot water" signs posted at all water fixtures on 06/18/19 and staff had been instructed to monitor residents when they used the hot water.<br>-Their corporate office ordered the mixing valves for the facility's hot water heaters on 06/18/19 and she expected the valves to be installed at the facility by 07/01/19.<br><br>The facility failed to maintain the hot water temperature between 100-116 degrees F resulting in hot water temperatures between 117-118 degrees F on the assisted living unit in a resident's bathroom and two spa bathrooms and hot water temperatures between 118-127 degrees F in the Special Care Unit in three resident bathrooms and two spa bathrooms which was detrimental to the safety and welfare of all the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection on June 18, 2019 in accordance with G.S. 131D-34 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 5, 2019. | D 113 | | |

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| D 131 | 10A NCAC 13F .0406(a) Test For Tuberculosis<br><br>10A NCAC 13F .0406 Test For Tuberculosis<br>(a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to assure 3 of 6 staff sampled (B, C, E) were tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Health Services.<br><br>The findings are:<br><br>1. Review of Staff E's personnel record revealed:<br>-Staff E was hired on 03/11/19 as a supervisor / medication aide.<br>-Staff E had a TB skin test placed on 01/14/19 and read as negative on 01/16/19.<br>-There was no documentation of a second step TB skin test within 12 months of Staff E's TB skin tests completed in January 2019.<br><br>Interview with Staff E on 06/21/19 at 3:27pm revealed:<br>-She had worked at another facility owned by the same corporation prior to coming to work at this facility in March 2019.<br>-She had a TB skin test completed at the previous facility. | D 131 | | |

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-She knew she needed to get a second step TB skin test when she was hired at this facility but she had not gotten it done yet.
-She would go to the local health department next week and have a second step TB skin test completed.

Interview with the Administrator on 06/21/19 at 11:40am revealed:
-The new Business Office Manager (BOM) checked personnel files at the end of May 2019 and had some concerns about missing TB skin tests for some staff, including Staff E.
-Staff E transitioned from another facility owned by the corporation and Staff E would need to go to the local health department to get TB skin testing completed.
-Staff E, along with other staff, was notified at the beginning of June 2019 to get TB skin testing completed.

2. Review of Staff B's personnel record revealed:
-She had worked at the facility since 01/11/17 as a personal care aide (PCA).
-There was no documentation of any tuberculin (TB) skin test.

Interview with Staff B on 06/21/19 at 3:38pm revealed:
-She had been working at the facility since January 2017.
-She remembered getting a 2 step TB skin test at the local health department.
-She remembered getting them when she was hired in 2017.
-She would call the local health department and get the TB skin test.

Interview with the Administrator on 06/21/19 at 5:13pm revealed:

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-She was unable to find Staff B's TB skin tests.
-The Business Office Manager (BOM) was responsible for reviewing staff records.
- The BOM started working at the facility on 04/01/19.
-BOM started reviewing staff records at the end of May 2019.
-She had a list of staff that must get TB skin test.
-Staff B was on the list.

3.Review of Staff C's personnel record revealed:
-She was hired as a personal care aide (PCA) on 08/13/18.
-There was documentation for one tuberculosis (TB) skin test read on 08/27/18 as 0mm (negative).
-There was no additional documentation for TB skin test in Staff B's personnel record.

Attempted telephone interview with Staff C on 06/21/19 at 05:09pm was unsuccessful.

Interview with the Administrator on 05/20/19 at 11:40pm revealed:
-She started as the Administrator on 04/19.
-The Business Office Manager (BOM) was responsible for ensuring information required was maintained in the employee personnel record, including TB skin test results.
-The new BOM started on 04/19.
-The new BOM brought to her attention that staff's tuberculosis (TB) 2 step skin test were a concern, some were missing.
-She started reviewing staff personnel records at the end of 05/19.
-She and the new BOM started a list of staff who needed to get a 2 step TB test, or at least one step by 06/30/19.
-The staff would go to the local health department to get the TB test.

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| D 131 | Continued From page 23<br>-A notice was given to staff regarding 2 step TB testing on 06/01/19.<br>-There was no second step TB skin test for Staff C available for review by the end of the survey. | D 131 | | |
| D 164 | 10A NCAC 13F .0505 Training On Care Of Diabetic Resident<br><br>10A NCAC 13F .0505 Training On Care Of Diabetic Residents<br>An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:<br>(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.<br>(2) Training shall include at least the following:<br>(a) basic facts about diabetes and care involved in the management of diabetes;<br>(b) insulin action;<br>(c) insulin storage;<br>(d) mixing, measuring and injection techniques for insulin administration;<br>(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;<br>(f) blood glucose monitoring; universal precautions;<br>(g) universal precautions;<br>(h) appropriate administration times; and<br>(i) sliding scale insulin administration.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to assure 1 of 4 medication aides sampled (Staff F) received training on the care of | D 164 | | |

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| D 164 | Continued From page 24<br>diabetic resident's prior to performing fingerstick blood sugars and the administration of insulin.<br><br>The findings are:<br><br>Review of Staff F's personnel record revealed:<br>-The date of hire was 02/11/19 as a medication aide (MA).<br>-There was no documentation of training on the care of a diabetic resident.<br><br>Review of a resident's April 2019 electronic Medication Administration Record (eMAR) revealed:<br>-Staff F documented administering insulin at 8:00am and 12:00pm on 4/23/19 and 4/25/19.<br>-Staff F administered 12 units of insulin.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 101 and 11:30am was 188 on 4/23/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 180 and 11:30am was 201 on 4/25/19.<br><br>Review of a resident's May 2019 electronic Medication Administration Record (eMAR) revealed:<br>-Staff F documented administering insulin at 7:30am on 05/28/19, 05/29/19, and 05/30/19.<br>-Staff F documented administering insulin at 8:00am on 05/01/19, 05/02/19, 05/07/19, 05/08/19, 05/13/19, 05/16/19, 05/20/19, 05/21/19, 05/22/19 and 05/23/19.<br>-Staff F documented administering insulin at 11:30am on 05/23/19, 05/28/19, 05/29/19, and 05/30/19.<br>-Staff F documented administering insulin at 12:00pm on 05/01/19, 05/02/19, 05/07/19, 05/08/19, 05/13/19, 05/16/19, 05/20/19, 05/21/19 and 05/22/19. | D 164 | | |

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| D 164 | Continued From page 25<br>-Staff F documented administering insulin at 5:30pm on 05/01/19, 05/06/19, and 05/18/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 118, 11:30am was 120, 4:30pm was 118 and 8:00pm was 125 on 05/01/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 111, 11:30am was 152 on 05/02/19.<br>-Staff F documented performing fingerstick blood sugars at 4:30pm was 113, 8:00pm was 137 on 05/06/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 121, 11:30am was 224 on 05/07/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 106, 11:30am was 199 on 05/08/19.<br><br>Review of a resident's June 2019 electronic Medication Administration Record (eMAR) revealed:<br>-Staff F documented administering insulin at 7:30am on 06/04/19, 06/05/19, 06/11/19, 06/12/19, 06/13/19, 06/18/19 and 06/19/19.<br>-Staff F documented administering insulin at 8:00am on 06/20/19.<br>-Staff F documented administering insulin at 11:30am on 06/04/19, 06/05/19, 06/11/19, 06/12/19, 06/13/19, 06/18/19 and 06/20/19.<br>-Staff F documented administering insulin at 5:30pm on 06/05/19.<br>-Staff F documented administering insulin at 8:00pm on 06/03/19, 06/05/19 and 06/14/19.<br>-Staff F documented performing fingerstick blood sugars at 4:30pm was 87 and 8:00pm was 168 on 06/03/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 166 and 11:30am was 168 on 06/04/19. | D 164 | | |

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| D 164 | Continued From page 26<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 155, 11:30am was 295, 4:30pm was 133 and 8:00pm was 115 on 06/05/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 111 and 11:30am was 233 on 06/11/19.<br>-Staff F documented performing fingerstick blood sugars at 7:30am was 129 and 11:30am was 118 on 06/12/19.<br><br>Telephone interview with the facility contracted training provider on 06/21/19 at 10:42am revealed:<br>-She was a Registered Nurse (RN) and had been providing staff training at the facility since 2015.<br>-She provided training at the facility, per there request.<br>-The facility has capability of doing courses online.<br>-They made a copy of the staff sign in list for each course provided.<br>-If there was a in person training, the RN would sign off and have the staff sign.<br>- She did not see, or have any sign in sheets that she provided, or did in person for diabetes or Staff F.<br>-She did not see, or have any sign in sheets that she provided, or did a in person diabetes class for the facility since 2017 to present.<br>-It is the facility responsibility to let her know when to schedule a diabetic training<br><br>Interview with the Administrator on 06/21/19 at 11:40am revealed:<br>-Staff F was hired as a MA.<br>-She was not aware that Staff F did not have completed training on diabetic care.<br>-Staff F did not have documentation of a completed training on the care of diabetic | D 164 | | |

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| D 164 | Continued From page 27<br>residents before administering insulin.<br>-She was responsible for coordinating and scheduling staff training.<br><br>Attempted telephone interviews with Staff F on 06/21/19 at 3:55pm were unsuccessful. | D 164 | | |
| D 188 | 10A NCAC 13F .0604(e) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.<br>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:<br>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) | D 188 | | |

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| D 188 | Continued From page 28<br>(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.<br>(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 6 of 12 shifts sampled for six days in June 2019..<br><br>The findings are:<br><br>Review of the facility's 2019 license revealed:<br>-The facility had a capacity of 122 residents.<br>-The facility was licensed for 72 beds on the AL hall.<br><br>Review of a resident census report dated 06/08/19 (Saturday) revealed the facility's in-house census on the assisted living (AL) was 32 residents, which required at least 16 hours of staff duty on third shift.<br><br>Review of the punch time detail report dated 06/08/19 (Saturday) revealed there were 15 hours of staff duty provided on third shift, leaving the shift short staffed by 1 hour. | D 188 | | |

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| D 188 | Continued From page 29<br><br>Confidential interview with staff revealed:<br>-There had been problem with working short staffed in the facility for several months, but short staff had got worse since February 2019 when the new Administrator started.<br>-There was not enough staff to work because a lot of people had been fired since February.<br>-The short-staffing was worse on the second and third shift.<br>-Most of the time only two personal care aides and one medication aide were scheduled to work on the AL hall.<br>-Sometimes, the residents had to wait if they needed help because there was not enough staff to answer the call bells.<br><br>Review of the facility's census report revealed the facility's census on the assisted living (AL) hall was 32 residents on 06/07/19 - 06/09/19 and 06/14/19 - 06/16/19 which required at least 20 hours of aide hours on second shift.<br><br>Review of the facility's second shift staff time records from 06/07/19 - 06/09/19 and 06/14/19 - 06/16/19 revealed:<br>-There were 15 hours and 55 minutes of aide hours for second shift on 06/07/19, leaving the facility short 4 hours and five minutes of aide hours.<br>-There were 17 hours and 19 minutes of aide hours for second shift on 06/16/19, leaving the facility short 2 hours and 41 minutes of aide hours.<br><br>Review of the facility's census report revealed the facility's census on the AL hall was 32 residents on 06/07/19 - 06/09/19 and 06/14/19 - 06/16/19 which required at least 16 hours of aide hours on third shift. | D 188 | | |

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| D 188 | Continued From page 30<br><br>Review of the facility's third shift staff time records from 06/07/19 - 06/09/19 and 06/14/19 - 06/16/19 revealed:<br>-There were 11 hours and 30 minutes of aide hours for third shift on 06/07/19, leaving the facility short 4 hours and 30 minutes of aide hours.<br>-There were 15 hours of aide hours for third shift on 06/08/19, leaving the facility short 1 of aide hours.<br>-There were 11 hours and 30 minutes of aide hours for third shift on 06/09/19, leaving the facility short 4 hours and 30 minutes of aide hours.<br>-There were 11 hours and 30 minutes of aide hours for third shift on 06/16/19, leaving the facility short 4 hours and 30 minutes of aide hours.<br><br>Interview with a resident on 06/18/19 at 11:25am revealed:<br>-The facility only had a few staff.<br>-Some staff did not work here very long.<br>-He wasn't sure if they didn't last because of the pay or the hard work.<br><br>Interview with a family member on 06/19/19 at 7:52pm revealed the facility did not have many staff working the floor.<br><br>Interview with the Administrator on 06/21/19 at 5:37pm revealed:<br>-She was responsible for the staffing schedule on the assisted living hall.<br>-She had frequent call outs.<br>-Someone from management was on call seven days a week and they would cover the first call out.<br>-If there was a second call out, then manangement on call would have to to find | D 188 | | |

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| D 188 | Continued From page 31<br>someone to cover the call out.<br>-This was a rural area and "we just don't get many applications" and it was hard finding qualified people to fill the open positions.<br>-She was aware of how much staff is required for the facility's census. | D 188 | | |
| D 234 | 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio<br><br>10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations<br>(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 Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to assure 3 of 5 residents sampled (#1, #3, #5) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 01/18/19 revealed diagnoses included dementia, atrial fibrillation, anemia, diabetes mellitus type II, gout, pedal edema, and long-term use of anti-coagulant. | D 234 | | |

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| D 234 | Continued From page 32<br><br>Review of Resident #1's Resident Register revealed he was admitted to the facility on 09/25/17.<br><br>Review of Resident #1's tuberculosis (TB) skin tests revealed:<br>-There was one TB skin test placed on 09/20/17 and read as negative on 09/22/17.<br>-There was no documentation of any other TB skin tests in the record.<br><br>Telephone interview with Resident #1's primary care provider (PCP) on 06/20/19 at 2:35pm revealed there was no documentation in the resident's medical record of any TB skin tests being completed at the PCP's office.<br><br>Telephone interview with Resident #1's power of attorney (POA) / family member on 06/21/19 at 10:05am revealed:<br>-The resident had a TB skin test at the local health department prior to moving into the facility.<br>-She was told by facility staff that the facility would take care of getting the resident's second step TB skin test completed.<br><br>Refer to interview with the Administrator on 06/21/19 at 5:14pm.<br><br>2. Review of Resident #3's current FL-2 dated 01/31/19 revealed diagnoses included dementia and loss of memory.<br><br>Review of Resident #3's Resident Register revealed she was admitted to the facility on 02/01/19.<br><br>Review of Resident #3's tuberculin (TB) screening records revealed: | D 234 | | |

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-Resident #3 was administered a TB skin test on 01/21/19 and read as negative on 01/24/19.
-There was no documentation of any other TB skin test in Resident #3's record.

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

Refer to interview with the Administrator on 06/21/19 at 5:14pm.

3. Review of Resident #5's FL-2 dated 05/13/19 revealed:
-Diagnoses included Alzheimer's disease and severe neuro-cognitive disorder with behavioral disturbances.
-His level of care was placed for the Special Care Unit (SCU).

Review of Resident #5's Resident Register revealed he was admitted to the facility on 05/14/18.

Review of Resident #5's tuberculosis (TB) skin tests revealed:
-There was one TB skin test placed on 05/07/18 and read as negative on 05/09/18.
-There was no documentation of any other TB skin tests in the record.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

Telephone interview with Resident #5's primary care provider (PCP) on 06/20/19 at 11:23am revealed there was no documentation in the resident's medical chart of any TB skin tests being completed at the PCP's office.

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| D 234 | Continued From page 34<br><br>Refer to interview with the Administrator on 06/21/19 at 5:14pm.<br><br>Interview with the Administrator on 06/21/19 at 5:14pm revealed:<br>-She could not find a second step TB skin test results for the residents.<br>-Residents were required to have a one-step TB skin test upon admission.<br>-Residents were supposed to get a second step TB skin test within 2 weeks of the first TB skin test.<br>-The Special Care Unit Coordinator (SCC) was responsible for overseeing the TB skin tests for all residents in the facility to make sure the TB skin tests were completed.<br>-The current SCC started in the position about 3 weeks ago.<br>-The Administrator audited resident TB records "a couple of weeks ago" (could not recall exact date) and identified some residents did not have two step TB skin tests on file.<br>-She had ordered TB serum and they currently have it on hand.<br>-A facility nurse would be place TB skin tests on 06/25/19 for the residents who needed them.<br>-The goal was to have all the TB skin test placed and read by 06/30/19. | D 234 | | |
| D 310 | 10A NCAC 13F .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Adult Care Homes:<br>(4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. | D 310 | | |

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| D 310 | Continued From page 35<br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 sampled resident (#5) was served nectar thickened liquids as ordered.<br><br>The findings are:<br><br>Review of Resident #5's FL-2 dated 05/13/19 on 06/19/19 at 12:49pm revealed:<br>-Diagnoses included Alzheimer's disease and severe neuro-cognitive disorder with behavioral disturbances.<br>-His level of care was placed for the Special Care Unit (SCU).<br><br>Review of a diet order dated 03/28/19 on 06/19/19 at 12:49pm revealed Resident #5 was to receive nectar thickened liquids.<br><br>Review of the facility's therapeutic diet list posted in the kitchen on 06/19/19 at 10:40am revealed:<br>-Resident #5 was supposed to have thickened liquids but the consistency was not specified.<br>-The therapeutic diet list was last updated on 06/17/19.<br><br>Interview with the dietary manager on 06/19/19 at 10:42am revealed:<br>-Resident #5 was supposed to have thickened liquids but she did not know what the consistencies was supposed to be.<br>-The medication aides were responsible to put the thickener in any liquids Resident #5 drank.<br><br>Interview with the Administrator on 06/19/19 at 1:15pm revealed:<br>-She believed Resident #5 was supposed to have his liquids thickened to nectar thickened consistency. | D 310 | | |

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-She did not know the order for nectar consistency was not listed on Resident #5's FL-2.
-She thought the dietary order dated 03/28/19 was sufficient since it was less than a year old.
-She would contact Resident #5's primary care provider care for an updated dietary order.

Telephone interview with Resident #5's primary care provider on 06/20/19 at 11:23am revealed Resident #5 required nectar-thickened liquids due to a history of swallowing problems.

Review of Resident #5's medication administration records (MARs) for April, May, and June 2019 revealed:
-There was computer generated entries for thickening powder to be given with meals at nectar consistency scheduled at 8:00am, 12:00pm, and 5:00pm (Thickening powder used for patients who have trouble swallowing thin liquids to help prevent aspirating.).
-Resident #5's thickening powder was documented as administered by the initials of the medication aide.

Observation of Resident #5 during the lunch meal service on 06/19/19 from 11:20am to 11:39am revealed:
-Resident #5 was sitting at the dining room table in the SCU and was served initially an eight-ounce glass of iced tea and an eight-ounce glass of ice water by the SCU staff.
-Neither the iced tea nor the ice water had been thickened to nectar-thick consistency.
-A personal care aide (PCA) removed the glasses of iced tea and ice water and took them back to the kitchen.
-The PCA returned from the kitchen and brought Resident #5 an eight-ounce glass of tea and an eight-ounce glass of water.

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-The PCA also had a container of an instant food and beverage thickener in her hand.
-The PCA used the teaspoon from Resident #5's table setting and mixed two teaspoons each in the eight-ounce glass of tea and the eight-ounce glass of water she served to Resident #5.
-Mixing instructions for the instant food and beverage thickener for nectar consistency were to "mix two tablespoons of thickener with eight-ounces of fluid using the enclosed scoop for level measuring".
-The mixtures in both glasses was thin and watery and not nectar-thick consistency.
-Resident #5 drank all the tea and all the water without any problems with swallowing or coughing noted.
-The medication aide did not mix Resident #5's thickener for any of the liquids that Resident #5 was served during his lunch meal.

Interview with the PCA on 06/19/19 at 11:25am revealed:
-She had been taught to mix Resident #5's liquids with two teaspoons of thickener because Resident #5 needed his liquids to be at nectar-thick consistency.
-She could not remember who trained her to mix the Resident #5's thickener or when she had received the training.
-She did not report mixing Resident #5's thickener in his liquids to the medication aide.
-She was not sure who was responsible for mixing Resident #5's thickener with his liquids.
-She knew Resident #5 needed thickener in his liquids because he had swallowing problems.

Interview with a medication aide (MA) on 06/20/19 at 10:10am revealed:
-She was the MA who worked the 7:00am to 3:00pm shift in the SCU on 06/19/19.

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| D 310 | Continued From page 38<br>-Resident #5 had Thick-It liquid and Thick-It powder on the medication cart.<br>-She only gave Resident #5 his thickened liquids when she gave his medications.<br>-She did not make sure Resident #5 received his thickened liquids with meals.<br>-She thought Resident #5 was getting his thickened liquids from the dietary staff in the kitchen,<br>-She did not know if any of the PCAs had been trained to mix thickened liquids.<br><br>Interview with four PCAs in the SCU on 06/19/19 at 5:55pm revealed none of the PCAs knew Resident #5 was supposed to have nectar-thickened liquids with his meals.<br><br>Interview with the Special Care Unit Care Coordinator (SCC) on 06/19/19 at 6:05 revealed:<br>-He was sure who was responsible to ensure Resident #5 received his nectar-thickened liquids.<br>-He had only been the SCC for about 3 weeks.<br><br>Interview with the Administrator on 06/19/19 at 6:20pm revealed:<br>-She did not know Resident #5 was not receiving his nectar-thickened liquids as ordered.<br>-None of the PCAs had been trained to mix thickened liquids for the residents.<br>-It was her expectation for the medication aides to mix Resident #5's thickened liquids because they were responsible to document the Thick-It administration on the MAR.<br>-It was not the responsible of the dietary staff to mix Resident #5 thickener in his liquids.<br><br>Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. | D 310 | | |

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| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents (#9, #10) observed during the medication passes including errors with insulin for both residents; and for 1 of 5 residents sampled (#1) for record review including errors with medications to prevent blood clots and heart disease, for iron deficiency anemia, heart/blood pressure, high cholesterol, gout, and Alzheimer's dementia.<br><br>The findings are:<br><br>1. The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 | D 358 | | |

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| D 358 | Continued From page 40<br>opportunities during the 8:00am/9:00am and the 11:30am/12:00pm medication passes on 06/19/19.<br><br>a. Review of Resident #10's current FL-2 dated 09/05/18 revealed diagnoses included dementia, hypertension, diabetes mellitus type 2, chronic kidney disease, obesity, history of recurrent urinary tract infections and incontinence.<br><br>Review of Resident #10's physician order dated 06/12/19 revealed an order for Humalog KwikPen 28 units subcutaneous three times a day with meals. (Humalog is a fast-acting insulin used to lower blood sugar. According to the manufacturer, the Humalog KwikPen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)<br><br>Review of Resident #10's June 2019 electronic medication administration record (e-MAR) revealed:<br>-There was an entry to check the resident's blood sugar before meals and at bedtime.<br>-There was an entry to administer Humalog KwikPen 28 units subcutaneously 3 times a day with meals (Prime pen with 2 units prior to each use- pen expires in 28 days).<br>-Humalog was scheduled to be administered at 8:00am, 11:30am and 5:30pm.<br>-The resident's blood sugar ranged from 145 - 420 from 06/01/19 to 06/19/19.<br><br>Observation of the 11:30am medication pass on 06/19/19 revealed:<br>-Resident #10's blood sugar was 255.<br>-The medication aide (MA) did not perform a 2-unit air shot prior to dialing up the 28 units of Humalog for administration. | D 358 | | |

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-The MA administered the 28 units of Humalog to Resident #10's right upper arm at 11:36am.

Interview with the MA on 06/19/19 at 1:51pm revealed:
-The Licensed Health Professional Support (LHPS) nurse did the training on the insulin pens.
-She was taught to prime the insulin pen before the first-time use.
-She was taught to turn the dial to 1 or 2 units to prime the pen before each use.
-She usually primed the pen before each use with 1 unit to make sure bubbles and air were out before administering the insulin.
-She forgot to prime the Humalog KwikPen for Resident #10 that morning during the 11:30am medication pass.

Interview with Resident #10 on 06/19/19 at 4:25pm revealed:
-She received insulin every day.
-She did not know how the MA prepared the insulin to be administered.

Interview with the Administrator on 06/19/19 at 2:39pm revealed:
-The LHPS nurse did the training on the insulin pens.
-The LHPS nurse taught the MAs to dial up 2 units and perform an air shot before each injection.
-They last had diabetic training on 06/05/19.

Interview with the LHPS nurse on 06/21/19 at 10:42 revealed she did a diabetic class on 06/05/19 at the facility.

b. Review of Resident #9's current FL-2 dated 03/14/19 revealed diagnoses of dementia, advanced degenerative joint disease of

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| D 358 | Continued From page 42<br>shoulders, diabetes mellitus 2, edema, right hip pain, and vertigo.<br><br>Review of Resident #9's physician order dated 04/24/19 revealed an order to check fingerstick blood sugars (FSBS) before meals and bedtime.<br><br>Review of Resident #9's physician order dated 05/22/19 revealed an order for Novolog FlexPen 8 units subcutaneous 3 times a day after meals. (Hold if FSBS is less than (<) 100 and eats < 50 % of meal.) (Novolog is a rapid-acting insulin used to lower blood sugar.)<br><br>Review of Resident #9's June 2019 electronic medication administration record (e-MAR) revealed:<br>-There was an entry to check the resident's blood sugar before meals and at bedtime.<br>-There was an entry to administer Novolog FlexPen inject 8 units subcutaneous 3 times a day after meals (Hold if FSBS < 100 and eats < 50% of meal).<br>-Novolog was scheduled to be administered at 7:30am, 11:30am, and 5:30pm.<br>-The resident's blood sugars ranged from 62 - 295 from 06/01/19 to 06/19/19.<br>-There was no documentation on the e-MAR regarding the percentage of meals eaten.<br><br>Observation of the 11:30am medication pass on 06/19/19 revealed:<br>-Resident #9's FSBS was 68 at 10:58am.<br>-The medication aide (MA) did not administer any Novolog insulin.<br>-The MA documented the insulin was held due to FSBS being < 100.<br>-The resident had not eaten lunch because it had not been served. | D 358 | | |

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| D 358 | Continued From page 43<br><br>Observation of the lunch meal on 06/19/19 from 11:35am - 12:01pm revealed:<br>-Resident #9 ate approximately 75% of her lunch meal.<br>-Resident #9 ate ½ of the hamburger steak, ½ of the zucchini, all of the pineapple, all of the mashed potatoes, all 4 of the hushpuppies, and drank all of the tea and water.<br><br>Interview with the MA on 06/19/19 at 1:25pm revealed:<br>-She held Resident #9's Novolog for any blood sugar < 100.<br>- Even if Resident #9 ate greater than (>)50% she would still hold the Novolog insulin if the FSBS was < 100.<br>-She had not noticed the order was to hold the insulin if FSBS was < 100 and if the resident ate < 50%.<br>-She thought if the FSBS was < 100 it did not matter how much the resident ate.<br>-She did not always see how much Resident #9 ate at meals.<br>-Sometimes the personal care aides (PCAs) would tell her how much the resident ate.<br>-Staff did not document how much of each meal Resident #9 ate.<br><br>Interview with a PCA on 06/19/19 at 1:45pm revealed:<br>-If any resident did not eat, the PCAs reported it to the MA.<br>-She did not report how much any resident ate to the MA unless a resident did not eat any of their meal.<br>-She did not document how much any resident ate for any meal.<br><br>Telephone interview with Resident #9's primary care provider (PCP) on 06/19/19 at 2:02pm | D 358 | | |

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| D 358 | Continued From page 44<br>revealed:<br>-The order for Resident #9 was for staff to check the resident's blood sugar before meals.<br>-If the resident's blood sugar was < 100 and if the resident ate < 50% of the meal, then staff was supposed to hold the insulin.<br>-Staff would have to monitor how much the resident ate at each meal to determine if the resident's Novolog insulin should be administered after meal as ordered.<br>-Since the resident's blood sugar was < 100 before lunch that day (06/19/19) but the resident ate > 50% of her lunch meal, the resident should have received Novolog after she ate the lunch meal.<br>-The resident would have to meet both criteria in order for the insulin to be held according to the order.<br>-She just saw the resident for a visit that day (09/19/19) and she would be decreasing the resident's insulin dosage because the resident was having some low blood sugars.<br><br>Interview with the Administrator on 06/19/19 at 2:39pm revealed:<br>-The MAs would need to monitor how much Resident #9 ate at meals to help determine if the resident's insulin should be held or administered.<br>-There should be somewhere to document the resident's meal consumption on the e-MARs.<br><br>2. Review of Resident #1's current FL-2 dated 01/18/19 revealed diagnoses included dementia, atrial fibrillation, anemia, diabetes mellitus type II, gout, pedal edema, and long-term use of anti-coagulant.<br><br>a. Review of Resident #1's current FL-2 dated 01/18/19 revealed:<br>-There was an order for Eliquis 5mg twice daily. | D 358 | | |

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| D 358 | Continued From page 45<br>(Eliquis is a blood thinner used to prevent blood clots.)<br>-There was an order for Ferrous Sulfate 220mg/5ml take 5ml twice a day. (Ferrous Sulfate is used to treat iron deficiency anemia.)<br><br>Review of Resident #1's April 2019 electronic medication administration record (e-MAR) revealed:<br>-There was an entry for Ferrous Sulfate 220mg/5ml take 5ml twice a day and it was scheduled for administration at 8:00am and 8:00pm.<br>-Ferrous Sulfate was not documented as administered on 04/28/19 at 8:00pm due to family ordered.<br><br>Review of Resident #1's May 2019 e-MAR revealed:<br>-There was an entry for Eliquis 5mg take 1 tablet every 12 hours and it was scheduled for administration at 8:00am and 8:00pm.<br>-Eliquis was not documented as administered on 05/10/19 at 8:00am due to awaiting for family to bring.<br>-There was an entry for Ferrous Sulfate 220mg/5ml take 5ml twice a day and it was scheduled for administration at 8:00am and 8:00pm.<br>-Ferrous Sulfate was not documented as administered from 8:00pm on 05/02/19 - 8:00am on 05/07/19 and on 05/08/19 at 8:00am due to family ordered medication, waiting on family to bring in medication.<br><br>Review of Resident #1's June 2019 e-MAR revealed:<br>-There was an entry for Ferrous Sulfate 220mg/5ml take 5ml twice a day and it was scheduled for administration at 8:00am and | D 358 | | |

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| D 358 | Continued From page 46<br>8:00pm.<br>-Ferrous Sulfate was not documented as administered from 8:00am on 06/16/19 - 8:00am on 06/17/19 and on 06/18/19 at 8:00am due to waiting on family to bring meds.<br><br>Review of Resident #1's care notes revealed:<br>-04/23/19: Resident's family member was called regarding refills on medication. The family member stated she would bring some of the medications tomorrow (04/24/19) or Thursday (04/25/19) but she would have to order others. (The note did not specify names of any medications.)<br>-04/30/19: Phone call made to resident's family member that resident needed refill on Ferrous Sulfate and that she needed to bring it with the rest of the medications that were previously called about.<br>-04/30/19 (2:53pm): Resident's family member called back concerning Ferrous Sulfate and stated she previously spoke with a supervisor who had requested the family member bring the Ferrous Sulfate due to it was getting low. Staff told the family member this was another reminder call.<br>-05/03/19: Ferrous Sulfate liquid, waiting for resident's family member to bring in.<br>-05/06/19: Ferrous Sulfate liquid, waiting for resident's family member to bring in. Family member stated she ordered it and was just waiting for it to come in the mail.<br>-05/07/19: Ferrous Sulfate not given, waiting for resident's family member to bring it.<br>-05/08/19: Ferrous Sulfate, waiting for resident's family member to bring in medication. The family member stated as soon as it came through the mail, she would bring it in.<br>-05/09/19: Spoke with resident about his Eliquis and told resident to call his family member | D 358 | | |

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because he was running low on Eliquis. Resident stated he would.
-05/10/19: The resident's family member was notified this morning about his Eliquis. The family member stated she had a bottle and she would drop it off later this afternoon. The resident missed his morning dose of Eliquis.
-05/10/19 (12:35pm): The resident's family member dropped off 1 unopened bottle of Eliquis.
-06/16/19: The resident is out of Ferrous Sulfate, waiting for the resident's family member to bring it in.
-06/17/19: The resident did not receive Ferrous Sulfate, waiting for the resident's family member to bring it in.
06/18/19: The resident did not receive Ferrous Sulfate, waiting for the resident's family member to bring it in.
06/18/19: Spoke with a nurse at the resident's doctor office and informed her this was the third day the resident had been without his Ferrous Sulfate and the family member had been informed to bring it to the facility. Nurse stated that "it was fine and thanks for informing".
-06/18/19: Phone call was made to the resident's family member concerning the Ferrous Sulfate; a voicemail was left.
-06/13/19 (late entry): Spoke with the resident's family member to make sure she ordered his Ferrous Sulfate.

Interview with a medication aide (MA) on 06/19/19 at 11:13am revealed:
-Resident #1's family member ordered and brought the resident's medications to the facility.
-The family member would order the medications once the MAs let the family member know they were needed.
-The MAs usually let the family member know to order the medications when there was a two

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| D 358 | Continued From page 48 | D 358 | | |

week supply remaining.
-It usually took about one week for the family member to get the medications and bring them to the facility.
-The resident recently ran out of his Ferrous Sulfate liquid for 3 days (referring to 06/16/19 - 06/18/19) and that had happened more than once with the Ferrous Sulfate.
-She notified the resident's primary care provider's (PCP) office about the resident running out of Ferrous Sulfate in June 2019 but she was not sure if the PCP was notified the other times the resident ran out.
-They facility had a back-up pharmacy but they did not use it for Resident #1 because the resident's family member had told them not to use it.
-She remembered Resident #1's Eliquis running low but she did not recall the resident running out of it.

Interview with a second MA on 06/20/19 at 4:55pm revealed:
-Resident #1's family member ordered and brought all of his medications to the facility.
-If they got down to 15 pills of any of his medications, she would let the resident's family member know.
-Staff should document in the care notes when the family was contacted to bring the resident's medications.
-Every so often, the resident might have one medication the family had not brought and he runs out of so the facility would call the back-up pharmacy.
-If the resident missed 3 days of his medications, she would call the PCP to let them know.

Interviews with Resident #1's family member on 06/19/19 at 4:25pm and 06/21/19 at 10:05am

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| D 358 | Continued From page 49<br>revealed:<br>-She ordered the residents' medications and received them from a mail order pharmacy.<br>-She would bring the resident's medications to the facility.<br>-Most of the time, the facility staff called her in time for her to order refills on medications before they ran out.<br>-The facility had used their back-up pharmacy a couple of times when the facility staff did not let her know in time and the medication ran out.<br>-She was billed by the back-up pharmacy and she had told the facility not to use the back-up pharmacy.<br>-Resident #1 only missed 1 dose of Eliquis to her knowledge.<br>-The resident missed the dose of Eliquis on a Friday in May 2019.<br>-She was notified by the facility last Thursday, 06/13/19, that the resident had a couple days supply left of the Ferrous Sulfate.<br>-She brought the Ferrous Sulfate to the facility on Tuesday, 06/18/19.<br>-With enough notice, she could get the medications from the resident's pharmacy.<br><br>Interview with the Administrator on 06/20/19 at 2:06pm revealed:<br>-Resident #1's family member ordered his medications.<br>-The facility gave a two weeks notice (when there was a two week supply remaining) to the resident's family member.<br>-The resident's family member was good about getting the medications to the facility but sometimes there was a delay on the mail order shipment.<br>-The resident's family member would not let the facility get any medications from the back-up pharmacy for the resident. | D 358 | | |

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| D 358 | Continued From page 50<br>-They did not document the quantity of medications brought in by the resident's family.<br>-They documented in the care notes the medications were brought in, but the documentation may not be specific to the medications.<br>-They did not order medications from the back-up pharmacy if the resident ran out; they just called the PCP.<br><br>Telephone interview with Resident #1's PCP on 06/20/19 at 2:35pm revealed:<br>-She did not recall being notified of Resident #1 missing any doses of medications, including Eliquis or Ferrous Sulfate, and she did not see a note in the resident's record.<br>-The facility should notify them if the resident was out of medications and needed refills.<br>-She was not concerned about the resident missing doses of the Ferrous Sulfate because his last hemoglobin had improved.<br>-The PCP did not voice a concern for the one missed dose of Eliquis.<br><br>b. Review of Resident #1's physician's order sheet dated 05/30/19 revealed:<br>-There was an order for Metoprolol 25mg twice a day. (Metoprolol is for heart / blood pressure.)<br>-There was an order for Zocor 40mg take ½ tablet at bedtime. (Zocor lowers cholesterol.)<br>-There was an order for Allopurinol 100mg twice a day. (Allopurinol is for gout.)<br>-There was an order for Aspirin 81mg 1 tablet at bedtime. (Aspirin is for prevention of heart disease.)<br>-There was an order for Aricept 10mg at bedtime. (Aricept is for Alzheimer's dementia.)<br>-There was an order for Eliquis 5mg every 12 hours. (Eliquis is a blood thinner used to prevent blood clots.) | D 358 | | |

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| D 358 | Continued From page 51<br><br>Review of Resident #1's care note dated 03/23/19 revealed:<br>-The resident refused his Aspirin and Eliquis.<br>-The medication aide (MA) tried several attempts to administer the medications.<br>-The resident stated he needed to show his family member the two pills he was receiving.<br>-The MA stated he needed to take the medications where the MA could see him take the meds.<br>-The resident refused the medications; MA offered again but the resident still refused so the medications were discarded.<br>-The resident then called his family member.<br>-The MA spoke with the family member about the medications and how the MA kept trying to administer them.<br>-The family member asked the MA over and over to tell her what medications were not administered.<br>-The MA told the family member numerous times over the phone the two medications.<br>-The MA stated she would document in the electronic medication administration record (e-MAR) the medications that were refused.<br><br>Interview with Resident #1's family member on 06/19/19 at 4:25pm revealed:<br>-There was a problem with the administration of Resident #1's medication on 03/23/19.<br>-She got a call from the resident on 03/23/19 at 7:37pm.<br>-The resident told her that the MA threw his pills away.<br>-The family member came to the facility to talk with the resident and the MA that night.<br>-The MA told the family member that she did not have to tell the family member anything.<br>-The resident had received a medication cup with | D 358 | | |

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| D 358 | Continued From page 52 | D 358 | | |

two pills that night.
-The resident had questioned the MA about the number of pills in the cup because there should have been 6 pills in the cup.
-The MA threw the pills in the trash.
-She had a meeting with the Administrator on 03/29/19 about the incident with the resident's medications on 03/23/19.
-The Administrator was told by the MA that the family member wanted to get into the medication cart to see which medications the resident missed.
-She was unable to determine which medications the resident missed on 03/23/19.

Interview with Resident #1 on 06/20/19 at 1:35pm revealed:
-There were 3 pills in the medication cup (referring to 03/23/19).
-There were supposed to be 6 pills in the cup.
-He told the MA and showed her the list of medications he kept in his room.
-The MA would not listen to him and she threw the pills away.

Review of Resident #1's March 2019 e-MAR revealed:
-There were 6 oral pills scheduled to be administered to the resident at either 8:00pm or 9:00pm.
-The medications included: Allopurinol at 9:00pm, Aspirin at 9:00pm, Aricept at 9:00pm, Eliquis at 8:00pm, Metoprolol at 9:00pm, and Zocor at 9:00pm.
-All of these medications were documented as administered on the night of 03/23/19 at their scheduled times except Aspirin which was documented that it was not administered.
-There was no reason documented for the missed dose of Aspirin.

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| D 358 | Continued From page 53<br>-No medications were documented as refused at 8:00pm/9:00pm on 03/23/19.<br><br>Interview with the MA on 06/20/19 at 4:55pm revealed:<br>-She was the Resident Care Coordinator (RCC) on 03/23/19 when she had to administer medications because the facility was short staffed.<br>-Resident #1 was not familiar with her at that time because she did not usually administer the resident's medications.<br>-She was administering 8:00pm/9:00pm medications when the resident refused his Zocor and Aspirin.<br>-There were 4 pills in the cup that she had prepared and the resident was at the medication cart in the hallway.<br>-The resident questioned 2 of the pills in the cup and said they were not his pills.<br>-She checked the e-MARs and told the resident that it was his pills.<br>-She tried to redirect the resident to take the pills but he refused over and over.<br>-She wasted the pills because the resident refused to take them.<br>-This occurred sometime between 7:00pm - 9:00pm on 03/23/19.<br>-The resident's family member came to the facility after 10:00pm on 03/23/19 but the MA had already wasted the pills and it was beyond the timeframe that the MA could administer the pills.<br>-The resident refused Aspirin and Eliquis on 03/23/19 instead of Aspirin and Zocor (changing her previous statement).<br>-When asked why there were 4 pills in the cup but 6 pills were scheduled to be administered at 8:00pm/9:00pm, the MA could not explain.<br>-The MA stated she was running late with administering medications that night on 03/23/19. | D 358 | | |

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| D 358 | Continued From page 54<br><br>-She could not say which medications the resident actually took that night on 03/23/19 but she knew the resident did not receive 6 pills.<br>-She could not explain why she documented the medications as administered on the e-MAR and why she did not document which two pills were refused on the night of 03/23/19.<br><br>Interview with the Administrator on 06/21/19 at 5:14pm revealed:<br>-On 03/23/19, the MA documented the resident did not get his medications that night because he refused because the count was off.<br>-She knew the resident did not receive some of his medication that night but she could not recall what medications the resident did not receive.<br>-She was not aware of the incident with Resident #1's medications on 03/23/19 being reported to the primary care provider (PCP).<br><br>Telephone interview with Resident #1's PCP on 06/20/19 at 2:35pm revealed she did not recall being notified of Resident #1 missing any doses of medications and she did not see a note in the resident's record. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment; | D 367 | | |

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| D 367 | Continued From page 55<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 5 residents sampled (#1, #5) including inaccurate documentation of medications to prevent blood clots and heart disease, for iron deficiency anemia, heart/blood pressure, high cholesterol, gout, and Alzheimer's dementia (#1); and inaccurate documentation for a resident who did not receive nectar thickened liquids as ordered (#5).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 01/18/19 revealed diagnoses included dementia, atrial fibrillation, anemia, diabetes mellitus type II, gout, pedal edema, and long-term use of anti-coagulant. | D 367 | | |

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| D 367 | Continued From page 56<br><br>Review of Resident #1's physician's order sheet dated 05/30/19 revealed:<br>-There was an order for Metoprolol 25mg twice a day. (Metoprolol is for heart / blood pressure.)<br>-There was an order for Zocor 40mg take ½ tablet at bedtime. (Zocor lowers cholesterol.)<br>-There was an order for Allopurinol 100mg twice a day. (Allopurinol is for gout.)<br>-There was an order for Aspirin 81mg 1 tablet at bedtime. (Aspirin is for prevention of heart disease.)<br>-There was an order for Aricept 10mg at bedtime. (Aricept is for Alzheimer's dementia.)<br>-There was an order for Eliquis 5mg every 12 hours. (Eliquis is a blood thinner used to prevent blood clots.)<br><br>Review of Resident #1's care note dated 03/23/19 revealed:<br>-The resident refused his Aspirin and Eliquis.<br>-The medication aide (MA) tried several attempts to administer the medications.<br>-The resident stated he needed to show his family member the two pills he was receiving.<br>-The MA stated he needed to take the medications where the MA could see him take the meds.<br>-The resident refused the medications; MA offered again but the resident still refused so the medications were discarded.<br>-The resident then called his family member.<br>-The MA spoke with the family member about the medications and how the MA kept trying to administer them.<br>-The family member asked the MA over and over to tell her what medications were not administered.<br>-The MA told the family member numerous times over the phone the two medications.<br>-The MA stated she would document in the | D 367 | | |

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| D 367 | Continued From page 57<br>electronic medication administration record (e-MAR) the medications that were refused.<br><br>Interview with Resident #1's family member on 06/19/19 at 4:25pm revealed:<br>-There was a problem with the administration of Resident #1's medication on 03/23/19.<br>-She got a call from the resident on 03/23/19 at 7:37pm.<br>-The resident told her that the MA threw his pills away.<br>-The family member came to the facility to talk with the resident and the MA that night.<br>-The MA told the family member that she did not have to tell the family member anything.<br>-The resident had received a medication cup with two pills that night.<br>-The resident had questioned the MA about the number of pills in the cup because there should have been 6 pills in the cup.<br>-The MA threw the pills in the trash.<br>-She had a meeting with the Administrator on 03/29/19 about the incident with the resident's medications on 03/23/19.<br>-The Administrator was told by the MA that the family member wanted to get into the medication cart to see which medications the resident missed.<br>-She was unable to determine which medications the resident missed on 03/23/19.<br><br>Interview with Resident #1 on 06/20/19 at 1:35pm revealed:<br>-There were 3 pills in the medication cup (referring to 03/23/19).<br>-There were supposed to be 6 pills in the cup.<br>-He told the MA and showed her the list of medications he kept in his room.<br>-The MA would not listen to him and she threw the pills away. | D 367 | | |

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| D 367 | Continued From page 58<br><br>Review of Resident #1's March 2019 (e-MAR) revealed:<br>-There were 6 oral pills scheduled to be administered to the resident at either 8:00pm or 9:00pm.<br>-The medications included: Allopurinol at 9:00pm, Aspirin at 9:00pm, Aricept at 9:00pm, Eliquis at 8:00pm, Metoprolol at 9:00pm, and Zocor at 9:00pm.<br>-All of these medications were documented as administered on the night of 03/23/19 at their scheduled times except Aspirin which was not documented as administered.<br>-There was no reason documented for the missed dose of Aspirin.<br>-No medications were documented as refused at 8:00pm/9:00pm on 03/23/19.<br><br>Interview with the MA on 06/20/19 at 4:55pm revealed:<br>-She was the Resident Care Coordinator (RCC) on 03/23/19 when she had to administer medications because the facility was short staffed.<br>-Resident #1 was not familiar with her at that time because she did not usually administer the resident's medications.<br>-She was administering 8:00pm/9:00pm medications when the resident refused his Zocor and Aspirin.<br>-There were 4 pills in the cup that she had prepared and the resident was at the medication cart in the hallway.<br>-The resident questioned 2 of the pills in the cup and said they were not his pills.<br>-She checked the e-MARs and told the resident that it was his pills.<br>-She tried to redirect the resident to take the two pills but he refused over and over. | D 367 | | |

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| D 367 | Continued From page 59<br>-She wasted the two pills because the resident refused to take them.<br>-This occurred sometime between 7:00pm - 9:00pm on 03/23/19.<br>-The resident refused Aspirin and Eliquis on 03/23/19 instead of Aspirin and Zocor (changing her previous statement).<br>-When asked why there were 4 pills in the cup but 6 pills were scheduled to be administered at 8:00pm/9:00pm, the MA could not explain.<br>-She was running late with administering medications that night on 03/23/19.<br>-She could not say which medications the resident actually took that night on 03/23/19 but she knew the resident did not receive 6 pills.<br>-She could not explain why she documented the medications as administered on the e-MAR and why she did not document which two pills were refused on the night of 03/23/19.<br><br>Interview with the Administrator on 06/21/19 at 5:14pm revealed:<br>-If the resident refused medication, it should be documented on the e-MAR as refused in the comment section.<br>-The MAs should not click the medications as administered on the e-MAR if they were not administered.<br>-Documentation on the e-MAR should be accurate.<br><br>2. Review of Resident #5's FL-2 dated 05/13/19 revealed:<br>-Diagnoses included Alzheimer's disease and severe neuro-cognitive disorder with behavioral disturbances.<br>-His level of care was documented as the Special Care Unit (SCU).<br><br>Review of a diet order dated 03/28/19 revealed | D 367 | | |

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| D 367 | Continued From page 60<br>Resident #5 was to receive nectar thickened liquids.<br><br>Review of the therapeutic diet list posted in the kitchen on 06/19/19 at 10:40am revealed:<br>-Resident #5 was supposed to have thickened liquids but the consistency was not specified.<br>-The therapeutic diet list was last updated on 06/17/19.<br><br>Interview with the Administrator on 06/19/19 at 1:15pm revealed:<br>-She believed Resident #5 was supposed to have his liquids thickened to nectar thickened consistency.<br>-She did not know the order for nectar consistency was not listed on Resident #5's FL-2.<br>-She thought the dietary order dated 03/28/19 was sufficient since it was less than a year old.<br>-She would contact Resident #5's primary care provider care for an updated dietary order.<br><br>Telephone interview with Resident #5's primary care provider on 06/20/19 at 11:23am revealed Resident #5 required nectar-thickened liquids due to a history of swallowing problems.<br><br>Review of Resident #5's electronic medication administration records (e-MARs) for April, May, and June 2019 revealed:<br>-There was computer generated entries for thickening powder to be given with meals at nectar consistency scheduled at 8:00am, 12:00pm, and 5:00pm (Commercial thickening powder is used for patients who have trouble swallowing thin liquids to help prevent aspirating).<br>-Resident #5's thickening powder was documented as prepared by the initials of the medication aide (MA). | D 367 | | |

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| D 367 | Continued From page 61<br><br>Observation of Resident #5 during the lunch meal service on 06/19/19 from 11:20am to 11:39am revealed:<br>-Resident #5 was served his thickened liquids by a personal care aide (PCA).<br>-The PCA used a teaspoon from Resident #5's table setting and mixed two teaspoons each of an instant food and beverage thickener to Resident #5's eight-ounce glass of tea and eight-ounce glass of water.<br>-Mixing instructions for the instant food and beverage thickener for nectar consistency were to "mix two tablespoons of thickener with eight-ounces of fluid using the enclosed scoop for level measuring".<br>-The mixtures in both glasses were thin and watery and not nectar-thick consistency.<br>-Resident #5 drank all the tea and all the water without difficulty or coughing noted.<br>-The MA was not present in the SCU dining room area and did not mix Resident #5's thickener for Resident #5's liquids served during his lunch meal.<br><br>Interview with a MA on 06/20/19 at 10:10am revealed:<br>-She was the MA who worked the 7:00am to 3:00pm shift in the SCU on 06/19/19.<br>-Resident #5 had thickening liquid and thickening powder on the medication cart.<br>-She only gave Resident #5 his thickened liquids when she gave his medications.<br>-Resident #5 had oral medications to be administered at daily at 8:00am and 8:00pm.<br>-She did not realize Resident #5 had thickening powder ordered to be prepared at daily 8:00am, 12:00pm, and 8:00pm.<br>-She had been documenting on the Resident #5's e-MAR as preparing the thickening powder at 12:00pm but she did not give Resident #5 his | D 367 | | |

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thickening powder at lunch.
-She thought Resident #5 was getting his thickening powder from the dietary staff in the kitchen and she documented that it was done on e-MAR.

Review of Resident #5's e-MAR for April 2019 revealed the MA documented she prepared thickening powder for Resident #5 at 12:00pm on 04/03/19, 04/04/19, 04/09/19, 04/10/19, 04/11/19, 04/17/19, 04/18/19, 04/21/19, 04/23/19, and 04/25/19.

Review of Resident #5's e-MAR for May 2019 revealed the MA documented she prepared thickening powder for Resident #5 at 12:00pm on 05/01/19, 05/02/19, 05/07/19, 05/08/19, 05/13/19, 05/15/19, 05/16/19, 05/18/19, 05/20/19, 05/21/19, 05/22/19, 05/23/19, 05/28/19, 05/29/19, and 05/30/19.

Review of Resident #5's e-MAR for June 2019 revealed the MA documented she prepared thickening powder for Resident #5 at 12:00pm on 06/01/19, 06/05/19, 06/11/19, 06/12/19, 06/13/19, 06/18/19, and 06/19/19.

Observation of Resident #5 during the dinner meal service on 06/19/19 from 5:35pm to 5:55pm revealed:
-Resident #5 was sitting at the dining room table in the SCU and was served an eight-ounce glass of ice water by a PCA in the SCU dining room.
-Resident #5 did not receive any thickener with his water during the dinner meal.

Review of Resident #5's e-MAR for June 2019 revealed a second MA documented prepared thickening powder for Resident #5 at 5:00pm on 06/19/19.

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| D 367 | Continued From page 63<br><br>Interview with a MA for the SCU on 06/19/19 at 6:15pm revealed:<br>-She used the thickening liquid and thickening powder to give Resident #5 nectar-thickened liquids when she administered his medications.<br>-She thought the dietary staff were supposed to mix Resident #5's thickened liquids for his meals.<br>-She did not verify Resident #5 received his thickened liquids with his dinner on 06/19/19.<br>-She documented it on the Resident #5's e-MAR because she thought it had been done.<br>-She did not know if any of the PCAs were trained to mix thickened liquids for the residents.<br><br>Interview with the Administrator on 06/19/19 at 6:20pm revealed:<br>-She did not know Resident #5 was not receiving his nectar-thickened liquids as ordered.<br>-It was her expectation for the medication aides to mix Resident #5's thickened liquids because they were responsible to document the thickening powder preparation on the e-MAR.<br>-The MAs should not be documenting anything on the e-MAR unless the MA had administered or prepared it. | D 367 | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and | D 375 | | |

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| D 375 | Continued From page 64<br>documented in the resident's record; and<br>(2) specific instructions for administration of prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews, and interviews, the facility failed to assure 3 of 4 residents sampled (#1, #6, #7) who self-administered medications had physicians' orders to self-administer and were competent and physically able to self-administer including a resident with medications for heartburn, constipation, gas and bloating, Vitamin B12 deficiency, dry eyes, allergic rhinitis, inflammatory skin conditions, and pain (#6); a resident with an oral medication for acute chest pains and topical medications for aches and pains, inflammatory skin conditions, fungal infections, dry, scaly, itchy skin, and dandruff (#1); and a resident with a lubricant eye drop for dry eyes and a topical medication for itching (#7).<br><br>The findings are:<br><br>Review of the facility's policy and procedure for resident self-administration of medications revealed:<br>-Resident will be competent and physically able.<br>-Self-administration will be ordered by a physician or other legally authorized person to prescribe and kept in the resident's record.<br>-Specific instructions for administration of the medication will be printed on the label.<br>-All medications will be listed on Self-Administration Form and signed by the physician. | D 375 | | |

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-The physician will be notified if a resident has a change in mental or physical ability or is non-compliant with the physician's orders or facility policies.

1. Review of Resident #6's current FL-2 dated 05/29/19 revealed:
-Diagnoses included diabetes, community acquired pneumonia, and acute on chronic combined systolic/diastolic congestive heart failure.
-There was an order for Acetaminophen 325mg 2 tablets every 6 hours as needed for pain. (Acetaminophen is a pain reliever and fever reducer.)
-There was an order for Triamcinolone 0.5% cream apply a small amount to face once a day as needed for itching/rash, may keep in room. (Triamcinolone is a prescription topical steroid cream used to treat inflammatory skin conditions.)
-There was an order for Artificial Tears 1.4% instill 1 drop in each eye twice a day, may keep at bedside and self-administer. (Artificial Tears is a lubricant eye drop used to treat dry eyes.)

Review of Resident #6's order for self-administration form dated 05/29/19 revealed the primary care provider (PCP) wrote an order to discontinue Triamcinolone 0.5% cream and signed it on 05/29/19.

Review of Resident #6's Resident Register revealed:
-The resident was admitted to the facility on 07/17/17.
-The resident documented as having an adequate memory.
-The resident was documented as requiring assistance with bathing, dressing, and

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| D 375 | Continued From page 66<br>ambulation.<br><br>Review of Resident #6's current assessment and care plan dated 02/20/19 revealed:<br>-The resident was documented as oriented and having adequate memory.<br>-The resident was documented as requiring supervision with eating.<br>-The resident was documented as requiring limited assistance with toileting, ambulation, grooming, and transferring.<br>-The resident was documented as requiring extensive assistance with bathing and dressing.<br><br>Interview with a supervisor/medication aide (MA) on 06/18/19 at 10:42am revealed:<br>-Resident #6 self-administered eye drops as needed (prn).<br>-Resident #6 did not self-administer any other medications.<br><br>Observations of Resident #6's room on 06/18/19 at 12:23pm and 5:39pm revealed:<br>-Resident #6 had several medications on top of a bedside table to the right of the entrance to his bathroom and on top of the built-in chest of drawers in the left corner of the room.<br>-Resident #6 did not have a roommate.<br>-There was a box (24 effervescent tablets size) of Alka Seltzer. (Alka Seltzer is for heartburn and upset stomach.)<br>-There was a large bottle of Gold Bond Medicated Body Lotion. (Gold Bond is a topical medication used to relieve dry, itchy skin).<br>-There were 2 bottles (30 tablets size each) of Beano and one bottle had expired 11/17. (Beano is for gas and bloating.)<br>-There was a jar of Triamcinolone 0.1% cream with an expiration date of 10/23/18.<br>-There was a tube of Hydrocortisone 1% cream. | D 375 | | |

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(Hydrocortisone cream is an over-the-counter topical steroid used to treat inflammatory skin conditions.)
-There was a bottle (2 fluid ounces size) of liquid Vitamin B12 1000mcg drops with an expiration date of 03/19. (Vitamin B12 is a supplement used to treat Vitamin B12 deficiency.)
-There was a bottle of Flonase 50mcg nasal spray that expired 04/18. (Flonase is a steroidal nasal spray used for allergic rhinitis / seasonal allergies.)
-There was a bottle of Similasan homeopathic eye drops that expired 05/15. (Similasan is a homeopathic eye drop used to treat dry eyes.)
-There was a bottle (180 tablets dispensed) of Acetaminophen 325mg tablets.
-There was a bottle of Colace 100mg tablets that expired on 07/13/18. (Colace is a stool softener.)
There as a box (20 softgel size) of Extra Strength Gas-X softtgels. (Gas-X is for gas and bloating.)
-There was a box (24 tablet size) of Ex-lax tablets. (Ex-lax is a laxative.)
-There was a bottle of Milk of Magnesia. (Milk of Magnesia is a laxative and an antacid.)
-There were no Artificial Tears observed in the resident's room.

Interviews with Resident #6 on 06/18/19 at 12:23pm and 5:39pm revealed:
-He kept some medications in his room and self-administered them.
-He did not know how long he had the medications in his room.
-He used the Gold Bond Medicated lotion on his skin when it was itching.
-He took Beano once every 2 days for gas and bloating.
-He could not recall when or how often he used the Triamcinolone 0.1% cream.
-He put Hydrocortisone 1% cream on his legs

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when needed for itching.
-He did not take Vitamin B 12 drops much and he could not recall the last time he took any.
-He did not have any Artificial Tears but his eyes got "scratchy" sometimes.
-He used Similasan eye drops once a week.
-He used the Flonase nasal spray once a week for a runny nose.
-He took Alka Seltzer, Acetaminophen, Gas-X, Ex-lax, Colace, and Milk of Magnesia when he needed them but he could not be specific on the dosage used for either medication.

Review of Resident #6's physician's orders revealed:
-There were no orders for the resident to receive or self-administer Alka Seltzer, Gold Bond Medicated lotion, Beano, Colace, Flonase nasal spray, Hydrocortisone 1% cream, Vitamin B12 drops, Similasan eye drops, Gas-X, Ex-lax, or Milk of Magnesia.
-There was an order dated 05/22/19 to discontinue Triamcinolone 0.1% cream.
-There was no order to self-administer Acetaminophen.

Interview with a second shift MA on 06/18/19 at 5:50pm revealed:
-Resident #6 had some medicated creams in his room at one time but she thought they were taken out of his room about a month ago because they were discontinued.
-She did not think Resident #6 should self-administer his own medications because the resident was forgetful and needed reminders and he was physically weak.
-No one had reported to her that they had seen any medications in Resident #6's room and she had not seen any in his room.
-The resident's family visited at times and may

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have brought some medications to the resident.
-The resident would need physician's orders to self-administer any medications.

Interview with the Administrator on 06/18/19 at 6:00pm revealed:
-She was not aware Resident #6 was keeping and self-administering medications.
-She had asked the resident's family member not to bring medications to the resident.
-The resident would also go out on shopping trips and buy and bring back medications to the facility with him.
-Staff should notify the supervisor on duty or the Administrator if they see any medications in residents' rooms, including Resident #6.

Telephone interview with Resident #6's PCP on 06/19/19 at 2:10pm revealed:
-Resident #6 had orders to self-administer some creams at one time (could not recall dates) but those orders were discontinued because the resident no longer needed the medications.
-The resident had orders to self-administer Artificial Tears and she was "okay" with the resident administering the eye drops since it was Artificial Tears.
-In the past (could not recall date), the resident had self-administered some laxatives without orders to do so.
-She did not believe the resident was "competent" to administer any oral medications due to his cognitive status.

Telephone interview with Resident #6's family member on 06/20/19 at 7:30pm revealed:
-Resident #6 knew he was not supposed to have medications in his room.
-He had told the resident in the past (no date given) that the resident could not keep

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| D 375 | Continued From page 70<br>medications in his room.<br><br>Refer to interviews with the Administrator on 06/18/19 at 6:00pm and 06/19/19 at 8:05am.<br><br>2. Review of Resident #1's current FL-2 dated 01/18/19 revealed:<br>-Diagnoses included dementia, atrial fibrillation, anemia, diabetes mellitus type II, gout, pedal edema, and long-term use of anti-coagulant.<br>-The resident was documented as being intermittently disoriented.<br>-There was an order for Nitroglycerin 0.4mg place 1 tablet under tongue as needed for chest pains every 5 minutes x 3 doses. (Nitroglycerin is used to relieve acute chest pain.)<br>-There was an order for Aspercreme apply to back 3 times a day as needed. (Aspercreme is a topical pain reliever.)<br>-There was an order for Lidex 0.05% apply small amount once a day as needed to legs for itching/stinging, keep in room and self-apply. (Lidex is a topical steroid medication used to treat inflammatory skin conditions.)<br>-There was an order for Nizoral 2%, apply a small amount twice a day as needed for facial dandruff (redness/scaling/itch), self-apply and keep in room. (Nizoral is used to treat topical fungal infections.)<br>-There was an order for Men-Phor apply as needed for sunspots on arms, keep at bedside and self-administer. (Men-Phor is a topical pain reliever and anti-itch lotion.)<br>-There was an order for Sebex shampoo, lather capful into scalp, leave on for 5 minutes then rinse use once a day as needed for dandruff, may keep at bedside and self-administer. (Sebex is medication shampoo used to treat dry, flaky, itching scalp.)<br>-There was an order for Therapeutic shampoo, | D 375 | | |

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| D 375 | Continued From page 71<br>lather capful into scalp, leave on 5 minutes then rinse, use daily as needed for dandruff, self-administer and keep in room. (Therapeutic shampoo is used to treat itchy, flaky scalp.)<br>-There was an order for Triamcinolone cream 0.1% apply daily to legs as needed for skin rash, self-administer and keep in room. (Triamcinolone is a topical steroid cream used to treat inflammatory skin conditions.)<br><br>Review of an "order for self-administration" form for Resident #1 dated 05/30/19 revealed:<br>-There was an order for Aspercreme gel 10%, apply to lower back and shoulders 3 times daily.<br>-There was an order for Nitroglycerin 0.4mg 1 tablet under tongue as needed for chest pain every 5 minutes x 3 doses, call physician if no relief.<br>-There was an order for Lidex cream 0.05% apply small amount once a day as needed to legs for itch/sting, avoid face and groin.<br>-There was an order for Nizoral cream 2%, apply small amount twice a day as needed for facial dandruff, scaling, and itching.<br>-There was an order for Men-Phor lotion apply as needed to sunspots on arms.<br>-There was an order for Sebex shampoo, lather capful into scalp, leave on 5 minutes before rinsing, use once a day for dandruff.<br>-There was an order for Therapeutic shampoo, lather capful into scalp, leave 5 minutes before rinsing, use once a day as needed for dandruff.<br>-There was an order for Triamcinolone cream 0.1% apply to legs as needed for skin rash.<br>-The computer printed note at the bottom of the page indicated if there was a change in competency, physical ability, or if the resident became non-compliant with physician orders, the facility would contact the physician immediately for further direction. | D 375 | | |

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| D 375 | Continued From page 72<br><br>Review of Resident #1's Resident Register revealed:<br>-The resident was admitted to the facility on 09/25/17.<br>-The resident was documented as being forgetful and needing reminders.<br>-The resident was documented as requiring assistance with scheduling appointments and orientation to time and place.<br><br>Review of Resident #1's current assessment and care plan dated 03/21/19 revealed:<br>-The resident was documented as oriented but forgetful and needed reminders.<br>-The resident was documented as requiring supervision with eating, toileting, ambulation, bathing, dressing, and grooming.<br>-The resident was documented as independent with transferring.<br><br>Observations of Resident #1's room on 06/20/19 at 1:35pm and 06/21/19 at 9:25am revealed:<br>-Resident #1 had medications on top of a table beside his recliner and on shelves above the toilet in his bathroom.<br>-Resident #1 did not have a roommate.<br>-The resident had a bottle of Nitroglycerin 0.4mg tablets in the manufacturer container that he kept in his pants pocket.<br>-There was no prescription label on the Nitroglycerin bottle and the manufacturer's expiration date was faded and not legible.<br>-The bottle appeared to have been opened because there was no cotton filler inside the bottle.<br>-There was a bottle of Aspercreme lotion, a tube of Diphenhydramine cream, and a tube of Nizoral cream on the shelves above his toilet.<br>-There were 2 bottles of Men-Phor lotion on the | D 375 | | |

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table beside his recliner.
-There was no Lidex cream, Sebex shampoo, Therapeutic shampoo, or Triamcinolone cream observed in the resident's room.

Interviews with Resident #1 on 06/20/19 at 1:35pm and 06/21/19 at 9:25am revealed:
-He kept some medications in his room and self-administered them.
-He had the bottle of Nitroglycerin about 1 and ½ years.
-The Nitroglycerin bottle had been opened but he had not used any recently.
-He used the Aspercreme on his lower back and shoulder.
-He did not use the Diphenhydramine cream.
-He used the Nizoral cream on his face once a day.
-He used the Men-Phor lotion on his arms; he would use the second bottle after he finished using the first bottle.
-The resident did not have any other medications in his room.
-He did not know if he was supposed to use any medicated shampoos.
-The resident stated he had memory problems.

Review of Resident #1's physician's orders revealed there was no order for the resident to receive or self-administer Diphenhydramine cream.

Interview with a supervisor/medication aide (MA) on 06/21/19 at 1:53pm revealed:
-Resident #1 self-administered topical medications and Nitroglycerin tablets.
-She gave the resident a bottle of Nitroglycerin about a month ago to keep in his room.
-She opened the bottle of Nitroglycerin and took the cotton filling out before she gave it to the

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resident because the resident told her could not get a pill out of the bottle if the cotton was in the way.
-The resident did not have any Nitroglycerin in the facility's back up supply of medication.
-She thought the resident did "okay" with self-administering his topical medications.
-She last checked on the resident's self-administration medications about 3 weeks ago but she did not document it.
-She did not remember seeing any Diphenhydramine cream in the resident's room.
-She did not know Resident #1 did not have all of the medications he was supposed to self-administer in his room.

Interview with the Administrator on 06/21/19 at 5:14pm revealed:
-Resident #1 only self-administered Aspercreme to her knowledge.
-She did not recall the resident having orders to self-administer other medications but she would review the self-administration forms.
-The MAs should report to the primary care provider (PCP) if a resident was not self-administering medications correctly.

Telephone interview with Resident #1's PCP on 06/20/19 at 2:35pm revealed:
-She signed orders for the resident to self-administer some medications on 05/30/19 because the resident's family member wanted the resident to have those medications at bedside.
-The resident had dementia, but she was "okay" with the resident applying the topical medications.
-If the resident's Nitroglycerin tablets were expired; he needed a new bottle.

Telephone interview with Resident #1's family member on 06/21/19 at 10:05am revealed:

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-Resident #1 self-administered Nitroglycerin tablets and some topical medications.
-The resident should have a back up supply of Nitroglycerin at the facility.
-The resident could not remember where to apply the topical medications so she would write locations for the resident to apply on the labels.
-The Diphenhydramine cream may have been in his toiletry items when the resident moved into the facility.
-The resident may have used the Diphenhydramine in the past to apply to bug bites on his skin.
-The resident may have a tube of Triamcinolone cream in a drawer in his room or he may have run out.
-The Sebex or Therapeutic shampoos may have been used about a year ago because the resident did not complain of dandruff anymore.

Refer to interviews with the Administrator on 06/18/19 at 6:00pm and 06/19/19 at 8:05am.

3. Review of Resident #7's current FL-2 dated 10/31/18 revealed:
-Diagnoses included dementia, schizophrenia, anxiety, congestive heart failure, hypertension, premature ventricular contractions, and physical deconditioning.
-There was an order for Visine Tears, instill 1 drop in both eyes 4 times a day. (Visine Tears is a lubricant eye drop used to relieve dry eyes.)
-The resident was documented as wearing eyeglasses.

Review of Resident #7's Resident Register revealed:
-The resident was admitted to the facility on 05/20/13.
-The resident was documented as having

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adequate memory.
-The resident was documented as requiring assistance with bathing, dressing, and toileting.
-The resident was documented as wearing eyeglasses.

Review of Resident #7's current assessment and care plan dated 10/30/18 revealed:
-The resident was documented as sometimes disoriented.
-The resident was documented as forgetful and needed reminders.
-The resident wore eyeglasses.
-The resident was documented as requiring limited assistance with eating.
-The resident was documented as requiring supervision with toileting, ambulation, bathing, dressing, and grooming.
-The resident was documented as independent with transferring.

Review of a physician's order sheet dated 11/08/18 revealed an order for Visine Tears instill 1 drop into both eye 4 times a day ("self-administered").

Review of an "order for self-administration" form for Resident #7 dated 05/30/19 revealed:
-There was an order for Visine Tears instill 1 drop in both eyes 4 times a day.
-The computer printed note at the bottom of the page indicated if there was a change in competency, physical ability, or if the resident became non-compliant with physician orders, the facility would contact the physician immediately for further direction.

Observation of Resident #7's room on 06/18/19 at 12:32pm revealed:
-There was a styrofoam cup with a bottle of eye

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drops inside the cup sitting on the bedside table on the right of the bed.
-There was one bottle of LiquiTears eye drops in the styrofoam cup.
-There was a tube of Cortisone 10 cream on the bedside table on the left side of the bed.
-The resident had a slight tremor in her hands.

Interviews with Resident #7 on 06/18/19 at 12:32pm revealed:
-She kept some eye drops in her room and self-administered them.
-She used eye drops for infection and some for dryness.
-She used the LiquiTears at night and she put 1 drop in each eye. (LiquiTears is a lubricant eye drop but it has different ingredients than Visine Tears. LiquiTears and Visine Tears are not the same.)
-She did not answer when asked if she had any other eye drops in her room.
-The drops helped with dryness of her eyes.
-She used the LiquiTears eye drops for infection.
-When asked if she could administer the eye drops by herself, the resident stated, "I manage alright".
-She was only supposed to use the LiquiTears eye drops at bedtime.
-She could not recall how she got the bottle of eye drops.
-She did not use the Cortisone 10 cream anymore; she thought she was allergic to it.

Review of Resident #7's physician's orders revealed there were no orders for the resident to receive or self-administer Cortisone 10 cream or LiquiTears eye drops.

Interview with a second shift medication aide (MA) on 06/18/19 at 5:50pm revealed:

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-The MAs usually administered an antibiotic eye drop to Resident #7 each night at bedtime.
-She did not know Resident #7 self-administered LiquiTears eye drops.
-Resident #7 would not be able to self-administer eye drops because the resident's hands were weak and her hands shook.
-If any staff observed medications in a resident's room, they were supposed to tell the MA and the MA would report it to the Administrator.
-No one had reported to her they had seen any medications in Resident #7's room.

Interview with the Administrator on 06/18/19 at 6:00pm revealed:
-She did not know Resident #7 was not self-administering eye drops as ordered.
-She did not know Resident #7 had Cortisone cream in her room.
-Staff should notify the supervisor on duty or the Administrator if they saw any medications in residents' rooms, including Resident #7.
-She would contact Resident #7's primary care provider (PCP) about the eye drops.

Telephone interview with a nurse at Resident #7's PCP's office on 06/20/19 at 12:22pm revealed:
-No one had notified their office that Resident #7 was not administering her eye drops correctly or she was having any trouble physically administering the eye drops.
-The PCP would expect to be notified if the resident was not capable of administering the eye drops or was being non-compliant with the orders.

Review of a physician's order faxed to the facility on 06/20/19 revealed an order that Resident #7 should not self-administer her own eye drops.

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| D 375 | Continued From page 79<br>Refer to interviews with the Administrator on 06/18/19 at 6:00pm and 06/19/19 at 8:05am.<br><br>Interviews with the Administrator on 06/18/19 at 6:00pm revealed:<br>-Staff should notify the supervisor on duty or the Administrator if they see any medications in residents' rooms.<br>-A resident should not self-administer medications without an order to self-administer.<br>-A resident should not self-administer medications if they could not identify how the medication should be taken or the reason a medication should be taken.<br>-She had sent a letter to all residents' families on 05/23/19 to remind them residents could not have medications in their rooms without prior approval and signed physician's orders. | D 375 | | |
| D 463 | 10A NCAC 13F .1306 Admission To The Special Care Unit<br><br>10A NCAC 13F .1306 Admission To The Special Care Unit<br>In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:<br>(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.<br>(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.<br>(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 | D 463 | | |

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and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (#2, #3) residing in the Special Care Unit (SCU) met the requirements including a pre-admission screening for appropriate placement and a disclosure regarding policy and procedures of the SCU.

The findings are:

1. Review of Resident #2's current FL-2 dated 01/09/19 revealed:
-Diagnoses included dementia.
-SCU was documented as the recommended level of care.
-There was documentation Resident #2 was constantly disoriented and a wanderer.

Review of Resident #2's Resident Register revealed an admission date to the facility of 12/17/17.

Review of Resident #2's record revealed:
-There was no documentation of a pre-admission screening prior to admission to the SCU.
-There was no documentation that a disclosure regarding policies and procedures in the SCU was provided by the facility to family members.

Review of Resident #2's physician progress note dated 06/05/19 revealed:

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-Resident #2 was oriented to person. She could answer a few simple questions. Obvious moderate dementia.
-Resident #2 was moved to the SCU in January 2019.

Telephone interview with Resident #2's physician assistant (PA) on 06/20/19 at 10:51am revealed:
-Resident #2 was last seen on 06/05/19.
-She was aware she was moved to the SCU in January 2019.
-She completed and signed a new FI-2 for Resident #2 to be transferred to the SCU on 01/09/19.
-Resident #2's family was aware of the move to the SCU.
-She did not see in her database or did not recall of any pre-admission screening or disclosure form done by the facility prior to her admission to the SCU.

Attempted telephone interview with Resident #2's guardian on 06/20/19 at 10:20am was unsuccessful.

Interview with the Special Care Coordinator on 06/20/19 at 1:52pm revealed:
-He became the SCC 3 week ago.
-He recalled Resident #2 was moved to the SCU around the beginning of the year.
-He was not aware of any SCU pre-admission screening or disclosure forms, to be completed.
-He was not for sure if any pre-admission screening or disclosure forms were completed for Resident #2 when she moved to the SCU at the beginning of the year.

Interview with the Administrator on 06/21/19 at 12:15pm revealed:
-She was aware that Resident #2 was moved to

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| D 463 | Continued From page 82<br>the SCU from the Assisted Living (AL) sometime around the beginning of the year.<br>-She did not know that a pre-admission screening should be completed prior to admission to the SCU.<br>-She did not know that a disclosure form regarding policies and procedures in the SCU was to be provided by the facility to family members.<br>-The SCC would be responsible for the pre-admission screening and disclosure form to be completed.<br>-There was no pre-admission screening completed for Resident #2 prior to admission to the SCU.<br>-There was no disclosure regarding policies and procedures in the SCU provided by the facility to family members for Resident #2.<br><br>2. Review of Resident #3's current FL- 2 dated 01/31/19 revealed:<br>-Diagnoses included dementia and loss of memory.<br>-SCU was documented as the recommended level of care.<br>-There was documentation that Resident #3 was constantly disoriented.<br><br>Review of Resident #3's Resident Register revealed an admission date of 02/01/19 to the SCU.<br><br>Review of Resident #3's record revealed:<br>-There was no documentation of a pre-admission screening prior to admission to the SCU.<br>-There was no documentation that a disclosure regarding policies and procedures in the SCU | D 463 | | |

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| D 463 | Continued From page 83<br>was provided by the facility to family members.<br><br>Interview with the Special Care Coordinator (SCC) on 06/20/19 at 1:52pm revealed:<br>-He became the SCC 3 week ago.<br>-He recalled Resident #3 was moved to the SCU around the beginning of the year.<br>-He was not aware of any SCU pre-admission screening or disclosure forms, to be completed.<br>-He was not for sure if any pre-admission screening or disclosure forms were completed for Resident #3 when she moved to the SCU at the beginning of the year.<br><br>Interview with the Administrator on 06/21/19 at 12:15pm revealed:<br>-She was aware that Resident #3 was moved to the SCU from Assisted Living (AL) sometime around the beginning of the year.<br>-She did not know that a pre-admission screening should be completed prior to admission to the SCU.<br>-She did not know that a disclosure form regarding policies and procedures in the SCU was to be provided by the facility to family members.<br>-There was no pre-admission screening completed for Resident #3 prior to admission to the SCU.<br>-There was no disclosure regarding policies and procedures in the SCU provided by the facility to family members for Resident #3. | D 463 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than | D 465 | | |

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| D 465 | Continued From page 84<br>one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to assure there was sufficient staff present on the Special Care Unit (SCU) for 7 of 12 shifts sampled for six days in June 2019.<br><br>The findings are:<br><br>Review of the facility's 2019 license revealed:<br>-The facility had a capacity of 122 residents.<br>-The facility was licensed for 50 beds in the SCU.<br><br>Confidential interview with staff revealed:<br>-The staff worked short staffed all the time.<br>-The past 3 to 4 months staff worked extremely short staffed, especially second and third shifts.<br>-For example, 06/16/19, there was only one personal care aide (PCA) for the entire building from 3pm -7pm and there were only two medication aides (MAs) for the entire second shift.<br><br>Review of the facility's second shift staff time records for the SCU from 06/07/19 - 06/09/19 revealed:<br>-There were 31 hours and 37 minutes of aide hours for second shift on 06/07/19, leaving the facility short 23 minutes of aide hours.<br>-There were 29 hours and 54 minutes of aide | D 465 | | |

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| D 465 | Continued From page 85 | D 465 | | |

hours for second shift on 06/09/19, leaving the facility short 2 hours and 6 minutes of aide hours.

Review of the facility's census report revealed the facility's census in the Special Care Unit (SCU) was 32 residents on 06/07/19 - 06/09/19 which required at least 32 hours of aide hours on second shift.

Review of the facility's third shift staff time records from 06/07/19 - 06/09/19 revealed:
-There were 22 hours and 30 minutes of aide hours for third shift on 06/08/19, leaving the facility short 3 hours and 6 minutes of aide hours.
-There were 22 hours and 45 minutes of aide hours for third shift on 06/09/19, leaving the facility short 2 hours and fifty-one minutes of aide hours.

Review of the facility's census report revealed the facility's census on the SCU was 32 residents on 06/07/19 - 06/09/19 which required at least 25.6 hours (25 hour and 36 minutes) of aide hours on third shift.

Review of the facility's second shift staff time records for the SCU from 06/14/19 - 06/16/19 revealed:
-There were 29 hours and 45 minutes of aide hours for second shift on 06/14/19, leaving the facility short 2 hours and 15 minutes of aide hours.
-There were 22 hours and 8 minutes of aide hours for second shift on 06/16/19, leaving the facility short 9 hours and 52 minutes of aide hours.

Review of the facility's census report revealed the facility's census in the Special Care Unit (SCU) was 32 residents on 06/14/19 - 06/16/19 which

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| D 465 | Continued From page 86<br>required at least 32 hours of aide hours on second shift.<br><br>Review of the facility's third shift staff time records from 06/14/19 - 06/16/19 revealed there were 24 hours and 21 minutes of aide hours for third shift on 06/15/19, leaving the facility short 1 hour and 15 minutes of aide hours.<br><br>Review of the facility's census report revealed the facility's census on the SCU was 32 residents on 06/14/19 - 06/16/19 which required at least 25.6 hours (25 hour and 36 minutes) of aide hours on third shift.<br><br>Interview with a medication aide on 06/21/19 at 5:40pm revealed:<br>-The facility had been short staffed for several months in the SCU.<br>-Short staffing was worse on second and third shifts.<br>-Staffing at the facility had gotten worse since February 2019 when the new Administrator was hired.<br>-Most shifts were only staffed with two PCAs and a MA during the second and third shifts.<br>-A lot of staff had been fired and there was not any new staff hired to replace them and that left the facility short staffed.<br>-She complained to the Administrator about a month and half before about being short staffed.<br>-The Administrator told her that they were in the process of trying to hire more staff.<br>-It was hard for the staff to take care of the residents when they did not have enough help.<br><br>Interview with the Administrator on 06/21/19 at 5:37pm revealed:<br>-She was responsible for the staffing schedule on the SCU. | D 465 | | |

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| D 465 | Continued From page 87<br>-Staff called out frequently.<br>-Someone from management was on call seven days a week and covered the 1st call out.<br>-If there was a second call out they had to find someone to cover the call out.<br>-She was aware of how much staff was required. | D 465 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to assure residents received care and service which were adequate, appropriate, and in substantial compliance with relevant federal and state laws and rules and regulations as related to water temperatures and medication aide training.<br><br>The findings are:<br><br>1. Based on observations, interviews and record reviews, the facility failed to assure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 9 water fixtures including a sink in a resident bathroom and sinks, showers, and a tub in two spa bathrooms on the assisted | D912 | | |

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| D912 | Continued From page 88<br>living hall and 7 of 10 water fixtures including sinks in three resident room bathrooms; sinks and showers in two spa bathrooms in the Special Care Unit (SCU). [Tag 113 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].<br><br>2. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 medication aides (MAs) sampled (Staff D and Staff F) met the requirements to administer medications including Staff D who did not have documentation of completing the medication clinical skills checklist or the 5,10 or 15 hour state approved medication training course and Staff F who had not completed the 10-hour state approved medication administration training course. [Tag 935 G.S. 131D-4.5(B)b Adult Care Home Medications Aide Training and Competency (Type B Violation)]. | D912 | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.<br><br>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:<br>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:<br>a. The key principles of medication administration. | D935 | | |

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| D935 | Continued From page 89<br>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration.<br>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 medication aides (MAs) sampled (Staff D and Staff F) met the requirements to administer medications including Staff D who did not have documentation of completing the medication | D935 | | |

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| D935 | Continued From page 90 | D935 | | |

clinical skills checklist or the 5,10 or 15 hour state approved medication training course and Staff F who had not completed the 10-hour state approved medication administration training course.

The findings are:

1. Review of Staff D's personnel record revealed:
-Staff D's hire date was 06/01/99.
-There was no documentation of a medication clinical skills checklist.
-There was documentation Staff D passed the written medication aide exam on 07/11/00.
-There was no documentation of Staff D completing the 5-hour, 10 hour, or 15-hour state approved medication aide training courses.

Interview with Staff D on 06/21/19 at 10:42am revealed:
-She had worked at the facility since 1999.
-She started in the Special Care Unit (SCU) as a personal care aide (PCA).
-She worked at the facility about a year before she started administering medications.
-She remembered being checked off by a nurse before administering medications.
-She did not know where they kept the personnel records because the facility had changed ownership several times.

Review of residents' April 2019, May 2019 and June 2019 medication administration records revealed:
-Staff D documented administration of medications including insulin on 04/01/19 - 04/04/19, 04/06/19 - 04/07/19, 04/09/19 - 04/12/19, 04/15/18 - 04/18/19, 04/20/19 - 04/21/19, and 04/23/19 - 04/26/19.
-Staff D documented administration of

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| D935 | Continued From page 91<br>medications including insulin on 05/03/19, 05/06/19 - 05/08/19, 05/11/19 - 05/16/19, 05/19/19, 05/21/19 - 05/23/19, and 05/28/19 - 05/30/19.<br>-Staff D documented administration of medications including insulin on 06/01/19 - 06/02/19, 06/04/19 -06/07/19, 06/10/19 - 06/12/19, and 06/13/19 - 06/19/19.<br><br>Observation of Staff D during the medication pass on 06/19/19 revealed Staff D made a medication error with the administration of insulin. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration.]<br><br>Interview with the Administrator on 06/21/19 at 11:40am revealed:<br>-Staff D had worked in the facility 17 years and had been checked off on her medication clinical skills checklist (unable to specify when this happened).<br>-She had gotten Staff D's old personnel record out of the storage building behind the facility.<br>-She did not find Staff D's medication clinical skills checklist.<br><br>Refer to interview with the Administrator on 6/21/19 at 11:40am.<br><br>2. Review of Staff F's personnel record revealed:<br>-Staff F's hire date was 02/11/19 as a medication aide (MA).<br>-Staff F passed the written MA exam on 03/12/15.<br>-Staff F had been checked off on her medication clinical skills checklist on 04/01/19.<br>-Staff F completed the 5-hour state approved medication aide training course on 05/29/19.<br>-There was no documentation of Staff F completing the 10 hour state approved medication aide training course. | D935 | | |

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| D935 | Continued From page 92<br><br>Review of residents' April 2019, May 2019 and June 2019 medication administration records revealed:<br>-Staff F documented administration of medications including insulin on 4/23/19 and 4/25/19.<br>-Staff F documented administration of medications including insulin on 05/01/19, 05/02/19, 05/06/19 - 05/08/19, 05/13/19, 05/16/19, 05/18/19, 05/20/19 - 05/23/19, and 05/28/19 - 05/30/19.<br>-Staff F documented administration of medications including insulin on 06/03/19 - 06/05/19, 06/11/19 - 06/13/19, and 06/18/19 - 06/20/19.<br><br>Observation of Staff F during the medication pass on 06/19/19 revealed Staff F made a medication error with the administration of insulin. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration.]<br><br>Interview with the Administrator on 06/21/19 at 11:40am revealed:<br>-Staff F had been checked off on her medication clinical skills checklist on 04/01/19.<br>-Staff F had completed the 5-hour state approved medication aide training course on 05/29/19.<br>-She had gotten Staff F's old personnel record out of the storage building behind the facility.<br>-She did not find Staff F's 10-hour state approved medication aide training course.<br><br>Attempted telephone interviews with Staff F on 06/21/19 at 3:55pm was unsuccessful.<br><br>Refer to interview with the Administrator on 6/21/19 at 11:40am. | D935 | | |

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| D935 | Continued From page 93<br><br>Interview with the Administrator on 06/21/19 at 11:40am revealed:<br>-She could not find any more information for the personnel records.<br>-When she hired a new medication aide (MA) they had to provide proof they had worked as a MA in the last 24 months.<br>-They had to shadow a MA on the cart for 5 days before giving medications.<br>-They had to shadow a personal care aide (PCA) on the floor for 5 days.<br>- If a PCA wanted to become a MA, they must work at the facility 6 months before they take the medication training class.<br>-The pharmacy had a 15 hour online training the PCA could complete.<br>-Then they could shadow the MA on the medication cart.<br>-Then the Licensed Health Professional Support Nurse would have to check them off.<br><br>The facility failed to assure 2 of 4 medication aides sampled (D,F) met the requirements to administer medications including Staff D who did not have documentation of completing the medication clinical skills checklist or completing the 5 hour, 10 hour, or 15 hour state approved medication administration training course; and Staff F who had not completed the 10-hour state approved medication administration training course. Staff D and Staff F made medication errors with the administration of insulin during the medication passes observed on 06/19/19. The facility's failure to have qualified medication aides administering medications was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection on June 21, 2019 in accordance with G.S. 131D-34 for | D935 | | |

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| D935 | Continued From page 94<br>this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 5, 2019. | D935 | | |