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HEATH HOUSE	919 WILMA SIGMON ROAD LINCOLNTON, NC 28092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on 02/02/22 through 02/04/22.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents 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: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION	D 164		

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D 164	Continued From page 1 Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled medication aides (Staff A and B), who obtained fingerstick blood sugars (FSBS) and administered insulin to residents, completed training on the care of diabetic residents. The findings are: 1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 03/17/17. -There was no documentation Staff A had completed training on the care of diabetic residents. Review of 2 diabetic residents' December 2021 electronic medication administration records (eMARs) revealed Staff A documented she checked FSBS and/or administered insulin on 21 days from 12/01/21 to 12/31/21. Review of 2 diabetic residents' January 2022 eMARs revealed Staff A documented she checked FSBS and/or administered insulin on 18 days from 01/01/22 to 01/31/22. Interview with Staff A on 02/04/22 at 6:54pm revealed: -She was hired at the facility in March 2017 (unable to recall the exact date of hire). -She remembered that she had trainings but was unable to recall if the training was specific to care of diabetic residents. -When she worked as a MA, and she administered insulin to residents and obtained FSBS. -The previous Resident Care Coordinator (RCC) was responsible for setting up trainings and ensuring trainings were completed.	D 164		

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D 164	Continued From page 2 Refer to interview with the Corporate Vice President of Operations on 02/04/22 at 6:35pm. 2. Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B was hired on 07/30/20. -There was no documentation she had completed training on the care of diabetic residents. Review of 2 diabetic residents' December 2021 electronic medication administration records (eMARs) revealed Staff B documented she checked FSBS and/or administered insulin on 19 days from 12/01/21 to 12/31/21. Review of 2 diabetic residents' January 2022 eMARs revealed Staff B documented she checked FSBS and/or administered insulin on 11 days from 01/01/22 to 01/31/22. Attempted telephone interview with Staff B on 02/04/22 at 6:40pm was unsuccessful. Refer to interview with the Corporate Vice President of Operations on 02/04/22 at 6:35pm. _____ Interview with the Corporate Vice President of Operations on 02/04/22 at 6:35pm revealed: -The new company took over operations of the facility on 12/01/21. -Personnel records did not get addressed because all the previous staff including the Administrator resigned after 12/01/21. -She was not aware there was no documentation that staff had completed training on the care of diabetic residents. _____ The facility failed to ensure 2 of 2 sampled staff (Staff A and B); who administered insulin to	D 164		

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D 164	Continued From page 3 residents prior to receiving training on the care of diabetic residents, resulted in the staff not contacting the physician when a resident had dangerously low and high FSBS readings and not administering insulin as ordered which resulted in a resident being hospitalized twice for uncontrolled diabetes. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 for this violation on 02/08/22. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 21, 2022 [Refer to Tag D 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure follow up with health care providers for 3 of 5 sampled residents (#4, #2 and #6) including a resident who had orders for a rapid-acting sliding scale insulin requiring physician notification for blood sugars over 450 or less than 70 (#4); a resident who had increased swelling in both her feet and	D 273		

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ankles after a fall (#2); and a resident who had orders for compression therapy to be applied and removed daily (#6).

The findings are:

1. Review of Resident #4's current FL2 dated 09/13/21 revealed:
-Diagnoses included diabetes mellitus type 2, adult failure to thrive, essential hypertension, coronary artery disease, atherosclerotic heart disease, and acute kidney failure.
-There was an order for Novolog (a rapid-acting insulin used to lower blood sugar levels) sliding scale insulin (SSI): For fingerstick blood sugar (FSBS) less than 131 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units and call the doctor for further dosing.
-There was an order to check FSBS before meals, at bedtime and as needed if symptomatic.

Review of the facility's Diabetic Standing Orders for Resident #4 dated 10/22/21 revealed:
-There was an order with instructions if a resident had a blood sugar reading of less than 70, give the resident 4 ounces of juice or regular soda, and recheck the blood sugar in 15 minutes. If the blood sugar was above 70, call the physician. If the blood sugar was still less than 70, call 911.
-There was an order to notify the physician if a resident had a blood sugar reading greater than 450.

Review of Resident #4's signed physician's orders dated 01/04/22 revealed there was an order for Novolog SSI: For FSBS less than 131 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 =

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D 273	Continued From page 5 10 units, 401-450 = 12 units, 451-500 = 15 units, 500 or higher give 0 units and call the doctor. Review of Resident #4's December 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog SSI: FSBS less than 131 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units and call the doctor for further dosing. -FSBS readings from 12/01/21 through 12/31/21 ranged from 69 to 590. -Resident #4's FSBS on 12/01/21 at 5:00pm was 535; there was no documentation the primary care provider (PCP) had been notified. -Resident #4's FSBS on 12/24/21 at 8:00am was 69; there was no documentation the PCP had been notified. -There was an entry to check FSBS at bedtime scheduled for 8:00pm. -Resident #4's FSBS on 12/03/21 at 8:00pm was 502; there was no documentation the PCP had been notified. Review of Resident #4's January 2022 eMAR revealed: -There was an entry for Novolog SSI: FSBS less than 131 = 0 units, 131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-450 = 12 units, 451-500 = 15 units and call the doctor for further dosing. -FSBS readings from 01/01/22 through 01/31/22 ranged from 58 to 600. -Resident #4's FSBS on 01/09/22 at 12:00pm was 68; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/17/22 at 8:00am was 66; there was no documentation the PCP had been notified.	D 273		

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D 273	Continued From page 6 -Resident #4's FSBS on 01/20/22 at 8:00am was 58; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/20/22 at 5:00pm was 458; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/21/22 at 8:00am was 60; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/22/22 at 8:00am was 559; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/22/22 at 12:00pm was 544; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/22/22 at 5:00pm was 600; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/24/22 at 8:00am was 552; there was no documentation the PCP had been notified. -There was an entry to check FSBS at bedtime scheduled at 8:00pm. -Resident #4's FSBS on 01/03/22 was 553 at 8:00pm; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/05/22 was 461 at 8:00pm; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/24/22 was 600 at 8:00pm; there was no documentation the PCP had been notified. -Resident #4's FSBS on 01/31/22 was 498 at 8:00pm; there was no documentation the PCP had been notified. Review of Resident #4's progress notes dated 01/25/22 revealed: -The night shift medication aide (MA) noted at 4:17am, Resident #4 had complained of chest	D 273		

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pains and her FSBS was over 600.
-The lead supervisor (LS) had been notified and requested that Resident #4 be sent to the hospital.

Review of Resident #4's Hospital Discharge Summary dated 01/28/22 revealed:
-Hospital Course Diagnoses included hyperosmolar non-ketotic state (a condition of very high blood glucose levels) due to type 2 diabetes mellitus, COVID-19 infection, non-ST wave elevated myocardial infarction (NSTEMI) (heart attack), hyperkalemia (elevated blood potassium levels), acute kidney injury (AKI), hypertension, hyponatremia (low blood sodium levels), and chest pain.
-Resident #4's blood glucose level upon arrival to the emergency room (ER) was noted to be 957.
-Resident #4 had been admitted to the intensive care unit (ICU) on an insulin drip.
-The last hemoglobin A1c lab (a blood lab that measures average blood sugar for the previous three months) for Resident #4 was in December of 2021 and was 10 (a normal hemoglobin A1c is 5.7) which indicated an average blood glucose level of 240. Per hospital physician note based on this lab result: "uncontrolled diabetes mellitus as an outpatient is evident."

Interview with a MA on 02/03/22 at 5:30pm revealed:
-She worked the evening of 01/20/22 and checked Resident #4's FSBS at 5:00pm when it was 458. She could not remember if she had notified the PCP of this FSBS reading.
-She had worked the evening of 01/24/22 and checked Resident #4's FSBS at 5:00pm when it was 600, and at 8:00pm when it was 600.
-On the evening of 01/24/22, she used the online triage notification system to notify Resident #4's

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PCP that her glucometer had read "HI," and she was told to administer an additional 15 units of insulin. She administered 15 units of Novolog but could not remember if she documented it anywhere or if she rechecked Resident #4's FSBS afterward.
-The way Resident #4's SSI order was entered into the eMAR, if she entered a FSBS over 500 the eMAR had a pop-up notification to administer 0 units of insulin and contact the PCP.
-If the eMAR pop-up notification was to call the PCP for further insulin dosing due to a FSBS over 500, she usually contacted either the LS or the Resident Care Coordinator (RCC) for guidance first.
-If she sent a notification to the PCP through the triage notification system and did not hear back from the PCP, she would contact the LS or RCC.
-MAs used to document PCP notifications in the paper record but since the facility changed to the online triage notification system, she sometimes forgot to document when she contacted a supervisor or PCP.
-She had realized the night prior (02/02/22) that she had been saving her chart notes in the computer system incorrectly and they had not been saving.

Interview with the RCC on 02/04/22 at 9:15am revealed:
-She was under the impression that the Diabetic Standing Order (with instructions to contact the PCP for a FSBS over 450) was overruled by Resident #4's Novolog SSI order (with instructions to contact the PCP for a FSBS of 500 or higher).
-She had not thought about clarifying the order because it was not unusual for some of the residents to have more specific parameters.
-She was unable to discontinue the Diabetic

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Standing Order for Resident #4 because all the diabetic residents needed to have those orders in their record and on their eMAR.
-If the PCP was contacted due to a FSBS less than 70 or over 500 and the PCP advised to administer additional insulin or to recheck the FSBS, the MAs were expected to document it in the progress notes.
-When a FSBS over 500 was entered into the eMAR for Novolog SSI, the eMAR had a pop-up notification instructing to administer 0 units of insulin and to contact the PCP; they had not attempted to change this pop-up in the eMAR to advise administering the Novolog SSI and also contacting the PCP for further dosing instructions.
-The facility did not have a protocol in place for what a MA should do if they sent a notification to the PCP but did not hear back.
-She would either keep paging the PCP or send the resident to the ER if she did not hear back from the PCP within an hour.
-There was no other place the MAs would be documenting PCP notifications aside from on the eMAR or in the progress notes.

A request was made for Resident #4's February 2022 eMAR but was not provided prior to exit on 02/04/22.

Interview with the Executive Director (ED) on 02/04/22 at 11:30am revealed:
-She did not know of Resident #4's high and low FSBS readings until she had been sent to the hospital on 01/25/22.
-She expected the MAs to notify the PCP (either by phone or the online triage notification system) for any FSBS outside of the normal range (70-450) and to let either herself or a supervisor know immediately.
-If the MA did not receive a response back from

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the PCP regarding the FSBS reading, the MA should send the resident to the hospital.
-The MAs should be documenting all PCP notifications in the progress notes, along with any additional insulin administered or FSBS rechecks.

Telephone interview with a representative from Resident #4's PCP's office on 02/04/22 at 11:55am revealed:
-On 12/01/21, their office had been notified by the facility at 6:29pm that Resident #4 had a FSBS reading that displayed as "HI" on the glucometer and staff had administered the scheduled dose of 22 units of Lantus (a long-acting insulin used to lower blood sugar levels).
-The nurse practitioner (NP) reviewed and advised staff that if Resident #4 had symptoms in the past two hours to give 2 units of Novolog, recheck FSBS in 4 hours and call back if FSBS was over 400.
-At 7:25pm that evening, the PCP's office was notified Resident #4's FSBS was still reading "HI" so they advised to administer 4 additional units of Novolog. No further calls were received, or orders were given that day.
-The PCP's triage notification center received no further notification until 01/25/22.
-The facility sent a notification early in the morning on 01/25/22 letting them know that Resident #4 was being sent to the hospital for chest pains.
-The PCP's office had no notification from the facility on 01/31/22 that Resident #4's FSBS was 498.
-The PCP's office received a notification from the facility on 02/01/22 at 7:35pm that Resident #4 had a FSBS of 554, the doctor advised to recheck FSBS around 10:30pm and call if still over 400. They had not received a call back.
-The service their office provided was for triage

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so they only received notifications if the PCP was unavailable; they did not have access to any other notifications that may have come from the facility regarding Resident #4's FSBS.

Telephone interview with another MA on 02/04/22 at 12:25pm revealed:
-MAs were supposed to notify the PCP via telephone if Resident #4 had a FSBS over 500, but the week prior she had needed to send an online triage notification because she was unable to get a response from the PCP and it had been one hour.
-She worked day shift (until 3:00pm) on 01/20/22 when Resident #4's FSBS was 58. She checked to see if Resident #4 had symptoms then gave her some orange juice and rechecked her FSBS.
-She could not remember if she documented the juice or what the FSBS was upon rechecking it.
-She did not notify the PCP of the low FSBS, she did not have a reason why.
-She worked day shift on 01/22/22 when Resident #4's FSBS was 559 at 8:00am and 544 at 12:00pm. She had not administered any insulin because the eMAR said to give 0 units and to contact the PCP.
-Resident #4 was not symptomatic and she called the PCP but received no response, so she thought she notified either the LS or the RCC.
-She would have called 911 if Resident #4 had been symptomatic.
-She worked day shift on 01/24/22 when Resident #4's FSBS was 552 at 8:00am and 600 at 12:00pm. She had attempted to notify the PCP via telephone but did not receive a call back prior to the end of her shift so she notified the oncoming MA of the situation.
-The 5:00pm FSBS on 01/24/22 was documented under her name because the MA working after her had not realized she was documenting under

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her name.
-She did not administer any insulin to Resident #4 on 01/24/22 because the order on the eMAR was to administer 0 units of insulin and contact the PCP.

Interview with the LS on 02/04/22 at 1:25pm revealed:
-Staff were supposed to contact her during any shift if a resident had a FSBS outside of the ordered parameters but most of the MAs did not notify her.
-If a MA notified her about high or low FSBS values, she advised them to complete the online triage notification for contacting the PCP.
-She had never received a call from a MA letting her know they were unable to get a timely response from the PCP and asking for guidance.
-She did not remember being notified of Resident #4's FSBS being 600 or her complaints of chest pain at 4:17am on 01/25/22 as documented in the progress notes prior to Resident #4 being sent to the hospital.

Interview with the RCC on 02/04/22 at 2:00pm revealed:
-Only one MA contacted her for FSBS readings outside of the normal range or if she was sending a notification to the PCP.
-She worked the day of 01/24/22, but could not remember if the MA working that day had notified her of Resident #4's high FSBS readings.
-If staff did not notify her with resident concerns, the only other staff they would notify would be the LS.
-If staff notified her of a FSBS less than 70 or over 500 for Resident #4, she would have told them to notify the PCP via the online triage notification system.

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Telephone interview with a third MA on 02/04/22 at 7:30pm revealed:
-She had worked on 01/05/22 when Resident #4's FSBS was 461 at 8:00pm. She had notified the LS who told her that Resident #4's FSBS had been high all day and the PCP was going to be seeing her the following day, so she did not notify the PCP that night.
-She had been the MA to check Resident #4's FSBS the morning of 01/17/22 when it was 66. She gave Resident #4 some orange juice and then reported the FSBS to the oncoming day shift to follow up on. She did not notify the PCP.
-The MAs did not contact the PCPs, either the LS or the RCC would notify the PCP via phone or the online triage notification.
-She had been the MA working the night shift of 01/24/22 into 01/25/22 when Resident #4 had complained of chest pain and her FSBS was reading "over 600."
-Due to the reports of chest pain she had called emergency medical services (EMS) to come to the facility for Resident #4; upon arrival they checked her FSBS and since it read "HI" on their glucometer they took her to the Emergency Room.
-She had not been trained on how to use the online triage notification system, but she documented the complaint of chest pain, the FSBS value and that EMS were called in the progress notes.

Review of a second inpatient hospital record for Resident #4 dated 02/02/22 revealed:
-Resident #4 had arrived back to the ER on 02/02/22 with complaints of chest pain and her blood sugar was 713.
-Admission diagnoses included chest pain, elevated troponin (a blood lab that indicates heart damage), hyperglycemia (elevated blood sugar)

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and hypertensive urgency (high blood pressure without symptoms).

Resident #4 remained inpatient at the hospital at the time of survey exit on 02/04/22 with plans to discharge to a rehabilitation facility.

2. Review of Resident #2's current FL2 dated 06/09/21 revealed:
-Diagnoses included type 2 diabetes mellitus without complication, bipolar disorder, other malaise, other abnormalities of gait and mobility, and difficulty in walking.
-Resident #2 was semi-ambulatory and used a walker.

Review of Resident #2's physician's orders dated 01/04/22 revealed diagnoses included hypertension and hyperlipidemia.

Review of Resident #2's Care Plan dated 01/19/22 revealed:
-She required limited assistance with bathing, grooming, personal hygiene, dressing, mobility, transfers, eating, and toileting.
-Resident #2's skin was normal and there were no skin care needs.

Review of Resident #2's Accident/Incident Report dated 01/25/22 at 8:15am revealed:
-She was observed face down on the floor in her bathroom.
-Resident #2 stated she lost her balance.
-Emergency medical services (EMS) was called, but Resident #2 refused to be sent out to the hospital.

Review of Resident #2's progress note dated 01/25/22 at 10:05am revealed:
-Resident #2 was observed face down on the

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floor in her bathroom.
-She had an abrasion on the center of her forehead with slight swelling.
-EMS was called to assist Resident #2, but she refused to be sent to the emergency room (ER).

Review of Resident #2's progress note dated 01/25/22 at 9:36pm revealed:
-Resident #2 told the medication aide (MA) Supervisor, the resident thought she may have broken her foot when she fell on the morning of 01/25/22.
-The top of Resident #2's right foot had a bruise on it.

Review of Resident #2's radiology report dated 01/26/22 revealed:
-Resident #2's right knee, ankle and foot were x-rayed.
-There were no findings with Resident #2's right knee.
-There was soft tissue swelling in Resident #2's right ankle.
-There were no findings with Resident #2's right foot.

Observation of Resident #2 on 02/02/22 at 10:51am revealed:
-Resident #2 had swelling in both feet and ankles with a rounded, puffy appearance on the top of her feet.
-There was more swelling in her right foot and than the left foot.

Interview with Resident #2 on 02/02/22 at 10:51am revealed:
-She fell in the bathroom about a week ago and landed on her foot.
-She saw her primary care physician (PCP) through a telehealth visit on 01/25/22 and the

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PCP ordered an x-ray which was negative for a fracture.
-She refused to go to the ER after her fall because she had been previously and there were long wait times to be seen.

Interview with Resident #2 on 02/04/22 at 9:05am:
-When she fell on 01/25/22, she hurt her right foot, but since then both her ankles and feet started swelling.
-She did not have any puffiness in her feet or ankles prior to her fall on 01/25/22.
-She told any staff who came into her room to look at the swelling in her feet and ankles after her fall on 01/25/22.
-She had not seen her PCP and did not know of any new orders since her telehealth visit on 01/25/22.

Interview with a nurse at Resident #2's home health agency on 02/03/22 at 12:08pm revealed:
-Resident #2 was admitted to skilled nursing services on 01/07/22 and had been seen weekly since 01/07/22.
-Resident #2 was last seen by a nurse on 01/24/22 and there was no documentation of any concerns with swelling in Resident #2's feet and ankles.
-There was documentation Resident #2 had trace edema on 01/11/22 and 01/19/22.
-The facility had not notified her Resident #2 had increased swelling in her feet and ankles.
-She found out about the swelling this morning on 02/03/22, during a routine visit to draw lab work.
-The swelling may have "popped up" since Resident #2 fell on 01/25/22.
-She would be contacting Resident #2's PCP.

Interview with a MA/Supervisor on 02/03/22 at

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D 273	Continued From page 17 5:46pm revealed: -Resident #2 had swelling in her legs and feet since she was admitted to the facility, but her legs and feet started swelling more after her fall on 01/25/22. -Resident #2 thought she had broken her right foot, but she did not want to go to the hospital to get her foot checked out. -She did not notify Resident #2's PCP of increased swelling in her legs and feet after her fall on 01/25/22. -The Resident Care Coordinator (RCC) or the Lead Supervisor (LS) were responsible for following up with Resident #2's PCP. Interview with a nurse from Resident #2's PCP's office on 02/04/22 at 12:07pm revealed: -Resident #2 was seen by the PCP via a telehealth visit on 01/25/22 due to a fall, her refusing EMS and a physical therapy (PT) referral. -On 01/26/22, staff reported Resident #2 had an injury from a fall on 01/25/22 and x-rays were ordered and completed on 01/26/22. -There were no notifications from the facility after 01/26/22 regarding increased swelling in both Resident #2's feet and ankles. Interview with Lead Supervisor (LS)on 02/04/22 at 12:32pm revealed: -She was working on 01/25/22 when Resident #2 fell. -Resident #2 did not complain about pain in her right foot or ankle on 01/25/22, but she complained about having pain on 01/26/22. -She noticed swelling in Resident #2's feet and ankles on 01/26/22. -She had not contacted Resident #2's PCP after her x-ray on 01/26/22 regarding swelling in both feet and ankles because there was a new PCP	D 273		

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starting at the facility this week.
-She did not know if any other staff contacted the PCP or home health regarding the swelling.

Interview with the RCC on 02/04/22 at 1:58pm revealed:
-Resident #2 did not have any swelling in her foot prior to her fall on 01/25/22.
-The home health nurse saw Resident #2 on 02/03/22 and brought the swelling to her attention, and she and the home health nurse started to coordinate care for Resident #2.
-Facility staff had not reported to her concerning any increased swelling in both feet after Resident #2's fall on 01/25/22.
-Resident #2 had not complained to her about her feet and ankles being swollen.
-She or the LS were responsible for following up with residents' PCPs regarding health care concerns.
-She had not followed up with Resident #2's PCP because she had not been made aware of the swelling prior to 02/03/22.

Interview with a personal care aide (PCA) on 02/04/22 at 4:43pm revealed:
-One day during the last week or so, Resident #2 told her she could not move her feet.
-She raised the covers up to look at Resident #2's feet and saw that both her feet and ankles were swollen.
-There was more swelling in Resident #2's right foot and it was a bluish/gray color.
-She asked Resident #2 if she had told a MA and Resident #2 said that she had.
-She took Resident #2's word and did not tell anyone about the swelling in her feet and ankles.
-She had just started her shift and thought other staff were already aware of the swelling in Resident #2's feet and ankles.

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D 273	Continued From page 19 Interview with a second PCA on 02/04/22 at 5:24pm revealed: -She last worked on Wednesday, 02/02/22, and noticed Resident #2 had swelling in her feet and ankles. -She did not say anything to anyone because she assumed everyone already knew. -She thought the MA/Supervisor may have known about Resident #2's swelling because she was instructed to provide increased assistance to Resident #2. Interview with a third PCA on 02/04/22 at 5:37pm revealed: -She noticed Resident #2 had swelling in both her feet and ankles a few days ago. -Resident #2 had slight swelling previously, but not like she had now after the fall on 01/25/22. -Resident #2 could barely put pressure on her feet. -Her right foot and ankle were more swollen than the left foot and ankle. -She told the MA/Supervisor about Resident #2's swelling a few days ago. Interview with the Administrator on 02/04/22 at 2:49pm revealed: -Staff should have noticed swelling in both Resident #2's feet and ankles when they assisted her with personal care. -The Supervisor should have followed up with Resident #2 after her fall on 01/25/22. -The RCC should have reviewed reports regarding Resident #2's fall and then "put eyes on her" to see if there had been any changes in her status after the fall. -If there were changes with Resident #2 after her fall, the RCC should have followed up with her PCP.	D 273		

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-She would have expected staff to follow up with Resident #2's PCP regarding the swelling in her ankles and feet.

3. Review of Resident #6's current FL2 dated 09/01/21 revealed:
-Diagnoses included diabetes, cerebral vascular accident, chronic kidney disease, and hypertension.
-There was an order for lymphapress (compression therapy used for management of lymphedema) 2 hours daily to bilateral legs.

Review of Resident #6's Care Plan dated 09/17/21 revealed Resident #6 required limited assistance with bathing, grooming, personal hygiene, dressing, mobility, transfers, eating, and toileting.

Review of Resident #6's electronic Medication Administration Record (eMAR) for December 2021 revealed:
-There was an entry for lymphapress apply to bilateral legs for 2 hours daily to be applied at 10:00am and removed at 12:00pm.
-There was documentation lymphapress was applied and removed for 31 of 31 opportunities from 12/01/21 through 12/31/21.

Review of Resident #6's eMAR for January 2022 revealed:
-There was an entry for lymphapress apply to bilateral legs for 2 hours daily to be applied at 10:00am and removed at 12:00pm.
-There was documentation lymphapress was applied for 30 of 31 opportunities and removed for 31 of 31 opportunities from 01/01/22 through 01/31/22.

Review of Resident #6's eMAR for February 2022

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revealed:
-There was an entry for lymphapress apply to bilateral legs for 2 hours daily to be applied at 10:00am and removed at 12:00pm.
-There was documentation lymphapress was applied and removed for 2 of 3 opportunities from 02/01/22 through 02/03/22.

Observation of Resident #6's room during the tour of the facility on 02/02/22 at 11:23am revealed:
-Resident #6 was in his room sitting in his recliner with his feet elevated.
-Resident #6 did not have his lymphapress applied.
-The lymphapress was on the floor between Resident #6's bed and his recliner.
-The lymphapress machine was on a side table near Resident #6's recliner and was plugged in.
-Resident #6's legs were covered and there was no observation of his legs.

Interview with Resident #6 on 02/02/22 at 11:24am revealed:
-He had the lymphapress due to swelling in his legs and feet.
-The lymphapress was supposed to be applied daily.
-He had not used the lymphapress yet today.
-He put the lymphapress on himself and staff did not apply them.
-Sometimes he forgot to put the lymphapress on, but his family member called to remind him to put them on.

Observation of Resident #6 on 02/03/22 at 1:10pm revealed:
-Resident #6 was in his room sitting in his recliner with his feet elevated.
-Resident #6 did not have his lymphapress

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D 273	Continued From page 22 applied. -Resident #6 placed the lymphapress on his legs over his pants and turned the machine on to start the lymphapress boot compressions. Interview with Resident #6 on 02/03/22 at 1:10pm revealed: -He had not applied the lymphapress today. -He normally applied the lymphapress all by himself. -Staff did not apply the lymphapress daily, and staff did not remind him to apply them. -Staff applied the lymphapress when he asked them to. -He would like to say that he applied the lymphapress every day, but he sometimes did not get it done. -When he applied the lymphapress, it remained on his legs and feet approximately 45 minutes to an hour and he was supposed to have his legs elevated. Interview with Resident #6's family member on 02/04/22 at 10:30am revealed: -Resident #6 used the lymphapress for lymphedema and swelling in his legs. -He was supposed to wear the lymphapress daily for at least one hour and sometimes longer depending on the amount of swelling he had. -Staff sometimes reminded Resident #6 to apply his lymphapress, but he applied it himself. -She reminded Resident #6 to apply his lymphapress when she talked to him. Interview with the Lead Supervisor (LS) on 02/04/22 at 12:32pm revealed: -Resident #6 was to wear the lymphapress for 2 hours daily. -Resident #6 applied and removed the lymphapress himself.	D 273		

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D 273	Continued From page 23 -Sometimes he did not let staff put them on at the scheduled time and staff sometimes called his family member so she would have him to put them on. -She had not let the doctor know Resident #6 sometimes did not allow staff to put the lymphapress on because would put it on later in the day most of the time. -She documented lymphapress was refused on yesterday, 02/03/22, but she typically did not document the lymphapress was refused if it was not applied at the scheduled time. -Resident #6 allowed her to apply the lymphapress today. Interview with the RCC on 02/04/22 at 1:58pm revealed: -The MAs were supposed to apply Resident #6's lymphapress to his legs and feet daily and he was to wear the lymphapress for 2 hours. -No MA told her Resident #6 refused to have his lymphapress applied daily. -She did not know Resident #6 was applying the lymphapress himself. -Resident #6 should not apply his own lymphapress without an order from his PCP for him to do so. -Staff should not document on the eMAR the lymphapress was applied if they did not apply it. Interview with the Administrator on 02/04/22 at 2:49pm revealed: -She expected staff to apply Resident #6's lymphapress daily for 2 hours and document they had applied it. -She did not know Resident #6 was applying the lymphapress himself and had not applied it daily. -Staff should have contacted Resident #6's PCP for an order for him to apply his own lymphapress if he was going to apply it.	D 273		

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D 273	Continued From page 24 Attempted interview with Resident #6's PCP on 02/04/22 at 9:56am was unsuccessful. _____ The facility failed to ensure referral and follow up for 3 of 5 sampled residents by not notifying the PCP when a resident's FSBS was greater than 500 which resulted in the resident being admitted to the hospital intensive care unit on an insulin drip with uncontrolled diabetes, and FSBS greater than 900 (#4); a resident who had a diagnosis of hypertension and had increased swelling in both feet and ankles after a fall (#2); and a resident who was inconsistently applying and removing lymphapress to his legs (#6). This failure placed residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/22 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 6, 2022	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and	D 338		

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interviews the facility failed to ensure residents were free of verbal abuse and treated with respect and dignity related to a staff (Staff C) yelling at residents, treating residents rudely, cursing and belittling residents and not providing assistance to a resident who had a broken leg (#1) and verbal abuse to other residents.

The findings are:

1. Review of Resident #1's current FL2 dated 11/22/21 revealed diagnoses included hypertension, diabetes mellitus type 2, hypothyroidism, chronic anticoagulation, and bipolar disorder.

Review of Resident #1's Care Plan dated 06/01/21 revealed:
-She required limited assistance with toileting, ambulation, grooming and transferring.
-She required extensive assistance with bathing and dressing.
-She was independent with eating.

Interview with Resident #1 on 02/02/22 at 12:00pm revealed:
-Staff C, with the "blue hair" always ordered her to get in the bed.
-Staff C said "get in the bed - time for you to go to bed."
-She was grown and was not ready to go to bed.
-She broke her leg and Staff C had to help her into the bed.
-Staff C made her go to bed at a certain time since she broke her leg.
-When Staff C came around she was "sarcastic" to her and her roommate.
-Sometimes Staff C was hard to deal with and was not very pleasant.
-Staff C would get in her face and say in a hateful

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tone "you got to be good," treating her like she was a child.
-One day, Staff C said to her roommate that you "stole my drink" off the cart, which was not true because the roommate had not left the room.
-Later Staff C came back and asked them both for a dollar to buy her a soda.

Interview with Resident #1's roommate on 02/04/22 at 10:10am revealed:
-Last night (02/03/22), Staff C was very hateful to her roommate.
-Staff C refused to help her roommate get up out of the recliner to go to the bathroom.
-Staff C was yelling at the roommate and told her to get her [expletive] in the wheelchair.
-She told Staff C not to talk to her roommate that way, and Staff C yelled at her and told her to shut-up.
-She was not afraid of Staff C, she wished if Staff C was not happy at the facility she would leave and not come back.

Interview with Resident #1 on 02/04/22 at 11:08am revealed:
-Last night (02/03/22), she asked Staff C to help her to the bathroom and to help take her incontinent brief off.
-Staff C said, "no, you can do it yourself."
-She told Staff C that she was unable to do it because her left leg was broken and she had a big boot on.
-Staff C did not help but watched her struggle to get out of the recliner with her broken leg.
-Once she stood up, Staff C said, "sit your [expletive] in the chair."
-Staff C, positioned herself in front of her and lightly shoved her, pushing her down in the chair.
-Her roommate told Staff C to stop treating her like that.

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-Staff C yelled at the roommate and said "shut-up."
-She had tried everything that she could think of to be nice to Staff C, and she was still mean to her.
-Staff C often made her cry because she was so mean to her.
-Resident #1 started to cry and said, "I like all people, why is she so mean to me?"
-Resident #1 said she tried to get along with Staff C.
-She did not know what she had done to make Staff C treat her so badly.
-Staff C complained that she did not like working at the facility.
-Staff C was unhappy working at the facility because some days she worked 14 to 16 hours per day.
-She told the medication aide (MA) and the MA said "that's her way of doing things."
-She told the Lead Supervisor (LS) last week how Staff C treated her and she did nothing about Staff C.
-She told the Resident Care Coordinator (RCC) weekly about how Staff C treated her and the RCC said that she would talk to Staff C, but she still treated her mean and rude.
-No one had done anything about Staff C.

Telephone interview with Resident #1's Power of Attorney (POA) on 02/04/22 at 9:01am revealed:
-Resident #1 called last night (02/03/22) and said the PCA with "blue hair" was mean to her.
-Resident #1 asked the PCA to help her to the bathroom.
-The PCA told Resident #1 she did not need any help, she could do it herself.
-The PCA did not help Resident #1.
-After Resident #1 got herself up out of the reclining chair, the PCA told her to sit her

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[expletive] in the wheelchair.
-Resident #1 fell two weeks ago and broke her lower left leg.
-The resident now had a big boot on her left leg making it difficult for the resident to rise up from a sitting position.
-Resident #1 always complained to her about the PCA with "blue hair" not being nice to her.
-The resident said the PCA always talked rude, sarcastic, and belittled Resident #1 like she was a child.
-The PCA also told Resident #1 to go to bed at a certain time and she had no idea why.

Interview with Resident #1's roommate on 02/04/22 at 10:10am revealed:
-Last night (02/03/22), Staff C was very hateful to her roommate.
-Staff C refused to help her roommate get up out of the recliner to go to the bathroom.
-Staff C was yelling at the roommate and told her to get her [expletive] in the wheelchair.
-She told Staff C not to talk to her roommate that way, and Staff C yelled at her and told her to shut-up.
-She was not afraid of Staff C, she wished if Staff C was not happy at the facility she would leave and not come back.

Interview with the RCC on 02/04/22 at 2:50pm revealed:
-Resident #1 had complained to her many times that Staff C was mean, rude and belittled her.
-She talked with Staff C several times regarding how she treated residents.
-She had even written up Staff C because of how she treated residents.
-She was made of aware of an incident that happened last night regarding Staff C and Resident #1.

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D 338	Continued From page 29 -Resident #1 told her that Staff C refused to help her pull up her incontinent brief and assist her with transferring from the recliner to the wheelchair. -Staff C told the resident she was able to pull up the incontinent brief herself and did not help the resident. -She did not write-up Staff C, she verbally told Staff C, that she was supposed to help the residents, that was her job. Interview with a resident on 02/02/21 at 12:20pm revealed: -Staff C was mean, rude and "talked ugly" to her. -She was not afraid of Staff C and talked back to her. -Once, Staff C accused her of taking her soda off the medication cart. -Staff C's accusation was not true because she did not drink that type of soda, and she had not left the room. -Staff C always tried to accuse her of doing something and she yelled at her and her roommate. -Staff C was "just mean" and she often complained that she did not like working at the facility. -She wished Staff C would leave if she was so unhappy because she was making everyone else unhappy. Interview with a second resident on 02/02/22 at 10:40am revealed: -Staff C was very "mean" and yelled at her. -She had to get Staff C's permission to do anything. -Around 3 to 4 months ago she had an altercation with Staff C. -She was in the residents' common living area "TV room" watching something on the TV.	D 338		

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-Staff C came to the room and said, "it's my turn" and turned the channel to a football game.
-Staff C told her,"you got a TV in your room, go to your room and watch TV."
-She was upset and left the TV room and went to her room.
-Later, Staff C came to her room and told her that she could go back to the TV room.
-She was upset and yelled at Staff C, telling her to get out of her room.
-Ever since that incident Staff C had been mean to her and yelled at her all the time.
-Staff C "talked down" to her and other residents' and ordered them to do things like "they were children".
-Staff C was never nice to her.

Interview with a third resident on 02/02/22 at 10:50am revealed:
-She had witnessed Staff C being rude, mean and yelled at a resident.
-Staff C did not treat her like that because Staff C knew that she would not take it.

Interview with a medication aide (MA) on 02/03/22 at 5:25pm revealed:
-Resident #8 had complained to her that Staff C was rude and being ugly to her.
-She thought that she had told the Lead Supervisor (LS) about Staff C, but was not sure.

Interview with a second MA on 02/04/22 at 7:25pm revealed:
-Residents had complained that Staff C was mean to her.
-She told the RCC and LS and nothing was done about Staff C.

Interview with a fourth resident on 02/03/22 at 3:10pm revealed:

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-Staff C would sometimes give her a hard time by telling her she could not do certain things (she did not provide an example).
-Staff C never cursed at her but did talk to her like she was "a 2-year-old".
-Staff C always spoke to her like she was yelling; she always had a loud volume and tone of voice.
-She did not like the way she felt after interacting with Staff C because she made her feel "less than."
-She had not told anyone about Staff C talking down to her because she felt everyone already knew how Staff C spoke to the residents.

Interview with Staff C on 02/03/22 at 4:48pm revealed:
-She was not rude or mean to the residents.
-She treated the residents how she would treat her family member.
-The residents took advantage of staff and wanted staff to do things for them that they could do themselves.
-The residents were unappreciative of staff and treated staff mean.
-Some days she worked 14 to 16 hours and was tired.

Interview with a MA on 02/03/22 at 5:25pm revealed:
-She had seen Staff C be loud with the residents, rude and sarcastic towards residents.
-She told Staff C to watch her tone.
-The previous Administrator and RCC were aware of how Staff C treated the residents and they did nothing about Staff C because the facility was short staffed.
-She thought that she had told the LS about Staff C, but was not sure.

Interview with a fifth resident on 02/04/22 at

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D 338	Continued From page 32 9:05am revealed: -She and 3 other residents were sitting at a table in the dining room talking after they finished their meal, but she did not remember when. -Staff C got mad at the residents because they were still in the dining room. -Staff C told the residents they had to get out because she had work to do in the dining room. -Staff C started yelling at the residents saying, "goodbye, goodbye." -Staff C made her feel like "a child". Interview with the Resident Care Coordinator (RCC) on 02/04/22 at 2:50pm revealed: -Residents had complained to her several times, more than three times about Staff C talking rude to them, belittling them and being sarcastic with them. -She talked with Staff C several times regarding how she treated residents. -She had even written up Staff C because of how she treated residents. -She did not write up Staff C again for being verbally abusive to the residents. -On 01/25/22 or 01/26/22, the Administrator had a meeting with Staff C about her rudeness to residents. -She was not sure exactly what was discussed in the meeting between the Administrator and Staff C. Interview with the Administrator on 02/04/22 at 2:19pm revealed: -She did not know Staff C was verbally abusive to residents. -No one made her aware that Staff C was rude or belittled residents. -She started working at the facility on 01/05/22. -Three days later she heard Staff C say something in a loud tone to a resident.	D 338		

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-She pulled Staff C into her office told her to watch her tone when talking with residents.
-She had not been made aware that Staff C was rude to residents, sarcastic, belittled residents or refused to assist residents with personal care needs.
-The RCC told that she had two staff to write-up but did not tell if one of the staffs was Staff C.

Interview with a staff on 02/04/22 at 4:43pm revealed:
-Staff C antagonized residents.
-She once saw staff have to get in between Staff C and a resident to break up their argument.
-Staff C repeatedly went into a resident's room at bedtime and turned his television volume up when the resident had asked her to turn it down.
-Staff C threatened to hit a resident with a door.
-She told whoever the medication aide (MA) was on duty when she worked.
-"I do not know how she still has a job."

Interview with a second staff on 02/04/22 at 5:24pm revealed:
-Residents reported to her Staff C was rude to them and Staff C had also been rude to her.
-She told the Lead Supervisor (LS) and the Resident Care Coordinator (RCC) about the residents' complaints of Staff C and they responded that they had given her a warning.

Interview with a third staff on 02/04/22 at 5:37pm revealed:
-Staff C had an attitude when she interacted with residents.
-One resident told her Staff C cursed at her.
-She told the RCC about the residents' concerns with Staff C.

Interview with a second MA on 02/04/22 at

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D 338	Continued From page 34 7:25pm revealed: -Residents often complained about Staff C, mainly on shower days. -Staff C ordered residents to "get in the shower" and would not assist the residents with their personal care needs. -Residents complained that Staff C hurt their feelings and treated them like they were children. -One morning, Staff C made a resident cry because the resident wanted coffee in her cup and Staff C refused. _____ The facility failed to ensure residents were free of verbal abuse and being belittled by a staff (Staff C) who yelled, was loud and rude to residents and told residents they had to leave the dining room after a meal, ordering a resident to go to bed, ordering residents to get in the shower and not providing assistance to residents during a shower; failing to provide personal assistance to a resident with a broken leg which resulted in the resident crying. This failure resulted in residents being verbally abused which was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/03/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 21, 2022.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner	D 344		

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for verification or clarification of orders for medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observation, record review and interviews the facility failed to clarify medication orders for 1 of 5 sampled residents (Resident #1) related to decreased dosage of blood pressure medication and a medication for depression.

The findings are:

Review of Resident #1's current hospital FL2 dated 11/22/21 revealed diagnoses included hypertension and bipolar disorder.
-She was ambulatory and continent of bladder and bowel.

a. Review of Resident #1's hospital FL2 dated 11/22/21 revealed discharge medication orders for amlodipine 5mg once daily (used to treat hypertension).

Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 10mg on the eMAR scheduled for administration at 8:00am.
-Amlodipine 10mg was documented as

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administered 30 of 31 days from 12/01/21 through 12/31/21.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry for amlodipine 10mg on the eMAR scheduled for administration at 8:00am.
-Amlodipine 10mg was documented as administered 31 of 31 days from 01/01/22 through 01/31/22.

Review of Resident #1's February 2022 eMAR revealed:
-There was an entry for amlodipine 10mg on the eMAR scheduled for administration at 8:00am.
-Amlodipine 10mg was documented as administered 3 of 3 days from 02/01/22 through 02/03/22.

Interview with Resident #1 on 02/02/22 at 12:00pm revealed:
-She was not aware of her medications ordered.
-The medication aides (MAs) administered her medications and she did not know what they administered.

Telephone interview with Resident #1's PCP on 02/04/22 at 12:13pm revealed:
-She had been Resident #1's PCP for six months.
-She thought Resident #1 was administered amlodipine 5mg once daily.
-She had never ordered amlodipine 10mg.
-The problem was the facility also sometimes had the facility's PCP sign Resident #1's medication orders.
-On 02/03/22, the facility sent a medication list with Resident #1 to the appointment.
-The medication list had order dates from 2019 and 2020, and no current orders from her.
-She looked at the medication list sent by the

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facility, and noticed Resident #1 was administered amlodipine 10mg once daily.
-She had never ordered amlodipine 10mg.
-Her records showed that she only ordered amlodipine 5mg once daily.
-No one at the facility had called to clarify the order for amlodipine 10mg verse 5mg.
-She thought the facility should update Resident #1's medication orders using her orders only.

Interview with a pharmacist at the facility's contracted pharmacy on 02/04/22 at 9:34am revealed:
-The most current order the pharmacy had for Resident #1's amlodipine was for 10mg once daily which was dated 02/04/21.
-The pharmacy did not have the hospital FL2 dated 11/22/21.
-The pharmacy had never received an order or dispensed amlodipine 5mg for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 02/04/22 at 9:27am revealed:
-She had been the RCC for a little over one month.
-She had worked at the facility for 14 years and was a MA administering medications to the residents prior to becoming the RCC.
-It was the facility's protocol when FL2s from a hospital visit was received, and orders did not match orders on the eMAR, then the new order should be clarified with the resident's PCP.
-If the order was faxed and the PCP did not respond then someone should have contacted the PCP to clarify the order before continuing to administer medications.
-It was usually the RCC's responsibility to contact the PCP to clarify medication orders.
-She was not aware Resident #1's hospital FL2 dated 11/22/21 decreased amlodipine from 10mg

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to 5mg.
-She was aware there were no orders on the eMARs from Resident #1's current PCP but two previous facility providers who no longer visited the facility.
-Resident #1 had been with her current PCP for about six months.
-She was unable to explain why no one had contacted Resident #1's PCP since 11/22/21 to identify if amlodipine should be decreased from 10mg to 5mg.

Interview with the Administrator on 02/04/22 at 2:42pm revealed:
-She had worked at the facility for three weeks and was not aware Resident #1's amlodipine was administered incorrectly.
-The facility's policy was that when medication orders were received staff should send orders to the pharmacy.
-If a resident went to the hospital and had medication order change, then the MA should send the order to the pharmacy and contact the resident's PCP.
-There should be documentation to show this was done and when.
-The MA should make several attempts to contact the resident's PCP.
-If the MA was unable to communicate with the PCP the MA should let her know.

b. Review of Resident #1's current hospital FL2 dated 11/22/21 revealed an order for olanzapine 5mg once daily (used to treat bipolar).

Review of Resident #1's December 2021 eMAR revealed:
-There was an entry for olanzapine 10mg on the eMAR scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as

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D 344	Continued From page 39 administered 30 of 31 days from 12/01/21 through 12/31/21. Review of Resident #1's January 2022 eMAR revealed: -There was an entry for olanzapine 10mg on the eMAR scheduled for administration at 8:00am. -Olanzapine 10mg was documented as administered 31 of 31 days from 01/01/22 through 01/31/22. Review of Resident #1's February 2022 eMAR revealed: -There was an entry for olanzapine 10mg on the eMAR scheduled for administration at 8:00am. -Olanzapine 10mg was documented as administered 3 of 3 days from 02/01/22 through 02/03/22. Interview with Resident #1 on 02/02/22 at 12:00pm revealed: -She had anxiety disorder, but she was not aware of medications used to treat her anxiety. -The MA administered her medication and did not tell her anything about clarifying medication orders. -The MA did not tell her if there was a problem or concern with her medication orders. Telephone interview with Resident #1's POA on 02/03/22 at 3:53pm revealed: -Today (02/03/22), Resident #1's PCP complained to her that the medication list sent to her by the facility did not have the resident's current medication orders. -The PCP told her the medications listed had order dates from 2019 and 2020 from previous providers. -The PCP should be the only provider writing orders for medications for Resident #1.	D 344		

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D 344	Continued From page 40 -The PCP told her the facility sent the PCP faxes all the time but had not sent medication orders to be clarified. Interview with a pharmacist at the facility's contracted pharmacy on 02/03/22 at 1:30pm revealed: -The current order the pharmacy had for Resident #1's olanzapine was dated 12/17/20, from the facility's previous PCP. -The pharmacy did not have an order from Resident #1's current PCP for olanzapine 5mg. -The pharmacy did not have the hospital FL2 dated 11/22/21. -The pharmacy had never received an order or dispensed olanzapine 5mg for Resident #1. Telephone interview with Resident #1's PCP on 02/04/22 at 12:13pm revealed: -Resident #1 should be administered olanzapine 5mg once daily, not 10mg. -She had been Resident #1's PCP for six months. -She had never ordered olanzapine 10mg. -The order for olanzapine 10mg must have existed prior to her becoming the resident's PCP. -She saw Resident #1 on 12/06/21, and the last order in her records was for olanzapine 5mg. -No one at the facility had contacted her to clarify an order for olanzapine 10mg. Interview with the RCC on 02/04/22 at 9:27am revealed: -The order for olanzapine 10mg dated 12/17/20 was from the facility's previous PCP. -Resident #1 been with a private PCP for at least six months. -It was the facility's protocol when FL2s from a hospital visit was received, and orders did not match orders on the eMAR, then the new order should be clarified with the resident's PCP.	D 344		

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D 344	Continued From page 41 -She was not sure why Resident #1's order for olanzapine 5mg had not been clarified with the PCP. Interview with the Administrator on 02/04/22 at 02/04/22 at 2:42pm revealed: -She was not aware Resident #1 was administered olanzapine incorrectly. -The facility's policy if a resident went to the hospital and had a medication order change then the MA should send the order to the pharmacy and contact the resident's PCP. -There should be documentation to should this was done and when. -If the MA should make several attempts to contact the resident's PCP. -If the MA was unable to communicate with the PCP the MA should let her know.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #6) including an	D 358		

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antihypertensive and antipsychotic medication (#1), and blood thinners (#6).

The findings are:

1. Review of Resident #1's current hospital FL2 dated 11/22/21 revealed:
-Diagnoses included hypertension and bipolar disorder.
-She was ambulatory and continent of bladder and bowel.

a. Review of Resident #1's hospital FL2 dated 11/22/21 revealed discharge medication orders for amlodipine 5mg once daily (used to treat hypertension).

Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for amlodipine 10mg scheduled for administration at 8:00am.
-Amlodipine 10mg was documented as administered 30 of 31 days from 12/01/21 through 12/31/21.

Review of Resident #1's monthly vital sign sheet for December 2021 revealed a blood pressure of 128/70 on 12/14/21.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry for amlodipine 10mg scheduled for administration at 8:00am.
-Amlodipine 10mg was documented as administered 31 of 31 days from 01/01/22 through 01/31/22.

Review of Resident #1's monthly vital sign sheet for January 2022 revealed a blood pressure of

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D 358	Continued From page 43 122/68 on 01/06/22 and 114/78 on 01/15/22. Review of Resident #1's February 2022 eMAR revealed: -There was an entry for amlodipine 10mg scheduled for administration at 8:00am. -Amlodipine 10mg was documented as administered 3 of 3 days from 02/01/22 through 02/03/22. Observation of Resident #1's medications on hand on 02/03/21 at 12:33pm revealed: -Amlodipine 10mg was available for administration. -Amlodipine 10mg was filled and dispensed on 01/04/22 for a quantity of 30 tablets. -There were 5 tablets remaining. -There was no amlodipine 5mg on hand at the facility. Interview with Resident #1 on 02/02/22 at 12:00pm revealed: -She was not aware of her medications ordered. -The medication aides (MAs) administered her medications and she did not know what they administered. -Her family member was her Power of Attorney (POA) and took care of all things for her. -Recently, she had two falls. -The first fall; she was not feeling well, and she lost her balance and fell face forward on the floor. -She hit her head and injured her noise. -She had bruises on her face and her face hurt. -The second fall; she felt dizzy which caused her to fall to the floor and she broke her left leg. Telephone interview with Resident #1's POA on 02/03/22 at 3:53pm revealed: -Resident #1 had a fall earlier in year of 2021, then had two falls within the past month and a	D 358		

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half.
-The third fall resulted in a broken leg.
-Resident #1 had complained to her almost daily about feeling lightheaded and dizzy.
-She told Resident #1 to tell the MA that she was dizzy and lightheaded.
-She never questioned Resident #1's medications but trusted the facility staff to administer the medications as ordered.
-The last two times that Resident #1 fell she had complained about feeling dizzy before falling.
-Today (02/03/21) at the Primary Care Provider's (PCP) office Resident #1's blood pressure (BP) was very low, it was 100/50.
-The PCP pointed out that some of Resident #1's medications never got changed as ordered on the hospital FL2 dated 11/22/21.
-Mainly, a BP medication, which could have caused Resident #1 to feel dizzy and fall.

Telephone interview with Resident #1's PCP on 02/04/22 at 12:13pm revealed:
-She had been Resident #1's PCP for six months.
-She thought Resident #1 was administered amlodipine 5mg once daily.
-She had never ordered amlodipine 10mg.
-Yesterday (02/03/22), she received a medication list sent with Resident #1 to the appointment.
-The medication list had medication order dates from 2019 and 2020, and no current orders from her.
-She thought the facility should update Resident #1's medication orders.
-Resident #1 had been sent to the hospital three times related to falls due to feeling lightheaded and dizzy.
-Yesterday (02/03/22), in her office Resident #1's BP was low, 100/58.
-She had not seen Resident #1 since 12/06/21, which was a follow-up after the 11/22/21

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hospitalization.
-On the 11/22/21 hospital FL2, there was an order for amlodipine 5mg once daily.
-Yesterday (02/03/22), she looked at the medication list sent by the facility, and she noticed Resident #1 was administered amlodipine 10mg once daily.
-She thought the amlodipine 10mg may have been a contributing factor to Resident #1's falls; one of which resulted in a broken leg.
-The amlodipine 10mg may have caused the resident's BP to drop low making her feel lightheaded and dizzy.
-Yesterday (02/03/22), she discontinued amlodipine 10mg and ordered BP three times daily.

Interview with a pharmacist at the facility's contracted pharmacy on 02/04/22 at 9:34am revealed:
-The most current order the pharmacy had for Resident #1's amlodipine was for 10mg once daily which was dated 02/04/21.
-The pharmacy did not have the hospital FL2 dated 11/22/21.
-The pharmacy never received an order or dispensed amlodipine 5mg for Resident #1.

Interview with the Resident Care Coordinator (RCC) on 02/04/22 at 9:27am revealed:
-She was not aware Resident #1's hospital FL2 dated 11/22/21 decreased amlodipine from 10mg to 5mg.
-She was aware there were no orders on the eMARs from Resident #1's current PCP but by two previous facility providers who no longer visited the facility.
-Resident #1 had occasionally mentioned that at times she felt dizzy, but she did not associate that with being related to the resident's BP

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medication.

Interview with the Administrator on 02/04/22 at 02/04/22 at 2:42pm revealed:
-She was not aware Resident #1 was administered amlodipine incorrectly.
-The facility's policy was that when medication orders were received staff should send orders to the pharmacy.
-If a resident went to the hospital and had medication order changes, the MA should send the order to the pharmacy and contact the resident's PCP.
-She expected medications to be administered as ordered.
-She was aware Resident #1 had a fall, but was not aware the resident complained about feeling dizzy or lightheaded.

b. Review of Resident #1's current hospital FL2 dated 11/22/21 revealed an order for olanzapine 5mg once daily (used to treat bipolar disorder).

Review of Resident #1's December 2021 eMAR revealed:
-There was an entry for olanzapine 10mg on scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as administered 30 of 31 days from 12/01/21 through 12/31/21.

Review of Resident #1's January 2022 eMAR revealed:
-There was an entry for olanzapine 10mg scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as administered 31 of 31 days from 01/01/22 through 01/31/22.

Review of Resident #1's February 2022 eMAR

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revealed:
-There was an entry for olanzapine 10mg scheduled for administration at 8:00am.
-Olanzapine 10mg was documented as administered 3 of 3 days from 02/01/22 through 02/03/22.

Observation of Resident #1's medications on hand on 02/03/21 at 12:33pm revealed:
-Olanzapine 10mg was available for administration.
-Olanzapine 10mg was filled and dispensed on 01/02/22 for a quantity of 30 tablets.
-There were 4 tablets remaining.
-There was no olanzapine 5mg on hand at the facility.

Interview with Resident #1 on 02/02/22 at 12:00pm revealed:
-She had an anxiety disorder, but she was not aware of medications used to treat her anxiety.
-The MA administered her medications and did not tell her what the medications were used to treat.

Telephone interview with Resident #1's POA on 02/03/22 at 3:53pm revealed:
-Today (02/03/22), Resident #1's PCP complained to her that the medication list sent by the facility did not have the resident's current medication orders.
-The PCP said the medications listed had order dates from 2019 and 2020 from previous providers.
-The PCP should be the only provider writing orders for medications for Resident #1.

Interview with a pharmacist at the facility's contracted pharmacy on 02/03/22 at 1:30pm revealed:

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-The current order the pharmacy had for Resident #1's olanzapine 10 mg was dated 12/17/20, from the facility's previous PCP.
-The pharmacy did not have an order from Resident #1's current PCP for olanzapine 5mg.
-The pharmacy did not have the hospital FL2 dated 11/22/21.
-The pharmacy had never received an order or dispensed olanzapine 5mg for Resident #1.

Telephone interview with Resident #1's PCP on 02/04/22 at 12:13pm revealed:
-Resident #1 should be administered olanzapine 5mg once daily, not 10mg.
-She had been Resident #1's PCP for six months.
-She had never ordered olanzapine 10mg.
-The order for olanzapine 10mg must have existed prior to her becoming the resident's PCP.
-She saw Resident #1 on 12/06/21, and the last order in her records was for olanzapine 5mg.
-She had noticed the facility sent her a medication list with orders from previous providers that had order dates from 2019 and 2020 and did not include her current medication orders.

Interview with the RCC on 02/04/22 at 9:27am revealed:
-The order for olanzapine 10mg dated 12/17/20 was from the facility's previous PCP.
-Resident #1 had been with a private PCP for at least six months.
-It was the previous RCC's responsibility to ensure new orders matched orders on the eMARs.

Interview with the Administrator on 02/04/22 at 02/04/22 at 2:42pm revealed:
-She was not aware Resident #1 was administered olanzapine 10 mg instead of

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olanzapine 5 mg.
-According to the facility's policy, if a resident went to the hospital and had a medication order change then the MA should send the order to the pharmacy and contact the resident's PCP.
-There should be documentation to show this was done and when.
-She expected all residents' medications to be administered as ordered.

2. Review of Resident #6's FL2 dated 09/01/21 revealed diagnoses included diabetes, cerebrovascular accident, chronic kidney disease, and hypertension.

Review of Resident #6's physician's orders dated 01/04/22 revealed there was an order to start Eliquis 2.5mg (a blood thinner) take 1 tablet twice daily for 10 days then discontinue. Hold Aspirin (a blood thinner) until Eliquis was completed.

Review of a physician's order request for Resident #6 dated 01/13/22 revealed:
-There was a request to have Eliquis for 10 days discontinued due to his family's request.
-The form was signed by the Resident Care Coordinator (RCC).
-There was no response or order from the physician.

Review of Resident #6's electronic Medication Administration Record (eMAR) for January 2022 revealed:
-There was an entry for Eliquis 2.5mg 1 tablet twice daily for 10 days to be administered at 8:00am and 8:00pm.
-There was documentation Eliquis was administered for 2 of 13 opportunities on 01/13/22 at 8:00am and 01/18/22 at 8:00pm.
-There was documentation Eliquis was not

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administered due to resident refused, medication not available, and family refusal on 01/14/22 at 8:00pm through 01/19/22 at 8:00am.
-There was an entry for Aspirin 81mg chew and swallow 2 tablets daily at 8:00am; the order was suspended from 01/12/20 through 01/20/22 per the physician.
-There was documentation Aspirin was not administered from 01/13/22 through 01/20/22.

Interview with a representative from the facility's contracted pharmacy on 02/02/22 at 1:48pm revealed:
-Resident #6 had an order dated 01/12/22 for Eliquis 2.5mg 1 tablet daily for 10 days and hold Aspirin 81mg 2 tablets daily until Eliquis was completed.
-There was an order to discontinue Eliquis on 01/19/22 due to family request.

Interview with a medication aide (MA)/Supervisor on 02/03/22 at 5:46pm revealed:
-She called Resident #6's responsible party to let her know he had an order for Eliquis.
-Resident #6's responsible party told her to she had refused the order for Eliquis and not to administer Eliquis to Resident #6.
-She did not think Eliquis was ever dispensed to the facility.
-Resident #6 was not administered Eliquis for 10 days and he was not administered Aspirin throughout the duration of the order.
-She told the RCC and the Lead Supervisor (LS) that Resident #6's responsible party did not want him to be administered Eliquis.
-She did not contact Resident #6's Primary Care Provider (PCP) regarding not administering Eliquis or to see if the Aspirin should continue to be held.
-She did not know if the RCC or the LS contacted

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D 358	Continued From page 51 Resident #6's PCP regarding the medication orders for Eliquis and Aspirin. Interview with Resident #6's responsible party on 02/04/22 at 10:30am revealed: -She received a call from the facility pharmacy regarding an order for Eliquis. -She was upset Eliquis had been ordered for Resident #6 and she had not been consulted. -Resident #6 had a stroke in the past and if he needed to take a blood thinner, it would not be Eliquis. -She requested the facility staff not to administer Eliquis to Resident #6. -She did not know there was an order to hold Resident #6's Aspirin while he was on Eliquis. Interview with the LS on 02/04/22 at 12:32pm revealed: -Resident #6 had an order for Eliquis in January 2020, but his responsible party refused for him to take the medication. -She had administered the first dose of Eliquis, but she did not administer any additional doses due to the responsible party's request for Resident #6 not to have it. -Resident #6's responsible party wanted him back on Aspirin. -She or the RCC reached out to Resident #6's PCP regarding the order for Eliquis and Aspirin, but she did not know when. -There was no order to continue Aspirin until the Eliquis was discontinued on 01/19/22. Interview with the RCC on 02/04/22 at 1:58pm revealed: -Resident #6 had an order for Eliquis for 10 days and to hold Aspirin while taking Eliquis. -Resident #6's responsible party requested the order for Eliquis to be discontinued.	D 358		

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	HAL055007	A. BUILDING: _____ B. WING _____	R 02/04/2022

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D 358	Continued From page 52 -She emailed a physician's order request to Resident #6's physician to discontinue Eliquis for 10 days due to the family's request; the physician's order request was emailed to the PCP twice on 01/14/22 and twice on 01/18/22. -She did not get a response from Resident #6's PCP until he had a telehealth visit on 01/19/22. -The order for Eliquis was discontinued on 01/19/22 and Resident #6 started back on Aspirin on the same date. Interview with the Administrator on 02/04/22 at 2:49pm revealed: -She expected staff to contact Resident #6's PCP with any medication changes or concerns. -If staff was unable to get a response from Resident #6's PCP, they should have let her know so that she could make contact. Attempted interview with Resident #6's PCP on 02/04/22 at 9:56am was unsuccessful. _____ The facility failed to administer medications as ordered for Resident #1 by not decreasing the resident's blood pressure medication as ordered which resulted in the resident becoming hypotensive, lightheaded and dizzy which could have resulted in falls with bruises and a fractured left leg; and not administering blood thinners as ordered for Resident #6. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/03/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 21,	D 358		

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D 358	Continued From page 53 2022	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to submit a report of allegations of verbal abuse by Staff (Staff C) to the Health Care Personnel Registry (HCPR) within 24 hours and complete a 5 day report after becoming aware of the allegations. The findings are: Review of Staff C's, personal care aide (PCA) personnel record revealed Staff C was hired on 06/04/21 as personal care aide. Review of a Corrective Action Form for Staff C revealed: -On 12/29/21, Staff C received verbal counseling. -The issues addressed was being rude to the residents and belittling residents. -The form was signed by the Resident Care Coordinator (RCC) and witnessed by the lead Supervisor (LS). Interview with Staff C on 02/03/22 at 4:48pm revealed:	D 438		

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D 438	Continued From page 54 -She was not rude or mean to the residents. -She treated the residents how she would treat her family member. -The residents took advantage of staff and wanted staff to do things for them that they could do themselves. -The residents were unappreciative of staff and treated staff mean. -Some days she worked 14 to 16 hours and was tired. Interview with a MA on 02/04/22 at 7:25pm revealed: -Residents often complained about Staff C, mainly on shower days. -Staff C ordered residents to "get in the shower" and would not assist the residents. -One morning, Staff C made a resident cry because the resident wanted coffee in a cup and Staff C refused. -She told the RCC and LS and nothing was done about Staff C. Interview with the RCC on 02/04/22 at 2:50pm revealed: -Residents had complained to her several times, more than three times about Staff C talking rude to them, belittling them and being sarcastic with them. -She talked with Staff C several times regarding how she treated residents. -She had even written up Staff C because of how she treated residents. -She did not write up Staff C again for being verbally abusive to the residents. -On 01/25/22 or 01/26/22, the Administrator had a meeting with Staff C about her rudeness to residents. -She was not sure exactly what was discussed in the meeting between the Administrator and Staff	D 438		

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D 438	Continued From page 55 C. -She had not reported Staff C to the Health Care Personnel Registry (HCPR) because she did not know that she had to report Staff C. -Also, she did not know the process of reporting staff to the HCPR. Interview with the Administrator on 02/04/22 at 2:19pm revealed: -She did not know Staff C was verbally abusive to residents. -No one made her aware that Staff C was rude or belittled residents. -She started working at the facility on 01/05/22. -Three days later she heard Staff C say something in a loud tone to a resident. -She pulled Staff C into her office told her to watch her tone when talking with residents. -She had not been made aware that Staff C was rude to residents, sarcastic, belittled residents or refused to assist residents with personal care needs. -The RCC told her that she had two staff write-ups to complete. -The RCC did not tell her why she was writing up the staff and did not tell her if the write-ups were related to Staff C's treatment of the residents. -She had not reported Staff C to the HCPR because no one had made her aware of Staff C's verbal abuse to the residents. _____ The facility failed to ensure allegations of verbal abuse was reported to the HCPR resulting in Staff C continuing to work with residents and continued to verbally abuse residents after the facility was made aware of the allegations. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____	D 438		

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D 438	Continued From page 56 The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 02/09/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 21, 2022. [Refer to Tag 338 10A NCAC 13F .0909 Residents Rights (Type B Violation).]	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to training on care of diabetic residents, health care, and medication administration. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled medication aides (Staff A and B), who obtained fingerstick blood sugars (FSBS) and administered insulin to residents, completed training on the care of diabetic residents. [Refer to Tag D 0164, 10A NCAC 13F .0505 Training on Care of Diabetic	D912		

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D912	Continued From page 57 Residents (Type B Violation).] 2. Based on observations, record reviews and interviews, the facility failed to ensure follow up with health care providers for 3 of 5 sampled residents (#4, #2 and #6) including a resident who had orders for a rapid-acting sliding scale insulin requiring physician notification for blood sugars over 450 or less than 70 (#4); a resident who had increased swelling in both her feet and ankles after a fall (#2); and a resident who had orders for compression therapy to be applied and removed daily (#6). [Refer to Tag D 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1 and #6) including an antihypertensive and antipsychotic medication (#1), and blood thinners (#6). [Refer to Tag D 0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents were free from verbal abuse related to residents' rights and health care personnel registry.	D914		

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D914	Continued From page 58 The findings are: 1. Based on observations, record reviews, and interviews the facility failed to ensure residents were free of verbal abuse and treated with respect and dignity related to a staff (Staff C) yelling at residents, treating residents rudely, cursing and belittling residents and not providing assistance to a resident who had a broken leg (#1) and verbal abuse to other residents. [Refer to Tag D 0338, 10A NCAC 13F .0909 Residents Rights (Type B Violation).] 2. Based on interviews and record reviews, the facility failed to submit a report of allegations of verbal abuse by Staff (Staff C) to the Health Care Personnel Registry (HCPR) within 24 hours and complete a 5 day report after becoming aware of the allegations. [Refer to Tag D 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation).]	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (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: (1) A five-hour training program developed by the Department that includes training and instruction	D935		

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D935	Continued From page 59 in all of the following: a. The key principles of medication administration. 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. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 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. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (A) who administered medications had completed the state approved 5-hour and 10-hour medication aide training course as required. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired as a MA at the facility on	D935		

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D935	Continued From page 60 03/17/17. -Staff A passed the written MA exam on 11/24/15. -Staff A completed the Medication Administration Clinical Skills Validation Checklist on 04/05/17. -There was documentation Staff A completed a 10 hour MA training course on 04/11/17. -There was no documentation of completion of a 5 hour MA training course. Review of December 2021 electronic Medication Administration Record (eMAR) for 5 of 5 sampled residents revealed there was documentation Staff A administered medications on 12/06/21, 12/07/21, 12/11/21, 12/15/21, 12/17/21, 12/18/21, 12/20/21, 12/24/21, 12/27/21, 12/28/21, 12/29/21, and 12/30/21. Review of January 2022 eMARs for 5 of 5 sampled residents revealed there was documentation Staff A administered medications on 01/04/22, 01/05/22, 0108/22, 01/10/22, 01/13/22, 01/18/22, 01/19/22, 01/21/22, 01/23/22, 01/24/22 and 01/28/22. Review of February 2022 eMARs for 5 of 5 sampled residents revealed there was documentation Staff A administered medications on 02/02/22 and 02/03/22. Interview with Staff A on 02/04/22 at 6:54pm revealed: -She was hired at the facility in March 2017 (unable to recall the exact date of hire). -She remembered that she did MA training but was unable to recall when the training was completed. -She recalled watching videos but was unable to recall if the training was completed by an RN. -The previous RCC was responsible for setting up trainings.	D935		

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D935	Continued From page 61 Interview with the Corporate Vice President of Operations on 02/04/22 at 6:35pm revealed: -The new company took over operations of the facility on 12/01/21. -Employee personnel records did not get addressed because all the previous staff walked out after the Administrator left. -She was not aware Staff A had no documentation that she completed 5 hour MA training. [Refer to Tag D 0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D935		