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	HAL007014	A. BUILDING: _____ B. WING _____	R 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARA MANOR	1218 PAMLICO STREET WASHINGTON, NC 27889

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D 000	Initial Comments The Adult Care Licensure Section and the Beaufort County Department of Social Services conducted an annual and follow-up survey on 10/15/21.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to provide bathing assistance and nail care for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 04/20/21 revealed: -Diagnoses included chronic pain, pacemaker, hypertension and bilateral leg amputation. -He used a wheelchair to assist with mobility. -There was no information related to orientation status. Review of Resident #1's current care plan dated 04/20/21 revealed that he required extensive assistance from staff with toileting, ambulation, bathing, dressing, grooming and transferring.	D 269		

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Observation of Resident #1 on 10/15/21 at 11:30am revealed:
-He had irregularities to his right arm just above and below the elbow.
-His fingernails were long with some jagged edges on both hands.
-There was dirt visible under his finger nails.
-Large flakes of skin were observed on his scalp and the hair on his head was stuck together by the dander.
-The hair on his head was greasy.

Interview with Resident #1 on 10/15/21 at 11:30am revealed:
-His right arm had been crushed in an accident and he had lost his legs years ago and this limited the use of his arm causing him to need assistance from staff to wash his hair.
-He needed assistance with bathing.
-He thought staff had assisted him to bathe about 1 week prior but was unsure.
-He did not remember when staff had last assisted him with nail care.

Review of Resident #1's personal care logs for September 2021 revealed:
-There was documentation that a bed bath was completed with limited assistance on 09/11/21, 09/13/21-09/14/21, 09/18/21-09/19/21, 09/24/21 and 09/27/21-09/30/21 on second shift.
-There was documentation that a bath was completed on 09/21/21 on second shift but the documentation did not clarify whether this was tub, shower, bed bath or sponge bath.
-There was documentation of nail care with limited assistance on 09/11/21, 09/14/21,09/18/21-09/19/21,09/21/21,09/24/21 and 09/26/21-09/30/21 on second shift.
-There was documentation of shampooing the hair on 09/14/21 on second shift.

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D 269	Continued From page 2 Review of Resident #1's personal care logs for October 2021 revealed: -There was documentation of an independent bath on 10/03/21,10/05/21, 10/07/21-10/08/21, 10/10/21, and 10/12/21 on second shift. -There was documentation of skin care completed independently on 10/03/21-10/05/21 on second shift. -There was documentation that skin care was completed with extensive assistance on 10/07/21-10/08/21 on second shift. -There was documentation that skin care was completed with limited assistance on 10/10/21 and 10/12/21 on second shift. -There was documentation that shampooing was not completed for any shift. Interview with a personal care aide (PCA) on 10/15/21 at 3:25pm revealed: -Resident #1 required assistance with bathing because he could not use his arm to wash his hair as well as he used to. -He would sometimes refuse to bathe or would tell staff he had already had a bath earlier in the day. -She knew his hair was dirty and needed washing. -She knew his nails were dirty and long. -She had not reported to anyone that he was dirty and refusing bathing and nail care. Interview with the Facility Manager on 10/15/21 at 3:20pm revealed: -Resident #1 required staff assistance to transfer to the shower chair and bathing. -He expected staff to assist Resident #1 to bathe every other day. -He knew staff were not documenting personal care for the resident consistently but did not know	D 269		

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D 269	Continued From page 3 why the personal care logs were not completed. -He expected to be notified when residents refused personal care. Second interview with the Faciltiy Manager on 10/15/21 at 3:40pm revealed he was not told by staff that Resident #1 refused personal care.	D 269		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#2) related to a wound on his left great toe that was red and inflamed with thick yellow drainage and was not reported to the primary care provider (PCP) or home health (HH). The findings are: Review of Resident #2's current FL-2 dated 03/08/21 revealed: -Diagnoses included gait instability, diabetes, arthritis and back pain. -The resident was semi-ambulatory and used a wheelchair. Review of Resident #2's care plan dated 03/26/21 revealed the resident required supervision with transfers and ambulation, limited assistance with toileting, dressing and grooming and extensive	D 273		

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D 273	Continued From page 4 assistance with bathing. Observation of Resident #2 on 10/15/21 at 8:33am revealed: -The resident was lying down in his bed with both legs elevated watching television. -There was an open wound with thick yellow drainage on his left great toe approximately 2 centimeters (cm) by 1cm. -The area surrounding the wound was red, inflamed, shiny, and the skin was swollen. Interview with Resident #2 on 10/15/21 at 8:33am revealed: -He had problems with his balance. -He had an open wound on his left great toe that the Home Health Nurse (HHN) came to bandage several times a week. -He purchased hydrogen peroxide to apply to his wound. -He experienced pain on his left great toe every day. -The pain on his left great toe was a 10 on the numerical pain scale at least three times a day (the numerical pain scale measures pain on a scale from 0-10 with 0 being no pain and 10 being the most severe pain). -He saw the podiatrist approximately 2 months ago for foot care to have his toenails trimmed. -He had an appointment scheduled with the podiatrist next week. Interview with a medication aide (MA) on 10/15/21 at 2:48pm revealed: -Home health nursing services started providing wound care for Resident #2 approximately two weeks ago. -Sometimes Resident #2 did not allow staff to clean the wound on his left great toe. -She noticed the wound on his left great toe	D 273		

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appeared to be more infected last week.
-She thought she had informed the Facility Manager of Resident #2's left great toe appearing more infected last week but could not remember if she had or not.
-She did not inform the resident's PCP or the HHN about Resident #2's left great toe appearing to be more infected.
-She could not provide a reason that she did not inform the resident's PCP or the HHN about his left great toe appearing to be more infected.
-MAs were responsible for notifying the PCP and the Facility Manager if there was a concern about residents or they had a change in condition.

Telephone interview with Resident #2's HH Clinical Manager and HHN on 10/15/21 at 3:27pm revealed:
-Resident #2 received physical therapy to improve his balancing.
-On 09/24/21 the physical therapist observed a wound on the resident's left great toe and notified the HH agency.
-On 09/24/21 the physical therapist showed a MA at the assisted living facility (ALF) the wound on his left great toe and asked her to schedule a podiatrist appointment for the resident.
-The physical therapist did not document the name of the MA she showed the wound to or asked to schedule a podiatrist appointment.
-On 09/27/21 the HHN obtained a verbal order from Resident #2's primary care provider (PCP) to initiate wound care for his left great toe, one time a week for 4 weeks.
-The HHN initiated wound care for Resident #2's left great toe on 09/28/21.
-On 10/11/21 the HHN documented that Resident #2 told her staff had not been helping him with his dressing changes.
-On 10/11/21 the HHN asked a MA if they could

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provide dressing changes to the resident's wound if she provided them with education.
-On 10/11/21 the HHN provided education to the MA on wound care for the resident as needed.
-The HHN did not document the name of the MA that she provided wound care education.
-A HHN provided wound care every three days and as needed to the resident's left great toe.

Interview with the Facility Manager on 10/15/21 at 1:15pm revealed:
-He had been the Facility Manager since 09/21/21.
-He was responsible for supervising the MAs and personal care aides (PCA).
-He was responsible for contacting the Administrator and PCP to report any problems, concerns or issues.

A second interview with the Facility Manager on 10/15/21 at 4:15pm revealed:
-He was responsible for making appointments for residents.
-The previous Facility Manager had scheduled Resident #2's appointment to the podiatrist for 09/29/21.
-He did not know why Resident #2 missed his appointment with the podiatrist on 09/29/21.
-He was informed by the HHN that Resident #2 needed a podiatrist appointment; which he scheduled for 10/19/21.
-The last time he saw Resident #2's wound on his left great toe was 10/01/21; it appeared swollen, red, and shiny but did not have any yellow drainage.
-When a personal care aide (PCA) or MA notice any change in a resident they were expected to notify him; he would assess and then contact the resident's PCP.

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Telephone interview with Resident #2's podiatrist on 10/15/21 at 3:15pm revealed:
-The resident was seen by the podiatrist on 06/28/21.
-The resident had a follow up appointment on 09/29/21 but did not come to this appointment.
-A follow-up appointment was rescheduled for 10/19/21.

Interview with the Administrator on 10/15/21 at 4:30pm revealed:
-She had seen Resident #2's wound on his great left toe at 4:20pm.
-The resident needed to be assessed by a physician today, due to the risk of further infection.
-She described the wound on Resident #2's left great toe as swollen, skin was broken with yellow drainage, and the skin around the wound was red.

A second interview with the Administrator on 10/15/21 at 4:57pm revealed:
-She met with the HHN and Resident #2 to observe the wound on his left great toe for a second time.
-She and the HHN both agreed that Resident #2 needed to be seen by an urgent care provider as soon as possible.
-The owner of the facility transported Resident #2 to a local urgent care, but it was too late for appointments.
-Resident #2 would be transported by the Facility Manager to a local urgent care to assess the wound on his left great toe on 10/16/21.

Interview with the HHN on 10/15/21 at 4:57pm revealed:
-She provided wound care to Resident #2's left great toe this afternoon.

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D 273	Continued From page 8 -She voiced her concerns to the Administrator and Facility Manager her concerns about the resident's left great toe. -She agreed that the resident should be seen by a local urgent care by 10/16/21 due to her concern that the wound was infected. -She did not want the resident to go without treatment since the wound on his left great toe appeared infected. Attempted telephone interview with Resident #2's PCP on 10/15/21 at 3:13pm was unsuccessful. _____ The facility failed to notify the PCP for 1 of 3 sampled residents (#2), who had a history of diabetes and decreased peripheral circulation of his left great toe wound that became red, painful and was draining thick yellow drainage. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	D 276		

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orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#2) regarding physician orders to check finger stick blood sugar daily.

The findings are:

Review of Resident #2's current FL-2 dated 03/08/21 revealed:
-Diagnoses included gait instability, diabetes, arthritis and back pain.
-The resident was semi-ambulatory and used a wheelchair.

Review of Resident #2's physician orders dated 07/30/21 revealed there was an order to obtain a fingerstick blood sugar (FSBS) every day for monitoring; there were no parameters.

Review of Resident #2's October 2021 medication administration record (MAR) revealed:
-There was an order to obtain the residents FSBS every day for monitoring.
-There was no documentation that the resident's FSBS was checked on 10/04/21 and 10/05/21.

Interview with Resident #2 on 10/15/21 at 8:33am revealed:
-The medication aides (MAs) usually checked his FSBS at 7:00am.
-His FSBS had not been checked this morning.
-Some mornings the MAs did not check his FSBS.

Interview with the Home Health Nurse (HHN) on

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D 276	Continued From page 10 10/15/21 at 5:40pm revealed: -She came to the facility to observe a wound on the residents left great toe that had become more infected. -She asked the Facility Manager/MA for Resident #2's FSBS for the past two days. -The Facility Manager/MA was unable to provide her with of Resident #2's last two FSBS (10/04/21 and 10/05/21). Interview with the Facility Manager/medication aide (MA) on 10/15/21 at 5:50pm revealed: -Resident #2's FSBS's were checked every day at 7:00am. -He did not realize that he had not checked or documented FSBS for Resident #2 on 10/04/21 or 10/05/21. -He got busy and forgot to document the residents FSBS. -He could not provide the HHN Resident #2's FSBS from the past two days because his FSBS had not been checked. -All MAs were expected to follow physician orders. -Resident #2 had diabetes and poor circulation. -He reviewed MARs every 3 days but must have missed Resident #2 not having his FSBS checked every day as ordered. Interview with the Administrator on 10/15/21 at 6:21pm revealed: -She was not aware that Resident #2 did not have his FSBS checked every day as ordered by his physician. -It was the responsibility of the MAs to ensure they followed physician orders. -The Facility Manager/MA was responsible for completing weekly audits of MARS. -She was concerned that Resident #2 did not have his FSBS checked daily because he was a	D 276		

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D 276	Continued From page 11 diabetic and had an infected wound on his left great toe. Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/15/21 at 3:13pm was unsuccessful.	D 276		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: SKINNER, SUSAN Based on observations, interviews, and record reviews the facility failed to ensure activities were provided to promote active involvement by all residents. The findings are: Observation of the facility on 10/15/21 8:15am revealed there was not an activity calendar posted in the facility for the month of October 2021. Observation of activity supplies on 10/15/21 at 10:00am revealed:	D 315		

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-There was one bookshelf with 25 books in the resident's lounge.
-There was a television in the lounge.
-There was one board game on a table in the resident's lounge.
-There was a small plastic container that contained 30 paint brushes, 4 COVID-19 Information Booklets, one ink pen and one ball of twine.

Interview with a resident on 10/15/21 at 8:29am revealed the facility did not offer any activities.

Interview with a second resident on 10/15/21 at 8:54am revealed the facility did not provide any activities to the residents; she wished she could play bingo.

Interview with a third resident on 10/15/21 at 9:15am revealed the residents only ate and slept, he would enjoy going to the park or just getting out.

Interview with a fourth resident on 10/15/21 at 10:20am revealed:
-There were not any activities provided at the facility.
-The resident used to enjoy playing cards and bingo but there had not been any group activities for over a year.

Interview with a personal care aide (PCA) on 10/15/21 at 9:20am revealed:
-The activity calendar was not displayed in the hallway near the nurse's station; she thought it was posted but was unable to locate one.
-The activity director would probably prepare the activity calendar tonight and post it in time for the weekend.

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D 315	Continued From page 13 Interview with a second PCA on 10/15/21 at 9:35am revealed the facility usually provided a bingo game at several times a week for the residents. Observation of a second PCA on 10/15/21 at 9:38am revealed she was unable to locate a bingo game in the facility. Interview with the Facility Manager on 10/15/21 at 1:15pm revealed the monthly activity calendar was not posted in the facility on the bulletin board and he was not sure why the activity director had not posted the calendar. Interview with the Administrator on 10/15/21 at 5:45pm revealed: -She was not aware that there was not an activity calendar posted on the bulletin board. -The activity director had given the calendar to another staff person to post but realized it was not posted once the state surveyor brought to her attention. -Many residents did not want to participate in activities. -She was not aware that several residents voiced a desire for more activities today to the state surveyor -She expected residents to have access to an activity calendar each month. -The activity director was responsible for providing activities to the residents. -The activity director was not at the facility today and would return to the facility next week.	D 315		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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	HAL007014	A. BUILDING: _____ B. WING _____	R 10/15/2021

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D 367	Continued From page 14 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (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). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medication administration records were accurate to include documentation of the Medication Aide (MA) who administered the medications to 2 of 3 residents sampled (#1, #2). The findings are: 1. Review of Resident #2's current FL-2 dated 03/08/21 revealed: -Diagnoses included gait instability, diabetes, arthritis and back pain. -The resident was semi-ambulatory and used a wheelchair. -There was an order for Colace 100mg (used for constipation), take one capsule daily. -There was an order for Avodart 0.5mg (used for	D 367		

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D 367	Continued From page 15	D 367		

an enlarged prostate) take on capsule daily.
-There was an order for Glipizide ER 5mg (used for diabetes), take one tablet daily.
-There was an order for Januvia 100mg (used for diabetes), take one tablet daily.
-There was an order for Lovastatin 10mg (used for cholesterol), take one tablet daily.
-There was an order for Meloxicam 15mg (used for pain), take one tablet daily.
-There was an order for Multivitamin (used for a supplement), take one tablet daily.
-There was an order for Vitamin D2 50,000 units (used for bone health), take one capsule one time a week.
-There was an order for Glyburide-Metformin 5-500mg (used for diabetes), take two tablets 2 times a day.
-There was an order for Gabapentin 300mg (used for nerve pain), take one capsule three times a day.

Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Colace 100mg, Avodart 0.5mg, Glipizide ER 5mg, Januvia 100mg, Lovastatin 10mg, Meloxicam 15mg and Multivitamin scheduled at 8:00am.
-Colace, Avodart, Glipizide ER, Januvia, Lovastatin, Meloxicam and Multivitamin were documented as administered on 09/24/21 and 09/30/21 by the current Facility Manager/medication aide (MA) using the previous Facility Manager/MA initials.
-There was an entry for Vitamin D2 50,000 units scheduled at 8:00am.
-Vitamin D2 50,000 units was documented as administered on 09/28/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials.

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D 367	Continued From page 16 -There was an entry for Glyburide-Metformin 5-500mg scheduled at 8:00am and 8:00pm. -Glyburide-Metformin 5-500mg was documented as administered at 8:00pm on 09/21/21, 8:00am and 8:00pm on 09/24/21, 8:00pm on 09/25/21, 8:00pm on 09/26/21, 8:00am on 09/28/21, and 8:00am and 8:00pm on 09/30/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials. -There was an entry for Gabapentin 300mg scheduled at 8:00am, 2:00pm and 8:00pm. -Gabapentin was documented as administered at 8:00pm on 09/21/21, 8:00am, 2:00pm and 8:00pm on 09/24/21, 8:00pm on 09/25/21, 8:00pm on 09/26/21, 8:00am on 09/28/21, and at 8:00am, 2:00pm and 8:00pm on 09/30/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials. Review of Resident #2's October 2021 eMAR revealed: -There was an entry for Colace 100mg, Avodart 0.5mg, Glipizide ER 5mg, Januvia 100mg, Lovastatin 10mg, Meloxicam 15mg and Multivitamin scheduled at 8:00am. -Colace, Avodart, Glipizide ER, Januvia, Lovastatin, Meloxicam and Multivitamin were documented as administered on 10/01/21, 10/05/21, 10/08/21, 10/12/21 and 10/13/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials. -There was an entry for Vitamin D2 50,000 unit scheduled at 8:00am. -Vitamin D2 50,000 unit was documented as administered on 10/05/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials. -There was an entry for Glyburide-Metformin 5-500mg scheduled at 8:00am and 8:00pm. -Glyburide-Metformin 5-500mg was documented	D 367		

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as administered at 8:00am and 8:00pm on 10/01/21, 8:00pm on 10/02/21, 8:00pm on 10/03/21, 8:00am on 10/05/21, 8:00am and 8:00pm on 10/08/21, 8:00pm on 10/09/21, 8:00pm on 10/10/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials.
-There was an entry for Gabapentin 300mg scheduled at 8:00am, 2:00pm and 8:00pm.
-Gabapentin was documented as administered at 8:00am, 2:00pm and 8:00pm on 10/01/21, 8:00pm on 10/02/21, 8:00pm on 0/03/21, 8:00am and 2:00pm on 10/05/21, 8:00am, 8:00am, 2:00pm and 8:00pm on 10/08/21, 8:00pm on 10/09/21, 8:00pm on 10/10/21, 8:00am, 2:00pm and 8:00pm on 10/12/21, 8:00am and 2:00pm on 10/13/21 and 2:00pm on 10/14/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials.

Refer to interview with the Facility Manager/MA on 10/15/21 at 1:35pm.

Refer to the interview with the Administrator on 10/15/21 at 1:35pm.
2.Review of Resident #1's current FL-2 dated 04/20/21 revealed:
-Diagnoses included chronic pain, pacemaker, hypertension and bilateral leg amputation.
-There was an order for Lisinopril 20mg, take 2 tablets daily. (Lisinopril is prescribed for the treatment of hypertension.)
-There was an order for Amlodipine Besylate 10mg (used for the treatment of high blood pressure), take 1 tablet daily.
-There was an order for aspirin 81mg chewable tablet (used to prevent a heart attack or stroke in certain high-risk patients), take 1 tablet every day.
-There was an order for atorvastatin 40mg (used to decrease cholesterol levels in the blood), take

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1 tablet every day.
-There was an order for citalopram HBR 20mg tablet (used to treat depression), take 1 tablet once daily.
-There was an order for gabapentin 600mg (used to treat nerve pain), take 1 tablet 3 times a day.
-There was an order for omeprazole DR 20mg (used to treat acid reflux), take 2 capsules every day.
-There was an order for Xtamza ER 9mg (used to treat chronic pain), take 1 capsule 2 times a day.

Review of Resident #1's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine Besylate 10mg, aspirin 81mg, atorvastatin 40mg, citalopram HBR 20mg, lisinopril 40mg, omeprazole DR 20mg (2 capsules) to be administered each day at 8:00am.
- Amlodipine,aspirin, atorvastatin, citalopram HBR, lisinopril and omeprazole DR were documented as administered at 8:00am on 09/24/21, 09/28/21 and 09/30/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials.
-There was an entry for Xtamza 9mg to be administered twice a day at 8:00am and 8:00pm.
-There was documentation of administration of Xtamza ER 9mg on 09/21/21 at 8:00pm, on 09/24/21 at 8:00am and 8:00pm, on 09/25/21 and 09/26/21 at 8:00pm, on 09/28/21 at 8:00am and on 09/30/21 at 8:00am and 8:00pm by the current Facility Manager/MA using the previous Facility Manager/MA initials.
-There was an entry for gabapentin 600mg to be administered three times a day at 8:00am, 2:00pm, and 8:00pm.
-Gabapentin was documented as administered on 09/21/21 at 8:00pm, 09/24/21 at 8:00am,

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2:00pm and 8:00pm, 09/25/21 at 8:00pm, 09/26/21 at 8:00pm, 09/28/21 at 8:00am, and 09/30/21 at 8:00am, 2:00pm and 8:00pm by the current Facility Manager/MA using the previous Facility Manager/MA initials.

Review of Resident #2's October 2021 eMAR revealed:
-There was an entry for Amlodipine Besylate 10mg, aspirin 81mg, atorvastatin 40mg, citalopram HBR 20mg, lisinopril 40mg and omeprazole DR 20mg (2 capsules)to be administered each day at 8:00am
-Amlodipine Besylate, aspirin, atorvastatin, citalopram HBR, lisinopril and omeprazole DR was documented as administered at 8:00am on 10/01/21, 10/05/21, 10/08/21, 10/12/21 and 10/13/21 by the current Facility Manager/MA using the previous Facility Manager/MA initials.
-There was an entry for Xtamza ER 9mg to be administered twice a day at 8:00am and 8:00pm.
-Xtamza ER 9mg was documented as administered on 10/01/21 at 8:00am and 8:00pm, 10/02/21 at 8:00pm,10/03/21 at 8:00pm, 10/05/21 at 8:00am, 10/08/21 at 8:00am and 8:00pm,10/09/21 at 8:00pm, 10/10/21 at 8:00pm, 10/12/21 at 8:00am and 8:00pm, and 10/13/12 at 8:00am by the current Facility Manager/MA using the previous Facility Manager/MA initials.
-There was an entry for gabapentin 600mg to be administered three times a day at 8:00am, 2:00pm, and 8:00pm.
- Gabapentin 600mg was documented as administered on 10/01/21 at 8:00am, 2:00pm and 8:00pm, 10/02/21 at 8:00pm, 10/03/21 at 8:00pm, 10/05/21 at 8:00am and 2:00pm, 10/08/21 at 8:00pm, 2:00pm and 8:00pm, 10/09/21 at 8:00pm, 10/10/21 at 8:00pm, 10/12/21 at 8:00am, 2:00pm and 8:00pm, 10/13/21 at 8:00am and 2:00pm, and 10/14/21 at 2:00pm by the current

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D 367	Continued From page 20 Facility Manager/MA using the previous Facility Manager/MA initials. Refer to interview with the Facility Manager/MA on 10/15/21 at 1:35pm. Refer to the interview with the Administrator on 10/15/21 at 1:35pm. _____ Interview with the Facility Manager/MA on 10/15/21 at 1:35pm revealed: -He had been the Facility Manager since 09/21/21 and routinely administered medications to the residents. -He documented the administration of medication for each resident under the previous Facility Managers name because he had not been put into the facilities documentation system. -The previous Facility Manager administered medications on 09/29/21 and 10/07/21 but those were the only days that her initials on the eMAR were correct. -He had not notified the Administrator that he was not documenting under his name when documenting administration of medications until 10/15/21. Interview with the Administrator on 10/15/21 at 1:35pm revealed she did not know that the Facility Manager had not been put in the documentation system and was documenting administration of medication under the name of the previous administrator since he was hired on 09/21/21.	D 367		
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:	D912		

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D912	Continued From page 21 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 every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#2) related to a wound on his left great toe that was red and inflamed with thick yellow drainage and was not reported to the primary care provider (PCP) or home health (HH). [Refer to Tag C273 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912		