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D 000	Initial Comments The Adult Care Licensure Secton conducted an annual and follow up survey on 11/03/21 - 11/04/21.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure 1 of 3 staff (Staff A) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 08/17/21 as a medication aide/personal care aide (MA/PCA). -There was no documentation a North Carolina (NC) Health Care Personnel Registry (HCPR) check was completed upon hire on 08/17/21. Observation of Staff A on 11/04/21 at 8:14am revealed Staff A was working as a MA and observed administering medications to residents. Interview with the Resident Care Director (RCD) on 11/04/21 at 6:30pm revealed the Business Office Manager (BOM) was responsible for completing the NC HCPR checks upon hire on	D 137		

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D 137	Continued From page 1 new staff. Interview with the BOM on 11/04/21 at 6:32pm revealed: -She was responsible for completing all NC HCPR checks upon hire for staff. -She used two named government websites to search for any findings on the NC HCPR for Staff A. -She would provide the results of the searches done from the websites searched for Staff A Review of Staff A's information for a NC HCPR check provided by the BOM revealed: -There were two individual exclusion reports for Staff A from two named government database websites. -The website search results were not from the NC HCPR website. A second interview with the BOM on 11/04/21 at 6:38pm revealed: -She reviewed a NC HCPR check from another staff's record. -She did complete a NC HCPR check for Staff A. -She would search for Staff A's NC HCPR check completed on hire and would provide a copy for review. Attempted interview with Staff A on 11/04/21 at 6:45pm was unsuccessful. Interview with the Administrator on 11/04/21 at 7:30pm revealed: -A review of Staff A's personnel record would be completed, and he would provide Staff A's NC HCPR check completed on hire for review. -He expected for the BOM to complete NC HCPR checks on all the new staff upon hire.	D 137		

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D 137	Continued From page 2 Review of a NC HCPR check for Staff A dated 11/04/21 revealed: -Staff A was not listed on the NC HCPR. -The NC HCPR check was completed 2 1/2 months after Staff A's hire date of 08/17/21.	D 137		
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 personal care to 1 of 5 residents sampled (#3) related to foot care. The findings are: Review of Resident #3's current FL-2 dated 10/15/21 revealed diagnoses included diabetes mellitus type 2 (DM2). Review of Resident #3's current care plan dated 10/15/21 revealed: -The resident required limited staff assistance with toileting, dressing, grooming/personal hygiene, transferring, and ambulation. -The resident required extensive staff assistance with bathing. -The resident required the use of a wheelchair for	D 269		

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ambulation, had limited bilateral upper extremity strength, was sometimes disoriented, and was forgetful and needed reminders.

Review of Resident #3's current Licensed Health Professional Support (LHPS) evaluation dated 08/24/21 revealed the resident required staff assistance with activities of daily living (ADLs).

Observation of Resident #3's feet on 11/03/21 at 4:10pm revealed:
-The resident had thick, cracked and flaking skin to the top of both ankles.
-The top and bottom of the residents' feet and toes were dry and scaly, and the skin flaking.
-The resident had thick, scaly skin to the top of her left foot near her toes.
-The resident had moist, flaking skin between her toes on both feet.
-The residents' heels were dry and cracked.
-The resident had a buildup of creamy to pale yellow colored substance under all the toenails of her right foot.

Review of Resident #3's personal care log revealed:
-There was no month or year documented on the log.
-There were numbers 1 - 31 electronically documented at the top of the log.
-There was a section for bathing on first, second, and third shifts.
-The resident was documented as requiring limited staff assistance for bathing.
-There was a check mark placed beside bathing for first, second, and third shift under numbers 1 - 3.

Interview with a personal care aide (PCA) on 11/04/21 at 8:58am revealed:

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-Skin assessment sheets were to be completed by the PCA with every bath.
-Personal care logs were to be completed every day with tasks.
-A check beside the task on the personal care log indicated the task had been performed.
-Resident feet were to be washed with every bath.
-PCAs were not allowed to perform nail care for a diabetic resident.
-A resident did not have to wait for their assigned bath day to be bathed.
-Resident #3's personal care log without a month or year documented was for November 2021.
-The numbers 1 - 31 at the top indicated the date of the month.
-A check mark beside the task indicated the task was performed.
-She did not know why a check mark was on Resident #3's personal care log beside bathing for first, second, and third shift on days 1 - 3 because the resident was bathed two times a week.

Interview with a PCA on 11/03/21 at 4:15pm revealed:
-Resident #3 was scheduled to be bathed during first shift two - three times a week.
-She did not remember the days.
-She last observed Resident #3's feet about a week ago when she changed her socks and the resident did not have dry, flaking skin.
-She applied lotion on Resident #3's feet because she had dry skin.

Interview with a PCA on 11/04/21 at 7:55am revealed:
-Resident #3 was totally dependent upon staff for bathing and dressing.
-Resident #3 was sponge bathed because she

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did not like to get in the shower.
-She last gave Resident #3 a sponge bath on 11/03/21.
-She did not wash Resident #3's feet on 11/03/21 because the resident did not want her feet washed.
-She last washed Resident #3's feet and between her toes on 10/30/21.
-Resident #3 had a buildup of flaking skin on her feet and between her toes on 10/30/21.
-She told the medication aide/supervisor (MA/S) on 10/30/21 Resident #3 had a buildup of flaking skin on her feet and between her toes.
-She would frequently put lotion on Resident #3's feet because the skin would flake.

Interview with the MA/S on 11/04/21 at 8:18am revealed:
-She had never seen Resident #3's feet prior to today, 11/04/21.
-Staff had not reported to her Resident #3 had dry, flaking, or scaling skin on her feet or between her toes.
-The PCAs reported to her or the Regional Care Director (RCD) when residents had any skin issues such as flaking or dry skin.
-PCAs completed a resident skin assessment sheet with each bath.
-Any skin issues were to be documented on the skin assessment sheets.
-After seeing Resident #3's feet today, 11/04/21, the resident deserved better treatment and care than the personal care she had received from staff.

Interview with the RCD on 11/04/21 at 3:46pm revealed:
-She had never seen Resident #3's feet prior to today, 11/04/21.
-Resident #3's feet were ashy and skin flaking

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D 269	Continued From page 6 today, 11/04/21. -Resident #3 did not have to wait for her shower day to receive a bath or her feet washed. -PCAs were to complete resident skin assessment sheets with every bath to include sponge baths. -PCAs were to document dry and/or scaly skin on the resident skin assessment sheets. -She would review resident skin assessment sheets to see what the PCAs were documenting. -She would not know Resident #3 had dry, flaking, scaly skin if the PCAs did not document it on the skin assessment sheets. -The PCAs documented skin assessments on the resident's personal care log once baths were completed. -She had never checked behind the PCAs to ensure Resident #3's feet were washed. -She never asked staff if they were providing foot or nail care to the residents. -She would sometimes do random resident foot inspections. -She last performed a random resident foot inspection three weeks ago. -There were no skin integrity issues identified. -She had never performed a random foot inspection on Resident #3. Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/04/21 at 4:32pm revealed: -She expected Resident #3's feet and toes washed with every bath including sponge baths. -Resident #3 was diabetic and was at risk for skin break down, infection, and amputation from poor foot care. -Resident #3 would not have dry, scaly skin and buildup of skin between her toes if she was being properly bathed. -It was unacceptable for Resident #3 to have	D 269		

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D 269	Continued From page 7 moisture and buildup of skin between her toes, and scaly skin on her feet. -She examined Resident #3 on 07/02/21 and was shocked at how the resident's feet looked. -The resident's toenails were thick, long, curling up and around and looked like " ...talons". -She expected the facility to provide better foot care to the resident than what had been provided. -She referred the resident to podiatry. Interview with the Administrator on 11/04/21 at 6:30pm revealed: -He expected resident's feet to be washed with every bath. -He expected staff to report to the MA or RCD when a resident's feet were dry, flaking, and/or scaly and toenails long. Attempted interview with Resident #3's family member on 11/03/312 at 5:15pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.	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 2 of 5 sampled residents	D 273		

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(#3, #4) for a diabetic resident who refused to wear compression stockings, had scabs to the top of ankles, and scaly flaking skin to her feet and legs, and had missed appointments with cardiology, gastroenterology, and her Primary Care Provider (PCP) (#3); and a wheelchair dependent resident whose PCP was not notified of a missed physical and occupational therapy referral, long jagged toenails, cough with runny nose and sneezing, and right elbow swelling (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 10/15/21 revealed diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN),kidney disease, hypokalemia, diastolic congestive heart failure (CHF) , and hyperlipidemia.

a. Review of Resident #3's cardiologist after visit summary report dated 06/04/21 revealed the resident was scheduled for an appointment with her gastroenterologist on 07/06/21.

Review of Resident #3's progress notes from 07/06/21 - 08/06/21 revealed there was no documentation the resident was evaluated by a gastroenterologist on 07/06/21.

Review of Resident #3's physician visit notes from 07/06/21 - 11/04/21 revealed there was no documentation the resident was evaluated by a gastroenterologist.

Telephone interview with Resident #3's PCP on 11/04/21 at 4:32pm revealed:
-She was able to access the resident's gastroenterologist appointment and visit history.
-The resident had an appointment scheduled on 05/04/21 with her gastroenterologist to be

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evaluated for blood in her stool.
-On 05/04/21, the appointment was rescheduled to 06/01/21 by the gastroenterologist because the resident was alone.
-The 06/01/21 appointment was rescheduled to 07/06/21 by the gastroenterologist because the resident was greater than 15 minutes late for the appointment.
-The 07/06/21 appointment was canceled by the gastroenterologist because the resident could not confirm the reason for the visit.
-The facility was to reschedule the 07/06/21 appointment when staff could accompany the resident to the appointment.
-The resident had an appointment on 08/31/21 that was canceled because the facility was on COVID-19 quarantine.
-The resident was examined by gastroenterology on 10/18/21 and diagnosed with a rectal bleed and chronic anemia.
-The resident was to return for an endoscopy if her hemoglobin was low with continued rectal bleeding.
-The resident was treated in the ED on 11/02/21 for rectal bleeding and diagnosed with a thrombosed hemorrhoid.

Interview with the RCD on 11/04/21 at 6:00pm revealed:
-The facility was on COVID-19 quarantine from 08/11/21 - 09/20/21.
-There was no one special person assigned to review resident's provider notes or hospital discharge summaries for appointments or orders.
-Whoever was working when the resident returned from the hospital or provider visit was responsible to review for orders and/or appointments.
-The transporter was responsible for scheduling and transporting residents to their medical

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appointments.
-Resident #3 was taken to a specialty appointment and the specialist would not see her without her family member present.
-She did not remember the specialist but thought there was an appointment on 07/06/21.
-The transporter gave her a copy of the resident's appointment when scheduled.
-The transporter gave her a weekly schedule of residents appointments.
-She knew the residents were going to their medical appointments when she saw them leaving the facility with the transporter.
-She had no other oversight to ensure residents appointments were made and kept.

Interview with the Administrator on 11/04/21 at 6:30pm revealed he expected the RCD to ensure resident appointments were made and kept.

Interview with the Regional Director of Clinical Services (RDCS) on 11/04/21 at 6:35pm revealed:
-She expected the transporter to be certain residents were not late for their appointments.
-She expected the transporter to remain with residents while at their medical appointments.

The transporter was not available for interview on 11/04/21 at 6:40pm.

Attempted telephone interview with Resident #3's family member on 11/03/21 at 5:15pm was unsuccessful.

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

Refer to interview with the RCD on 11/04/21 at

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D 273	Continued From page 11 3:46pm. b. Review of Resident #3's cardiologist after visit summary report dated 06/04/21 revealed: -The resident was treated for shortness of breath. -The resident was scheduled for a return appointment on 09/07/21 for an echocardiogram (ultrasound of the heart used to identify signs/symptoms of heart disease) and EKG (evaluates the electrical activity of the heart). -The resident was scheduled for a return appointment with the cardiologist on 09/07/21. Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/04/21 at 4:32pm revealed: -The resident had diagnoses of left ventricular hypertrophy (enlargement and thickening of the left ventricle) and uncontrolled hypertension. -The resident had a previous cardiology appointment scheduled for 05/25/21. -The 05/25/21 cardiology appointment was canceled by the facility. -The resident was treated by cardiology on 06/04/21 for shortness of breath. -The resident was scheduled for a cardiology follow up appointment on 09/07/21. -The appointment was canceled by the facility because the resident was on quarantine. -The facility did not reschedule the appointment. -She expected the facility to follow up with the resident's cardiology appointments. -She expected any missed cardiology appointments to be rescheduled and kept. -She did not know if the resident was symptomatic because she had not seen the resident since 07/02/21. -The resident was at increased risk of heart attack or stroke due to left ventricular hypertrophy and uncontrolled hypertension and the facility	D 273		

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should follow-up with her scheduled cardiology appointments.

Interview with the Resident Care Director (RCD) on 11/04/21 at 6:00pm revealed:
-The facility was on COVID-19 quarantine from 08/11/21 - 09/20/21.
-There was no one special person assigned to review a resident's provider notes or hospital discharge summaries for orders or appointments needed.
-Whoever was working when the resident returned from the hospital or provider visit was responsible to review for orders and/or appointments.
-The transporter was responsible for scheduling resident appointments and transporting them.
-The transporter gave her a copy of the resident's appointments when scheduled.
-The transporter gave her a weekly schedule of resident medical appointments.
-She knew the residents were going to their medical appointments when she saw them leaving the facility with the transporter.
-She had no other process to ensure residents appointments were made and kept.

Interview with the Administrator on 11/04/21 at 6:30pm revealed he expected the RCD to ensure resident appointments were made and kept.

Attempted interview with Resident #3's cardiologist on 11/04/21 at 4:30pm was unsuccessful.

The transporter was not available for interview on 11/04/21 at 6:40pm.

Attempted telephone interview with Resident #3's family member on 11/03/21 at 5:15pm was

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D 273	Continued From page 13 unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the RCD on 11/04/21 at 3:46pm. c. Review of Resident #3's facility progress notes dated 08/18/21 - 10/02/21 revealed: -On 08/18/21, the resident had a "change in behavior" and blood sugar "BS" was "low". -There was no time documented. -On 08/18/21 at 5:45am, the resident was transferred to the emergency department (ED). -There was no documentation the Resident's Primary Care Provider (PCP) was notified. Review of Resident #3's local hospital discharge summary report dated 08/20/21 revealed: -On 08/18/21, EMS assessed the resident's BS to be 59 at the facility. -The resident arrived at the ED with an altered mental status. -The resident was diagnosed with acute encephalopathy secondary to hypoglycemia. -There were orders to discontinue Glipizide (a medication used to lower blood sugar), accu-check test strips, and a blood glucose meter. -The resident was to have a post-hospital follow up appointment with her PCP. Review of Resident #3's local hospital after visit summary report dated 08/20/21 revealed the resident was scheduled for a post-hospital follow up appointment for low BS with her PCP on 08/25/21.	D 273		

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D 273	Continued From page 14 Review of Resident #3's facility progress notes dated 08/18/21 - 11/03/21 revealed there was no documentation the resident was treated by her PCP for a 08/25/21 hospital follow up appointment. Telephone interview with Resident #3's PCP on 11/04/21 at 4:32pm revealed: -She was not informed by the facility the resident's BS was low on 08/18/21 and required a hospital admission. -She did not know when appointments were made for the resident because she did not schedule the appointments. -She expected the facility to notify her when the resident was discharged from the hospital so she could have ordered daily BS checks and evaluated the resident for possible medication changes. -She reviewed the residents appointment log. -The resident had a post-hospital follow up appointment scheduled for 08/25/21. -The appointment was rescheduled by the facility for 10/28/21. -The 10/28/21 appointment was canceled by the facility. The reason was not documented. -The resident currently had a post-hospital follow up appointment scheduled for 11/10/21. -She had not seen the resident for a post-hospital follow up appointment since discharge 08/20/21. -Had the facility notified her the resident was discharged from the hospital she would have reviewed the resident's hospital discharge summary and ordered daily finger stick BS checks until the resident's next appointment. -She would have requested the 8/25/21 appointment to be rescheduled sooner than October 2021. -She expected the facility to keep the residents' post-hospital follow up appointments.	D 273		

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D 273	Continued From page 15 Interview with the Resident Care Director (RCD) on 11/04/21 at 6:00pm revealed: -The facility was on COVID-19 quarantine from 08/11/21 - 09/20/21. -There was no one assigned to review resident's health care provider notes or hospital discharge summaries. -Whoever was working when the resident returned from the hospital or provider visit was responsible to review for orders and/or appointments. -The transporter was responsible for scheduling and transporting residents to their medical appointments. -The transporter gave her a copy of the resident's appointment when the appointments were made. -She knew the residents were going to their medical appointments when she saw them leaving the facility with the transporter. -She did not know Resident #3's 08/20/21 or 10/28/21 PCP appointment was canceled. -She had no other process to ensure resident appointments were made and kept. Interview with the Administrator on 11/04/21 at 6:30pm revealed: -He did not know Resident #3 had a hospital follow up appointment that was rescheduled for 10/28/21 and was not kept. -He expected resident appointments to be made and kept. Interview with the Regional Director of Clinical Services (RDCS) on 11/04/21 at 6:35pm revealed the transporter was responsible to be certain resident appointments were kept and transporting residents to their appointments. The transporter was not available for interview on	D 273		

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D 273	Continued From page 16 11/04/21 at 6:40pm. Attempted telephone interview with Resident #3's family member on 11/03/21 at 5:15pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. Refer to interview with the RCD on 11/04/21 at 3:46pm. d. Observation of Resident #3 on 11/03/21 at 4:10pm revealed: -Resident #3 was sitting in a recliner located in her bedroom. -There were scabs to the front of Resident #3's ankles just above her feet. -Resident #3 had dry scaly skin to her lower legs and feet. Interview with the personal care aide (PCA) on 11/04/21 at 7:55am revealed she did not notice scabs to the front of Resident #3's ankles just above her feet on 11/03/21. Interview with the mediation aide/supervisor (MA/S) on 11/04/21 at 8:18am revealed: -She had not seen Resident #3's legs or feet. -She had not been notified by staff Resident #3 had scabs to the front of her ankles. -She had not been notified by staff Resident #3 had dry scaly skin to her lower legs and feet. -She expected staff to notify her Resident #3 had scabs to the front of her ankles so she could notify her Primary Care Provider (PCP). -She expected staff to have notified her Resident #3 had dry scaly skin to her lower legs and feet so she could have notified her PCP.	D 273		

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D 273	Continued From page 17 Interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm revealed: -Skin integrity issues were documented on the skin assessment sheets with each bath. -Dry, scaly skin, and long toenails were examples of what was to be documented on the skin assessment sheet. -The PCA was to report scaly skin, dry skin, scabs, a break in skin, redness, or bruising to the MA and the MA would complete a skin assessment sheet. -The MA was responsible to give the skin assessment sheet to the RCD or Administrator. -The RCD or Administrator was responsible to notify the resident's PCP. Telephone interview with Resident #3's PCP on 11/04/21 at 4:32pm revealed: -She was not notified of scabs to the tops of Resident #3's ankles. -She expected the facility to have notified her Resident #3 had scabs. Review of Resident #4's progress notes dated 08/18/21 - 11/03/21 revealed: -There was no documentation the resident had scabs, or dry scaly skin to the lower legs, ankles, and/or feet. -There was no documentation the resident's PCP had been notified the resident had scabs or dry, scaly skin. Interview with the Administrator on 11/04/21 at 6:30pm revealed: -He did not know until today, 11/04/21, Resident #3 had scabs to the tops of her ankles and dry, scaly skin to her lower legs and feet. -He expected staff to notify Resident #3's provider of any skin integrity issues to include	D 273		

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D 273	Continued From page 18 scabs when discovered. Attempted telephone interview with Resident #3's family member on 11/03/21 at 5:15pm was unsuccessful. Based on observations, interviews, and record reviews Resident #3 was not interviewable. 2. Review of Resident #4's current FL-2 dated 08/04/21 revealed diagnoses included diabetes mellitus type 2 (DM2), hypertension (HTN), and glaucoma. a. Observation of Resident #4 on 11/03/21 at 7:10am revealed he was lying in bed, his eyes were glassy and red, and was sniffling and sneezing. Interview with Resident #4 on 11/04/21 at 7:35am revealed: -He had a cough, was sneezing, and had a runny nose for about one and a half weeks. -He had a head cold and felt bad this week. -He told several medication aides (MA) of his cough, sneezing, and runny nose. -He wanted treatment for these symptoms. -The MAs told him they would "see what they can do" but never got back with him. Interview with a personal care aide (PCA) on 11/04/21 at 7:55am revealed: -Resident #4 had told her about five days ago he felt bad and was getting a cold. -She told the MA at that time the resident complained of feeling bad and was getting a cold. Interview with the medication aide/supervisor (MA/S) on 11/04/21 at 8:18am revealed: -Resident #4 reported to her on 10/30/21 and	D 273		

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D 273	Continued From page 19 10/31/21 first shift he had a cough and runny nose. -Resident #4 did not ask to see his Primary Care Provider (PCP) for the cough and runny nose. -She did not notify Resident #4's PCP he had a cough and runny nose because the PCP was difficult to contact during the weekends. -She could have left a voice mail for the resident's PCP during the weekend but didn't think she would return the call. -She was going to notify Resident #4's PCP at her next facility visit on 11/02/21. -She forgot to notify Resident #4's PCP during her last facility visit on 11/02/21 the resident had a cough and runny nose. Interview with Resident #4's PCP on 11/04/21 at 10:00am revealed: -She was not notified prior to today the resident complained of a stuffy nose, sneezing, and felt bad. -She expected to have been notified when the resident first reported symptoms so she could have evaluated him because it was possible, he could have contracted COVID-19. Interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm revealed: -Staff had not notified her Resident #4 complained of a cough, sneezing, and runny nose. -She expected staff to tell her as soon as Resident #4 reported a cough, sneezing and/or runny nose so she could have notified the resident's PCP. Review of Resident #4's facility progress notes revealed there was no documentation the resident's PCP had been notified of the resident's cough, sneezing, and runny nose.	D 273		

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D 273	Continued From page 20 Refer to interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm b. Review of Resident #4's physician visit form dated 08/17/21 revealed: -The resident had difficulty walking. -There was an order for Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat. Review of Resident #4's subsequent physician visit form dated 10/14/21 revealed: -The resident had difficulty walking, arthritis, and weakness. -There was an order for PT/OT to evaluate and treat. Interview with Resident #4 on 11/03/21 at 7:10am revealed: -He was dependent upon staff assistance for bathing, and dressing. -He was dependent upon a wheelchair for mobility. -He did not receive a PT/OT evaluation in August 2021. Interview with the medication aide/supervisor (MA/S) on 11/04/21 at 8:18am revealed: -The MA/S and/or Resident Care Director (RCD) were responsible for notifying home health providers of PT/OT referrals. -The RCD gave Resident #4's August 2021 PT/OT order to the in-house therapy department. -She did not know the facility's in-house therapy department was unable to treat Resident #4. Interview with the facility's contracted in-house Rehabilitation Director on 11/04/21 at 10:00am revealed:	D 273		

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-She was working from home when she electronically received Resident #4's order for PT/OT to evaluate and treat around 08/17/21.
-She arrived at the facility around 08/19/21 and told the OT and RCD Resident #4 could not receive services due to his insurance.
-The RCD was responsible for contacting a home health provider to schedule a PT/OT evaluation.
-Resident #4 was opened for therapy services by a home health (HH) provider in October 2021.

Interview with the Administrator on 11/03/21 at 4:45pm revealed:
-It was the responsibility of the RCD to give PT/OT orders to the facility's contracted in-house therapy department.
-The facility's contracted therapy department would let the RCD know if a resident could not be treated.
-It was the responsibility of the RCD to refer the resident to an outside home health provider by the next business day if that resident was unable to be treated by the facility's contracted in-house therapy department.

Interview with the RCD on 11/03/21 at 4:54pm revealed:
-It was the responsibility of the RCD to contact outside home health therapy providers for residents who could not be treated by the facility's contracted in-house therapy provider.
-The Rehabilitation Director did not tell her Resident #4 could receive services by the facility's contracted in-house therapy provider in August 2021.

Interview with Resident #4's Primary Care Provider (PCP) on 11/04/21 at 10:00am revealed:
-She ordered the resident to be treated by PT and OT on 08/17/21 because the resident was

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new to the facility, legally blind, and was dependent upon a wheelchair for mobility.
-She wanted to ensure the resident would adjust safely to the facility with the use of the wheelchair.
-She did not know the 08/17/21 PT/OT order was not completed.
-She ordered Resident #4 have a PT/OT evaluation on 10/14/21 because the resident was having pain and weakness.
-She expected to have been notified by the facility the resident had not been evaluated by PT/OT as ordered on 08/07/21.
-The resident was at risk for falls because he was blind and dependent upon the wheelchair for mobility.

Attempted telephone interview with Resident #4's HH provider on 11/04/21 at 12:30pm was unsuccessful.

c. Observation of Resident #4's toenails on 11/04/21 at 7:45am revealed:
-The residents left first toenail extended past his toe, was pointed, and was jagged.
-The resident's left second and third toenails were extended past his toes and curved towards the toe pads, sharp on the corners, and jagged.
-The cuticles for the first through fifth nailbeds were dry flaky, and overgrown.
-The resident's right first through fifth toenails were extended past his toes and jagged.
-The resident's right second through fourth toenails curved under the pads of his toes and into the skin.
-The skin to the bottom of the resident's third toe was black where the nail curved into the skin.
-The bottom of the resident's feet and toes were dry and scaly.

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Interview with Resident #4 on 11/04/21 at 7:35am revealed:
-He wanted his toenails cut.
-After first arriving at the facility, he would try to cut his toenails with nail clippers but lost them.
-His toes and feet did not hurt.

Interview with the personal care aide (PCA) on 11/04/21 at 7:55am revealed:
-She would assist Resident #4 with his baths and dressing.
-She last assisted Resident #4 with bathing one week ago.
-One of Resident #4's fifth toenail was jagged and caught on the resident's sock while dressing him.
-Resident #4 told her he wanted his toenails cut.
-She cut Resident #4's fifth toenail because it caught on the sock.
-She did not remember the condition of Resident #4's other toenails and feet.

Interview with a second PCA on 11/04/21 at 8:58am revealed skin assessment sheets were to be completed by the PCA with every bath.

Interview with Resident #4's Primary Care Provider (PCP) on 11/04/21 at 10:00am revealed:
-She was not notified by the facility prior to today the resident's toenails were long, jagged, and growing into his skin.
-She saw the resident's feet and toenails this morning, 11/04/21.
-It would take about two months for the resident's toenails to get in the condition they were currently in.
-She expected to have been notified prior to today the condition of the resident's toenails and feet.
-The resident was placed on the list to be examined by the facility podiatrist next week.
-The resident was at risk for pain and infection

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D 273	Continued From page 24 from the toenails curling into the resident's skin. Interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm revealed: -Resident #4 had not been treated by podiatry. -Staff had not notified her Resident #4's toenails were jagged and growing past his toes and/or into his skin. -Had she known Resident #4's toenails were growing past his toes and in his skin, she would have notified Resident #4's PCP. Interview with the Administrator on 11/04/21 at 6:30pm revealed: -He expected the PCAs to notify the MA or RCD when a resident's toenails were long extending past their toes. d. Observation of Resident #4 on 11/03/21 at 7:10am revealed his right elbow was swollen approximately the size of a golf ball. Interview with Resident #4 on 11/04/21 at 7:35am revealed: -He had right elbow swelling, tightness, and soreness without injury for one month -He told the medication aides (MAs) and personal care aides (PCAs) his right elbow was swollen and sore about one month ago. -The MAs and PCAs did nothing about the elbow swelling and soreness. -He had not seen his Primary Care Provider (PCP) for the right elbow swelling and soreness. -He wanted to see the PCP. Interview with the PCA on 11/04/21 at 7:55am revealed: -She assisted Resident #4 with his baths and dressing. -She last assisted Resident #4 with bathing one	D 273		

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D 273	Continued From page 25 week ago. -She did not see swelling to Resident #4's elbow at that time. -Resident #4 had not told her his elbow was swollen and sore. Interview with Resident #4's PCP on 11/04/21 at 10:00am revealed: -She was not notified of the resident complaint of right elbow pain and swelling prior to today. -She evaluated the resident today, 11/04/21, and the resident had right elbow swelling, but did not report pain. -The resident was diagnosed with bursitis (inflammation of the bursa which caused swelling and fluid collection) of the right elbow and prescribed a steroid. -The resident may require an orthopedic referral for possible fluid aspiration. -The resident was at risk for infection and/or cellulitis without treatment. Interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm revealed: -She did not know until today Resident #4 had complained of right elbow swelling. -She expected staff to notify her as soon as Resident #4 reported to them his elbow was swollen and/or sore and she would have notified the residents PCP. Interview with the Administrator on 11/04/21 at 6:30pm revealed he expected the PCP to be informed by the MA or the RCD of any resident medical concerns. Refer to interview with the RCD on 11/04/21 at 3:46pm. _____ Interview with the Resident Care Director (RCD)	D 273		

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D 273	Continued From page 26 on 11/04/21 at 3:46pm revealed she was available for staff to report resident concerns 24 hours a day seven days a week. _____ The facility failed to ensure healthcare follow-up for 2 of 5 residents (#3 and #4) which included follow-up for a scheduled gastroenterologist appointment for Resident #3 who had continued rectal bleeding with chronic anemia and a low hemoglobin level and follow-up with a cardiologist appointment for an echocardiogram and an electrocardiography (EKG) for Resident #3 who had a diagnosis of left ventricular hypertrophy and uncontrolled hypertension. The facility's failure was detrimental to the resident's health and safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 19, 2021.	D 273		
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:	D 358		

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Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by the primary care provider and in accordance with the facility's policies for 2 of 4 sampled residents (#4, #6) observed during the medication pass including errors with a medication used to lower blood sugar (#6), and to decrease pain from arthritis (#4, #6); and for 3 of 5 residents sampled (#1, #3, #4) for record review for a controlled medication used to treat anxiety (#1), a diuretic to decrease fluid (#3), and a supplement to aid in sleep (#4).

The findings are:

1. The medication error rate was 11% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00am medication pass on 11/04/21.

Review of the facility's undated Medication Policy and Procedures revealed:
-The purpose of the policy was to ensure the understanding of responsibilities for the administration of ordered drugs to the residents.
-Medications would be administered within one hour before or one hour after the prescribed or scheduled time unless an emergency precluded the administration.

a. Review of Resident #4's current FL-2 dated 08/04/21 revealed:
-Diagnoses included diabetes type 2, hypertension and glaucoma.
-The resident's orientation status was blank.

Review of an order for Resident #4 dated 10/14/21 revealed there was an order for Celebrex 50mg daily with food. (Celebrex is a medication used to treat arthritic pain).

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D 358	Continued From page 28 Observation of the 8:00am medication pass on 11/04/21 revealed: -The medication aide (MA) prepared Resident #4's medications for administration, including Celebrex 50mg at 8:06am. -The MA entered the room and administered Resident #4's medications, including Celebrex 50mg at 8:10am. -Resident #4 did not have a plated meal in the room and was not observed eating at 8:10am when the MA gave the resident water and observed the resident swallow the medications. Review of Resident #4's November 2021 medication administration record (MAR) revealed: -There was an entry for Celebrex 50mg daily with a meal with a scheduled administration time at 8:00am. -Celebrex 50mg was documented as administered at 8:00am from 11/01/21 - 11/04/21. Observation in the hallway of the facility on 11/04/21 at 8:24am revealed a staff entered Resident #4's room with a tray of plated food. Observations in the hallway and in Resident #4's room on 11/04/21 at 8:52am revealed: -There was a plated meal consisting of dry cereal, eggs, bacon, one biscuit covered with plastic wrap and a cup of juice and a cup of milk in the resident's room. -The resident was in the hallway in his wheelchair. Interview with Resident #4 on 11/04/21 at 9:00am revealed: -He was getting ready to eat his breakfast now. -He snacked all the time but had not eaten this morning, he just returned from smoking a	D 358		

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cigarette.
-He usually received his medication in the mornings right before breakfast or while he was eating.
-He was not sure if he took any medications in the morning that needed to be taken with food.
-He was not having any problems with heartburn, diarrhea or stomach pains.

Interview with the MA observed during the 11/04/21, 8:00am medication pass on 11/04/21 at 4:15pm revealed:
-She had spoken with the Dietary Manager this morning (11/04/21) prior to starting her 8:00am medication pass who informed her the residents' trays were coming out at that time.
-She usually started her 8:00am medication pass on the opposite end of Resident #4's hallway however, a resident who resided in a room close to Resident #4 requested his medications earlier which caused Resident #4 to receive his medication's earlier than usual.
-She tried to administer medications ordered with a meal when the residents' trays were in their room, immediately after the resident had eaten or within 30 minutes after the meal.
-She thought Resident #4's Celebrex was ordered with a meal to help the medication work better and avoid making the resident sick on his stomach.

Interview with the Resident Care Director (RCD) on 11/04/21 at 5:21pm revealed Resident #4 could experience stomach issues if Celebrex was not given as ordered with a meal.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 11/04/21 at 9:13am revealed:
-It was important for Resident #4 to take Celebrex

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as ordered with a meal because the medication could cause the stomach lining to erode, gastric ulcers, a gastrointestinal bleed, stomach upset and heartburn..
-Staff at the facility needed to administer Resident #4's Celebrex as ordered by the primary care provider (PCP).
-There were labeled directions on Resident #4's bottle of Celebrex to administer the medication with a meal.

Interview with Resident #4's PCP on 11/14/21 at 10:04am revealed:
-There was a risk of gastrointestinal symptoms when Celebrex was not taken with food.
-She expected staff to administer Resident #4's medications as ordered.

Refer to the interview with the RCD on 11/04/21 at 5:21pm.

Refer to the interview with the Administrator on 11/04/21 at 5:17pm.

b. Review of Resident #6's current FL-2 dated 09/28/21 revealed:
-Diagnoses included diabetes, hypertension and major depressive disorder.
-There was an order for Celebrex 200mg daily with food. (Celebrex is a medication used to treat arthritic pain).
-There was an order for Metformin 500 mg twice daily with meals. (Metformin is a medication used to lower the blood sugar).

Observation of the 8:00am medication pass on 11/04/21 revealed:
-The medication aide (MA) prepared Resident #6's medications for administration, including Celebrex 200mg and Metformin 500mg at

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8:30am.
-Resident #6 was sitting in a chair in her room with a table in front of her when the MA entered the room.
-The MA gave Resident #6 a cup of water and a cup containing the prepared medications, including Celebrex 200mg and Metformin 500mg at 8:34am.
-Resident #6 removed the medications from the cup and placed each medication in groups of two on the table in front of her.
-The resident swallowed all the grouped medications while the MA observed the resident swallow the medications at 8:36am.
-Resident #6 did not have a plated meal in the room and was not observed eating at 8:36am when the MA administered the resident's medication.

Interview with Resident #6 on 11/04/21 at 8:37am revealed her family member would arrive shortly to take her to an eye appointment.

Review of Resident #6's November 2021 medication administration record (MAR) revealed:
-There was an entry for Celebrex 200mg daily with food with a scheduled administration time at 8:00am.
-Celebrex 200mg was documented as administered at 8:00am from 11/01/21 - 11/04/21.
-There was an entry for Metformin 500mg twice daily with meals with a scheduled administration time at 8:00am and 5:00pm.
-Metformin 500mg was documented as administered at 8:00am and 5:00pm from 11/01/21 - 11/04/21 at 8:00am.

Interview with Resident #6 on 11/04/21 at 4:51pm revealed:
-She estimated she ate breakfast this morning,

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D 358	Continued From page 32 (11/04/21) around 7:30am. -She knew Metformin was supposed to be taken with meals, but she was not aware of any other medications she took in the morning that needed to be taken while eating. -She usually received her medications in the morning while she was eating breakfast and occasionally after breakfast. -She was not having any gastrointestinal symptoms such as heartburn, diarrhea or stomach pains. Interview with the MA observed during the 11/04/21, 8:00am medication pass on 11/04/21 at 4:15pm revealed: -Resident #6 had informed her she had a medical appointment scheduled this morning, 11/04/21. -She usually administered Resident #6's 8:00am medication immediately after breakfast when she came out of the dining room because she had medications at 8:00am that were ordered with a meal. -She tried to administer medications ordered with a meal to residents when the residents' tray was in their room, immediately after the resident had eaten or within 30 minutes after the meal. Interview with the Resident Care Director (RCD) on 11/04/21 at 5:21pm revealed Resident #6 could experience stomach issues if Celebrex and Metformin was not given with a meal. Interview with Resident #6's PCP on 11/14/21 at 10:04am revealed: -There was a risk of gastrointestinal symptoms when Celebrex and Metformin was not taken with food. -She expected staff to administer Resident #6's medication as ordered.	D 358		

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D 358	Continued From page 33 Refer to the interview with the RCD on 11/04/21 at 5:21pm. Refer to the interview with the Administrator on 11/04/21 at 5:17pm. 2. Review of Resident #1's current FL-2 dated 05/18/21 revealed: -Diagnoses included essential and a history of hypertension, hyperlipidemia, cardiomegaly, bladder neck obstruction, unspecified pneumonia and coronary arteriosclerosis. -The resident was intermittently disoriented. -There was an order for Lorazepam 0.5mg daily. (Lorazepam is a controlled medication used to treat anxiety and agitation). -There was an order for Lorazepam 0.5mg daily as needed for anxiety/agitation. Review of Resident #1's September 2021 medication administration record (MAR) revealed: -There was an entry for Lorazepam 0.5mg take one daily with a scheduled administration time of 9:00am. -Lorazepam 0.5mg was documented as administered from 09/01/21 - 09/30/21 with the exception there was a blank with no documentation off staff initials on 09/20/21 for the scheduled 9:00am dose. Review of Resident #1's controlled substance administration record (CSAR) for Lorazepam 0.5mg revealed: -The dispensed prescription label was for 1 of 2 with a quantity of 60 tablets dispensed on 07/13/21 for Lorazepam 0.5mg one daily and one daily as needed for anxiety. -The first dose of the 30 remaining doses for this CSAR was documented on 08/17/21 at 8:00am and the last dose was documented on 09/17/21	D 358		

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at "8".
-There was documentation Lorazepam 0.5mg was administered daily for the scheduled 9:00am dose except on 09/14/21 and 09/16/21 there was not an entry for the dates, times, doses given, MAs' signatures or subtraction for the remaining doses on hand.
-There was a total of 2 scheduled daily doses of Lorazepam not documented as administered as ordered.

Review of Resident #1's October 2021 (MAR) revealed:
-There was an entry for Lorazepam 0.5mg take one daily with a scheduled administration time of 9:00am.
-Lorazepam 0.5mg was documented as administered from 10/01/21 - 10/31/21 with the exceptions on 10/08/21 and 10/09/21 due to the resident being out of the facility.

Review of Resident #1's CSAR for Lorazepam 0.5mg revealed:
-The dispensed prescription label was for 1 of 1 with a quantity of 30 tablets dispensed on 09/01/21 for Lorazepam 0.5mg one daily.
-The first dose of the 30 doses for this CSAR was documented on 09/18/21 at 9:00am and the last dose was documented on 10/20/21 at 8:00am.
-The second dispensed prescription label was for 1 of 2 with a quantity of 60 tablets dispensed on 09/13/21 for Lorazepam 0.5mg one daily and one daily as needed for anxiety.
-The first dose of the 30 remaining doses for this CSAR was documented on 10/15/21 at 5:00pm and the last dose was documented on 11/03/21 at 9:00am.
-There was documentation Lorazepam 0.5mg was administered daily for the scheduled 9:00am dose except on 10/16/21, 10/22/21, 10/23/21,

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D 358	Continued From page 35 10/25/21 and 10/30/21 there was not an entry for the dates, times, doses given, signatures or subtraction for the remaining doses on hand . -There was a total of 5 scheduled daily doses of Lorazepam not documented as administered as ordered. Observation of Resident #1's medication on hand on 11/03/21 at 4:39pm revealed there were 60 tablets of Lorazepam 0.5mg tablets dispensed on 09/13/21 with 49 tablets remaining in the medication cards. Interview with a medication aide (MA) on 11/04/21 at 4:15pm revealed: -She was not aware of Resident #1 missing any of his scheduled Lorazepam 0.5mg daily. -There should be documentation by the MAs administering Resident #1's Lorazepam 0.5mg on the MAR and on the CSAR each time the medication was administered -At the change of shift, the oncoming and the off going MA completed a count of the residents' controlled substances. -The MAs were responsible to administer medications to residents, then document on the MAR and the CSAR the medication was given. -If there was no documentation for some of the daily doses on the CSAR for Resident #1's scheduled dose of Lorazepam 0.5mg daily then the resident could not have received the medication or the remaining doses of controlled tablets on hand would "be off" (not accurate). Interview with the Resident Care Director (RCD) on 11/04/21 at 5:21pm revealed: -She and the Administrator were responsible for completing resident record audits monthly but attempted to complete the audits weekly. -When resident record audits were completed,	D 358		

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she compared the MARS with the CSAR to ensure residents' medications were administered as ordered.
-She had not identified any issues with medications not being administered as ordered during her record audits.

Based on observations, interviews, and record reviews, Resident #1 was no interviewable.

Attempted telephone interview with Resident #1's family member on 11/03/21 at 6:20pm was unsuccessful.

Interview with Resident #1's PCP on 11/14/21 at 10:04am revealed she expected staff to administer the resident's medications as ordered.

Refer to the interview with the RCD on 11/04/21 at 5:21pm.

Refer to the interview with the Administrator on 11/04/21 at 5:17pm.

3. Review of Resident #3's current FL-2 dated 10/15/21 revealed:
-Diagnoses included hypertension (HTN), kidney disease, diabetes myelitis type 2 (DM2), hypokalemia, and diastolic congestive heart failure (CHF).
-Under the medication section was handwritten documentation to see attached physician orders.
-On the attached physician orders was a handwritten order for Torsemide 20 milligrams (mg) take two tablets every morning.
-The physician orders were dated 10/15/21.

Review of Resident #3's previous FL-2 dated 10/16/20 revealed there was an order for Lasix 40mg one tablet daily.

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D 358	Continued From page 37 Review of Resident #3's electronic physicians order dated 03/23/21 revealed: -There was an order for Lasix 40mg daily. -There was a fax timestamp dated 10/20/21 by Resident #3's pharmacy. Review of Resident #3's physician visit form dated 06/04/21 revealed: -There was an order to discontinue Lasix. -There was an order for Torsemide 40mg every morning. Review of Resident #3's cardiologist's physician visit note dated 06/04/21 revealed: -The resident was treated for shortness of breath. -Lasix was discontinued. -Torsemide was to be started. Review of Resident #3's physicians order sheet dated 09/20/21 revealed: -There was a handwritten order for Torsemide 20mg take two tablets every morning. -There was not an order for Lasix. Review of Resident #3's physician orders dated 10/13/21 revealed: -There was a handwritten order for Torsemide 20mg take two tablets every morning. -There was not an order for Lasix. Review of Resident #3's October 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Torsemide 20mg take two tablets every morning. -There was documentation Torsemide was administered at 8:00am from 10/01/21 - 10/12/21, 10/15/21, and 10/17/21 - 10/31/21. -There was a handwritten entry for Lasix 40mg take one tablet daily.	D 358		

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-There was documentation Lasix was administered at 8:00am from 10/21/21 - 10/31/21.

Review of Resident #3's November 2021 MAR revealed:
-There was an electronic entry for Torsemide 20mg take two tablets every morning.
-There was documentation Torsemide was administered at 8:00am from 11/01/21 - 11/03/21.
-There was a handwritten entry for Lasix 40mg daily.
-There was documentation Lasix was administered at 8:00am from 11/01/21 - 11/03/21.

Review of Resident #3's physician's orders and visit notes revealed there was no current order for Lasix.

Review of Resident #3's medication clarification form dated 11/04/21 revealed:
-There was an order to discontinue Lasix 40mg daily.
-There was an order to continue Torsemide 40mg every morning.

Interview with a medication aide (MA) on 11/04/21 at 2:50pm revealed:
-She would administer orders as documented on the MAR.
-She did not know Resident #3 did not have a current order for Lasix.
-The third shift MA was responsible for reviewing and transcribing orders on the MARs.

Interview with the Resident Care Director (RCD) on 11/04/21 at 3:46pm revealed:
-Resident #3's Lasix order dated 03/23/21 was faxed to the facility in October 2021 by the pharmacy.
-It was considered a current order because the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39	D 358		

pharmacy faxed the order.
-The pharmacy would not have faxed the order if the resident was not supposed to have the Lasix.

Interview with the Administrator on 11/03/21 at 4:30pm revealed:
-The third shift MA would review medication orders and transcribe them on the MARs.
-The RCD was expected to review medication orders and compare the orders to the MARs to ensure the orders were transcribed correctly by the following day.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/04/21 at 4:32pm revealed:
-The resident's cardiologist discontinued Lasix on 06/04/21.
-The resident's cardiologist ordered Torsemide 40mg daily on 06/04/21.
-She expected the facility to follow orders as written.
-The facility should not have administered Lasix to the resident because there was not a current Lasix order.
-She expected the facility to review orders thoroughly, saw the Lasix order was not current, and have called her or the resident's cardiologist for clarification prior to administration.
-Lasix and Torsemide were both diuretics that were excreted by the kidneys.
-The resident was in renal failure and administering both diuretics together would cause additional renal damage and a decrease in renal function.
-Administering Torsemide and Lasix together could cause dehydration which could contribute to hypoglycemic events, decreased cognition, tachycardia, a heart attack, and/or death.

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	HAL051025	A. BUILDING: _____ B. WING _____	R 11/04/2021

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D 358	Continued From page 40 Interview with the Regional Director of Clinical Services Registered Nurse (RDCSRN) on 11/01/21 at 6:30pm revealed: -The MAs reviewed orders and transcribed the orders on the MARs. -It was the responsibility of the RCD to have oversight of the MARs. -She expected the RCD to review all medication orders and ensure transcribed accurately on the MARs. Refer to the interview with the Resident Care Director (RCD) on 11/04/21 at 5:21pm. Refer to the interview with the Administrator on 11/04/21 at 5:17pm. Attempted interview with a third shift MA on 11/03/21 at 4:45pm was unsuccessful. Attempted interview with Resident #3's family member on 11/03/21 at 5:15pm was unsuccessful. Attempted interview with Resident #3's pharmacist on 11/04/21 at 4:45pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable. 4. Review of Resident #4's current FL-2 dated 08/04/21 revealed: -Diagnoses included diabetes myelitis type 2 (DM2), hypertension (HTN), and glaucoma. -There was an order for Melatonin 5 milligrams (mg) at bedtime. Review of Resident #4's physician order sheet	D 358		

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D 358	Continued From page 41 dated 08/17/21 revealed there was an order for Melatonin 5mg at bedtime. Review of Resident #4's September 2021 medication administration record (MAR) revealed there was no entry for Melatonin 5mg at bedtime. Observation of Resident #4's medication on hand on 11/03/21 at 3:03pm revealed the medication aide (MA) was unable to locate the Resident's Melatonin. Interview with the MA on 11/03/21 at 3:10pm revealed: -She last administered Melatonin to Resident #4 this morning. -Resident #4's Melatonin was prepackaged in a bubble pack by his pharmacist. -Resident #4 was not administered Melatonin in September 2021 because it was not listed on the MAR to administer. A second interview with the MA on 11/03/21 at 4:00pm revealed Resident #3's Melatonin had been located on another medication cart. Observation of Resident #4's Melatonin on 11/03/21 at 4:0pm revealed: -It was an over the counter bottle of Melatonin. -The bottle was not labeled with the resident's name. -The bottle was unopened. Telephone interview with Resident #4's pharmacist on 11/04/21 at 9:05am revealed: -They had never filled Melatonin for the resident. -They had never received orders for the resident. Telephone interview with the facility's contracted pharmacist on 11/04/21 at 9:50am revealed:	D 358		

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D 358	Continued From page 42 -They did not provide any medications for Resident #4. -They had never filled Melatonin for Resident #4. Interview with Resident #4's Primary Care Provider (PCP) on 11/04/21 at 10:00am revealed: -The resident was restless at night and was unable to sleep. -She ordered Melatonin to help the resident sleep and rest at night. -Not administering Melatonin to the resident may cause the resident to not be able sleep well. -Staff nor the resident reported to her the inability to sleep well. -Staff had not informed her Melatonin was not administered to the resident for September 2021. -She expected staff to administer medication as ordered. -She expected staff to notify her if a medication was not administered. -It was important for good health to keep the resident on a regular medication regiment. Interview with the MA on 11/04/21 at 10:24am revealed: -Resident #4 brought his Melatonin from home with him to the facility. -Resident #4's FL-2 and medication orders would have been sent to the pharmacy by the Resident Care Director (RCD) or the third shift MA. Interview with Resident #4 on 11/04/21 at 10:35am revealed: -He had difficulty sleeping at night since admitted to the facility. -He brought his medications from home with him to the facility. -Sometimes he would have to ask for his medications. -He thought the MAs did administer Melatonin to	D 358		

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D 358	Continued From page 43 him at night in September 2021. Refer to the interview with the RCD on 11/04/21 at 5:21pm. Refer to the interview with the Administrator on 11/04/21 at 5:17pm _____ Interview with the Resident Care Director (RCD) on 11/04/21 at 5:21pm revealed: -She and the Administrator were responsible to perform medication cart audits and resident record audits at least monthly however they attempted to complete the audits weekly. -The audits for medications included reviewing the residents' FL-2, subsequent orders, medication administration records (MARs) with the residents' medications on hand. -She and the Administrator completed random observations during medication passes with the MAs but she did not document when they were done. -She had not identified any issues or concerns during the random audits completed. -She expected medications to be given as ordered by the resident's primary care provider (PCP) when scheduled and follow the 6 residents rights including the right resident, right medication, right dose, right time, right route and the right documentation. Interview with the Administrator on 11/04/21 at 5:17pm revealed he expected staff to administer all residents' mediations as ordered.	D 358		
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 44 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 as 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 2 of 5 sampled residents (#3, #4) for a diabetic resident who refused to wear compression stockings, had scabs to the top of ankles, and scaly flaking skin to her feet and legs, and had missed appointments with cardiology, gastroenterology, and her Primary Care Provider (PCP) (#3); and a wheelchair dependent resident whose PCP was not notified of a missed physical and occupational therapy referral, long jagged toenails, cough with runny nose and sneezing, and right elbow swelling (#4). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		