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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 08/17/22- 08/18/22. | D 000 | | |
| D 201 | 10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br>(e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply.<br>(1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:<br>(A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)<br>(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) | D 201 | | |

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| D 201 | Continued From page 1 | D 201 | | |

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure aide hours met the minimum requirements for the Assisted Living (AL) unit for 6 of 18 sampled shifts from 07/30/22-08/14/22.

The findings are:

Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including assisted living (AL) with a capacity of 46 beds and the special care unit (SCU) with a capacity of 48 beds.

Review of the Daily Census Report dated 07/30/22 revealed the AL had a census of 22 which required 16 aide hours on second shift.

Review of staff timecards dated 07/30/22 revealed there was a total of 12.42 staff hours provided on second shift leaving a shortage of 3.58 hours.

Review of the Daily Census Report dated 07/31/22 revealed the AL had a census of 22 which required 16 aide hours on second shift.

Review of staff timecards dated 07/31/22 revealed there was a total of 13.32 staff hours provided on second shift leaving a shortage of 2.68 hours.

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| D 201 | Continued From page 2<br><br>Review of the Daily Census Report dated 08/06/22 revealed the AL had a census of 22, which required 16 aide hours on second shift.<br><br>Review of staff timecards dated 08/06/22 revealed there was a total of 8.5 staff hours provided on second shift leaving a shortage of 7.5 hours; time included the Resident Care Coordinator.<br><br>Review of the Daily Census Report dated 08/07/22 revealed the AL had a census of 22, which required 16 aide hours on second shift.<br><br>Review of staff timecards dated 08/07/22 revealed there was a total of 8.25 staff hours provided on second shift leaving a shortage of 7.75 hours; time included the Memory Care Manager.<br><br>Review of the Daily Census Report dated 08/14/22 revealed the AL had a census of 21, which required 16 aide hours on first shift and second shift.<br><br>Review of staff timecards dated 08/14/22 revealed<br>-There was a total of 15 staff hours provided on first shift leaving a shortage of 1 hour.<br>-There was a total of 9.75 staff hours provided on second shift leaving a shortage of 6.25 hours.<br><br>Interview with a personal care aide (PCA) on 08/18/22 at 10:46am revealed:<br>-The facility was still short staffed on all shifts.<br>-The staff shortages were concentrated on the weekends.<br>-She thought the medication aide (MA) notified the Administrator when there was not enough | D 201 | | |

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staff on a shift.
-She was not involved with notifying the Administrator if staff hours were low.
-Many staff would complain after realizing the shift was short of staff.
-She thought complaining was a waste of time because the residents still needed care.

Interview with a MA on 08/18/22 at 10:20am revealed:
-The schedule was completed by the Administrator.
-Staffing levels were still short primarily on the weekend.
-She thought staff called out on weekends and it was difficult to get other staff to come in on their off days.
-MAs worked 12-hour shifts and PCAs worked 8-hour shifts.
-She worked with one aide on the AL unit almost each day shift.
-She completed her medication pass and then helped with showers.
-The PCA working with her had to assist in the dining room and she gave medications on the 200 hall.
-When staffing was short, she would text the Administrator.
-The Administrator would send a group chat to all staff requesting someone to work.
-The group chat contained the shift and unit that needed staffing help.
-The Administrator and the care managers Resident Care Coordinator (RCC) and Memory Care Manager (MCM)) also helped on some weekends.

Interview with another MA on 08/18/22 at 3:00pm revealed:
-There were still staffing shortages on the AL unit.

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| D 201 | Continued From page 4<br>-There were times when she was the only staff from 3:00pm to 7:00pm.<br>-The PCAs left at 3:00pm and that left the MA alone on the AL unit.<br>-There were other times when the Administrator would move any PCAs from AL to work on the SCU.<br>-When she was alone on the AL unit, she did the best she could.<br>-She would help residents to the dining room and feed two residents.<br>-Once she was done with feeding the two residents, she toileted them.<br>-Then she administered medications to residents.<br>-A MA came in at 7:00pm and that MA administered medications to the opposite hall.<br>-She notified the Administrator when there was a shortage of staff, but she received no response.<br>-She also told the RCC who would remain over to help her many times.<br>-The RCC remained to help her with toileting residents and watching for call lights.<br><br>Interview with the RCC on 08/18/22 at 11:53am revealed:<br>-The Administrator made the schedule for staff and she did not provide any input.<br>-Her focus was the clinical side of the AL unit.<br>-She and the MCM worked as MAs on the floor.<br>-She worked the weekend of 08/06/22 and 08/07/22 along with the MCM.<br>-When there was a staffing shortage, the Administrator sent a group chat message to request help with staffing for a shift and unit.<br>-She and the MCM received a separate group chat message directing them to work a shift and unit.<br>-She did not work the previous weekend on 08/13/22 and 08/14/22 when there was a shortage of staff. | D 201 | | |

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| D 201 | Continued From page 5<br>-When staff complained of staffing shortages, she encouraged them to work together as a team and to hang in there.<br><br>Interview with the Administrator on 08/18/22 at 2:07pm revealed:<br>-She knew there were still staffing shortages.<br>-She was responsible for preparing the schedule.<br>-She prepared the schedule based on the census and attempted to overstaff the AL unit.<br>-She knew the census at this time was 21 on the AL unit and that required 16 hours of staffing on first and second shift.<br>-She knew staffing on the weekends was short.<br>-She would send out a group chat if she knew ahead of time to request staff to work extra hours.<br>-She often did not have anyone accept to work additional hours.<br>-She and the care managers worked shifts even on the weekends.<br>-She was responsible for ensuring staffing on the AL unit met the minimal requirements based on the census. | D 201 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW UP TO AN UNABATED TYPE A2 | D 358 | | |

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| D 358 | Continued From page 6<br>VIOLATION<br><br>Based on these findings, the previous Unabated Type A2 violation was abated. Noncompliance continues.<br><br>Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents (#3 and #4) for record review including errors with a medication used as a blood thinner and an iron supplement (#4) and a medication for nerve pain (#3).<br><br>The findings are:<br><br>Review of the medication administration policy of a new order revealed:<br>-The policy was not dated.<br>-All routine medication orders placed before 5:00pm shall be started with the next regularly scheduled dose following the next regular pharmacy delivery.<br><br>Review of the pharmacy delivery policy revealed:<br>-The policy was not dated.<br>-The delivery slip should be signed by the person receiving the medications from the courier.<br>-The package of medications should be opened and the packing slip should be retrieved.<br>-All medications in the box should be compared to the packing slip.<br>-Any discrepancies should be noted on the packing slip for the Resident Care Coordinator (RCC) or Memory Care Manager (MCM) to follow-up.<br>-The packing slip should be signed, dated and faxed to the pharmacy within 24 hours.<br><br>1. Review of Resident #4's current FL-2 dated | D 358 | | |

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| D 358 | Continued From page 7<br>03/17/22 revealed there were no diagnoses listed on the FL-2.<br><br>Review of Resident #4's physician's orders dated 03/17/22 revealed diagnoses included dementia with behavioral disturbances, hypertension and chronic diastolic congestive heart failure.<br><br>a. Review of Resident #4's physician's orders dated 07/13/22 revealed there was an order for ferrous sulfate (used as an iron supplement) 325mg one every other day for anemia.<br><br>Review of Resident #4's physician's orders dated 07/21/22 revealed:<br>-There was an order to discontinue ferrous sulfate 325mg every other day.<br>-There was a new order for ferrous sulfate 325mg once daily.<br><br>Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for ferrous sulfate 325mg every other day with a scheduled administration time of 8:00am.<br>-There was documentation ferrous sulfate was administered every other day at 8:00am from 07/01/22 to 07/21/22.<br>-There was documentation ferrous sulfate 325mg every other day was discontinued on 07/21/22.<br>-There was a second entry for ferrous sulfate 325mg once daily with a scheduled administration time of 8:00am dated 07/21/22.<br>-There was documentation ferrous sulfate was administered once daily from 07/26/22 to 07/31/22.<br>-There was no documentation ferrous sulfate was administered from 07/22/22 to 07/25/22. | D 358 | | |

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Review of Resident #4's Primary Care Provider's (PCP) visit note dated 07/20/22 revealed:
-Resident #4's hemoglobin (hgb) was 10.5 in March 2022. (A hemoglobin laboratory test measures the levels of hemoglobin, which are proteins in red blood cells that carry oxygen to your body, in the blood. Normal range for females 12.1 to 15.1).
-Resident #4's hgb had dropped to 8.7 in June 2022.
-Resident #4's iron supplement would be increased to daily and repeat Complete Blood Count (CBC) in one week.
-Resident #4 had a referral consult for gastro-intestinal dated 08/01/22.

Review of Resident #4's PCP visit note dated 07/27/22 revealed:
-Resident #4's hgb was 8.9 on 07/26/22.
-Resident #4 had an appointment with the Gastroenterologist scheduled in August 2022.

Review of the pharmacy packing slip dated 07/21/22 revealed 6 tablets of ferrous sulfate 325mg were shipped to the facility on 07/21/22.

Review of proof of delivery electronic signature form revealed ferrous sulfate 325mg was received in the facility and signed for by a medication aide (MA) on 07/22/22 at 10:52am.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/17/22 at 2:55pm revealed:
-The pharmacy had an order for Resident #4 to discontinue ferrous sulfate 325mg every other day dated 07/21/22.
-The pharmacy had an order for Resident #4 for ferrous sulfate 325mg once daily dated 07/21/22.
-The order for Resident #4's ferrous sulfate

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325mg was filled and shipped to the facility on 07/21/22.
-Ferrous sulfate should have been available for administration on 07/22/22.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/22 at 9:07am revealed:
-The ferrous sulfate 325mg was placed in Resident #4's multi-dose pack (MDP) on 07/26/22.
-The MDP would be shipped to the facility, placed on the medication cart and ready for administration on 07/29/22.
-The pharmacy sent enough ferrous sulfate for daily administration for 6 days prior to the medication being available in the MDP.

Observation of Resident #4's medication on hand on 08/17/22 at 11:17am revealed Resident #4's ferrous sulfate 325mg was available for administration in the MDP.

Interview with Resident #4 on 08/18/22 at 9:05am revealed:
-She knew she took ferrous sulfate each day.
-She took ferrous sulfate for anemia.
-She denied increase in fatigue or weakness.

Interview with a MA on 08/18/22 at 10:30am revealed:
-Residents' medications were delivered around 12:00pm.
-She did not recall receiving Resident #4's ferrous sulfate.
-She would sign the package slip once she compared the medications with the packing slip; the packing slip for 07/21/22 was not signed or dated.

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Interview with Resident #4's PCP on 08/18/22 at 2:00pm revealed:
-Resident #4's ferrous sulfate was increased from every other day to once daily due to low hgb.
-She was not aware that Resident #4 missed 3 doses of ferrous sulfate.
-The facility did not notify her that Resident #4 missed 3 doses of ferrous sulfate.
-She expected the facility to administer medications as ordered.
-She expected the facility to notify her if Resident #4 had missed more than three dosages of a medication.

Interview with the Memory Care Manager (MCM) on 08/18/22 at 10:55am revealed:
-She did not know who checked in Resident #4's ferrous sulfate.
-She verified the order for ferrous sulfate on 07/25/22 at 12:01pm.
-She did not recall if someone told her the medication was in the facility and the order needed to be approved or if she saw medication on the medication cart during an audit and approved the order.

b. Review of Resident #4's physician's orders dated 07/13/22 revealed there was an order for aspirin 325mg one every evening.

Review of Resident #4's physician's orders dated 07/21/22 revealed
-There was an order to discontinue aspirin 325mg daily.
-There was a new order for aspirin 81mg daily.

Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for aspirin 325mg once daily

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with a scheduled administration time of 5:00pm.
-There was documentation aspirin 325mg was administered once daily at 5:00pm from 07/01/22 to 07/21/22.
-There was documentation aspirin 325mg once daily was discontinued on 07/21/22.
-There was a second entry for aspirin 81mg once daily with a scheduled administration time of 8:00am dated 07/21/22.
-There was documentation aspirin 81mg was administered once daily from 07/26/22 to 07/31/22.
-There was no documentation aspirin was administered from 07/22/22 to 07/25/22.

Review of the pharmacy packing slip dated 07/21/22 revealed 6 tablets of aspirin 81mg were shipped to the facility on 07/21/22.

Review of proof of delivery electronic signature form revealed aspirin 81mg was received in the facility and signed for by a medication aide (MA) on 07/22/22 at 10:52am.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/17/22 at 2:55pm revealed:
-The pharmacy had an order for Resident #4 to discontinue aspirin 325mg once daily dated 07/21/22.
-The pharmacy had an order for Resident #4 for aspirin 81mg once daily dated 07/21/22.
-The order for Resident #4's aspirin 81mg was filled and shipped to the facility on 07/21/22.
-Resident #4's aspirin 81mg should have been available for administration on 07/22/22.

Telephone interview with a Pharmacist at the facility's contracted pharmacy revealed on 08/18/22 at 9:07am revealed:

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-The aspirin 81mg was placed in Resident #4's multi-dose pack on 07/26/22.
-The MDP would be shipped to the facility, placed on the medication cart and ready for administration on 07/29/22.
-The pharmacy sent enough aspirin for daily administration for 6 days prior to the medication being available in the MDP.

Observation of Resident #4's medication on hand on 08/17/22 at 11:17am revealed Resident #4's aspirin 81mg was available for administration in the MDP.

Interview with Resident #4 on 08/18/22 at 9:05am revealed:
-She knew she took aspirin every day.
-She took aspirin every day to prevent a stroke.
-She denied any blood in her urine or stool.

Interview with a MA on 08/18/22 at 10:30am revealed:
-Residents' medications were delivered around 12:00pm.
-She did not recall receiving Resident #4's aspirin.
-She would sign the package slip once she compared the medications with the packing slip; the packing slip for 07/21/22 was not signed or dated.

Interview with Resident #4's PCP on 08/18/22 at 2:00pm revealed:
-Resident #4's aspirin was decreased due to a potential bleed but not discontinued because the resident had cerebral vascular disease and a history of cerebral vascular attacks.
-She was not aware that Resident #4 missed 3 doses of aspirin.
-The facility did not notify her that Resident #4

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missed 3 doses of aspirin.
-She expected the facility to administer medications as ordered.
-She expected the facility to notify her if Resident #4 had missed more than three dosages of a medication.

Interview with the MCM on 08/18/22 at 10:55am revealed:
-She did not know who checked in Resident #4's aspirin.
-She verified the order for aspirin on 07/25/22 at 12:01pm.
-She did not recall if someone told her the medication was in the facility and the order needed to be approved or if she saw medication on the medication cart during an audit and approved the order.

Telephone interview with Resident #4's Power of Attorney (POA) on 08/18/22 at 7:57am revealed:
-He was aware that Resident #4 was having some issue with a low hgb.
-He was aware that Resident #4's PCP had made some changes with Resident #4's medication due to the low hgb.
-Resident #4 had seen a Gastroenterologist and was scheduled for an endoscopy in September 2022.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/17/22 at 2:55pm revealed:
-The pharmacy shipped medications Monday through Saturday; there was no shipment on Sunday.
-If a new order was received in the pharmacy by 5:00pm it would be shipped the same day and would arrive at the facility the next day.
-If the order was received in the pharmacy after

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| D 358 | Continued From page 14<br>5:00pm it would be shipped in 2 days.<br>-A facility representative would sign for the medication delivery upon receipt.<br><br>Interview with a medication aide (MA) on 08/18/22 at 10:30am revealed:<br>-The Resident Care Coordinator (RCC), the Memory Care Manager (MCM) or the Primary Care Provider (PCP) would fax orders to the pharmacy.<br>-The medications were signed for by a MA, the RCC or the MCM.<br>-The Assisted Living (AL) MA would check in the medication for the AL residents and the Memory Care MA would check in the medications for the memory care residents.<br>-The MA would compare the medications to the packing slip.<br>-When a new medication was delivered, the RCC, the MCM or the Administrator would be notified so the order could be approved and the medication could be administered.<br><br>Interview with a second MA on 08/18/22 at 11:15am revealed:<br>-She signed for the medication delivery on 07/22/22.<br>-She did not check the medications in for the Memory Care Unit (MCU); she worked in the Assisted Living.<br>-She took the medications to the MCU unit and gave them to the MA that was working so she could check them in.<br>-The MCU MA should check the medication in for the MCU residents.<br><br>Interview with the MCM on 08/17/22 at 4:05pm revealed:<br>-Medication deliveries from the pharmacy usually arrived during first shift. | D 358 | | |

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-The medications were checked in by the MAs, the RCC or the MCM.
-The medications were to be compared to the packing slip for accuracy.
-The RCC, MCM or the Administrator should be notified to verify new orders on the eMAR when new medications arrived at the facility so the medication could be administered.
-The new medications were to be placed in the medication cart after they were checked for accuracy.
-The pharmacy would send enough medications in a bubble pack for new or changed orders, until the medication was placed in the MDP.

Interview with the Administrator on 08/18/22 at 1:50pm revealed:
-Medications should be administered as ordered.
-She expected the MAs to notify the RCC/ MCM or the Administrator when a new medication was delivered so the order could be approved and the medication administered.

2. Review of Resident #3's current FL2 dated 06/22/22 revealed diagnoses included dementia and type 2 diabetes.

Review of Resident #3's physician's orders dated 07/13/22 revealed an order for Gabapentin 100mg three times a day (used to treat neuropathic pain).

Review of Resident #3's electronic medication administration record (eMAR) for 08/01/22-08/18/22 revealed:
-There was an entry for Gabapentin 50mg with a scheduled administration time of 6:00am, 12:00pm, and 6:00pm.
-There was documentation Gabapentin was administered on 08/01/22-/08/07/22 at 6:00am,

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12:00pm, and 6:00pm.
-There was an exception documented on 08/08/22 at 6:00am, 12:00pm, and 6:00pm as waiting on the pharmacy.
-There was an exception documented on 08/09/22 at 6:00am and 12:00pm as waiting on the pharmacy.
-There was documentation Gabapentin was administered on 08/09/22 at 6:00pm.
-There was an exception documented on 08/10/22 at 6:00am and 12:00pm as waiting on the pharmacy.
-There was documentation Gabapentin was administered on 08/10/22 at 6:00pm.
-There was documentation Gabapentin was administered on 08/11/22 at 6:00am.
-There was an exception documented on 08/11/22 at 12:00pm and 6:00pm as waiting on the pharmacy.
-There was an exception documented on 08/12/22 at 6:00am, 12:00pm, and 6:00pm as waiting on the pharmacy.
-There was an exception documented on 08/13/22 and 08/14/22 at 6:00am as waiting on the pharmacy.
-There was documentation Gabapentin was administered on 08/13/22 and 08/14/22 at 12:00pm and 6:00pm.
-There was an exception documented on 08/15/22 and 08/16/22 at 6:00am, 12:00pm, and 6:00pm as waiting on the pharmacy.
-There was documentation Gabapentin was administered on 08/17/22 at 6:00am

Observation of medications on hand for Resident #3 on 08/17/22 at 3:41pm revealed there was no Gabapentin 100mg available to be administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/17/22 at

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| D 358 | Continued From page 17<br><br>4:14pm revealed:<br>-Gabapentin 100mg was filled on 06/29/22 for 90 tablets; a one-month supply.<br>-There was a request to refill Resident #3's Gabapentin on 08/07/22 and 08/09/22 by staff at the facility, but the medication had not been refilled because a prescription was needed.<br>-There was a request from Resident #3's Primary Care Provider (PCP) on 08/12/22 to refill gabapentin but the medication could not be filled from the request form the provider had sent.<br>-She did not know if the PCP or the facility were notified on 08/12/22 the medication could not be refilled because there was no documentation on her end what had been done for follow up.<br><br>Based on eMAR documentation, medications dispensed, observations of medications on hand, and interviews, there would have not been any gabapentin 100mg available to be administered from 08/08/22-08/18/22; Resident #3 missed 10 days/30 doses of gabapentin 100mg.<br><br>Interview with a medication aide (MA) on 08/18/22 at 10:25am revealed:<br>-Resident #3 was out of gabapentin and the medication had been reordered.<br>-She could see in the eMAR system the medication had been reordered by the Memory Care Manager (MCM) on Friday, 08/12/22.<br><br>Observation of the eMAR screen on 08/18/22 at 10:25am revealed:<br>-Resident #3's eMAR was visible on the screen.<br>-There was a pop-up box labeled resupply.<br>-Gabapentin 100mg three times a day was listed.<br>-There was documentation a resupply request was completed on 08/12/22 at 8:42am by the MCM and status was successful. | D 358 | | |

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| D 358 | Continued From page 18<br><br>Interview with the MCM on 08/18/22 at 11:14am revealed:<br>-The facility had a new pharmacy they were using.<br>-The pharmacy had made refills easy in the eMAR system.<br>-If a medication was not on the cart, the MA could hit resupply on the eMAR and the medication would be refilled.<br>-If a resident was completely out of medication, she expected the MA to let her know.<br>-A resident should not run out of medication because it should have been reordered before the medication was out.<br>-They did not receive medications from the pharmacy every day, maybe every other day.<br>-The pharmacy sent a fax when a medication was refilled.<br>-They waited two days for medication to be delivered and if the medication was not received, they called the pharmacy.<br>-She did a cart audit (she did not recall the date) and Resident #3's gabapentin was not on the cart, so she reordered the medication herself.<br>-A storm had messed up the facility's internet and they were not receiving faxes, so she did not know the medication had not been refilled and the pharmacy needed a new prescription.<br>-She reached out to the pharmacy (she did not recall the date) and they told her they needed a new script every 30-days for gabapentin.<br>-She notified Resident #2's PCP.<br>-She called the pharmacy again yesterday, 08/17/22, and they said they were still waiting on a hard script.<br>-She notified Resident #2's PCP on 08/17/22 the pharmacy was still waiting on a hard script.<br><br>Telephone interview with Resident #3's PCP on 08/18/22 at 1:45pm revealed: | D 358 | | |

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| D 358 | Continued From page 19<br><br>-Resident #3's gabapentin was considered a controlled medication with the facility's new pharmacy.<br>-She was sending a refill request with her follow up pain visit, and it should not have been an issue to refill the medication.<br>-The MCM reached out to her again (she did not recall when) and she resent a refill request again.<br>-The facility's pharmacy said they did not get the request and she had personally sent the request electronically.<br>-It was no fault of the facility that Resident #2's gabapentin had not been refilled.<br>-Resident #2 had not exhibited any pain or behaviors so she had no acute concern he had not received the gabapentin.<br><br>Interview with the Administrator on 08/18/22 at 1:50pm revealed medications should be administered as ordered.<br><br>Based on observations, record review, and interviews it was determined Resident #3 was not interviewable. | D 358 | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of | D 375 | | |

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| D 375 | Continued From page 20<br>prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 1 resident sampled (#6) had a physician's order to self-administer eye drops.<br><br>The findings are:<br><br>Review of the facility's resident self-management and storage of medications policy revealed:<br>-The procedure and criteria contained in the standard must be met prior to allowing a resident to manage, administer, and store his/her own medications.<br>-A re-evaluation of the resident's ability to self-manage medications will be conducted quarterly or sooner.<br>-Any current resident who desired to self-manage his/her medication must first successfully complete the self-administration assessment in the electronic health record completed by the Resident Care Coordinator (RCC).<br>-The Administrator had to approve all self-management of medication.<br>-Once a resident successfully passed the evaluation, the RCC should ensure a physician's order was in place that indicated a resident was able to self-administer his/her medications.<br><br>Review of Resident #6's current FL-2 dated 03/15/22 revealed:<br>-Diagnoses included chronic obstruction pulmonary disease, depression, peripheral vascular disease, aortic stenosis, history of | D 375 | | |

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cerebral vascular accident, hypertension, chronic systolic heart failure, and dysphagia.
-There was an order for ketotifen fumarate (used to prevent and treat itching eyes caused by allergies) 0.025% instill one drop in both eyes twice daily.
-There was no order to self-administer medications.

Review of Resident #6's six-month physician orders revealed there was no order to self-administer medications.

Interview with Resident #6 on 08/10/22 at 2:43pm revealed:
-He did not keep any medications in his room.
-He used eye drops daily and the medication aide (MA) gave him his medications.
-He preferred to do his own administration of his eye drops.
-He thought he administered the eye drops better than the MAs.
-His eye doctor and staff had not taught him techniques for self-administering eye drops.
-He did not know if he had an order from his Primary Care Provider (PCP) for ketotifen fumarate eyedrops.

Observation of Resident #6 during the 08/17/22 morning medication pass revealed:
-The MA handed Resident #6's bottle of ketotifen fumarate eye drops to him.
-Resident #6 used his right hand to administer his eye drops into each eye.
-Resident #6 placed the dropper in the corner of his right eye and pressed the bottle once.
-Next, Resident #6 placed the dropper in the corner of his left eye and pressed the bottle once.

Telephone interview with a pharmacist at the

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facility's contracted pharmacy on 08/17/22 at 3:03pm revealed:
-Resident #6 had an order for ketotifen fumarate dated 05/13/22.
-Resident #6 had ketotifen fumarate eye drops dispensed on 07/08/22 and 08/12/22.
-Resident #6 did not have an order to self-administer eye drops.
-Ketotifen fumarate eye drops were used for allergies.
-The eyedropper should not touch any portion of the eye when administering eye drops.

Telephone interview with Resident #6's PCP on 08/18/22 at 9:42am revealed:
-She had not written a self-administration of medications order for Resident #6's eye drops.
-Resident #6 received ketotifen fumarate eye drops to treat allergies.
-Resident #6 was capable of self-administering eye drops to himself, but staff had not requested a self-administer order for his eye drops.
-She expected staff to report to her if Resident #6 did not use proper techniques in administering his eye drops.

Interview with a Memory Care Manager (MCM)/medication aide (MA) on 08/17/22 at 2:13pm revealed:
-She completed the morning medication pass on the Assisted Living unit.
-She administered medications to Resident #6, but he administered his own eye drops.
-She allowed Resident #6 to administer his eye drops because he was argumentative.
-In the past, she had offered to administer his eye drops but he did not want her to administer the eye drops.
-She did not offer Resident #6 technical assistance with the administration of his eye

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drops because she did not see that he touched the corner of his eye with the eye dropper.
-She told the Resident Care Coordinator (RCC) that Resident #6 would not allow her to administer his medications.
-She knew residents needed a self-administer of medications order in order to self-administer medications.
-Resident #6 did not have a self-administer order for eye drops.

Interview with another MA on 08/18/22 at 12:25pm revealed she allowed Resident #6 to administer his eye drops during the morning medication pass.

Interview with the RCC on 08/18/22 at 11:53am revealed:
-Resident #6 did not have a self-administer order for eye drops.
-The MCM told her that she allowed Resident #6 to self-administer his eye drops.
-Residents needed an order from the physician in order to self-administer medications.
-She was responsible for obtaining a self-administration of medication order if needed for residents.

Interview with the Administrator on 08/18/22 at 1:50pm revealed:
-She did not know Resident #6 self-administered his eye drops.
-Residents had to have an order to administer their own medication.
-The nurse had to complete a quarterly assessment for residents with an order to self-administer medications.
-She expected the MAs to tell the RCC that Resident #6 wanted to self-administer his eye drops.

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| D 375 | Continued From page 24<br>-She held the RCC responsible for obtaining an order from the physician for residents who wanted to self-administer their medications. | D 375 | | |
| D 465 | 10A NCAC 13F .1308(a) Special Care Unit Staff<br><br>10A NCAC 13F .1308 Special Care Unit Staff<br>(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO AN A2 VIOLATION<br><br>Based on these findings, the previous A2 Violation was abated. Noncomplaince continues.<br><br>Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 5 of 18 shifts sampled from 07/30/22-08/14/22.<br><br>The findings are:<br><br>Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including assisted living (AL) with a capacity of 46 beds and the special care unit (SCU) with a capacity of 48 beds. | D 465 | | |

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| | HAL001148 | A. BUILDING: _____ B. WING _____ | 08/18/2022 |

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| D 465 | Continued From page 25<br><br>Review of the facility's special care unit staffing (SCU) policy revealed:<br>-The policy was not dated.<br>-Staff would always be present in the (SCU) in sufficient numbers to meet the needs of the residents according to the following requirements.<br>-At no time should there be less than one trained staff person for up to eight residents on first and second shifts and one hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and 0.8 hours of staff time for each additional resident.<br><br>Review of the Daily Census Report dated 08/06/22 revealed there was a SCU census of 31 residents, which required 31 staff hours on second shift.<br><br>Review of staff timecards dated 08/06/22 revealed there was a total of 24.53 staff hours provided on second shift leaving a shortage of 6.5 hours.<br><br>Review of the Daily Census Report dated 08/07/22 revealed there was a SCU census of 31 residents, which required 31 staff hours on second shift and 24.8 staff hours on third shift.<br><br>Review of staff timecards dated 08/07/22 revealed:<br>-There was a total of 28.5 staff hours provided on second shift leaving a shortage of 2.5 hours.<br>-There was a total of 20.75 staff hours provided on third shift leaving a shortage of 4.05 hours.<br><br>Review of the Daily Census Report dated 08/13/22 revealed there was a SCU census of 30 residents, which required 30 staff hours on first shift. | D 465 | | |

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| D 465 | Continued From page 26 | D 465 | | |

Review of staff timecards dated 08/13/22 revealed there was a total of 24.59 staff hours provided on first shift leaving a shortage of 5.41 hours.

Review of the Daily Census Report dated 08/14/22 revealed there was a SCU census of 30 residents, which required 30 staff hours on first shift.

Review of staff timecards dated 08/14/22 revealed there was a total of 24.75 staff hours provided on first shift leaving a shortage of 5.25 hours.

Interview with a personal care aide (PCA) on 08/18/22 at 10:46am revealed:
-The facility was still short staffed on all shifts.
-She worked primarily on the SCU.
-The staff shortages were concentrated on the weekends.
-When she worked on the weekends in the SCU, often it was only she and another PCA.
-She was told people called out.
-There were new staff who came, trained and then quit.
-She did not receive any guidance from the medication aides (MA) when staffing hours were short.
-She and another PCA worked well together and would just focus to get the work done.
-During the weekdays there were 3 aides on the SCU, most of the time.
-However, during the weekends on the SCU the facility was short of staff and there were two PCAs on day shift.

Telephone interview with a MA on 08/18/22 at 9:20am revealed:
-The schedule was completed by the

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Administrator.
-She did not know what the staffing hours should be on the SCU for third shift.
-She came in at 7:00pm and there were 2 to 3 aides with her in the entire facility during third shift.
-MAs worked 12-hour shifts and PCAs worked 8-hour shifts.
-There was usually one MA for the AL unit and one for the SCU.
-If she had 2 or 3 aides in the AL unit, she would reassign one to the SCU.
-The Administrator and the care managers (Resident Care Coordinator (RCC) and Memory Care Manager (MCM)) also helped on some weekends.

Interview with another MA on 08/18/22 at 10:30am revealed:
-There were still staffing shortages.
-The Administrator made the schedule.
-The normal staffing hours for the SCU were one MA and four PCAs on first shift and second shift, and one MA with three PCAs on third shift.
-On second shift, there were usually only three PCAs on the SCU.
-The Administrator wanted to have a more staff than the minimal requirement, but people had emergencies or called out.
-She notified the Administrator when there was a shortage of staff.
-The Administrator sent out a group chat requesting help with staffing a specific unit and shift.
-The RCC and MCM worked to cover shifts on weekends.
-There were times when people just did not show up to work without any notice.
-The MAs helped on the floor now with showers and watching residents.

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| D 465 | Continued From page 28<br>-She thought the weekends were short in the SCU because of call outs.<br><br>Interview with the MCM on 08/18/22 at 11:25am revealed:<br>-The Administrator made the schedule for staff and she did not provide any input with the schedule.<br>-She took care of the clinical issues for the SCU.<br>-She worked as a MA on the floor to help out with staffing.<br>-She worked the weekend of 08/06/22 and 08/07/22 as well as 08/12/22.<br>-She worked all three shifts to fill in where needed.<br>-She and the MCM received a separate group chat message directing them to work a shift and the unit.<br>-They received this message when no one offered to work the shift.<br>-Staff had not complained of staff shortages to her recently.<br>-She knew the Administrator hired staff and placed them on the weekend that was most short of staff.<br>-Because, staffing was short she made a shower assignment sheet so that staff could ensure residents received care.<br>-She told staff to work together and take care of the residents even though staffing was short.<br><br>Interview with the Administrator on 08/18/22 at 2:07pm revealed:<br>-She knew there were still staffing shortages.<br>-She was responsible for preparing the schedule.<br>-She prepared the schedule based on the census and attempted to overstaff the SCU unit.<br>-She knew the census at this time was 30 on the SCU and that required one MA and three PCAs.<br>-She knew staffing on the weekends was short. | D 465 | | |

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| D 465 | Continued From page 29<br>-She would send out a group chat if she knew ahead of time to request staff to work extra hours.<br>-She often did not have anyone accept to work additional hours.<br>-She and the care managers worked shifts even on the weekends. | D 465 | | |