STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl092229	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VAL'S PLACE AT BROOKHAVEN	6112 WINTHROP DRIVE RALEIGH, NC 27612

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/20/22 - 09/21/22.	C 000		
C 172	10A NCAC 13G .0504 (b) Competency Validation For Licensed Health Pro 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Task (b) Competency validation shall be performed by the following licensed health professionals: (1) A registered nurse shall validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(1) through (28) of Rule .0903 of this Subchapter. (2) In lieu of a registered nurse, a respiratory care practitioner licensed under G.S. 90, Article 38, may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19) and (21) of Rule .0903 of this Subchapter. (3) In lieu of a registered nurse, a registered pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(8) of Rule .0903 of this Subchapter (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (27) of Rule .0903 of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure unlicensed staff were competency validated by a registered nurse to	C 172	Admin contact urologist and recieved verbal order from RN to stop I:O catheterizing for resident #1 on 9/22/22. on 9/22/22 urologist was scheduled to see resident at 3pm in person and signed order to D/C I:O cath. The facility will no longer allow staff to change catheters for any future residents. All future orders for I:O cath will be done by Home Health Agencies and the appropriate RN Resident currently have indwelling catheter. It is to be changed by HH RN once per month.	9/22

V. JUNE 11/16/2022

Reviewed and Acknowledged
W. Williams 11/17/22

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C 172	Continued From page 1 perform a licensed health professional support task for 1 of 1 resident (#1) who required in and out urinary catheterizations twice a day. The findings are: Review of Resident #1's current FL-2 dated 10/11/21 revealed: -Diagnoses included urinary tract infection, retention of urine, overactive bladder, acute kidney failure, and Parkinson's disease. -The section for information for bladder noted "in/out" beside external catheter. -The resident was documented as continent of bladder. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/26/19. Review of Resident #1's assessment and care plan dated 09/28/21 revealed: -The resident required extensive assistance with toileting, ambulation, and dressing. -The resident required total assistance with bathing and grooming. -The resident had daily urinary incontinence. -For catheter type, it was documented "CIC catheter twice daily". (CIC is clean intermittent catheterization. CIC is a procedure used to empty the bladder. It involves passing a catheter (small plastic tube) up the urethra (hollow tube in the body from which urine exits the body) into the bladder to allow the urine to empty. The catheter is removed after the urine has been drained. The process should be performed using a clean technique and is repeated at intervals throughout the day. CIC is used for health conditions that cause difficulty in urinating or emptying the bladder. Inserting a catheter can raise the risk of	C 172	[redacted] home Health is the HH provider. All staff have been validated for positioning and emptying of the urinary catheter bags and cleaning around the urinary catheter. All staff have been checked off on LHPS by NN in 30 days of employment. The staff will no longer perform I & O catheters. NN was updated who does quarterly LHPS for facility. New LHPS issued 10/5/22 with updated order of indwelling catheter. Monitoring system in place for Resident #1 to make sure staff is emptying indwelling catheter. Staff DON/E will monitor staff members weekly	9/22/22 11/1/22 11/10/22

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C 172	Continued From page 2 introducing infection-causing bacteria into the body. With any type of catheter, there is a higher chance of having a bladder infection or spasms, kidney infection, and urinary tract infection.) Review of Resident #1's hospital discharge summary dated 11/01/21 revealed: -The resident was admitted for cholangitis (infection of the bile ducts). -The resident had a history of urinary retention and recurrent urinary tract infections. -The resident had a history of incomplete voiding and got in and out catheterizations at her long-term care facility per the resident's guardian. Review of Resident #1's medical supply packing slip revealed catheter supplies were delivered on 08/18/22. Review of Resident #1's current licensed health professional support (LHPS) review dated 07/06/22 revealed: -The LHPS nurse documented no problems were noted or verbalized with in and out catheterizations. -The LHPS nurse checked "yes" for staff competency validated beside a handwritten task of in and out catheterizations. Interview with the Care Coordinator/Owner on 09/20/22 at 11:25am revealed the facility's current contracted LHPS nurse did not train and competency validate any facility staff on in and out catheterizations. Review of a printed documented with Resident #1's name in the facility's medication administration record (MAR) notebook revealed: -Precautions during Resident #1's catheter drainage (please read every day to verify	C 172	Continued from page 2.	11/11/22

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C 172	Continued From page 3 precaution). -Use new gloves while wearing mask during catheter drains. -Use designated sanitizing cleaner bottle on the urine collection bottle before and after the drain. -Use 3 new pads during each drain to prevent spillage of any urine into the bed sheets. -Immediately dispose of pad and gloves after performing catheter drain. -Use new (second set) of gloves to sanitize the collection bottle, the toilet, and toilet cover where urine was drained, and sanitize designated cleaner bottle and handle with paper towel. -Dispose of second set of gloves, sanitize your hands and use new third set of gloves to continue doing other tasks. -Don't forget to check the resident's temperature at 8:00am and 8:00pm. -If higher than 99, immediately call the Care Coordinator/Owner for further instructions. Review of Resident #1's record revealed there was no documentation of a physician's certification that an unlicensed personnel could perform the task of in and out catheterizations even on a temporary basis if trained by a registered nurse. Review of Resident #1's "Catheter Log" dated 07/01/22 - 09/20/22 revealed: -There was a column for the date, time, urine drained amount, and initials (staff). -In and out catheterizations were documented as completed by the facility's personal care aides (PCAs) and medication aides (MAs)/PCAs twice a day at 8:00am and 7:00pm each day. -The amount of urine documented as drained ranged from 100cc - 800cc from 07/01/22 - 09/01/22.	C 172	-Continued from page 3. 11/1/22	

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C 172	Continued From page 4 Review of Resident #1's July 2022 - September 2022 Temperature Logs revealed the resident's temperature ranged from 96.9 degrees Fahrenheit (F) - 98.6 degrees F. Interview with Resident #1 on 09/21/22 at 10:53am revealed: -The facility staff catheterized her in the mornings and at night. -She denied any current pain or symptoms of urinary tract infection. -She did not provide any further details about the in and out catheterizations performed by staff. Interview with the Care Coordinator/Owner on 09/20/22 at 11:25am revealed: -The facility's PCAs and MAs/PCAs had been performing in and out catheterizations for Resident #1 since the resident was admitted about 3 years ago. -A registered nurse (RN) from a home health agency came to the facility when the resident was admitted and trained her and the Supervisor-in-Charge (SIC) on how to perform the catheterizations. -She could not locate any documentation of the training and she did not know the name of the RN or how to contact her. -She and the SIC then trained the other staff on how to perform the in and out catheterizations. -She was an RN in another country but she was not licensed as an RN in this country or state. -She was not aware unlicensed staff were not allowed to perform in and out catheterizations. -She was not aware a physician had to certify unlicensed staff could be competency validated by an RN to perform the task or that it could only be for a temporary task. Interview with the SIC on 09/20/22 at 11:25am	C 172	Continued from page 4. 11/11/22	

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C 172	Continued From page 5 revealed: -She was a PCA, not a nurse or nurse aide. -She recently became the SIC and she supervised the MAs. -She and the Care Coordinator/Owner had been trained to perform the in and out catheterizations for Resident #1 about 3 years ago. -She did not recall the name of the RN who trained them. -She and the Care Coordinator/Owner trained the other facility staff (PCAs and MAs/PCAs) on how to perform the in and out catheterizations. Interviews with a MA/PCA on 09/20/22 at 9:08am and 5:45pm revealed: -She had worked at the facility for about 2 years. -The facility's Care Coordinator/Owner trained her on how to perform in and out catheterizations for Resident #1. -She had to demonstrate how to perform the catheterization when she was trained. -The resident's catheterizations were done twice a day, in the morning and evening. -She usually drained 300cc - 400cc of urine in the mornings and 500cc - 600cc in the evenings when she performed the catheterizations. -The resident urinated on her own at other times throughout the day. -The resident had not complained of any symptoms of urinary tract infection or pain. Interview with a second MA/PCA on 09/21/22 at 11:51am revealed: -She had worked at the facility since January 2022 as a PCA and she became a MA in July 2022. -The SIC trained her to perform Resident #1's in and out catheterizations in July 2022. -The SIC showed her how to perform the catheterization, then the SIC watched her perform	C 172	continued from page 1-5.	11/11/22

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C 172	Continued From page 6 the catheterization for the resident. -The resident had not voiced any complaints when she performed the in and out catheterizations. -The resident's urine was a "normal" yellow color with no odor or blood in the urine. -The resident had not complained of any symptoms of urinary tract infection or pain. Interview with a PCA on 09/21/22 at 12:12pm revealed: -She started working at the facility about a month ago. -The SIC trained her to perform Resident #1's in and out catheterizations in July 2022. -The resident's urine was yellow and had no odors. -The resident had not voiced any complaints when she performed the in and out catheterizations. -The resident had not complained of any symptoms of urinary tract infection. Attempted telephone interview with the facility's LHPS nurse on 09/21/22 at 12:52pm was unsuccessful. Telephone interview with a nurse from Resident #1's urology provider's office on 09/21/22 at 11:55am revealed: -The resident's urology provider was currently out of the office. -The resident was last seen by the urology provider about a year ago so it was time for the resident to be seen again. -The urology provider would do a bladder scan and re-evaluate to determine if the resident needed to continue with the in and out catheterizations. -The facility could hold in and out catheterizations	C 172	continued from page 1-6.	11/11/22

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C 172	Continued From page 7 until the resident was seen by the urologist provider tomorrow, 09/22/22. -It was possible for in and out catheterizations to cause infection. _____ The facility failed to ensure unlicensed staff were competency validated by a registered nurse to perform in and out urinary catheterizations for Resident #1, who had a history of urinary retention, urinary tract infections, and neurogenic bladder. The facility's Care Coordinator/Owner and SIC, who were also unlicensed staff, trained the facility's PCAs and MAs/PCAs to perform the in and out catheterizations. According to a nurse with Resident #1's urology provider's office, in and out catheterizations put the resident at risk of infections. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/20/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 5, 2022.	C 172	Continued from pages 1-7. 11/11/22 Per telephone conversation with Ms. Val June on 11/17/22 at 1:16pm: The correction date for Tag C172 is 11/5/22. MW 11/17/22	
C 173	10A NCAC 13G .0504 (c) Competency Validation For Licensed Health Pro 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (c) Competency validation of staff, according to Paragraph (a) of this Rule, for the licensed health professional support tasks specified in Paragraph (a) of Rule .0903 of this Subchapter and the performance of these tasks is limited exclusively	C 173	Per telephone conversation with Ms. Val June on 11/17/22 at 1:16pm: For Tag C173 - Refer to the plan of correction for Tag 172 on pages 1 and 2. The plan of correction date is 11/5/22. MW 11/17/22	

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C 173	Continued From page 8 to these tasks except in those cases in which a physician acting under the authority of G.S. 131D-2(a1) certifies that non-licensed personnel can be competency validated to perform other tasks on a temporary basis to meet the resident's needs and prevent unnecessary relocation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure unlicensed staff had been certified by a physician to be competency validated by a registered nurse for 1 of 1 resident (#1) who required in and out urinary catheterizations twice a day and failed to ensure it was a temporary task. The findings are: Review of Resident #1's current FL-2 dated 10/11/21 revealed: -Diagnoses included urinary tract infection, retention of urine, overactive bladder, acute kidney failure, and Parkinson's disease. -The section for information for bladder noted "in/out" beside external catheter. -The resident was documented as continent of bladder. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 09/26/19. Review of Resident #1's assessment and care plan dated 09/28/21 revealed: -The resident required extensive assistance with toileting, ambulation, and dressing. -The resident required total assistance with bathing and grooming. -The resident had daily urinary incontinence. -For catheter type, it was documented "CIC	C 173	continued from pages 1-8.	11/11/22

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C 173	Continued From page 9 catheter twice daily". (CIC is clean intermittent catheterization. CIC is a procedure used to empty the bladder. It involves passing a catheter (small plastic tube) up the urethra (hollow tube in the body from which urine exits the body) into the bladder to allow the urine to empty. The catheter is removed after the urine has been drained. The process should be performed using a clean technique and is repeated at intervals throughout the day. CIC is used for health conditions that cause difficulty in urinating or emptying the bladder. Inserting a catheter can raise the risk of introducing infection-causing bacteria into the body. With any type of catheter, there is a higher chance of having a bladder infection or spasms, kidney infection, and urinary tract infection.) Review of Resident #1's record revealed there was no documentation of a physician's certification that an unlicensed personnel could perform the task of in and out catheterizations even on a temporary basis if trained by a registered nurse. Review of Resident #1's "Catheter Log" dated 07/01/22 - 09/20/22 revealed: -There was a column for the date, time, urine drained amount, and initials (staff). -In and out catheterizations were documented as completed by the facility's personal care aides (PCAs) and medication aides (MAs)/PCAs twice a day at 8:00am and 7:00pm each day. Interview with Resident #1 on 09/21/22 at 10:53am revealed the facility staff catheterized her in the mornings and at night. Interview with the Care Coordinator/Owner on 09/20/22 at 11:25am revealed: -The facility's PCAs and MAs/PCAs had been	C 173	Continued from page 9 1-9.	11/11/22

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C 173	Continued From page 10 performing in and out catheterizations for Resident #1 since the resident was admitted about 3 years ago. -She and the SIC trained the PCAs and MAs/PCAs on how to perform the in and out catheterizations. -She was not aware a physician had to certify unlicensed staff could be competency validated by an RN to perform the task or that it could only be for a temporary task. Interview with the SIC on 09/20/22 at 11:25am revealed: -She was a PCA, not a nurse or nurse aide, and was recently promoted to SIC. -She and the Care Coordinator/Owner had been performing the in and out catheterizations for Resident #1 for about 3 years. -She and the Care Coordinator/Owner trained the PCAs and MAs/PCAs on how to perform the in and out catheterizations. Interviews with a MA/PCA on 09/20/22 at 9:08am and 5:45pm revealed: -She had worked at the facility for about 2 years. -The resident's catheterizations were done twice a day, in the morning and evening. Telephone interview with a nurse from Resident #1's urology provider's office on 09/21/22 at 11:55am revealed: -The resident's urology provider was currently out of the office. -The resident was last seen by the urology provider about a year ago so it was time for the resident to be seen again. -The urology provider would do a bladder scan and re-evaluate to determine if the resident needed to continue with the in and out catheterizations.	C 173	continued from page 1-10. 11/11/22	

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C 173	Continued From page 11 -The facility could hold in and out catheterizations until the resident was seen by the urologist provider tomorrow, 09/22/22. -It was possible for in and out catheterizations to cause infection.	C 173		11/11/22
C 280	10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve water to residents during the lunch and dinner meals on 09/20/22. The findings are: Review of the facility's Week 3 (Tuesday) Diet Menu posted in the kitchen on 09/20/22 revealed: -There were 3 meals (breakfast, lunch, and dinner) listed on the menu. -One cup of water was included in the menu for lunch and dinner. -There was a note typed in bold print at the bottom of the page, "Water is served with Every Meal". Observation of the lunch meal on 09/20/22 from 12:08pm - 12:34pm revealed: -There was 1 resident observed who ate lunch in the dining room.	C 280	Inservice training for all staff was performed by Admin and SIC on 9/22/22, 9/25/22, 9/30/22 for all meals to ensure staff serve water and 2 other drinks for each resident at each meal time. In the future staff who do not comply will be written up on retained immediately. All future staff will be trained upon when hired. Monitor system in place on 9/30/22 - 9/25/22, 9/22/22.	9/30/22

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C 280	Continued From page 12 -Two residents, who required feeding assistance, were fed by staff in their room. -All 3 residents observed during the lunch meal were served cranberry juice and 2% milk. -Water was not served or offered to either of the 3 residents observed during the lunch meal. Observation of the dinner meal on 09/20/22 at 5:13pm revealed: -There were 2 residents eating dinner at the table in the kitchen. -The residents had milk and/or cranberry juice with their meal. -Water was not served or offered to the residents eating dinner in the kitchen. Interview with a resident on 09/21/22 at 10:42am revealed: -She did not usually get water served with her meals. -She had to ask for water. Interview with the personal care aide (PCA) on 09/20/22 at 5:17pm revealed she gave no explanation for not serving water to the residents at lunch and dinner. Interview with the Supervisor-in-Charge (SIC) on 09/20/22 at 5:19pm revealed: -The residents should be served water at all meals. -Staff were aware water was to be served to the residents at all meals. Interview with the Administrator on 09/20/21 at 5:25pm revealed: -Water should be served to all residents at every meal. -Staff were aware they should serve water to the residents at every meal.	C 280	Monitoring system in place daily to make sure residents are being served water and 2 other beverages with each meal by employees D & E. Or one of employee on shift watching the other employee serve.	9/30/22 11/10/22

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C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by:	C 335	on 9/22/22 all staff had in service training which allowed and showed the proper way to administer medications to each residents. All staff were informed that no medication to be prepared ahead of time for any resident in the facility All staff were retrained on preparing medication by Billing MAR. All staff (medtech) were retrained on making sure to observe each resident when taking medication. All staff were trained to sign MAR one resident at a time after they	9/22/22

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C 335	Continued From page 14 Based on observations and interviews, the facility failed to ensure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for Resident #2 on the morning of 09/20/22. The findings are: Observation during tour of the facility on 09/20/22 from 9:29am - 9:45am revealed: -At 9:29am, the medication aide (MA) was in the kitchen stirring yogurt in a small white plastic cup. -The MA took the white plastic cup with yogurt and a second white plastic cup to Resident #2's room and put them on the table tray near the resident's bowl with oatmeal. -The MA then left the resident's room. -The white cup with yogurt had crushed pieces of oral medication mixed in the yogurt and had no labeling on the cup. -The name(s) and strength(s) of the medication(s) crushed in the yogurt was not labeled on the cup. -The second white cup contained 4 pills and had Resident #2's first name, the date, and "8am" written on the cup. -The medications in Resident #2's labeled white cup included two Furosemide 20mg tablets, one Diltiazem 240mg ER capsule, and one-half Sinemet 25/100mg tablet. (Furosemide is a diuretic for swelling. Diltiazem is for heart/blood pressure. Sinemet is for Parkinson's disease.) -The cups were not covered or protected from contamination or spillage. -At 9:40am, Resident #2 ate the yogurt with the crushed medication from the first white cup. -There were small pieces of the crushed medication left in the cup and not taken by the resident. -At 9:43am, Resident #2 took the pills in the other	C 335	observe resident take/swallow medication. All staff (medtechs) were trained to observe each resident take his/her medication. Staff was trained to sign MAR after each resident take medication. 9/25/22 Monitor system in place by employee Dir. Observe twice a week to see staff (medtechs) observe resident take medication. 11/10/22	

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C 335	Continued From page 15 white medication cup. -The MA or no other staff were in the room when Resident #2 took any of her morning medications. Interview with Resident #2 on 09/20/22 at 9:45am revealed: -She received her morning medications in the white cups each morning with her breakfast. -There was medication crushed in the yogurt. -The MA did not usually observe her when she took her medications. Interview with a second resident on 09/20/22 at 10:22am revealed: -She usually received her morning medications in a cup when staff brought her breakfast to her room. -The MAs usually left the medication cup with her in the room. -The MAs did not observe her take her medications. Interview with the MA on 09/20/22 at 5:22pm revealed: -She prepared all of the residents' morning medications at the same time. -She put each residents' oral pills in a medication cup with the resident's name, date, and time of administration labeled on the cup. -She made sure the residents were eating breakfast in their rooms before she took their medications to them. -She would take the residents their medications and then make residents' beds while the residents were eating. -She crushed and mixed Resident #2's Sevelamer 800mg tablet in yogurt and the resident usually ate the yogurt with her breakfast. (Sevelamer lowers phosphorus in kidney disease.)	C 335	- continued from page 15.	9/25/22

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C 335	Continued From page 16 -She did not always observe Resident #2 take her medication because the resident's family said the resident could take it herself. Interview with the Supervisor-in-Charge (SIC) on 09/20/21 at 5:25pm revealed: -No prepouring was allowed at the facility. -The MAs were supposed to prepare and administer one resident's medication at a time. -She had a meeting with the MAs last week about not prepouring medications. -She was not aware any MAs were currently prepouring medications. Interview with the Administrator on 09/20/21 at 5:25pm revealed: -The MAs were not supposed to prepour any medications. -The MAs were supposed to prepare and administered medications for one resident at a time. -She was not aware medications were being prepoured.	C 335	Continued from page 15. Per telephone conversation with Ms. Val June on 11/17/22 at 1:16pm; The correction date for Tag 335 is 9/25/22. MW 11/17/22	9/25/22
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	C 341	Per telephone conversation with Ms. Val June on 11/17/22 at 1:16pm; For Tag 341 - Refer to the plan of correction for Tag 335 on pages 14 and 15. The correction date for C341 is 9/25/22. MW 11/17/22	

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C 341	Continued From page 17 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the medication aide observed residents taking their medications and documented the administration of medications on the medication administration record immediately following administration of medications to the residents. The findings are: Observation during tour of the facility on 09/20/22 from 9:29am - 9:45am revealed: -At 9:29am, the medication aide (MA) took a white plastic cup with yogurt and a second white plastic cup to Resident #2's room and put them on the table tray near the resident's bowl with oatmeal. -The MA then left the resident's room. -The white cup with yogurt had crushed pieces of oral medication mixed in the yogurt. -The second white cup contained 4 pills. -At 9:40am, Resident #2 ate the yogurt with the crushed medication from the first white cup. -There were small pieces of the crushed medication left in the cup and not taken by the resident. -At 9:43am, Resident #2 took the pills in the other white medication cup. -The MA or no other staff were in the room when Resident #2 took any of her morning medications. Interview with Resident #2 on 09/20/22 at 9:45am revealed: -She received her morning medications in the white cups each morning with her breakfast. -The MAs did not usually observe her when she took her medications.	C 341	Continued from page 19.	9/25/22

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C 341	Continued From page 18 Interview with a second resident on 09/20/22 at 10:22am revealed: -She usually received her morning medications in a cup when staff brought her breakfast to her room. -The MAs usually left the medication cup with her in the room. -The MAs did not observe her take her morning medications. -She also received her evening medications with her supper meal in her room and the MAs did not usually observe her take those medications either. A second observation of Resident #2 on 09/20/22 at 5:13pm revealed: -Resident #2 was sitting at a table in the kitchen eating dinner. -Resident #2's medications were in an uncovered plastic medication cup on the table near her plate. -Resident #2 took the medications in the cup at 5:15pm. -The MA nor any other staff were in the kitchen or in view of Resident #2. -The resident was not observed taking her medication by the MA. Interview with the MA on 09/20/22 at 5:22pm revealed: -She prepared the residents' morning medications at the same time. -She put each residents' oral pills in a medication cup with the resident's name, date, and time of administration labeled on the cup. -She made sure the residents were eating breakfast in their rooms before she took their medications to them. -She would take the residents' their medications and then make residents' beds while the	C 341	Continued from correction 9/25/22 on page 15.	

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C 341	Continued From page 19 residents were eating. -She usually watched most residents take their medications. -She did not always observe Resident #2 take her medication because the resident's family said the resident could take it herself. -She documented her initials on the MAR for the morning medication for all residents at the same time, after the residents had eaten breakfast and taken their medications. Interview with the Supervisor-in-Charge (SIC) on 09/20/21 at 5:25pm revealed the MAs were supposed to observe the resident take their medication and document their initials on the MAR immediately after they observed the resident take their medications, prior to the next resident.	C 341		
C 911	G.S 131D 21(1) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure Resident #4 was treated with consideration and right to privacy related to a video/audio monitor being used in the resident's room without asking permission of the resident. The findings are: Review of Resident #4's current FL-2 dated	C 911	Camera was taken out of Resident #4 room immediately. SIC and Admin implemented signed document for each POA to sign and return to facility for permission of use of monitoring devices for safety purposes. Resident #4 POA was contacted on	9/22/22 11/10/22

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C 911	Continued From page 20 07/06/22 revealed diagnoses included depression, hypertension, hypothyroidism, and osteoporosis. Review of Resident #4's Resident Register revealed: -The resident was admitted to the facility on 07/21/22. -The resident's memory was adequate. Observation of the kitchen on 09/20/22 at 9:18am revealed: -There was a video/audio monitor receiving unit sitting on top of the kitchen counter. -Resident #4's first name and first initial of her last name were labeled on the bottom of the unit just below the screen. -The resident's room could be seen on the screen of the monitor including a lamp, a chair, and the side of a clothed body in the chair. -Voices could be heard from the receiving monitor unit. Observation throughout the survey on 09/20/22 from 9:00am - 6:00pm revealed: -A visitor entered and exited the facility through the door near the dining area and walked through the kitchen each time. -Resident #4's video/audio monitor receiving unit was sitting on the kitchen counter and the screen showing the resident in her room could be seen by the visitor. Interview with Resident #4 on 09/20/22 at 10:58am revealed: -She had not given the facility staff permission to put the video/audio monitor in her room. -The facility staff had not asked for permission to put the monitor in her room. -She was told by staff the video/audio monitor	C 911	9/22/22 and he signed the release form to use camera monitor in the resident room. Camera was reinstalled in residents room by end of day on 9/22/22. All future residents will be asked to sign this form or POA declare at time to have camera system for safety Purpose this form will be filed in resident charts by DIC or Admin. All video/audio devices will be moved to a location where only staff can view for safety Purposes. 9/22/22 11/4/22

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C 911	Continued From page 21 had to be in her room because she was at risk for falls. -She had not fallen in almost a year. A second interview with Resident #4 on 09/21/22 at 10:42am revealed she did not like feeling like she was being watched. Attempted telephone interview with Resident #4's power of attorney (POA) on 09/21/22 at 12:30pm was unsuccessful. Interview with the Care Coordinator/Owner on 09/20/22 at 5:35pm revealed: -Resident #4 had a live video/audio monitor in her room. -The resident was at risk for falls so the monitor was for safety. -She did not get a signed consent for the monitor from the resident or the resident's POA because she did not think about it being a privacy issue. -The resident and the resident's POA were aware of the monitor in the resident's room. -The video/audio monitor receiving unit was kept on the kitchen counter so staff could see the resident on the monitor screen while she was in her room. -She had not thought about other residents and visitors being able to see and hear Resident #4 on the monitor screen when they walked through the kitchen area.	C 911	No resident will have video/Audio installed in their room unless permission form is signed by POA and owner. 9/22/22 Per telephone conversations with Ms. Val Jeune on 11/14/22 at 4:01pm and 11/17/22 at 1:16 pm', The owner will be responsible for monitoring to ensure compliance with the rules. WW 11/17/22	