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	HAL092181	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 09/07/22-09/09/22.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there were no chronic odors of urine, feces and body odor on the special care unit (SCU). The findings are: Observations on the SCU on 09/07/22 from 9:27am until 11:01am revealed: -There was a generalized urine, feces and body odors in the hallways, common areas and more intensely in occupied resident rooms. -Initially there was only one housekeeper on the SCU, after approximately 10:15am there were three housekeepers cleaning the SCU including unoccupied rooms. Interview with a personal care aide (PCA) on 09/09/22 at 2:32pm revealed this was a SCU and sometimes there were odors. Interview with the Special Care Coordinator	D 075	The Covington shall have no chronic unpleasant odors. Director of Resident Care/ Resident Care Coordinator/ Special Care Coordinator re-educated staff that incontinent items are not to be discarded in the resident rooms and should be contained in a small trash bag prior to throwing into the soiled utility room. 9/21/22 RCC/SCC will make unit rounds no less than twice daily to ensure the facility smells pleasant and clean. Any odors noted will be addressed immediately, finding the root cause, correcting the cause, and requesting housekeeping to refresh the area. 10/24/22 Executive Director/Housekeeping Supervisor/ Maintenance Tech/ Designee will make facility rounds no less than twice daily to ensure the facility smells pleasant and clean. Any odors noted will be addressed immediately, finding the root cause, correcting the cause, and requesting housekeeping staff to clean the area. 10/24/22	

Received and Acknowledged 10/31/22 Tina B Nielsen

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D 075	Continued From page 1 (SCC) on 09/09/22 at 5:06pm revealed: -This was a memory care unit and there were odors, accidents and messes. -Housekeepers and staff cleaned the SCU every day. Interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm revealed: -Housekeepers were responsible for cleaning resident rooms. -Staff should see anything needing to be cleaned or repaired during rounds and with resident care. -If staff could correct the problem then staff should correct it; if staff was not able to correct it then they should report to the Supervisor or Care Coordinator. -She checked the environment of care daily.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the special care unit (SCU) was clean and free of all obstructions and hazards including a leaking air conditioning unit in the hallway, slippery floors in occupied resident rooms, sticky floors in the dining room, a missing electrical outlet cover, broken furniture in an occupied resident room and clogged toilets with	D 079	The Covington shall be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards. ED re-educated housekeeping team that commonly used areas must be cleaned more than one time per shift, especially on the Memory Care Unit. Also, these areas should be spot checked throughout the shift to ensure they do not need any extra attention due to a resident accident, etc. 9/19/22 ED re-educated all staff that it is everyone's responsibility to assist with the cleanliness of the residents' home, and if there are items seen out of place they should assist with correcting. ED also re-educated care staff that they should be assisting with tidying the residents' rooms when giving care, simply cleaning up after themselves and picking up any items they may have used and putting them back into their designated location. 9/21/22	

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D 079	Continued From page 2 stagnant feces in the bowl. The findings are: Observations on the special care unit (SCU) on 09/07/22 from 9:27am until 11:01am revealed: -The entire walking area of the floor in resident room 103 was slippery with a puddle of liquid between the bed and the closet. -On the other side of the bed there was a floor mat on the floor with a large brown stain resembling dried feces. -The nightstand between the two beds in resident room 103 was missing the top drawer. -There was a metal rod with sharp edges sticking out from under the bed closest to the window and just above the floor mat on the floor next to the bed closet to the door. -The drawers to second nightstand were pulled halfway out. -There was a wooden glide style rocking chair without a seat cushion which exposed wooden dowel seat supports spaced approximately three inches apart. -The bathroom in resident room 101 had a sign on the door which read, "Out of order, Don't have a plunger." -There were plastic bags on the floor of the bathroom and between the toilet seat and rim of the bowl towards the back of the toilet. -There was dried feces around the inside of the bowl with liquid feces at the bottom of the bowl. -The electrical outlet next to the first bed in resident room 108 was missing the cover exposing the outlet hardware and access to electrical wires. -The bathroom in resident room 143 had a sign on the door which read, "Out of order." -The entire walking area of the floor in resident room 145 was slippery.	D 079	ED re-educated all staff to notify a member of management immediately if an area needs housekeeping or maintenance attention, so that the appropriate person can be contacted. Housekeeping supervisor has implemented a deep cleaning schedule, and will notify the ED of which rooms will be deep cleaned each morning during management meeting. ED or Designee will follow up with the Maintenance Tech daily during management meeting on any open work orders or reported maintenance issues. They will discuss the status of repair, any areas of concern, as well as an estimated date of completion. ED will note any maintenance concerns during facility rounds; including broken furniture, inoperable plumbing, leaks, etc. and will ensure report is promptly made to maintenance by following the work order procedure. Once work orders are in place, ED will follow up with maintenance to ensure all areas are addressed, and to receive a date of completion. ED will verify during facility rounds.	9/21/22 9/23/22 10/24/22 10/24/22

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D 079	Continued From page 3	D 079		

-There were sticky areas and food particles on the floor around tables in the dining room.
-There was a wall mounted air conditioning unit at the end of the hall near resident room 165 with a puddle of water on the floor in front of the unit.
-The wall on the right side of the air conditioning unit had damage including several holes, water marks, a black substance around the edges and softening extending to the electrical outlet and window.
-Initially there was only one housekeeper on the SCU, after approximately 10:15am there were three housekeepers cleaning the SCU including unoccupied rooms.

Interview with a resident on 09/07/22 at 10:02am revealed:
-The toilet in resident room 143 had been out of order for "a pretty good while."
-He was not able to say how long it had been.
-The toilet did not flush right and he was not able to give any more details.

Interview with a personal care aide (PCA) on 09/09/22 at 2:32pm revealed:
-She did not think the feces had been in the toilet in resident room 101 long.
-She thought it could have happened the night before (09/06/22).
-The air conditioning unit in the hallway near resident room 165 had been broken and leaking for four months.
-The previous Maintenance Director looked at unit.
-She did not remember when that was.

Interview with a medication aide (MA) on 09/07/22 at 9:52am revealed:
-He believed the toilet in room 101 was clogged on 09/06/22 and documented in the maintenance

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D 079	Continued From page 4	D 079		

book.
-The Maintenance Director would probably be there today (09/07/22) to fix it.
-He did not know what was going on in room 103.
-He did not know what happened or how long it had been in that condition.
-He though he saw the fall mat folded up under the bed two days ago (09/05/22).

Interview with a housekeeper on 09/09/22 at 2:20pm revealed:
-He was responsible for cleaning windows, blinds, bathrooms, air conditioning filters, floors, floor mats and under furniture.
-He was also responsible for cleaning the dining room after breakfast and after lunch.
-He threw a fall mat away on 09/07/22 because it had feces on it, and he could not get it clean.
-He was told about the floor mat on 09/07/22; he did not know how long it been there.
-He took the nightstand, metal rod and rocking chair to the garbage outside.
-He had not seen resident room 103 in that condition prior to 09/07/22.
-The toilet in resident room 101 had been like that for a week.
-No one had reported it to maintenance.
-He could not remember if he had seen the toilet in room 101 or if he just knew about it.
-He saw the electrical outlet in resident room 108 today 09/09/22 and wrote it on the maintenance log sheet.
-The air conditioning unit had been leaking for several months.
-He did not know if the Maintenance Director knew about it because he was new.
-He did not think he had reported it to the Maintenance Director.
-He reported any needed repairs he saw to the Maintenance Director either verbally or by writing

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D 079	Continued From page 5	D 079		

it on a piece of paper.
-There was normally one housekeeper for the first floor (SCU) and one housekeeper for the second floor (assisted living).
-The two housekeepers split the ground floor where the offices, main dining room and activities room were.

Interview with the Housekeeping Supervisor on 09/07/22 at 10:44am revealed:
-She did not know about the toilets in resident rooms 101 and 143.
-She did not know about broken furniture and a soiled floor mat in resident room 103.
-Normally, staff working on the floor reported housekeeping and/or maintenance concerns to housekeepers, the Maintenance Director or the Special Care Coordinator (SCC).

Observation on the SCU on 09/09/22 at 2:17pm revealed the wall on the right side of the wall mounted air conditioning unit remained damaged including several holes, water marks, a black substance around the edges and softening extending to the electrical outlet and window.

Interview with the Maintenance Director on 09/09/22 at 4:14pm revealed:
-He saw the air conditioning unit in the hallway near resident room 165 and reported to the Regional Maintenance Director on 08/09/22.
-He did not know about the electrical outlet cover in resident room 108.
-The toilet in resident room 143 was fixed before 09/07/22 and the sign was left on the door.
-He did not know about the backed-up toilet in resident room 101 until 09/07/22.
-He did not know how long the toilet had been backed-up.
-When he was made aware of a repair need, he

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D 079	Continued From page 6 fixed it. -There was a maintenance request book with maintenance work order forms at the nursing station on each floor. -Residents, family members and staff could fill out the maintenance work order forms. -He checked the books daily. Interview with the SCC on 09/09/22 at 5:06pm revealed: -This was a memory care unit and there were odors, accidents and messes. -Housekeepers and staff cleaned the SCU every day. Interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm revealed: -Housekeepers were responsible for cleaning resident rooms. -Staff should see anything needing to be cleaned or repaired during rounds and with resident care. -If staff could correct the problem then staff should correct it; if staff was not able to correct it then they should report to the Supervisor or Special Care Coordinator (SCC). -She checked the environment of care daily.	D 079		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (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. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide	D 188	The Covington shall have staff on duty to meet the needs of the residents. The facility shall be able to meet the staffing requirements of rule area .0604(e), and have additional aide duty to meet the needs of the facility's heavy care residents. The Business Office Manager will continue to pull applications for open positions and schedule interviews for the care department. The ED/RCC/Designee will assist with completing interviews.	10/24/22

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D 188	Continued From page 7 duty hours on each 8-hour shift shall at all times be at least: (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.) (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.) (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) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) community were met for 7 of 18 sampled shifts.	D 188	ED educated staff that they are to call the Administrator with any need to be absent from work, as well as the appropriate manner to call out from work. ED also re-educated staff on the call out policy, which states to notify management at least 4 hours prior to the start of their shift to allow time to adjust scheduling and find coverage. ED/Lead Supervisor in Charge will reach out to staff to assist with coverage. If unable to get staff assistance, LSIC will cover shortage. If LSIC is already working and there is still a shortage, the Care Managers will take rotation to also assist with covering the shortage. If a Manager works to cover care hours, she will clock in and assure hours are allotted to pcs/care hours. If the Manager is the SCC, the RCC will cover the Memory Care Unit in management capacity to ensure oversight of 40 hours a week is in compliance.	9/21/22 10/24/22

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D 188	Continued From page 8 The findings are: Review of the facility's license effective 12/22/21 revealed the facility was licensed for a capacity of 120 beds including 60 beds for the assisted living (AL) area and 60 beds for the special care unit (SCU). Observation of the facility on 09/07/22 at 9:00am revealed: -The facility was a multi-level facility consisting of three floors (a ground floor, first and second floors). -The facility's current AL census on 09/07/22 was 35 residents. Interview with the Interim Executive Director on 09/07/22 at 1:00pm revealed: -The medication aides (MAs) worked 12 hour shifts 7:00am to 7:00pm and 7:00pm to 7:00am both weekdays and weekends. -The personal care aides (PCAs) worked 8 hour shift Monday - Friday (7:00am-3:00pm 1st shift, 3:00pm-11:00pm 2nd shift and 11:00pm-7:00am 3rd shift). -The PCAs worked 12 hour shifts, 7:00am to 7:00pm and 7:00pm to 7:00am, on the weekends. -There was one MA/PCA who only worked 8 hour shifts when scheduled to work. Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 09/05/22 revealed: -The AL census was 35 residents, which required 20 staff hours on first and second shifts and 16 staff hours on third shift. -Staff time cards had three staff in the facility on third shift from 11:00pm - 5:15am when the 4th staff member clocked in. -When the staff clocked out for breaks, only one	D 188		

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staff member was on AL and one staff member on SCU.
-The employee timecards had only four staff in the facility on third shift.
-The third shift assignment had one MA assigned to the facility to cover both the AL and SCU and one PCA was assigned to the AL.
-The staff time cards had a total of 8 hours 26 minutes staff hours provided on AL for third shift for a shortage of 7 hours and 34 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 09/04/22 revealed:
-The AL census was 35 residents, which required 20 staff hours on first shift.
-The first shift assignment had one MA and one PCA assigned to the AL.
-The staff time cards had a total of 16 hours 10 minutes staff hours provided on AL for first shift for a shortage of 3 hours and 50 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 09/03/22 revealed:
-The AL census was 35 residents, which required 20 staff hours on first shift.
-The first shift assignment had one MA and one PCA was assigned to the AL.
-The staff time cards had a total of 15 hours 56 minutes staff hours provided on AL for first shift for a shortage of 4 hours and 4 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 08/23/22 revealed:
-The AL census was 35 residents, which required 16 staff hours on third shift.
-The third shift assignment had one MA and one PCA was assigned to the AL.

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-There was a total of 11 hours 30 minutes staff hours provided on AL for third shift for a shortage of 4 hour and 30 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 08/22/22 revealed:
-The AL census was 35 residents, which required 20 staff hours on second shift.
-The second shift assignment had one MA and one PCA was assigned to the AL.
-There was a total of 8 hours 4 minutes staff hours provided on AL for second shift for a shortage of 11 hour and 56 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 08/21/22 revealed:
-The AL census was 35 residents, which required 20 staff hours on first and second shifts.
-The second shift assignment had one MA assigned to both AL and SCU and two PCAs were assigned to the AL.
-There was a total of 17 hours 27 minutes staff hours provided on AL for first shift for a shortage of 2 hours and 33 minutes.
-There was a total of 18 hours 20 minutes staff hours provided on AL for second shift for a shortage of 1 hour and 40 minutes.

Interview with an AL resident on 09/07/22 at 9:40am revealed:
-The facility was short staffed mainly on the weekends and on second and third shifts.
-He had to wait to receive his medicines and meals were often late.

Interview with another AL resident on 09/07/22 at 9:50am revealed:
-She required assistance to get up out of bed and

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often waited for staff to come help her out of the bed.
-She did not know how long she had to wait to get out of bed.
-The facility was short staffed mainly on the weekends and 2nd and 3rd shifts.
-There were times she would not get her morning medicines that were supposed to be at 8:00am until 10:00am or later.
-This would happen when there was only one medication aide to cover both floors (the AL and SCU).

Interview with a third AL resident on 09/07/22 at 9:55am revealed:
-Second and third shifts and weekends were usually the ones that were short staffed.
-There were usually two staff in the entire building to cover all both floors of the AL and the SCU.
-He would not get his medicines in the morning until after 10:00am when they were scheduled for 8:00am.
-His medicines were late more on the weekends.

Interview with a fourth AL resident on 09/07/22 at 10:04am revealed:
-Sometimes there was not enough staff in the facility.
-Her medications were sometimes administered late.
-A couple of weeks ago "on a Tuesday night" (referring to 08/23/22), she did not get her medications so she went to the desk to find staff.
-She could not find any staff on the AL floor so she pressed the call bell.
-No staff answered the call bell and she did not receive her medication that night.
-She had trouble sleeping that night because she missed her medication.

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D 188	Continued From page 12 Interview with a fifth AL resident on 09/07/22 at 10:36am revealed: -The facility was short staffed. -She had to wait for her medications every afternoon because the MA had to go to the SCU floor to administer medications too. -About 3 weeks ago, she rang the call bell and it took an hour for staff to respond. -There needed to be staff on every floor on every shift. Interview with a medication aide (MA) on 09/07/22 at 10:56am revealed: -The facility did not have enough staff. -There was usually 1 MA on first shift on the AL. -There was usually 1 PCA but sometimes 2 PCAs on first shift on the AL. -This past weekend on Saturday (09/03/22) and Sunday (09/04/22), the MA and 1 PCA were the only staff working on the AL from 7:00am - 7:00pm. Second interview with the Interim Executive Director on 09/09/22 at 7:30am revealed: -The lead MA made the schedule and the daily assignment sheets. -The assignment sheet would designate which floor/area the staff were assigned to work. -The time punches would document which floor the staff clocked in to work -The staff cannot change the time punch once they were clocked in. -When the staff realized the floors were not properly staffed, they should have rearranged the schedule to ensure the floors were covered. -She was not aware that the facility was short staffed on any dates. -She was not aware there was ever only four staff in the facility on second or third shift. -She was not sure what happened, unless staff	D 188		

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D 188	Continued From page 13 had called out.	D 188		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an individualized written program of personal care was completed in conjunction with the resident assessment for 3 of 3 special care unit (SCU) sampled residents (#3, #4 and #5) with one resident not receiving personal care assistance and did not have a planned program on how to meet her needs (#4) and 1 of 2 assisted living (AL)sampled residents (#2). The findings are: 1. Review of Resident #4's current FL-2 dated 06/30/22 revealed: -Diagnoses included dementia, edema, gait instability, hypothyroidism and hypertension. -The recommended level of care was skilled nursing. -The resident needed assistance with bathing and dressing; and was incontinent of urine and stool. Review of Resident #4's Resident Register revealed she was admitted to the facility on	D 259	The Covington shall ensure a care plan is developed for each resident in conjunction with the assessment that is an individualized, written program of personal care for each resident. It shall be completed within 30 days following admission. RCC/SCC completed 100% audit of resident population to ensure care plans were present and accurate for each resident. Residents identified to not have a written program of personal care, had an assessment and care plan completed at that time and the date was then placed in a tickler system for future compliance. 10/7/22 RCC/SCC ensured that all completed care plans had been signed by the assessor, sent to the provider for signature, and secured in the residents' medical record upon return. 10/7/22 RCC/SCC will ensure individualized assessment and care plan is completed within 30 days of admission of all future residents. 10/24/22 RCC/SCC will ensure care plan meetings are scheduled with Residents and Responsible Parties upon completion of the care plan. ED will attend. Resident's Providers will be invited. 10/24/22	

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D 259	Continued From page 14 06/02/21. Upon request on 09/07/22, 09/08/22 and 09/09/22, a care plan for Resident #4 was not available for review. Telephone interview with Resident #4's family member on 09/08/22 at 5:16pm revealed: -In June 2022, the Director of Care (DOC) asked her to come to the facility to plan for the resident because she needed more assistance. -The DOC said they planned to move the resident to a skilled nursing facility (SNF) because she needed more assistance than the staff could provide. -She did not hear back from the DOC until last month (August 2022) for a care planning meeting when she was told she had 30 days to move the resident. -She still had a little more time to consider placement options for the resident because she had not received any (discharge) paperwork from the DOC. Telephone interview with Resident #4's primary care provider (PCP) on 09/09/22 at 3:04pm revealed: -A SNF was considered in June 2022 due to agitation and staff unable to handle the resident's needs. The resident's family member initially did not want to use medications to manage agitation but had since agreed to the use of medications. -With the use of medications to help with agitation, Resident #4 was appropriate for the special care unit (SCU). -Ideally the family member, staff and mental health provider (MHP) would work together to develop a plan for behavior management.	D 259		

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Interview with the Director of Care (DOC) on 09/09/22 at 11:55am revealed:
-The FI-2 for Resident #4 completed in on 06/30/22 because it took more staff to provide care for the resident.
-The staff had to totally lift the resident at times with transfers to and from her wheelchair.

Interview with the SCC on 09/09/22 at 5:06pm revealed:
-She had not completed an updated care plan for Resident #4.
-The resident had a care plan; it just was not updated.

Upon request on 09/09/22, Resident #4's previous or outdated care plan was not available for review.

Refer to interview with the Director of Care (DOC) on 09/09/22 at 11:55am.

Refer to interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm.

[Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision, example 2]

2. Review of Resident #5's current FL-2 dated 02/21/22 revealed:
-Diagnoses included dementia, hypertension, hyperlipidemia, and gait instability.
-The recommended level of care was memory care.

Review of Resident #5's Resident Register revealed he was admitted on 07/03/19.

Upon request on 09/07/22, 09/08/22, and 09/09/22 a care plan for Resident #5 was not

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available for review.

Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed:
-She was responsible for completing care plans for residents on the SCU.
-She was in the process of updating SCU residents' care plans.

Refer to interview with the Director of Care (DOC) on 09/09/22 at 11:55am.

Refer to interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm.

3. Review of Resident #3's current FL-2 dated 07/08/21 revealed:
-Diagnoses included dementia, hypertension, stage 3 chronic kidney disease, lumbosacral disc herniation, anxiety, and depression.
-The recommended level of care was memory care.
-The resident needed assistance with bathing, dressing, transferring, ambulation and toileting.

Review of Resident #3's Resident Register revealed she was admitted on 06/03/21.

Upon request on 09/07/22 and 09/08/22, a care plan for Resident #3 was not available for review.

Upon request on 09/09/22, a signed care plan for Resident #3 dated 09/08/22 was available for review.

There were no other care plans available for review for Resident #3.

Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed:

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D 259	Continued From page 17 -She was responsible for completing care plans for residents on the SCU. -She was in the process of updating SCU residents' care plans. Refer to interview with the Director of Care (DOC) on 09/09/22 at 11:55am. Refer to interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm. 4. Review of Resident #2's current FL-2 dated 02/14/22 revealed: -Diagnoses included dementia and chronic obstructive pulmonary disease. -The recommended level of care was assisted living. -The resident needed assistance with bathing, dressing, grooming, and toileting. Review of Resident #2's Resident Register revealed he was admitted on 08/21/17. Upon request on 09/07/22 a care plan for Resident #2 was not available for review. Upon request on 09/08/22, a signed care plan for Resident #2 dated 09/07/22 was available for review. There were no other care plans available for review for Resident #2. Refer to interview with the Director of Care (DOC) on 09/09/22 at 11:55am. Refer to interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm. Interview with the Director of Care (DOC) on	D 259		

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D 259	Continued From page 18 09/09/22 at 11:55am revealed: -She was responsible for overseeing day to day clinical operations of the assisted living (AL) floor and the SCU. -The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) was responsible for completing care plans for residents on the SCU. Interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm revealed: -The DOC, RCC and SCC were responsible for completing resident care plans. -She had not been in her position long enough to review care plan related reports in the electronic record system.	D 259		
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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide incontinence care for 2 of 6 sampled residents (#4 and #6) who were dependent on staff for assistance with cleaning and changing after incontinence	D 269	The Covington 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. ED/Director of Resident Care re-educated care staff on the importance of making rounds at a minimum of every 2 hours; offering toileting/ incontinent care, and reporting any noted skin issues to their direct supervisor. 9/21/22 9/26/22 9/27/22 DRC in-serviced care staff on the importance of collecting accurate vital signs per provider orders, especially weights, as well as the importance of reporting discrepancies to the Care Managers to allow for proper MD notification. 9/26/22 9/27/22 Regional Ombudsman provided in-service to care staff on Personal Care & Supervision, as well as teamwork during her Residents' Rights training. 9/28/22 ED in-serviced staff on the importance of	

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D 269	Continued From page 19 episodes and repositioning when sitting in a wheelchair for more than two hours. The findings are: 1. Review of Resident #6's current FL-2 dated 08/25/22 revealed diagnoses included dementia, gait instability, osteoarthritis, iron deficiency anemia, type II diabetes mellitus, hypothyroidism and non-alcoholic steatohepatitis. Review of Resident #6's current care plan dated 09/08/22 revealed: -She was disoriented sometimes and ambulatory with a wheelchair. -She had limited range of motion in both her upper arms. -She had redness on her buttocks at times and was incontinent of urine and stool. -She needed limited staff assistance with eating, toileting, dressing and transfers. -She needed extensive staff assistance with bathing and grooming. Observations during the breakfast meal on 09/08/22 from 7:49am until 9:08am revealed: -Resident #6 entered the dining room at 7:49am with a large wet area over her buttocks. -She walked past a personal care aide (PCA) who assisted her to sit down at a table. -There was a urine odor within three feet of Resident #6. -The resident remained seated at the table through 8:15am when her plate was served, completing her meal at 8:50am and until 9:08am when the PCA prompted her to go to the recreation room for a movie. -Upon standing, Resident #6 had the large wet spot that had turned dark brown in color. -There was an odor of feces and urine within five	D 269	appropriate approach when attempting to provide care to Memory Care Residents. ED also reminded staff not to approach residents with excessive team members when attempting to provide care, in attempts to not overwhelm the resident. ED/RCC are working with the facility Mental Health Provider to schedule staff in-services regarding care of residents with aggressive behaviors. RCC/SCC will review shower sheets upon completion by the care staff. Any skin issues noted will be addressed promptly, including MD notification. Residents that are incontinent and beginning to have redness will have a request sent to the provider for barrier cream to protect their skin, as well as the RCC/SCC re-educating the care staff on the resident's increased toileting needs. RCC/SCC will make unit rounds no less than twice daily to ensure residents are receiving care that is adequate and appropriate. Any noted concerns will be addressed with staff immediately. ED will make facility rounds no less than twice daily to ensure residents are receiving care that is adequate and appropriate. Any noted concerns will be addressed with staff immediately, and then reported to the appropriate manager for follow up.	9/21/22 10/24/22 10/24/22 10/24/22 10/24/22

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feet of her.
-She walked with the assistance of a walker past the PCA.
-The PCA turned her head away from the resident as she walked by.
-As surveyor began to follow the resident the PCA alerted another PCA that Resident #6 needed incontinence care.

Observation of Resident #6 on 09/08/22 at 9:10am revealed:
-The PCA assisted the resident with removing her shoes, pants and incontinence brief while standing next to the bed in her room.
-The used incontinence brief was saturated with urine and loose stool.
-There was skin breakdown on the resident's buttocks and posterior thighs.
-The resident grimaced and moaned when the PCA wiped her buttocks with a disposable cleansing wipe.

Interview with a PCA on 09/08/22 at 9:10am revealed:
-Resident #6 had "a blowout" of loose stool because she drank milk with her breakfast.
-Sometimes the resident was able to take herself to the bathroom, but staff was supposed to check her for incontinence care needs every two hours and as needed.
-This was her first time checking Resident #6 for incontinence care since the shift started at 7:00am.
-Normally she checked residents after breakfast.
-She was not in the dining room when Resident #6 was seated.
-The redness on Resident #6's buttocks and posterior thighs was not new.
-The medication aides (MAs) knew about the redness and said it was because the resident had

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hemorrhoids.
-She did not know how long the redness had been there.
-They were not putting any barrier cream on the resident's buttocks and thighs.
-The resident's buttocks would get red whenever she had loose bowel movements.

Interview with a second PCA on 09/08/22 at 9:15am revealed:
-She was in the dining room this morning (09/08/22) when Resident #6 entered.
-The resident was clean and dry when she seated her at the table.
-She did not see the large wet spot on the resident's pants over her buttocks.

Second interview with the second PCA on 09/09/22 at 2:32pm revealed:
-First shift PCAs were responsible for getting residents up for the breakfast meal and making sure the residents were dressed, teeth were brushed, and hair was brushed.
-There was an average of nine residents first shift PCAs were responsible for getting up for breakfast.
-Residents who were already up from third shift and had more frequent episodes of urinary incontinence needed to be checked again before breakfast.
-Resident #6 had more frequent episodes of urinary incontinence.
-Normally, Resident #6 would still be in bed at the start of first shift.
-On 09/08/22, the resident was already up, and she assumed the resident was clean and dry when she was seated for breakfast.
-The redness on Resident #6's buttocks and posterior thighs happened on and off.
-This episode redness had been there for a week

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or two.
-The redness usually happened with loose stools and not with formed bowel movements.

Interview with a MA on 09/08/22 at 9:19am revealed:
-Resident #6 did have hemorrhoids and got redness on her buttocks when she had a bowel movement.
-She had told the resident's primary care provider (PCP) about the redness on the resident's buttocks but she did not remember when that was.
-Resident #6 did not have any barrier cream that staff put on her buttocks.

Second interview with the MA on 09/08/22 at 9:25am revealed:
-Resident #6 had a zinc ointment for her buttocks but it was discontinued in May 2022.
-Normally when PCAs saw redness or open areas on a resident's skin, they reported that to the MA.
-The MA was responsible for calling the PCP and documenting the observation and contact with the PCP in the electronic progress notes.
-No one had reported Resident #6's buttocks being red, raw and irritated to her before now.

Interview with the Special Care Coordinator (SCC) on 09/08/22 at 1:35pm revealed:
-Resident #6 was previously seen by home health for redness on her buttocks.
-She did not know that Resident #6 had red, raw and irritated skin on her buttocks and posterior thighs.

Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed she was not sure on the specifics needs of Resident #6.

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D 269	Continued From page 23 Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Refer to interview with the Special Care Coordinator (SCC) on 09/08/22 at 1:35pm. Refer to interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm. 2. Review of Resident #4's current FL-2 dated 06/30/22 revealed: -Diagnoses included dementia, edema, gait instability, hypothyroidism and hypertension. -The recommended level of care was skilled nursing. -The resident required assistance with bathing and dressing; and was incontinent of urine and stool. Upon request on 09/07/22, 09/08/22 and 09/09/22, a care plan for Resident #4 was not available for review. Interview with a personal care aide (PCA) on 09/07/22 at 10:19am revealed: -Resident #4 needed all staff on duty, usually four, to assist with transfers to and from her chair, bathing/showers, dressing and incontinence care. -Resident #4 resisted staff when they tried to help her. -Resident #4 was frequently incontinent and needed incontinence checks every hour. Telephone interview with Resident #4's family member on 09/08/22 at 5:16pm revealed: -She visited the resident weekly and each time she would find the resident wet and soiled. -Each time staff would say they were just about to	D 269		

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change her.
-Around Easter 2022 she found the resident lying in her bed in feces and urine with just a bed sheet on.
-She understood the resident could be difficult, but that did not mean she should be neglected.
-On Monday, 09/05/22 she visited and found the resident sitting in her wheelchair in feces and urine and there was urine on the floor in front of her.
-The resident was trying to get up from the chair by herself and could have slipped in the urine on the floor, fell and gotten hurt.

Interview with a second PCA on 09/09/22 at 4:28pm revealed:
-She worked second shift on 09/05/22.
-When she arrived to work Resident #4 was sitting in her wheelchair and her incontinence brief was not pulled up.
-The first shift staff said the resident was fighting them, so they left her like that.
-The resident had urinated and had a bowel movement in the wheelchair and needed to be cleaned.
-She found the resident in that condition frequently due to her behaviors.
-The resident's family member was visiting and helped her clean the resident.

Observations of Resident #4 on 09/08/22 from 7:52am until 10:20am revealed:
-At 7:52am, the resident was sitting in her wheelchair and was assisted to the dining room by a personal care aide (PCA).
-She remained in the dining room until 9:00am when staff assisted her to the recreation room.
-At 10:02am, a PCA approached the resident and said "[last name of resident], it's time to get you changed."

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D 269	Continued From page 25 -From 10:05am until 10:20am, three PCAs, one medication aide (MA) and the Special Care Coordinator (SCC) attempted to assist the resident in her room with incontinence care and change of position. -One PCA placed the new brief around the resident's legs and pulled up to her knees while the resident was seated in her wheelchair. -The staff prompted the resident stating, "I need you to stand up ...I need you to allow us to assist you ...You need to get changed." -The resident resisted staff and swung her arms toward staff when they attempted to assist her to stand. -The resident refused to stand, and staff left her sitting in her wheelchair in her room with the new incontinence brief at her knees. Interview with the SCC on 09/08/22 at 10:20am revealed: -The primary care provider (PCP) was aware Resident #4 frequently resisted care. -The resident did have an as needed (PRN) medication available for agitation. -The MA was looking into administering the PRN medication at this time (10:20am on 09/08/22). -There had not yet been a care planning meeting between staff and the PCP and mental health provider (MHP) related to approach and promoting cooperation between the resident and staff. Interview with a third PCA on 09/08/22 at 12:20pm revealed: -Resident #4 stood up by herself sometime after the PCA and other staff left the room and removed her incontinence brief and pulled up the new one. -The resident was now asleep in her bed. -She had checked on the resident for lunch and	D 269		

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observed her sleeping in her room.
-The resident had been in her wheelchair since just before breakfast until now, but staff had to respect the resident's refusal of assistance.
-She had not seen any redness or open areas on Resident #4's skin.

Observation of Resident #4 on 09/08/22 at 12:27pm revealed she was sleeping in her wheelchair in her room.

Interview with the MA on 09/08/22 at 1:04pm revealed:
-The resident had received the PRN medication for agitation and would probably be more cooperative.
-She and the SCC had met with the PCP and MHP today (09/08/22) and they were going to make changes to the resident's medication regimen and care plan.
-She had not seen any skin breakdown on Resident #4's buttocks and thighs.

Based on observations of Resident #4 from 7:50am until 10:20am on 09/08/22 and interviews with a PCA and MA, the resident had been in her wheelchair from before 7:50am until 1:05pm on 09/08/22.

Observations of Resident #4 on 09/08/22 at 1:04pm revealed:
-A PCA entered the resident's room and told the MA the Area Clinical Director (ACD) did not want the resident sitting in her wheelchair any longer.
-The PCA and MA assisted the resident to stand.
-The resident was not able to move from sitting to standing without staff assistance.
-Once standing, the resident held onto both staff to maintain standing while incontinence care was provided.

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D 269	Continued From page 27 -There was skin breakdown on the resident's buttocks and posterior thighs from the buttocks to her knees. Second interview with the SCC on 09/08/22 at 1:35pm revealed she did not know that Resident #4 had skin breakdown on her buttocks and posterior thighs. Second interview with the third PCA on 09/08/22 at 1:24pm revealed: -She and the other PCAs tried to assist Resident #4 up from her wheelchair every two hours. -Most the time, the resident was in the common areas with staff. -Sometimes staff would assist the resident from her wheelchair to one of the armchairs in the common area. Interview with a fourth PCA on 09/09/22 at 2:32pm revealed: -PCAs completed a shower sheet for residents after each shower and documented any redness. -Resident #4 was scheduled for second shift showers on Monday, Wednesday and Friday. -She had showered Resident #4 on 09/03/22 on first shift because the resident needed a shower and the resident did not have any redness on her skin. -According to the electronic record the last shower before 09/03/22 for Resident #4 was on 08/15/22. Review of Resident #4's Shower Skin Assessments for July, August and September 2022 revealed: -There were shower skin assessments completed on 07/20/22, 08/15/22 and 09/06/22; each were unscheduled shower skin assessments completed on first shift.	D 269		

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D 269	Continued From page 28 -There was no documentation of redness on the resident's skin. Second interview with the MA on 09/08/22 at 1:26pm revealed: -PCAs were responsible for incontinence care and repositioning residents every two hours and as needed. -MAs helped with resident personal care tasks when they were not administering medications to residents. -MAs were responsible for overseeing resident care. -She made sure residents were clean and dry and that PCAs were making rounds when she administered medications. -She also helped PCAs during every two hour rounds. -She supervised PCAs by answering their questions about residents and if she saw something that needed to be done, she would let the PCAs know. Third interview with the SCC on 09/09/22 at 5:06pm revealed: -PCAs were responsible for completing shower sheets after each shower. -She was responsible for monitoring completion of shower sheets and activities of daily living (ADL) records. She was certain Resident #4 had more than three showers since 07/01/22 because showers were documented on the ADL record. Telephone interview with Resident #4's primary care provider (PCP) on 09/09/22 at 3:04pm revealed: -She and the staff had not discussed the use of a barrier cream to prevent skin breakdown because of longer periods between incontinence care and	D 269		

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position changes related to episodes of agitation.
-She expected staff to provide incontinence care and repositioning at the same frequency as the facility's policy for all residents.
-Ideally the family member, staff and mental health provider (MHP) would work together to develop a plan for behavior management.

Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed:
-Five staff in the room with Resident #4 was too many staff for the resident.
-The staff should have left the room and two staff should have gone back after 15 or 30 minutes.
-Resident #4 should have been checked for incontinence and repositioning every hour.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

Refer to interview with the Special Care Coordinator (SCC) on 09/08/22 at 1:35pm.

Refer to interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm.

_____

Interview with the Special Care Coordinator (SCC) on 09/08/22 at 1:35pm revealed:
-Staff were responsible for completing rounds every two hours for residents on the SCU.
-The PCAs were responsible for incontinence care and repositioning residents.
-PCAs were responsible for reporting any skin breakdown on a resident's skin to the MA, Supervisor, SCC and/or Director of Care (DOC).
-PCAs were responsible for documenting the condition of residents' skin with each shower on a shower sheet.
-The MA was responsible for checking the

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resident's skin when skin breakdown was reported by the PCA.
-The MA was responsible for reporting any skin breakdown of a resident's skin to the PCP for follow up at the PCP's next visit to the facility.
-MAs were responsible for documenting in the electronic progress notes when skin breakdown was reported.

Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed:
-Staff were responsible for checking residents before meals to make sure they were clean and dry.
-PCAs were responsible for reporting any skin issues to the MA.
-MAs were responsible for reporting any skin issues to the SCC and bring up in the daily stand up meeting so that all staff were aware for follow up.
-MAs were responsible for documenting skin issues in the electronic progress notes.
-PCAs were responsible for making rounds every 15 minutes to two hours depending on the needs of the resident.
-The SCC was responsible for supervising the care of residents by making rounds every hour or more.
-The SCC was responsible to go to each resident room on each hall and check all residents.

_____

The facility failed to provide incontinence care for 2 of 6 sampled residents (#4 and #6) who were incontinent of bowel and bladder and dependent on staff for assistance with incontinence care. The failure of the facility to provide incontinence care resulted in Resident #4 and Resident #6 sustaining skin breakdown on their buttocks and posterior thighs which was detrimental to the health, safety and welfare of the residents and

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D 269	Continued From page 31 constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2022.	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: Based on observations, interviews and record reviews, the facility failed to follow up with the primary care provider (PCP) and a home health agency for 3 of 6 sampled residents (#2, #4 and #6) for multiple missed doses of Depakote (used for mood stabilization) (#2), a 26 pound weight gain in one month (#4) and a referral for wound care and skin breakdown on the buttocks and posterior thighs (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 08/25/22 revealed diagnoses included dementia, gait instability, osteoarthritis, iron deficiency anemia, type II diabetes mellitus, hypothyroidism and non-alcoholic steatohepatitis. Observation of Resident #6 on 09/08/22 at 9:10am revealed: -The resident's buttocks were red, raw and	D 273	The Covington shall ensure referral and follow-up to meet the routine and acute health care needs of residents. DRC in-serviced care staff on the importance of collecting accurate vital signs per provider orders, especially weights, as well as the importance of reporting discrepancies to the Care Managers to allow for proper MD notification. 9/26/22 9/27/22 Care Managers will round with In-House Providers to visit the residents that are being seen for the day. The Care Manager will process any and all orders per policy ensuring there is no delay in medication administration. This will allow for clarificationof orders in real time while the provider is present. Once orders are processed per policy, they will be secured in the resident's medical record by the Care Manager. New order information will be shared with Medication Aides. 10/24/22 RCC/SCC will re-implement the order processing system to ensure appropriate approval, processing, and follow-up on physician's orders and referrals. 10/24/22 Care Managers will re-educate Med Techs on the appropriate and mandatory use of the 24 hr communication log. Care Managers will review the log daily to ensure Med Techs 10/24/22	

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D 273	Continued From page 32 irritated. -The resident grimaced and moaned when the PCA wiped her buttocks with the cleansing wipe. Review of Resident #2's most recent Shower Skin Assessment dated 08/20/22 revealed she had redness on her "backside". Interview with a personal care aide (PCA) on 09/08/22 at 9:10am revealed: -The redness on Resident #6's buttocks and posterior thighs was not new. -She did not know how long the redness had been there. -They were not putting any barrier cream on the resident's buttocks and thighs. -The medication aides (MAs) knew about the redness and said it was because the resident had hemorrhoids. -The resident's buttocks would get red whenever she had loose bowel movements. Interview with a second PCA on 09/09/22 at 2:32pm revealed: -The redness on Resident #6's buttocks and posterior thighs happened on and off. -This time the redness had been there for a week or two. -The redness usually happened with loose stools and not with formed bowel movements. Interview with a MA on 09/08/22 at 9:19am revealed: -Resident #6 did have hemorrhoids and got redness when she had a bowel movement. -She had told the resident's primary care provider (PCP) about the redness but she did not remember when that was. -Resident #6 did not have any barrier cream that staff put on her buttocks.	D 273	are utilizing the communication log correctly as their reporting tool from shift to shift. ED will establish the expectation that home health/ hospice staff must exit with RCC/SCC or Designee prior to leaving after seeing a resident to ensure plan of care is clear as well as any potential changes. RCC/SCC are to review Home Health/ Hospice notes after each visit and secure in resident's record after review. RCC/SCC will review and bring the electronic activity report, incident reports, and medication compliance report to management meeting daily for review with the ED to ensure follow-up is completed.	10/24/22 10/24/22

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D 273	Continued From page 33 Second interview with the MA on 09/08/22 at 9:25am revealed: -Resident #6 had a zinc ointment for her buttocks but it was discontinued in May 2022. -Normally when PCAs saw redness or open areas on a resident's skin, they reported that to the MA. -The MA was responsible for calling the PCP and documenting the observation and contact with the PCP in the electronic progress notes. -No one had reported Resident #6's buttocks being red, raw and irritated to her before now. Telephone interview with the Home Health Clinical Secretary on 09/09/22 at 3:48pm revealed: -Resident #6 had been seen by home health for wound care and her last date of service was 08/09/22. -The resident had wounds on her left buttock, sacral area and left elbow that were all healed on 08/09/22. Telephone interview with Resident #6's PCP on 09/09/22 at 3:04pm revealed: -She was not aware Resident #6's buttocks and posterior thighs were red, raw and irritated until 09/08/22. -She expected staff to contact her or the physician's office group within 24 hours of noticing redness on a resident's skin. b. Review of Resident #6's electronic progress notes dated 08/22/22 revealed: -The primary care provider (PCP) ordered simple wound care until home health begins. -A medication aide (MA) placed an occlusive dressing over a skin tear on the resident's left elbow until home health could see her.	D 273		

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D 273	Continued From page 34 Review of Resident #6's electronic progress notes dated 08/23/22 through 09/08/22 revealed there was no documentation of a home health evaluation. Observation of Resident #6 on 09/09/22 at 4:59pm revealed she had a bulky gauze bandage secured with paper tape to her left elbow with no date or initials marked on the tape. Telephone interview with the Home Health Clinical Secretary on 09/09/22 at 3:48pm revealed they received a referral on 08/22/22 for wound care but were unable to accommodate the referral due to the home health agency's staffing issues. Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed she did not know the status of the home health referral for wound care from 08/22/22. Interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm revealed: -The SCC was responsible for follow up on the home health referral for the skin tear on Resident #6's elbow. -There was a standup meeting daily and staff were expected bring up special issues such as needed wound care. Attempted interview with Resident #6's Primary Care Provider on 09/09/22 at 5:33pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.	D 273		

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2. Review of Resident #4's current FL-2 dated 06/30/22 revealed diagnoses included dementia, edema, gait instability, hypothyroidism and hypertension.

Review of Resident #4's vitals report revealed:
-On 07/05/22, her weight was documented as 186.5 pounds.
-On 08/05/22, her weight was documented as 212.5 pounds.
-The next weight was documented as 213.2 pounds on 09/06/22.

Review of Resident #4's electronic progress notes dated 7/22/22 through 08/25/22 revealed:
-There was no documentation that the primary care provider (PCP) was notified of the 26-pound weight gain.
-There were no entries after 08/25/22.

Telephone interview with Resident #4's family member on 09/08/22 at 5:16pm revealed:
-The resident has gained weight since being at the facility.
-On admission in June 2021, the resident wore a size 14 and was now wearing a size 20.
-She was concerned for the resident's heart health and problems with lower extremity edema.

Interview with a personal care aide (PCA) on 09/09/22 at 2:32pm revealed:
-Weights were normally done by the medication aides (MA) but PCAs helped at times.
-She weighed Resident #4 one month ago and the resident weighed 184 pounds.

Telephone interview with Resident #4's PCP on 09/09/22 at 3:04pm revealed:
-She did not recall being notified of a 26 pound weight gain in one month for Resident #4.

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-If she had been aware, she would have requested the resident be reweighed to confirm the weight gain.

Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed:
-She knew Resident #4 had gained some weight but not 26 pounds.
-The PCP was aware of weight gain for the resident but not 26 pounds in one month.

Interview with the Interim Executive Director (ED) on 09/09/22 at 5:45pm revealed:
-There was a standup meeting daily and staff were expected bring up special issues such as needed weight gain.
-If the weights were documented in the electronic record, the Director of Care (DOC) was responsible to check for changes.
-The DOC was the checks and balances person.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

2. Review of Resident #2's current FL-2 dated 02/14/22 revealed:
-Diagnoses included dementia and chronic obstructive pulmonary disease.
-There was an order for Divalproex (Depakote) extended release (ER) 250 mg to be administered every morning.
-There was an order for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening.

Review of Resident #2's pharmacy reviews revealed:
-The last pharmacy review was completed on 05/27/22 by a pharmacist with a consulting

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pharmacy provider.
-The recommendation was to ensure the primary care provider (PCP) was aware of the missed doses of Divalproex in May 2022.
-There was no documentation that the recommendation had been followed and the PCP had been made aware of the missed doses of Divalproex in May 2022.
-There were no other quarterly pharmacy reviews available for review in order to identify other medication related problems.

Review of Resident #2's electronic medication administration record (eMAR) for May 2022 revealed:
-There was a computerized entry for Divalproex (Depakote) extended release (ER) 250 mg to be administered every morning at 8:00am.
-There was a computerized entry for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening at 8:00pm.
-There was documentation that Divalproex extended release (ER) 250 mg was administered each at morning at 8:00am from 05/01/22 through 05/17/22.
-There was documentation Divalproex extended release (ER) 250 mg was not administered 05/18/22 through 05/31/22 with the reason that awaiting new order and waiting for the family to pick up the medication.
-There were 14 out of 31 doses of Divalproex extended release (ER) 250 mg that were not administered.
-There was a computerized entry for Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm.
-There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm was administered each day at 8:00pm from 05/01/22

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through 05/07/22 and 05/09/22 through 05/16/22.
-There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was administered on 05/08/22 at 8:00pm.
-There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was not administered 05/17/22 through 05/31/22.
-There were 16 out of 31 doses of Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) that were not administered.

Review of Resident #2's eMAR for August 2022 revealed:
-There was a computerized entry for Divalproex (Depakote) (medication used for mood stabilization) extended release (ER) 250 mg to be administered every morning at 8:00am.
-There was a computerized entry for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening at 8:00pm.
-There was documentation that Divalproex extended release (ER) 250 mg was administered each at morning at 8:00am from 08/01/22 through 08/18/22 and 08/25/22 through 08/31/22.
-There was documentation Divalproex extended release (ER) 250 mg was not administered 08/19/22 through 08/24/22 with the reason that awaiting pick up and waiting for the family to pick up the medication.
-There were 6 out of 31 doses of Divalproex extended release (ER) 250 mg that were not administered.
-There was a computerized entry for Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm.
-There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was administered each day at 8:00pm

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from 08/01/22 through 08/16/22 and 08/24/22 through 08/31/22.
-There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was not administered 08/17/22 through 08/23/22 with the reason waiting for the family to pick up the medication.
-There were 7 out of 31 doses of Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) that were not administered.

Telephone interview with the primary care provider (PCP) for Resident #2 on 09/09/22 at 3:40pm revealed:
-She had been the PCP for this facility for seven years.
-She had been Resident #2's PCP since he had been admitted to the facility.
-She had not been notified of Resident #2 missing any doses of his Divalproex.
-She would be concerned of the missed doses since he was prescribed the Divalproex for his moods having Bipolar disorder.

Telephone interview with the mental health provider for Resident #2 on 09/09/22 at 3:40pm revealed:
-She was concerned if any of her patients were not receiving their prescribed medications.
-She had not been the mental health provider for Resident #2 back in May 2022.
-She expected medications to be given as ordered and to be notified if the resident was missing any doses.
-Missed doses of Divalproex would cause a decrease in the therapeutic levels that could cause the resident to have side effects and could cause changes in his behaviors.

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D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents on the special care unit (SCU) were treated with respect, consideration, dignity and full recognition of his or her individuality related to ensuring residents were clean and dry for meals, addressed respectfully by staff and consideration for needs of encouragement and engagement during meals. The findings are: a. Observations during the breakfast meal on 09/08/22 from 7:49am until 9:07am revealed: -A resident entered the dining room at 7:49am with a large wet area over her buttocks. -She walked past a personal care aide (PCA) who assisted her to sit down at a table. -There was a urine odor within three feet of the resident. -There were two other residents seated at the table for the breakfast meal. -The resident remained seated at the table through 8:15am when her plate was served, completing her meal at 8:41am and until 9:08am when the PCA prompted her to go to the recreation room for a movie. -Upon standing, she had the large wet spot that had turned dark brown in color. -There was an odor of feces and urine within five feet of the resident.	D 338	The Covington shall ensure the rights of all residents are guaranteed. The facility shall ensure that residents are treated with dignity, respect, consideration, and full recognition of his or her individuality. ED in-serviced staff on Residents' Rights, especially focusing on the Residents' right to be treated with dignity and respect. 9/16/22 Regional Ombudsman completed Residents' Rights training for facility staff, in addition to training on personal care and supervision, and teamwork. 9/28/22 ED re-educated staff about addressing residents with respect including Memory Care residents, ensuring personal care has been performed prior to sending residents to their meal, and appropriate approach. 9/21/22 Activity Director will ensure resident council meeting is held monthly. It will be posted on the resident activity calendar to ensure all residents are aware. 10/24/22	

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D 338	Continued From page 41 Interview with a PCA on 09/08/22 at 9:15am revealed: -She was in the dining room that morning when Resident #6 entered. -The resident was clean and dry when she seated her at the table. -She did not see the large wet spot on the resident's pants over her buttocks. Second interview with the PCA on 09/09/22 at 2:32pm revealed: -Normally, Resident #6 would still be in bed at the start of first shift. -On 09/08/22, the resident was already up, and she assumed the resident was clean and dry when she was seated for breakfast. Interview with the Special Care Coordinator (SCC) on 09/08/22 at 1:35pm revealed: -Staff were responsible for completing rounds every two hours for residents on the SCU. -The PCAs were responsible for incontinence care and repositioning residents. Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed: -Staff were responsible for checking residents before meals to make sure they were clean and dry. -PCAs were responsible for making rounds every 15 minutes to two hours depending on the needs of the resident. b. Observations during the breakfast meal on 09/08/22 from 8:13am until 9:07am revealed: -There were 23 residents in the dining room with two personal care aides (PCAs) during the breakfast service. -A third PCA and the medication aide (MA) were in and out of the dining room assisting residents	D 338		

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to and from the dining room and preparing medications.
-PCAs started serving breakfast plates to residents at 8:13am.
-There were several residents who stared out blankly or were sleeping at the tables with breakfast plates in front of them.
-The third PCA and the MA provided verbal prompting and assistance to the distracted and sleeping residents as they passed by tables.
-Two PCAs stood near the beverage cart between delivering meal plates and then removing plates from the tables.
-The two PCAs interacted and prompted residents in the special care unit (SCU) minimally from serving plates at 8:13am through 8:41am when most residents had finished eating.
-From 8:50am until 9:07am there were only 7 residents in the dining room with two PCAs standing by the beverage cart.
-The PCAs were conversing with one another and minimally interacted with the residents.
-The PCAs did not ask residents if they needed anything or offer help.

Interview with a personal care aide (PCA) on 09/09/22 at 2:48pm revealed:
-She was trained to go around the dining room during meals, check on residents and ask if they needed anything.
-Some residents did not want staff talking to them while they were eating.
-Staffing shortages since the COVID-19 pandemic have contributed to staff being exhausted, burned out and unable to respond to residents at times.

Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed staff were expected to engage residents during meals, talk

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with them during meals, offer help and see how things were going.

c. Observations during the breakfast meal on 09/08/22 from 8:13am until 8:25am revealed:
-There were three residents who were not served bacon or ham with their breakfast meal.
-The breakfast plate for the three residents included scrambled eggs and hash browns only.
-After 10 minutes and one resident completing her breakfast meal, chopped ham was provided for the three residents.

Interview with two personal care aides (PCAs) on 09/08/22 at 8:17am revealed:
-The three residents who did not get bacon were on mechanical soft diets.
-Residents who were on mechanical soft diets did not get meat on their plates because they could not chew meat.

Interview with the medication aide (MA) on 09/08/22 at 8:17am revealed:
-The residents who received mechanical soft diets should have an alternative to the bacon.
-The PCAs would have to go and check with the kitchen staff.

Observation of the kitchen on 09/08/22 at 7:38am revealed:
-There were signs posted in the kitchen regarding mechanical soft (MS) diets and what items would be included or excluded from it.
-Foods that were not considered mechanical soft were foods that were chewy, crunchy, hard or stringy.
-Any foods that required more chewing to break down were not included on the MS diet.
-Ground or diced meats were listed as acceptable forms of protein for the MS diet.

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D 338	Continued From page 44 Interview with the Kitchen Manager on 09/09/22 at 12:16pm revealed: -Residents who were on mechanical soft diets were not able to chew bacon. -Normally, chopped turkey sausage or chopped ham was substituted for bacon on mechanical soft plates. -The dietary aide just forgot to put it on the plates for those residents in the special care unit (SCU). -She had the chopped ham ready to go on the plates; she did not know why it was forgotten. d. Observations on the special care unit (SCU) on 09/08/22 at 9:50am revealed a personal care aide (PCA) approached the resident and said "[last name of resident], it's time to get you changed." Interview with the PCA on 09/08/22 at 10:02am revealed: -The resident answered to both her first name and just her last name. -She (the PCA) had a bad habit of calling the resident by her last name only. Observations on the SCU on 09/08/22 from 10:02am until 10:20am revealed the PCA repeatedly referred to the resident by her last name only without a prefix of Miss, Mrs or Ms. while attempting to provide incontinence care. Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed staff was expected to address resident with respect by first name or Mr. or Ms. e. Observations of Resident #4 on 09/08/22 from 10:05am until 10:20am revealed: -Three PCAs, one medication aide (MA) and the Special Care Coordinator (SCC) attempted to	D 338		

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assist the resident in her room with incontinence care and change of position.
-One PCA placed the new brief around the resident's legs and pulled up to her knees while the resident was seated in her wheelchair.
-The staff prompted the resident stating, "I need you to stand up ...I need you to allow us to assist you ...You need to get changed."
-The resident resisted staff and swung her arms toward staff when they attempted to assist her to stand.
-The resident refused to stand, and staff left her sitting in her wheelchair in her room with the new incontinence brief at her knees.

Interview with a personal care aide (PCA) on 09/08/22 at 12:20pm revealed:
-Resident #4 stood up by herself sometime after the PCA and other staff left the room and removed her incontinence brief and pulled up the new one.
-The resident had been in her wheelchair since just before breakfast until now (12:20pm), but staff had to respect the resident's refusal of assistance.

Interview with the Special Care Coordinator (SCC) on 09/08/22 at 10:20am revealed:
-The primary care provider (PCP) was aware Resident #4 frequently resisted care.
-The resident did have an as needed (PRN) medication available for agitation.
-The MA was looking into administering the PRN medication at this time (10:20am on 09/08/22).
-There had not yet been a care planning meeting between staff and the PCP and mental health provider (MHP) related to approach and promoting cooperation between the resident and staff.

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D 338	Continued From page 46 Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed: -Five staff in the room with Resident #4 was too many staff for the resident. -The staff should have left the room and two staff should have gone back after 15 or 30 minutes. Interview with the Special Care Coordinator (SCC) on 09/09/22 at 5:06pm revealed: -She monitored the care of residents every day. -She did not give a specific response of how she monitored staff. Interview with the Interim Executive Director (ED) on 09/08/22 at 1:51pm revealed: -Staff were responsible for checking residents before meals to make sure they were clean and dry. -Staff were responsible for treating residents with respect in how they talked to, cared for and engaged them.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record	D 358	The Covington shall ensure that the preparation and administration of medications and treatments by the staff are in accordance with MD orders, facility policies and procedures, and State Rule .1004. ED completed a refresher Med Tech in-service that covered the basics of med admin, including infection control and safely giving meds. 9/21/22 DRC re-educated Med Techs on the importance of following the 6 Rights of Med Administration, the importance of performing 3 checks prior to med admin, as well as reporting any noted medication discrepancies immediately upon finding them to their RCC/SCC. 9/26/22 9/27/22 DRC in-serviced Med Techs on correct procedure receiving medications from an outside 9/26/22 9/27/22	

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D 358	Continued From page 47 reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#7, #8, #9) observed during the medication pass including errors with medications for heart/blood pressure, low potassium levels, and low Vitamin B12 levels (#7), insulin and a medication for high cholesterol (#8), and an antipsychotic (#9); and for 1 of 5 sampled residents (#2) for record review including errors with a medication for mood stabilization. The findings are: 1. The medication error rate was 20% as evidenced by the observation of 6 errors out of 30 opportunities during the 8:00am, 9:00am, and 10:00am medication passes on 09/08/22. a. Review of Resident #7's current FL-2 dated 08/15/22 revealed: -Diagnoses included dementia with behaviors, congestive heart failure, atrial fibrillation, and gait instability. -There was an order for Carvedilol 6.25mg take 0.5 tablet (3.125mg) twice daily. (Carvedilol is used to treat high blood pressure, congestive heart failure, and atrial fibrillation.) Observation of the 8:00am medication pass on 09/08/22 revealed: -The medication aide (MA) prepared and administered one Carvedilol 6.25mg tablet to Resident #7 at 8:55am. -The resident was administered one Carvedilol 6.25mg tablet instead of a half tablet (3.125mg) as ordered. Review of Resident #7's September 2022 electronic medication administration record (eMAR) revealed:	D 358	pharmacy, as well as the correct procedure for processing pharmacy deliveries to ensure resident medications arrive to the facility correctly. DRC performed random med pass observations of the Med Techs during med pass. Observations were reviewed with the Med Tech for educational feedback, the respective Care Manager, and the ED who then filed in an education binder. 10/14/22 Area Clinical Director will perform random med pass observations at a minimum of 3 observations per month. Observations will be reviewed with the Med Tech for educational feedback, the respective Care Manager, and the ED who will then file in the education binder. 10/24/22 Med Techs will complete weekly MAR to cart audits per facility schedule, documenting on appropriate provided forms and submitting upon completion. LSIC will retrieve completed audits daily, compare to schedule to ensure required audits have been completed, review for completion, and follow up to ensure medications have arrived. 10/24/22 RCC/SCC/LSIC will follow- up on medications that do not arrive as scheduled in pharmacy delivery. 10/24/22 Care Managers will complete a weekly cart audit for quality assurance using a management audit tool. Any noted areas of noncompliance will be immediately corrected, but noted for tracking purposes. All completed management cart audits will be submitted to the ED for review. 10/24/22 RCC/SCC will ensure that any newly ordered medications from outside pharmacies are accompanied by an MD order, or will call the pharmacy to have the order sent to the facility. 10/24/22	

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D 358	Continued From page 48 -There was an entry for Carvedilol 6.25mg take 0.5 tablet (3.125mg) twice daily scheduled for 8:00am and 8:00pm. -Carvedilol was documented as administered from 09/01/22 - 09/08/22. Observation of Resident #7's medications on hand on 09/08/22 at 12:32pm revealed: -There was a bottle of Carvedilol 6.125mg tablets dispensed by an outside pharmacy with instructions to take 1 tablet twice a day. -The quantity dispensed was 180 tablets and there was a mixture of whole tablets and half tablets in the bottle. Interview with the MA on 09/08/22 at 12:32pm revealed: -She usually went by the instructions on the eMAR when administering medications. -If there was a discrepancy with the eMAR and the label not matching, the MAs should notify the Special Care Coordinator (SCC). -She did not notice the eMAR and the medication label did not match for the Carvedilol. -She had not noticed some of the tablets in the bottle were split in half. -She had never administered a half tablet of Carvedilol and she did not think the facility had a pill splitter to half the tablets. Interview with the SCC on 09/08/22 at 12:41pm revealed: -The MAs should read the labels on the medications and the instructions on the eMARs. -Resident #7's Carvedilol should be administered as ordered. -The facility had a pill splitter and the MAs could use the pill splitter to cut Resident #7's Carvedilol 6.25mg tablets in half.	D 358		

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Interview with the Director of Care (DOC) on 09/09/22 at 1:57pm revealed:
-The MAs should read the instructions on the eMAR and medication label prior to administering medications.
-If the medication label and eMAR did not match, the MAs should check with the SCC or the Resident Care Coordinator (RCC).
-The MAs should administer medications as ordered.

Review of Resident #7's vital signs report dated 06/01/22 - 09/09/22 revealed:
-The resident's heart rate ranged from 70 - 74.
-The resident's blood pressure ranged from 103/86 - 132/66.

Telephone interview with Resident #7's primary care provider (PCP) on 09/09/22 at 3:15pm revealed:
-Resident #7 was supposed to receive a half tablet of Carvedilol 6.25mg for her heart and blood pressure.
-She was concerned receiving a whole tablet of Coreg 6.25mg instead of 3.25mg could cause the resident's blood pressure or heart rate to drop too low.
-She wanted the facility to monitor the resident's blood pressure and heart rate.

Review of Resident #7's PCP order dated 09/08/22 at 4:17pm revealed:
-There was an order to monitor heart rate and blood pressure twice a day for 2 days.
-Call the PCP if the heart rate dropped below 60.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

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D 358	Continued From page 50 b. Review of Resident #7's current FL-2 dated 08/15/22 revealed an order for Potassium Chloride 20mEq take 1 tablet every day. (Potassium Chloride is used to treat low potassium levels.) Observation of the 8:00am medication pass on 09/08/22 revealed: -The medication aide (MA) prepared and administered one Potassium Chloride 10mEq tablet to Resident #7 at 8:55am. -The resident was administered Potassium Chloride 10mEq instead of 20mEq as ordered. Review of Resident #7's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Potassium Chloride 20mEq take 1 tablet every day scheduled at 8:00am. -Potassium Chloride was documented as administered from 09/01/22 - 09/08/22. Observation of Resident #7's medications on hand on 09/08/22 at 12:32pm revealed: -There was a bottle of Potassium Chloride 10mEq tablets dispensed on 12/02/21 by an outside retail pharmacy. -Instructions on the label were to take 2 tablets daily. Interview with the MA on 09/08/22 at 12:32pm revealed: -She usually went by the instructions on the eMAR when administering medications. -If there was a discrepancy with the eMAR and the label not matching, the MAs should notify the Special Care Coordinator (SCC). -She did not notice the eMAR and the medication label did not match for the Potassium Chloride.	D 358		

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-The resident should have received 2 Potassium Chloride 10mEq tablets during the medication pass observed that morning.

Interview with the SCC on 09/08/22 at 12:41pm revealed:
-The MAs should read the labels on the medications and the instructions on the eMARs.
-If the label and eMAR did not match, the MAs should call the pharmacy or the provider or they could check with her, the Resident Care Coordinator (RCC), or the Director of Care (DOC).
-Resident #7 should have received two Potassium Chloride 10mEq tablets to equal the 20mEq that was ordered.

Interview with the DOC on 09/09/22 at 1:57pm revealed:
-The MAs should read the instructions on the eMAR and the medication label prior to administering medications.
-If the medication label and eMAR did not match, the MAs should check with the SCC or the RCC.
-The MAs should administer medications as ordered.
-Resident #7 should have received 2 Potassium Chloride 10mEq tablets to equal 20mEq as ordered.

Review of Resident #7's lab results dated 06/03/22 revealed the resident's potassium level was within the normal range at 4.00 (reference range 3.4 - 5.1).

Telephone interview with Resident #7's primary care provider (PCP) on 09/09/22 at 3:15pm revealed:
-Resident #7 should have received 2 tablets of Potassium Chloride 10mEq to equal 20mEq.

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-Not receiving the full dose of Potassium Chloride could lead to low potassium levels.
-Resident #7's potassium levels had been checked every couple of months and she had no concerns about the resident's current potassium level.

Review of Resident #7's PCP order dated 09/08/22 at 4:17pm revealed an order to administer Potassium Chloride now.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

c. Review of Resident #7's current FL-2 dated 08/15/22 revealed an order for Vitamin B12 500mcg take 2 tablets (1,000mcg) every day. (Vitamin B12 is used to treat Vitamin B12 deficiency.)

Observation of the 8:00am medication pass on 09/08/22 revealed:
-The medication aide (MA) prepared and administered one Vitamin B12 tablet to Resident #7 at 8:55am.
-The resident was administered one Vitamin B12 500mcg tablet instead of 2 tablets as ordered.

Review of Resident #7's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Vitamin B12 500mcg take 2 tablets (1,000mcg) every day scheduled at 8:00am.
-Vitamin B12 was documented as administered from 09/01/22 - 09/08/22.

Observation of Resident #7's medications on hand on 09/08/22 at 12:32pm revealed:

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D 358	Continued From page 53 -There was a bottle of over-the-counter (OTC)Vitamin B12 500mcg tablets in the original manufacturer's container. -There was no prescription label on the OTC bottle but the resident's name was handwritten on the container. Interview with the MA on 09/08/22 at 12:32pm revealed: -She did not notice the instructions on the eMAR were for 2 tablets of Vitamin B12 to be administered. -The resident should have received 2 Vitamin B12 500mcg tablets during the medication pass observed that morning. Interview with the Special Care Coordinator (SCC) on 09/08/22 at 12:41pm revealed: -The MAs should read the instructions on the eMARs and administer medications as ordered. -Resident #7 should have received two Vitamin B12 500mcg tablets as ordered. Interview with the Director of Care (DOC) on 09/09/22 at 1:57pm revealed: -The MAs should read the instructions on the eMAR prior to administering medications. -The MAs should administer medications as ordered. -Resident #7 should have received 2 Vitamin B12 500mcg tablets instead of 1 tablet. Review of Resident #7's lab results dated 06/03/22 revealed the resident's Vitamin B12 level was within the normal range at 509 (reference range 211 - 911). Telephone interview with Resident #7's primary care provider (PCP) on 09/09/22 at 3:15pm revealed:	D 358		

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-Resident #7 should have received 2 tablets of Vitamin B12 500mcg to treat and prevent Vitamin B12 deficiency.
-She was not concerned at this time since the resident got the wrong dose on one occasion.

Review of Resident #7's PCP order dated 09/08/22 at 4:17pm revealed an order to administer Vitamin B12 now.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

d. Review of Resident #8's current FL-2 dated 12/13/21 revealed:
-Diagnoses included diabetes mellitus type 2, hypertension, chronic kidney disease stage 4, seizure disorder, and dementia.
-There was an order for Novolog Flexpen insulin inject 2 units every morning. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

Review of Resident #8's physician's orders dated 08/15/22 revealed an order for Novolog Flexpen insulin 2 units with breakfast.

Review of Resident #8's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen inject 2 units with breakfast scheduled at 8:00am.
-The resident's blood sugar was checked 4 times a day at 8:00am, 12:00pm, 5:00pm, and 8:00pm and ranged from 76 - 489 from 09/01/22 -

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D 358	Continued From page 55 09/08/22. Observation of the 8:00am medication pass on 09/08/22 revealed: -Resident #8's blood sugar was 76 at 8:15am. -The medication aide (MA) administered 2 units of Novolog insulin into Resident #8's right upper arm at 8:24am. -The MA did not perform a 2-unit air shot prior to dialing the insulin pen to 2 units to ensure no air bubbles and to ensure insulin was flowing from the pen. Interview with the MA on 09/08/22 at 09/08/22 at 1:43pm revealed: -She had training on the use of insulin pens when she started working at the facility and again about 2 months ago. -She thought a 2-unit air shot only had to be done once, when an insulin pen was first opened. -She did not realize a 2-unit air shot had to be done before each dose was dialed up Interview with the Director of Care (DOC) on 09/08/22 at 1:57pm revealed: -The MAs were trained on how to administer insulin and were checked of by a registered nurse prior to administering medications. -Novolog Flexpen should be primed with a 2-unit air shot prior to dialing the ordered dose to be administered. Interview with the facility's Area Clinical Director/Registered Nurse (ACD/RN) on 09/09/22 at 5:25pm revealed: -She trained and checked off the MAs on how to administer insulin pens on the medication administration clinical skills validation form. -The MAs were trained on how to properly attach the pen needle to the insulin pen and how to	D 358		

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prime the needle with a 2-unit air shot to ensure air bubbles were removed and the full dose was administered.

Interview with Resident #8 on 09/08/22 at 4:39pm revealed his blood sugar was checked and he usually received insulin a few times a day.

Telephone interview with Resident #8's primary care provider (PCP) on 09/09/22 at 3:15pm revealed:
-The MAs should be using proper technique when administering insulin with insulin pens.
-Proper technique should be used to ensure the full amount of insulin is administered.

e. Review of Resident #8's current FL-2 dated 12/13/21 revealed an order for Atorvastatin 40mg nightly. (Atorvastatin lowers cholesterol and triglycerides.)

Review of Resident #8's primary care provider (PCP) visit note dated 06/09/22 revealed:
-The resident had hyperlipidemia (high cholesterol and high triglycerides).
-Due to the resident's age and debility, the PCP would decrease the resident's Atorvastatin to the lowest effective dose.
-There was an order to decrease Atorvastatin to 20mg 1 tablet once a day.

Observation of the 8:00am medication pass on 09/08/22 revealed:
-The medication aide (MA) prepared and administered Atorvastatin 40mg to Resident #8 at 8:15am.
-The resident was administered Atorvastatin 40mg instead of 20mg as ordered.

Review of Resident #8's September 2022

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electronic medication administration record (eMAR) revealed:
-There was an entry for Atorvastatin 20mg take 1 tablet every day scheduled at 8:00am.
-Atorvastatin 20mg was documented as administered daily from 09/01/22 - 09/08/22.

Observation of Resident #8's medications on hand on 09/08/22 at 1:43pm revealed:
-There was a bottle of Atorvastatin 40mg tablets dispensed by an outside veteran's pharmacy on 08/30/22.
-The instructions on the medication label was to take 1 tablet every day for cholesterol.

Interview with the MA on 09/08/22 at 1:43pm revealed:
-She administered one whole tablet of Atorvastatin 40mg to Resident #8 because the eMAR and the label instructed to administer 1 tablet.
-She did not notice the medication listed on the eMAR was Atorvastatin 20mg and did not match the medication on hand, Atorvastatin 40mg.

Interview with the Director of Care (DOC) on 09/8/22 at 1:57pm revealed:
-The MAs should read the medication labels and the eMARs and administer the medication as ordered.
-If the medication label and the eMAR did not match, the MA should notify the Lead Supervisor, the Resident Care Coordinator (RCC), or the Special Care Coordinator (SCC).
-Resident #8 used the facility's contracted PCP but his medications were dispensed by an outside veteran's pharmacy which could have contributed to the discrepancy.

A second interview with the DOC on 09/09/22 at

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D 358	Continued From page 58 5:06pm revealed: -The MAs or supervisors were responsible for faxing Resident #8's orders to the primary pharmacy for profiling and entering on the eMAR system. -The MAs or supervisor should also fax Resident #8's orders to the resident's outside veteran's administration (VA) pharmacy for the medications to be dispensed. -The order to decrease Atorvastatin to 20mg was not faxed to the resident's outside VA pharmacy but should have been. Attempted telephone interview with Resident #8's outside VA pharmacy on 09/09/22 at 12:22pm was unsuccessful. Interview with Resident #8 on 09/08/22 at 4:39pm revealed he did not know if he took any medications for his cholesterol. Telephone interview with Resident #8's PCP on 09/09/22 at 3:15pm revealed: -She decreased Resident #8's Atorvastatin from 40mg to 20mg daily on 06/09/22. -She was not aware the resident continued to receive Atorvastatin 40mg instead of decreasing to 20mg. -She was trying to taper the resident off the Atorvastatin because he did not need it. -She was trying to decrease his medication burden to prevent unnecessary side effects. f. Review of Resident #9's current FL-2 dated 01/27/22 revealed: -Diagnoses included dementia with behavioral disturbance. -There was an order for Risperdal 0.5mg 1 tablet twice daily. (Risperdal is an antipsychotic that may be used to treat behavioral disturbances.)	D 358		

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D 358	Continued From page 59 Review of Resident #9's physician's order dated 08/11/22 revealed an order for a gradual dose reduction to decrease Risperdal to 0.5mg at bedtime. Review of Resident #9's physician's order dated 09/01/22 revealed an order to discontinue Risperdal 0.5mg and start Risperdal 0.25mg 1 tablet once daily. Observation of the 8:00am medication pass on 09/08/22 revealed: -The medication aide (MA) prepared and administered 6 pills to Resident #9 at 8:04am. -Risperdal was not prepared, administered, or offered to Resident #9 when she received her other morning medications at 8:04am. Review of Resident #9's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Risperdal 0.5mg take 1 tablet at bedtime scheduled for 8:00pm. -Risperdal 0.5mg at bedtime was noted to be discontinued on 09/02/22. -There was a second entry for Risperdal 0.5mg take 0.5 tablet (0.25mg) every day scheduled for 8:00am. -Risperdal 0.25mg was documented as administered at 8:00am from 09/03/22 - 09/08/22. Observation of Resident #9's medications on hand on 09/08/22 at 1:35pm revealed: -There was a multidose pack (MDP) with a start date of 09/09/22 with Resident #9's scheduled morning medications. -Risperdal was not included in the MDP. Interview with the MA on 09/08/22 at 1:35pm	D 358		

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revealed:
-She thought Resident #9's Risperdal was administered twice a day, morning and evening.
-She did not notice Risperdal was not included in the resident's MDP.
-She did not notice that she clicked on the eMAR indicating she had administered Risperdal to the resident when it was not administered that morning, 09/08/22.

A second interview with the MA on 09/08/22 at 3:10pm revealed:
-She checked the medication cart again and found a single bubble card with Resident #9's Risperdal.
-She overlooked the bubble card that morning, 09/08/22, during the medication pass.

Observation of Resident #9's medications on hand on 09/8/22 at 4:37pm revealed:
-There was a bubble card dispensed on 09/01/22 with Risperdal 0.5mg tablets.
-The quantity dispensed on the label was 3.5 Risperdal 0.5mg tablets.
-There was one half tablet (0.25mg) of each Risperdal 0.5mg tablet prepackaged in the bubbles.
-There was one half tablet (0.25mg) of the 3.5 tablets dispensed remaining in the bubble card.

Interview with Resident #9 on 09/08/22 at 4:45pm revealed she was not sure which medications she received and she let staff take care of her medications.

Interview with the Director of Care (DOC) on 09/8/22 at 1:57pm revealed:
-The MAs should read the medication labels and the eMARs and administer the medication as ordered.

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-If the MA had any questions about a medication discrepancy, the MA should notify the Lead Supervisor, the Resident Care Coordinator (RCC), or the Special Care Coordinator (SCC).

Telephone interview with Resident #9's primary care provider (PCP) on 09/09/22 at 3:15pm revealed:
-Resident #9 should have received Risperdal 0.25mg on 09/08/22.
-She was in the process of tapering the resident off of Risperdal.
-Since it was such a low dose of Risperdal, she was not concerned that the resident had missed one dose.

2. Review of Resident #2's current FL-2 dated 02/14/22 revealed:
-Diagnoses included dementia and chronic obstructive pulmonary disease.
-There was an order for Divalproex (divalproex) (used for mood stabilization) extended release (ER) 250 mg to be administered every morning.
-There was an order for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening.

Review of Resident #2's pharmacy reviews revealed:
-The last pharmacy review was completed on 05/27/22 by a pharmacist with a consulting pharmacy provider.
-The recommendation was to ensure the primary care provider (PCP) was aware of the missed doses of Divalproex in May 2022.
-There was no documentation that the recommendation had been followed and the PCP had been made aware of the missed doses of Divalproex in May 2022.
-There were no other quarterly pharmacy reviews

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D 358	Continued From page 62 available for review. Review of Resident #2's electronic medication administration record (eMAR) for May 2022 revealed: -There was a computerized entry for Divalproex (Depakote) extended release (ER) 250 mg to be administered every morning at 8:00am. -There was a computerized entry for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening at 8:00pm. -There was documentation that Divalproex extended release (ER) 250 mg was administered every morning at 8:00am from 05/01/22 through 05/17/22. -There was documentation Divalproex extended release (ER) 250 mg was not administered from 05/18/22 through 05/31/22 with the reason awaiting new order and waiting for the family to pick up the medication. -There were 14 out of 31 doses of Divalproex extended release (ER) 250 mg that were not administered. -There was a computerized entry for Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm. -There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm was administered every day at 8:00pm from 05/01/22 through 05/07/22 and 05/09/22 through 05/16/22. -There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was not administered from 05/17/22 through 05/31/22. -There were 16 out of 31 doses of Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) that were not administered. Review of Resident #2's eMAR for August 2022	D 358		

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	HAL092181	A. BUILDING: _____ B. WING _____	09/09/2022

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THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

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D 358	Continued From page 63 revealed: -There was a computerized entry for Divalproex (Depakote) (medication used for mood stabilization) extended release (ER) 250 mg to be administered every morning at 8:00am. -There was a computerized entry for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening at 8:00pm. -There was documentation that Divalproex extended release (ER) 250 mg was administered every at morning at 8:00am from 08/01/22 through 08/18/22 and 08/25/22 through 08/31/22. -There was documentation Divalproex extended release (ER) 250 mg was not administered 08/19/22 through 08/24/22 with the reason waiting for the family to pick up the medication. -There were 6 out of 31 doses of Divalproex extended release (ER) 250 mg that were not administered. -There was a computerized entry for Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) every evening at 8:00pm. -There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was administered every day at 8:00pm from 08/01/22 through 08/16/22 and 08/24/22 through 08/31/22. -There was documentation that Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) was not administered 08/17/22 through 08/23/22 with the reason waiting for the family to pick up the medication. -There were 7 out of 31 doses of Divalproex extended release (ER) 250 mg to take 2 tablets (500mg) that were not administered. Interview with a medication aide (MA) on 09/09/22 at 2:58pm revealed: -Resident #2's family brings in his medications. -The facility called the outside pharmacy the	D 358		

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D 358	Continued From page 64	D 358		

family used when Resident #2's refills were needed.
-The family would pick up the medicines and bring them in to the facility.
-It was hard to get the family to bring the medicines.
-He did not remember about the Divalproex.
-He did not recall any behavior changes.

Telephone interview with the primary care provider (PCP) for Resident #2 on 09/09/22 at 3:40pm revealed:
-She had been the PCP for this facility for seven years.
-She had been Resident #2's PCP since he had been admitted to the facility.
-She had not been notified of Resident #2 missing any doses of his Divalproex.
-She would be concerned of the missed doses since he was prescribed the Divalproex for his moods with having Bipolar disorder.

Telephone interview with the mental health provider for Resident #2 on 09/09/22 at 3:40pm revealed:
-She was concerned if any of her patients were not receiving their prescribed medications.
-She was not the mental health provider for Resident #2 in May 2022.
-She expected medications to be given as ordered and to be notified if the resident missed any doses.
-Missed doses of Divalproex would cause a decrease in the therapeutic levels that could cause the resident to have side effects and could cause changes in his behaviors.

_____

The facility failed to administer medications as ordered to 3 residents observed during the medication pass on 09/08/22, resulting in 6

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D 358	Continued From page 65 medication errors and a 20% error rate. Resident #7 was administered a whole tablet of Carvedilol 6.25mg instead of a half tablet putting the resident at risk of low heart rate and low blood pressure. Resident #7 received 10Meq of Potassium Chloride instead of 20mEq putting the resident at risk of having low potassium levels. The MA did not use proper technique for insulin pens when administering insulin to Resident #8 to ensure the removal of air bubbles and to ensure insulin was flowing from the pen needle. Resident #8 continued to receive Atorvastatin 40mg after the order was decreased to 20mg on 06/09/22 putting the resident at risk of unnecessary side effects for 3 months. Resident #9 was not administered an antipsychotic medication during the morning medication pass on 09/08/22 due to the MA failing to read the eMAR and check the labels on the medications on hand. Resident #2 missed multiple doses of a medication for mood stabilization putting the resident as risk for side effects and changes in behavior. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2022.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367	The Covington shall ensure that the resident's MAR is accurate for medication administration, as well as have accurate and complete documentation. RCC/SCC will ensure new medications from	

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D 367	Continued From page 66 record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#1) including inaccurate documentation for sliding scale insulin and a scheduled insulin with parameters for administration. The findings are: Review of Resident #1's current FL-2 dated 02/21/22 revealed diagnoses included diabetes mellitus type 2. a. Review of Resident #1's physician's order dated 09/01/22 revealed an order for Humalog sliding scale insulin (SSI) 3 times a day before meals according to the following scale: 150 - 200	D 367	outside pharmacies have an accompanying order. If the order is not available with the medication, the Care Manager will call the pharmacy to request a copy of the prescription. This will be the same process for E-scribe orders. Prescriptions from outside pharmacies will then be faxed for profile to the house pharmacy, and finally secured in the resident's record. Care Managers will ensure change of direction stickers are placed on medication packages that do not match the directions on the MAR, and that Med Techs are made aware so that documentation on the 24 Hr communication log can occur. RCC/SCC will print their resident medication lists and send to respective residents' PCPs to review and clarify for accuracy. This will continue until 100% of residents med lists have been completed. Once meds have been clarified, new FL2s will be completed and sent for signature. Care Managers will pull the medication compliance report and review for compliance and accuracy daily. Any needed follow-up will be discussed with the ED once completed.	10/24/22 10/24/22 10/24/22 10/24/22

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D 367	Continued From page 67 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; and greater than (>) 400 = 14 units. (Humalog is rapid-acting insulin used to lower blood sugar.) Review of Resident #1's September 2022 electronic medication administration record (eMAR) dated 09/01/22 - 09/06/22 revealed: -There was an entry for Humalog SSI 3 times a day before meals per sliding scale: 150 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; and > 400 = 14 units. -Humalog SSI was scheduled for 8:00am, 12:00pm, and 5:00pm. -There were staff initials documented from 09/02/22 - 09/06/22 at all 3 scheduled times. -There were no rows to document blood sugars, site of administration, or amount administered with the Humalog SSI entry. -There was a separate entry on a different page for the resident's blood sugar to be checked before meals and at bedtime scheduled for 8:00am, 12:00pm, 5:00pm, and 8:00pm. -At 8:00am, the resident's blood sugar ranged from 212 - 385 from 09/02/22 - 09/06/22 and would have required from 6 to 12 units of Humalog SSI on all 6 occasions. -At 12:00pm, the resident's blood sugar ranged from 183 - 309 from 09/02/22 - 09/06/22 and would have required from 4 to 10 units of Humalog SSI on all 6 occasions. -At 5:00pm, the resident's blood sugar ranged from 287 - 458 from 09/02/22 - 09/06/22 and would have required from 8 to 14 units of Humalog SSI on all 6 occasions. -There was no documentation to indicate how much, if any, Humalog SSI was administered on the 18 occasions it was required from 09/02/22 - 09/06/22.	D 367		

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D 367	Continued From page 68 Interviews with Resident #1 on 09/07/22 at 9:48am and 09/09/22 at 4:06pm revealed: -Her blood sugar was checked multiple times a day. -She received scheduled insulin and SSI depending on her blood sugar reading. -Her blood sugar usually ran high and it had not been low to her knowledge. Interview with a medication aide (MA) on 09/09/22 at 4:00pm revealed: -The eMAR did not always have a place to document the site or amount of insulin administered for Resident #1's Humalog SSI. -The eMAR would just show how much to administer and that was the amount he would administer. -He had administered Resident #1's Humalog SSI according to the scale on the eMAR. -He did not know why the amount he administered or the site of administration was not included on the entry for Resident 1's Humalog SSI. Interview with a second MA on 09/09/22 at 4:26pm revealed: -Resident #1's Humalog SSI order was new and the resident had needed it "a couple of days" when she worked. -She thought the eMAR usually had a box that came up for the MAs to document the site of administration and the amount of insulin administered. -She did not know why the site and amount of Resident #1's Humalog SSI was not on the eMAR. Interview with the Director of Care (DOC) on 09/09/22 at 5:13pm revealed:	D 367		

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-She was unaware the eMAR entry for Resident #1's Humalog SSI was not accurate.
-Entries for SSI should have a place to document the blood sugar, the amount administered, and the site of administration.
-The facility's contracted pharmacy usually entered the medication orders into the eMAR system but she or the Resident Care Coordinator (RCC) or Special Care Coordinator (SCC) had to approve orders on the eMARs prior to the orders becoming active in the eMAR system.
-The staff who approved the medication orders in the eMAR system should ensure the eMARs were set up correctly for the documentation of SSI.
-The RCC and SCC were responsible for weekly medication audits including review of the eMARs for accuracy.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 09/09/22 at 4:38pm revealed:
-The pharmacy staff usually entered medication orders into the eMAR system and facility staff had to approve the orders for them to become active.
-The facility staff could also enter medication orders into the eMAR system.
-She was uncertain who entered Resident #1's Humalog SSI order into the eMAR system.

Interview with the Interim Executive Director (ED) on 09/09/22 at 6:08pm revealed:
-The entry on the eMAR should have areas for the MAs to document the site of administration and the amount administered for Resident #1's Humalog SSI.
-The eMARs should be checked for accuracy by the SCC and the RCC every day.

b. Review of Resident #1's physician's order

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D 367	Continued From page 70 dated 05/02/22 revealed an order for Humalog insulin 10 units 3 times a day with meals if blood sugar is greater than (>) 300. (Humalog is rapid-acting insulin used to lower blood sugar.) Review of Resident #1's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog insulin inject 10 units 3 times daily with meals if blood sugar > 300. -Humalog insulin was scheduled for 8:30am, 12:30pm, and 5:30pm. -On two occasions when the resident's blood sugar was not > 300, it was documented 10 units of Humalog were administered. -On 07/13/22 at 8:30am, the blood sugar was 166 and 10 units of Humalog were documented as administered to the right abdomen. -On 07/23/22 at 8:30am, the blood sugar was 237 and 10 units of Humalog were documented as administered to the left abdomen. -The resident's blood sugars ranged from 105 - 577 from 07/01/22 - 07/31/22. Review of Resident #1's August 2022 eMAR revealed: -There was an entry for Humalog insulin inject 10 units 3 times daily with meals if blood sugar > 300. -Humalog insulin was scheduled for 8:30am, 12:30pm, and 5:30pm. -On one occasion when the resident's blood sugar was not > 300, it was documented 10 units of Humalog were administered. -On 08/31 at 8:30am, the blood sugar was 252 and 10 units of Humalog were documented as administered to the right arm. -The resident's blood sugars ranged from 104 - 542 from 08/01/22 - 08/31/22.	D 367		

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D 367	Continued From page 71 Review of Resident #1's September 2022 eMAR revealed: -There was an entry for Humalog insulin inject 10 units 3 times daily with meals if blood sugar > 300. -Humalog insulin was scheduled for 8:30am, 12:30pm, and 5:30pm. -On two occasions when the resident's blood sugar was not > 300, it was documented 10 units of Humalog were administered. -On 09/03/22 at 8:30am, the blood sugar was 212 and 10 units of Humalog were documented as administered to the right arm. -On 09/03/22 at 12:30pm, the blood sugar was 183 and 10 units of Humalog were documented as administered to the right arm. -The resident's blood sugars ranged from 183 - 458 from 09/01/22 - 09/06/22. Interviews with Resident #1 on 09/07/22 at 9:48am and 09/09/22 at 4:06pm revealed: -Her blood sugar was checked multiple times a day. -She received scheduled insulin and sliding scale insulin depending on her blood sugar reading. -She was not sure of the parameters for her insulin. -Her blood sugar usually ran high and it had not been low to her knowledge. Interview with a medication aide (MA) on 09/09/22 at 3:01pm revealed: -He documented administration of Resident #1's scheduled Humalog insulin in error when the resident's blood sugar was not > 300. -He could not explain why he would have documented 10 units was administered and a site of administration on those occasions. -He did not administer scheduled Humalog insulin	D 367		

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D 367	Continued From page 72 to the resident when her blood sugar was not > 300; it was documentation errors. Interview with a second MA on 09/09/22 at 4:26pm revealed: -On 07/13/22, she did not administer 10 units of Resident #1's scheduled Humalog insulin when the blood sugar was 166. -She may have documented the Humalog was administered with the site of administration in error. -The resident also received another scheduled insulin at 8:00am so she may have documented a site of administration for the Humalog in error since she would have administered the other insulin at that time. Interview with the Director of Care (DOC) on 09/09/22 at 5:13pm revealed: -Resident #1's scheduled Humalog should not be administered unless the blood sugar was >300. -The MAs should not initial the scheduled Humalog as administered if it was not administered. -There should not be a site of administration documented if no insulin was administered. -The MAs were responsible for reviewing the eMARs during weekly medication audits. -The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) were responsible for weekly medication audits including review of the eMARs for accuracy. Interview with the Interim Executive Director (ED) on 09/09/22 at 6:08pm revealed: -The MAs should follow the order and document the administration of Resident #1's scheduled Humalog insulin accurately on the eMAR. -The eMARs should be checked for accuracy by the SCC and RCC every day.	D 367		

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D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by:	D 400	The Covington shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly, which includes an on-site medication review for each resident. RCC/SCC will complete the Pharmacy Review within 14 days of receipt, and will keep the completed report in a binder organized by month for easy retrieval if needed. Physician responses will be faxed to pharmacy, and secured in the resident's record. Upon receipt of notification that the Review has been completed, the ED will set a deadline for the Care Managers to have the review completed. The ED will follow-up with the Care Managers by this deadline to verify that the review has been completed, orders processed, and documents filed in the residents' records.	10/24/22 10/24/22

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D 400	Continued From page 74	D 400		

Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy reviews were completed for 2 of 5 sampled residents (#2 and #3).

The findings are:

1. Review of Resident #2's current FL-2 dated 02/14/22 revealed:
-Diagnoses included dementia and chronic obstructive pulmonary disease.
-There was an order for Divalproex (Depakote) (used for mood stabilization) extended release (ER) 250 mg to be administered every morning.
-There was an order for Divalproex extended release (ER) 250 mg (2 tablets=500mg) to be administered every evening.

Review of Resident #2's Resident Register revealed an admission date of 08/21/17.

Review of Resident #2's pharmacy reviews revealed:
-The last pharmacy review was completed on 05/27/22 by a pharmacist with a consulting pharmacy provider.
-The recommendation was to ensure the primary care provider (PCP) was aware of the missed doses of Divalproex in May 2022.
-There was no documentation that the recommendation had been followed and the PCP had been made aware of the missed doses of Divalproex in May 2022.
-There were no other quarterly pharmacy reviews available for review in order to identify other medication related problems.

2. Review of Resident #3's current FL-2 dated 07/08/21 revealed:
-Diagnoses included dementia, hypertension,

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THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

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D 400	Continued From page 75 stage 3 chronic kidney disease, lumbosacral disc herniation, anxiety, and depression. -There was an order for Tylenol (used to treat minor pain) 650mg suppository to insert one every 6 hours as needed. -There was an order for Bisacodyl (used to relieve constipation) 10mg suppository insert one every day as needed. -There was an order Hyoscyamine Sulfate SL (Levsin) (used to dry up secretions) 0.125mg one sublingual every 4 hours as needed for secretions. -There was another order for Levsin SL (Hyoscyamine) one sublingual every 4 hours as needed for secretions. -There was an order for Morphine Concentrate (used to treat moderate to severe pain) 100mg/5mL prefilled syringes 0.25 mg every 4 hours as needed for severe pain or shortness of breath. -There was an order for Lorazepam (Ativan) (used to treat anxiety) 0.5 mg take 0.5 tablet (0.25mg) every morning for anxiety. -There was an order for Lorazepam (Ativan) 0.5 mg take one tablet before supper for anxiety. -There was an order for Lorazepam (Ativan) 0.5 mg take one tablet every 4 hours as needed for anxiety/agitation. Review of Resident #3's Resident Register revealed an admission date of 06/03/21. - After several requests, there were no quarterly pharmacy reviews for Resident #3 made available for review at time of exit.	D 400		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff	D 465		

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D 465	Continued From page 76 (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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, 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 in the special care unit (SCU), for 4 of 12 shifts sampled. The findings are: Observation of the facility on 09/07/22 at 9:00am revealed: -The facility was a multi-level facility consisting of three floors (a ground floor, first and second floors). -The special care unit (SCU) was located on the first floor which was accessible by locked doors to the stairwell with keypad access along with elevator access with keypad access to the first floor. -The facility's current SCU census on 09/07/22 was 22 residents. -There was a strong smell of urine and feces odor in the hallways, common areas and stronger in the occupied resident rooms on the SCU on 09/07/22 from 9:27am until 11:01am.	D 465	The Covington shall ensure that staff is present in the unit at all times in sufficient number to meet the needs of the resident; but at no time less than one staff person, who meets the orientation and training requirements for the SCU, for up to 8 residents on 1st and 2nd shifts & 1 hr for each additional resident; and one staff person for up to 10 residents on 3rd shift & 0.8 hrs for each additional resident. BOM will pull applications for open positions and schedule interviews for the care department. ED/RCC/SCC will assit with completing interviews. 10/24/22 ED in-serviced staff that they are to call the Administrator with any need to be absent from work, as well as the appropriate manner to call out. Staff also re-educated on the call out policy, which statesto notify management at least 4 hours prior to the start of their shift to allow time to adjust scheduling and find coverage. 9/21/22 Assignment sheets will be reviewed daily by the ED/LSIC/ Care Managers in management meeting to ensure adequate staffing is scheduled to meet the needs of the residents, and to ensure that the facility meets the minimum standard requirements for SCU staffing. 10/24/22 ED will obtain monthly schedule for the care department for the upcoming month, and will review with the LSIC weekly to ensure adequate staffing in the community. Master copies of schedules will be stored in a binder in the ED's office, and any changes will be updated on this schedule. Copies of the schedule and assignment sheets with the ED's initials will be provided to Care Managers to keep management team informed of current staffing at all times. 10/24/22	

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D 465	Continued From page 77 Observations on the SCU on 09/09/22 from 4:28pm until 4:59pm revealed: -At 4:28pm, there was a personal care aide (PCA) and a medication aide (MA) walking back in forth in the common area, dining room and resident rooms. -At 4:40pm, the PCA was in a resident room assisting with toileting/incontinence care, the MA was administering medications and there were 13 residents in the dining room with no staff in the dining room. -Three residents were in wheelchairs; one had a chair alarm on her wheelchair and three had walkers near the table. -There was a resident sitting in an armchair with a rollator next to her in the common area and a resident talking loudly to other residents from her wheelchair in the common area. -The Special Care Coordinator (SCC) left her office and the SCU at 4:40pm. -At 4:51pm, the PCA was assisting another resident with incontinence care and the MA was in the dining room with residents. -At 4:54pm, the resident in her wheelchair in the common area was talking louder (and was confused) to other residents, another resident was walking from hall to hall trying to open doors. -A resident attempted to comfort the resident in the wheelchair talking loudly. -At 4:59pm, the Housekeeping Supervisor began working as a PCA on the SCU. Interview with the Interim Executive Director on 09/07/22 at 1:00pm revealed: -The MAs worked 12 hour shifts 7:00am to 7:00pm and 7:00pm to 7:00am both weekdays and weekends. -The PCAs worked 8 hour shift Monday - Friday (7:00am-3:00pm 1st shift, 3:00pm-11:00pm 2nd shift and 11:00pm-7:00am 3rd shift).	D 465		

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-The PCAs worked 12 hour shifts, 7:00am to 7:00pm and 7:00pm to 7:00am, on the weekends.
-There was one MA/PCA who only worked 8 hour shifts when scheduled to work.

Review of the facility's license effective 12/22/21 revealed the facility was licensed for a capacity of 120 beds including 60 beds for the assisted living (AL) area and 60 beds for the SCU.

Review of the facility's resident census report, daily staff assignment sheet, and staff time cards dated 08/21/22 revealed:
-The SCU census was 25 which required 25 aide hours on first and second shifts.
-The second shift assignment had one MA and one PCA assigned to the SCU.
-Staff time cards had a total of 21 hours 22 minutes staff hours provided on SCU for second shift for a shortage of 3 hours and 38 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and staff time cards dated 08/23/22 revealed:
-The SCU census was 25 which required 25 aide hours on first and second shifts.
-The second shift assignment had one MA assigned to the facility to cover both the AL and SCU and two PCAs were assigned to the SCU.
-Staff time cards had a total of 19 hours 6 minutes staff hours provided on SCU for second shift for a shortage of 5 hours and 54 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and staff time cards dated 09/03/22 revealed:
-The SCU census was 22 which required 22 aide hours on first and second shifts.
-The second shift assignment had one MA assigned to the facility to cover both the AL and

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SCU and one PCA was assigned to the SCU.
-Staff time cards had a total of 15 hours and 33 minutes of staff hours provided on SCU for second shift for a shortage of 6 hours and 27 minutes.

Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 09/05/22 revealed:
-The SCU census was 22 which required 22 aide hours on first and second shifts.
-Staff time cards had a total of 11 hours 26 minutes staff hours provided on SCU for second shift for a shortage of 10 hours and 34 minutes.

Interview with an AL resident on 09/07/22 at 10:36am revealed:
-The facility was short staffed.
-She had to wait for her medications every afternoon because the MA had to go to the SCU to administer medications too.

Interview with a MA on 09/09/22 at 4:28pm revealed he was working with one PCA currently on the SCU and the SCC was in her office.

Telephone interview with a family member on 09/08/22 at 5:16pm revealed:
-There was not enough staff working on the SCU.
-Staffing was a problem since the COVID-19 pandemic.
-Staff did the bare minimum when providing care for the residents.
-She visited the SCU weekly and each time she would find her family member who resided on the SCU wet and soiled.
-Each time staff would say they were just about to change her.
-On Monday, 09/05/22, she visited and found her family member sitting in her wheelchair with feces

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and urine and urine was on the floor in front of her.
-The resident was trying to get up from the chair by herself and could have slipped in the urine on the floor, fell and gotten hurt.
-It was 3:00pm and all the first shift staff were gone and there was only one staff working on the SCU.
-She questioned how one staff was going to take care of all the residents on the SCU.
-By approximately 5:00pm, a second staff was working on the SCU.
-There were just two staff to take care of residents and serve dinner to all the residents.

Interview with a PCA on 09/09/22 at 4:28pm revealed:
-She worked second shift on 09/05/22.
-When she arrived to work a resident was sitting in her wheelchair and her incontinence brief was not pulled up.
-The first shift staff said the resident was fighting them, so they left her like that.
-The resident had urinated and had a bowel movement in the wheelchair and needed to be cleaned.
-She found the resident in that condition frequently.
-The resident's family member was visiting and helped her clean the resident.
-She was working on the SCU by herself initially.
-A second PCA arrived late for the shift (4:17pm per time card record) and the MA was working on both the AL and SCU.
-She worked five days per week and three of the five days were usually short staffed like today (09/09/22) with just two staff.
-Every Thursday and Friday, second shift was short staffed with just her and a MA on duty on the SCU.

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D 465	Continued From page 81 -The SCC, Resident Care Coordinator (RCC) and Director of Care (DOC) did not help staff provide direct care when shifts were short staffed. Interview with a second PCA on 09/09/22 at 2:32pm revealed there were usually enough staff on duty for first shift Monday through Friday. Interview with the SCC on 09/09/22 at 5:06pm revealed when there were staff shortages everyone helped with resident care. Second interview with the Interim Executive Director on 09/09/22 at 7:30am revealed: -The lead supervisor made the schedule and the daily assignment sheets. -The assignment sheet would designate which floor/area the staff were assigned to work. -The time punches would document which floor the staff clocked into work. -The staff could not change the time punch once they were clocked in. -When the staff realized the floors were not properly staffed, they should have rearranged the schedule to ensure the floors were covered. -She was not aware that the facility was short staffed on 08/21/22, 08/23/22, 09/03/22, and 09/05/22. -She was not aware there was ever only four staff in the facility on second shift. -She was not sure what happened on 08/21/22, 08/23/22, 09/03/22, and 09/05/22 unless staff had called out. [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision] _____ The facility failed to ensure the SCU was staffed to meet minimal staffing requirements for 4 of 12 shifts sampled, resulting in residents' personal	D 465		

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D 465	Continued From page 82 care needs not being met, chronic unpleasant odors, medications administered late and safety issues observed with water on the floors of residents' rooms and common areas and toilets not in working order. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 09/09/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2022.	D 465		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection;	D 611	The Covington shall establish and implement infection prevention and control policies and procedures consistent with CDC published guidelines. DRC/ED re-educated staff on Infection Control related to Covid-19. 9/21/22 ED re-educated staff on the mandatory expectation to wear a surgical mask appropriately while on shift as a part of their uniform. 9/21/22 ED ensures that she updates staff with the latest guidance related to COVID 19 Infection Control based on Company guidance and CDC guidelines. 10/24/22 ED monitors appropriate Infection Control procedures during twice daily facility rounds. 10/24/22	

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D 611	Continued From page 83 (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak;	D 611		

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D 611	Continued From page 84 (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic related to the use of personal protective equipment (PPE) by staff. The findings are: Review of the 01/21/22 CDC guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility revealed: -Personnel should always wear a face mask in the facility. -Face masks should not be worn under the nose or mouth. -A surgical mask can be used if a N95 mask is not available. -Appropriate PPE should be used by personnel	D 611		

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D 611	Continued From page 85 when coming in contact with the resident. Review of the facility's Infection Control regarding Coronavirus dated September 2021 revealed: -The facility had established Infection Control policies and procedures. -All staff members and visitors will wear masks while in the building. Observation upon entry to the facility on 09/07/22 at 9:00am revealed there were face masks available at the entrance with screening thermometer and electronic screening pad with questionnaire. Observation of the kitchen on 09/08/22 at 7:30am revealed: -The cook was cooking and plating meals on the tray line. -She did not wear a face mask. -Two other kitchen staff were observed in the kitchen. Observation of a medication aide (MA) on 09/08/22 at 8:28am revealed: -She wore a surgical face mask but it was under her nose. -The Interim Executive Director instructed her to pull up the mask over her nose. Observation of the cook in the kitchen on 09/08/22 at 8:26am revealed she wore a cloth face mask. Interview with the Kitchen Manager (KM) on 09/08/22 at 8:07am revealed: -All staff and visitors were supposed to wear masks while in the facility. -She said the cook would wear a mask "sometimes" because the KM would "sometimes"	D 611		

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D 611	Continued From page 86 enforce it. -She expected her kitchen staff to wear face masks while in the facility especially when preparing food. -She was not sure why the cook was not wearing a face mask. Interview with the Interim Executive Director on 09/08/22 at 8:28am revealed: -She received COVID-19 information and recommendations from the NCDHHS. -The facility's policy was all staff and visitors wear a medical face mask, not a cloth mask, while in the facility. -The mask should cover the nose and the mouth unless they were eating or drinking while on break. -She was not sure why the cook was not wearing a face mask earlier nor why she would wear a cloth face mask but she was "going to find out".	D 611		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure 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 personal care and supervision, medication administration, and special care unit	D912	See above POC Response.	

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THE COVINGTON	4510 DURALEIGH ROAD RALEIGH, NC 27615

(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
D912	Continued From page 87 staffing. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to provide incontinence care for 2 of 6 sampled residents (#4 and #6) who were dependent on staff for assistance with cleaning and changing after incontinence episodes and repositioning when sitting in a wheelchair for more than two hours. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#7, #8, #9) observed during the medication pass including errors with medications for heart/blood pressure, low potassium levels, and low Vitamin B12 levels (#7), insulin and a medication for high cholesterol (#8), and an antipsychotic (#9); and for 1 of 5 sampled residents (#2) for record review including errors with a medication for mood stabilization. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on observations, 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 the in the special care unit (SCU), for 6 of 18 shifts sampled. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type B Violation)].	D912		