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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079107	A. BUILDING: _____ B. WING _____	06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOYER'S AGAPE ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

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D 000	Initial Comments The Adult Care Licensure Section and the Rockingham County Department of Social Services conducted an annual and follow up survey on June 13, 2023 and June 14, 2023.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 residents sampled (# 3) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL2 06/12/23 revealed diagnoses included borderline intellectual functioning, oppositional defiant disorder, menorrhagia, insomnia, and stress reaction causing mixed disturbance of emotion and conduct. Review of Resident #3's Resident Register	D 234		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anitha Kurian — TITLE: DIRECTOR — (X6) DATE: 7/31/23

Reviewed and acknowledged with addendums 07/31/2023. Catherine Porter

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D 234	Continued From page 1 revealed there was an admission date of 06/09/23. Review of Resident #3's record for a tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test administered on 05/03/22 and read as negative on 05/06/22. -There was no documentation of a second TB skin test for Resident #3. Interview with Resident #3 on 06/14/23 at 2:40pm revealed she did not know when she had a TB skin test. Telephone interview with Residnet #3's Guardian on 06/13/23 at 4:50pm revealed: -Resident #3 had resided in several facilties since she became guardian in 2018. -Resident #3 had not been out into the community since 2018. -She was sure Resident #3 had several negative TB skin test with her multiple hospital admissions. -She would attempt to locate documentation for a 2-step TB skin test. Interview with the Executive Director (ED) on 04/14/23 at 3:20pm revealed: -She was responsible to ensure residents' admission paperwork for TB compliance. -Resident #3 was admitted from a sister facility. -Resident #3 had been in several previous facilities. -She assumed Resident #3 had a previous 2-step TB skin test, but did not have documentation. -She contacted Resident #3's Guardian for TB skin test documentation and was provided the one TB skin test. -She had not scheduled a TB skin test to be done for Resident #3 upon admission to the facility	D 234	Resident #3 had a second TB test but it was not in the Patients chart at the time. In fact Resident #3 had multiple TB screening during the course of her hospital visits. We were able to get the documentation for that 7/5/23 Resident #3 got discharged on 7/17/23 ED will make sure upon a new admission all the new admission requirements are met 7/16/23	

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type A2 Violation Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#3) related to a resident who left the facility and entered a busy highway while threatening self-harm. The findings are: Review of Resident #3's current FL2 dated 06/12/23 revealed diagnoses included borderline intellectual functioning, oppositional defiant disorder, menorrhagia, insomnia, and stress reaction causing mixed disturbance of emotion and conduct. Review of Resident #3's Resident Register revealed an admission date of 06/09/23. Review of Resident #3's care plan dated 06/13/23 revealed the resident was assessed as independent for dressing, ambulation, and transfers; needed supervision for eating and toileting, and needed limited assistance for bathing and grooming.	D 270	Resident #3 would always needing personnel attention therefore she continued to threaten the facility staff in order to get the attention, but actually not physically harming herself. MA always monitored her as she exit out the facility. called her guardian numerous times and gave the guardian a discharge notice for the resident #3. ~~Upon the admission of the~~ Guardian was not	

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D 270	Continued From page 3 Interview with Resident #3 during the initial facility tour on 06/13/23 at 10:22am revealed: -She was just back from [a named mental health treatment center]. -She was in the middle of the road trying to flag people down on 05/27/23. -She wanted to be hit by a car. -The medication aide/Supervisor (MA/S) called 911; the sheriff came to get her and took her to the hospital. -The MA/S was in his office watching Resident #3 when she left the facility. -She did something similar 2 weeks ago. -She was feeling better now and would try to be good. -She was supposed to have her phone for 3 hours each day, but could not get the phone from the MA/S. Observation of the facility's location on 06/13/23 and 06/14/23 revealed: -The facility was located on the north side of a two-lane highway leading eastward out of town. -The facility was located 100-150 feet off the highway. -The posted speed limit was 55 miles per hour in front of the facility and lowered to 45 miles per hour approximately 0.25 miles past the facility due to a long right-handed curve. -Vehicles were observed on 06/13/23 and 06/14/23 at various times from 9:00am to 5:00pm traveling at the posted speed. -There was a mobile home approximately 0.25 miles east of the facility and on the same side of the road. Review of documentation in Resident #3's resident's notes revealed: -On 05/12/23 [at 8:33pm per medication aide/Supervisor (MA/S)], Resident #3 started	D 270	able to find a placement at the time when she displayed some of those uncontrolled behaviours. Upon when ED did the initial assessment, ED was not told by her guardian all of the residents #3 behaviours, but soon after the admission we discovered resident #3's uncontrolled behaviour. Guardian has been looking for a placement since then. But finally Resident #3 got discharged on 7/17/23. ED will make sure and do every effort to screen the new admissions	

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D 270	Continued From page 4 acting out and wanted to go the local hospital for suicidal thoughts. -On 05/21/23, (no time provided) Resident #3 requested the MA/S to call 911 and wanted to go to the hospital for suicidal thought. The Guardian was called and she advised the MA/S not to call 911. Resident #3 walked to a neighbor's house and the Guardian let the MA/S call 911. Resident #3 went to the hospital. -On 05/27/23, Resident #3 started another episode and wanted to call 911. Resident #3 said she was self-harm and wanted to talk to someone. Per Guardian's instruction a call was placed to the local assertive community treatment (ACT) team and no one was answering calls. Finally, the MA/S called 911 and the sheriff came to take her to the hospital. Review of Resident #3's local hospital ER visit reports from Resident #3's record revealed: -On 04/29/23, there was an ER visit with the reason for visit documented as suicidal and diagnosis of suicidal ideation. -On 05/01/23, there was an ER visit with the reason for visit documented as suicidal and diagnosis of suicidal behavior without attempted self-injury. -On 05/10/23, there was an ER visit with the reason for visit documented as suicidal and diagnosis of suicidal ideation. -On 05/21/23, there was an ER visit with the reason for visit documented as suicidal and diagnosis of suicidal thoughts. Review of Resident #3's hospital ER visit notes dated 05/21/23 revealed: -Resident #3 presented to the ER with suicidal ideations on 05/21/23 at 9:30pm. -Resident was stopped by local law enforcement from running into the oncoming traffic.	D 270	to rule out any kind of uncontrolled behavioural issues which potentially harmful to the resident and other staff members, and also other current residents ED will monitor continually and ongoing 6/20/2023. Immediatly	

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D 270	Continued From page 5 -Resident #3 said she had been suicidal for 2 days. -Resident #3 was placed in a psychiatric hold area. -On 05/24/23 at 11:04am, Resident #3 was not suicidal and did not need inpatient psychiatric care; released back to facility. -On 05/24/23 around 4:00pm, Resident #3 was picked up by the Guardian's representatives and returned to the facility. Review of the local law enforcement event reports revealed: -On 05/27/23 at 11:47pm, an officer was dispatched to the facility. -On 05/28/23 at 12:21am, an officer transported a resident to a local hospital. -The 911 call came from an employee of the facility and a second call from the resident. -The resident stated she was feeling suicidal. -The resident was threatening to walk out into traffic. Review of Resident #3's hospital ER visit notes dated 05/28/23 revealed: -On 05/28/23 at 2:06am, Resident #3 presented to a local ER complaining of suicidal ideation. -Resident was found standing in the middle of the street with a plan for being hit by a motor vehicle. -Police recovered her and brought her to the facility. -She had a prior history of similar attempts. -On 06/02/23 at 6:20am, Resident #3 was discharged to a mental treatment center. Review of Resident #3's record revealed there was no documentation for increased supervision after the incidents of going to a neighbor's house on 05/13/23 or the road on 05/21/23 and 05/27/23.	D 270		

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D 270	Continued From page 6 Interview with the Executive Director (ED) on 06/13/23 at 10:45am revealed: -Resident #3 was recently admitted to the facility on 06/09/23 after a hospitalization at a mental health treatment center. -Resident #3 had previously resided in a sister facility for a short time and came to this facility for trial placement on 05/12/23 after a previous hospital emergency room (ER) visit related to the resident's calls to 911. -She had repeated ER visits from 05/12/23 to 05/27/23 for going outside the facility towards the road while threatening to go into the road with 911 calls for assistance required. -She was taken to the hospital on 05/27/23 by local law enforcement and transferred to a mental health treatment center with discharge from the treatment center back to the facility on 06/09/23. -The ED had multiple discussions with Resident #3's guardian and agreed to re-admit Resident #3 on 06/09/23. Telephone interview with Resident #3's Guardian on 06/13/23 at 2:50pm revealed: -She had been the Guardian for Resident #3 since 2018. -Resident #3 called her constantly requesting to go to the hospital for various conditions from stomach pain to thoughts of suicide. -She was very familiar with the multiple incidents involving Resident #3 and 911 calls resulting in the resident being taken to a local ER. -Resident #3 had exhausted most of the options for residence due to the frequent 911 calls and hospital visits. -Resident #3 had been involved with various day programs, regional ACTs teams, and multiple facilities. -Resident #3 had 69 hospital encounters from	D 270		

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D 270	Continued From page 7 May 2021 to May 2022. -Resident #3 was very familiar with verbiage and actions needed to seek and gain attention and hospital visits. -Resident #3 had not been assigned to the local ACT triage team because she kept missing enrollment interviews due to hospital visits. -There was a crisis intervention plan put in place with the last 06/09/23 mental health treatment facility visit and paperwork was being completed to get crisis control involved locally. -Resident #3 had used social media on her cell phone and IPad on numerous occasions to mislead individuals to meet her at facilities and a limited, but not supervised, use of the resident's cell phone and IPad was in place at the facility (3 hours per day). -Involvement with her immediate family members was unhealthy for Resident #3. -Resident #3 threatened to get in the road to ensure she was taken to the hospital for extra attention. -Increased supervision had not been discussed with the facility because Resident #3 did not hide her desire to call 911 to go to the hospital. -The Guardian had redirected Resident #3 over the phone many times, but occasionally she was not successful. -She requested the facility staff to call her first instead of calling 911 to attempt to reduce the 911 calls. Interview with the ED on 06/13/23 at 4:00pm revealed: -Resident #3 threatened to go to the road when she was unable to get a call to 911. -The MA/S and the ED had called the Guardian numerous times for her threats to go to the road if 911 was not called. -The facility could not restrain her from going out	D 270		

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D 270	Continued From page 8 the door. -The MA/S had called 911 to dispatch assistance when she refused to come back into the facility. Telephone interview with the local ACT team admissions coordinator on 06/14/23 at 12:30pm revealed: -Resident #3 did not have mental health treatment services at present. -The ACT team received a referral for services on 05/12/23 and completed an intake interview with Resident #3 on 05/15/23 at the current facility. -Required paperwork was completed and sent to the Guardian for approval. -She was waiting on the Guardian's signature on the application to start ACT team services for Resident #3. Telephone interview with Resident #3's primary care provider (PCP) on 06/14/23 at 2:15pm revealed: -He did not provide mental health services for Resident #3. -He had seen Resident #3 one time on a visit to a sister facility but was not sure if was March 2023 or maybe April 2023. -The facility had contacted him for an FL2 on 06/12/23 stating the resident had returned to the facility on 06/09/23 (Friday) after a hospitalization and needed medication orders for all her medications. -He had not been informed of any incidents related to Resident #3 attempting to go onto the highway or suicidal thoughts and ideations. -The facility would be responsible for supervising residents to the extent required to keep the residents safe. Interview with the ED on 04/14/23 at 4:00pm revealed the facility did not have a written policy	D 270	Resident #3 got act team in place	7/5/23

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D 270	Continued From page 9 for supervision of residents. Interview with the MA/S on 06/14/23 at 4:15pm revealed: -Resident #3 would be acting fine one minute and asking to call 911 the next due to her feeling suicidal. -She would ask to go to the hospital almost daily. She would ask him to call 911 for various reasons. -On 05/21/22 and 05/27/23, Resident #3 opened the front door, the door alarm sounded, but she walked out of the door. He responded immediately and asked the resident to come back into the facility, but as he would get closer, she would go closer to the highway. -He called the Guardian who agreed he should call 911. -Resident #3 was aware she was going out the alarmed door and she would watch for him to approach her. -He had not provided additional supervision for Resident #3, other than alarming the doors at night. Interview with the ED on 06/14/23 at 4:40pm revealed: -There was no increased supervision for Resident #3 after she was picked up by local law enforcement officers for being in the busy road or next to the busy road, at or after dark. -The facility had a form used for documenting increased supervision for other residents in the past. -She had not assigned increased supervision for Resident #3 after the incidents of going to a neighbor's house on 05/13/23, or to the road on 05/21/23 and on 05/27/23. -The MA/S was alerted by the door alarm when Resident #3 went out the front door on 05/21/23	D 270		

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D 270	Continued From page 10 and 05/27/23. -The MA/S contacted Resident #3's Guardian for assistance with trying to redirect Resident #3 from going to the road each time. -Resident #3 refused to respond to the MA/S's request to turn around and come back to the facility. -Resident #3's behaviors was intentional when she exited the facility, and did not think Resident #3 intended to hurt herself but she wanted to go the hospital for the additional attention. -She informed the Guardian the facility did not have staffing for one-on-one supervision for Resident #3 after the incident on 05/24/23 and Resident #3 would benefit from a different type of residential environment. -She did not plan to readmit Resident #3 after her discharge from the mental health treatment center on 06/09/23, but the Guardian could not find a different placement and Resident #3 did not have a place to go. _____ The facility failed to ensure supervision for a resident with a known history of leaving the facility, threatening to jump in front of an automobile to cause self-harm, and getting onto the busy road (Resident #3) which placed the resident at risk for being struck by passing automobiles. This failure placed Resident #3 at substantial risk for physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/14/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 14, 2023.	D 270	Facility was instructed by the guardian resident #3 that resident #3 do not required more care or supervision than what she is getting. But ED put a safety check on log : resident #3 and documented in her chart 6/15/23 Residents requiring more supervision will be monitored by staff and documented on a safety check log every 30 minutes for as long as the resident requires monitoring. ED will check safety documentation daily ongoing.	

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D 276	Continued From page 11	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#1) related to an order for daily weights. The findings are: Review of Resident #1's current FL2 dated 05/29/23 revealed diagnoses included chronic diastolic and systolic heart failure, atrial flutter and a history of coronary artery bypass grafts. Review of Resident #1's physician's orders revealed: -There was an order from a hospital discharge summary dated 04/18/23 to record Resident #1's daily weight on the same scale at the same time of day and to call the primary care provider (PCP) if 3-4-pound weight gain in 1-2 days or 2 pounds *overnight*. -There was an order from a hospital discharge summary dated 05/05/23 to record daily weight on the same scale at the same time of day and to call the PCP if there was a 3-pound weight gain in 24 hours or 5 pounds in 1 week.	D 276	ED will assure after each discharge from the hospital ED will go through the hospital discharge summary and take necessary steps, or any new orders from the discharge summary will be send out to PCP and follow up on that if PCP needs to make any new orders as per	

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D 276	Continued From page 12 Review of Resident #1's electronic Medication Administration Records (eMARs) for April 2023 (04/19/23 through 04/30/23), May 2023 and June 2023 (06/01/23 through 06/13/23) revealed there was not an entry for daily weight. Interview with a medication aide (MA) on 06/13/23 at 9:40am revealed: -Resident #1 did not currently have an order to check his weight daily. -He or the Executive Director (ED) faxed all discharge summaries from hospital visits to the PCP. -The MAs did not read over the discharge summaries and expected the PCP to order what he felt necessary from the discharge paperwork. -The MAs would not have pointed out or clarified if he wanted to order something listed on the discharge summary. -There was a scale in the office and Resident #1 went to the office once or twice a week on his own and weighed himself. -Resident #1 did not tell him his weights and he did not record them anywhere or call the PCP to report Resident #1 had a weight gain. -Resident #1 had scheduled furosemide (medication used to treat swelling) ordered due to his heart failure. Interview with a pharmacist at the facility's contracted pharmacy on 06/13/23 at 10:44am revealed daily weight would not show up on Resident #1's profile at the pharmacy because the facility entered their own orders for all vital signs, except for blood glucose checks on the eMAR. Interview with Resident #1 on 06/14/23 at 8:35am revealed: -He did not know his PCP wanted him to weigh	D 276	the resident discharge summary. 6/15/23 ED communicated with the PCP to send out an order for daily weight log for resident #1 and follow the instructions as per the discharge summary 6/20/23 6/20/23	

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D 276	Continued From page 13 every day and let him know if he gained too much overnight or within a week. -His weight had remained between 175 and 179 pounds since he was admitted in mid-April 2023. -He had not had any episodes of excessive swelling, shortness of breath or difficulty breathing. -He took furosemide and had always weighed himself 1 or 2 times a week due to his heart failure. -The facility had a scale in the office so he would just walk to the office and weigh himself whenever he thought to do it. -He did not tell staff what his weight was at any time. Telephone interview with Resident #3's PCP on 06/14/23 at 2:00pm revealed: -He expected all orders on residents' discharge summaries to be followed. -All orders should be started, and he would discontinue orders if he felt they were not necessary during his next visit in the facility. -Resident #1 was new to him, but he needed daily weights as all heart failure patients do. -He did not know the facility had not implemented the order for daily weights. -He expected the facility to implement the order for daily weights when they were ordered in April 2023. Interview with the ED on 06/14/23 at 9:00am revealed: -Resident #1 did not currently have an order to check his weight daily. -She or the MA faxed all discharge summaries from hospital visits to the PCP. -The staff did not read over the discharge summaries and expected the PCP to order what he felt necessary from the discharge paperwork.	D 276		

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D 276	Continued From page 14 -The staff would not have pointed out or clarified if he wanted to order something listed on the discharge summary.	D 276		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #4) with physician's orders for a heart healthy low sodium (HHLS) diet (#1) and a no concentrated sweets (NCS) diet (#4). The findings are: 1. Review of Resident #1's current FL2 dated 05/29/23 revealed: -Diagnoses included chronic diastolic and systolic heart failure, atrial flutter and a history of coronary artery bypass grafts. -There was no order for a diet listed on the FL2. Review of Resident #1's physician's orders dated 04/018/23 revealed there was an order to follow a	D 296	ED communicated with the facility PCP in regards to resident #1 HHLS diet order to be send out and ED will make sure its documented in his chart and also the HHLS diet menu will be Posted in the Kitchen → 6/20/23 ED communicated with the Dietary Aide for the facility to Prepare a therapeutic diet menus for the facility for guidance of food service staff and it will be Posted in the Kitchen. 6/20/23	

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D 296	Continued From page 15 Heart Healthy Low Sodium (HHLS) diet. Observation of the kitchen on 06/13/23 at 12:05pm revealed: -There were no therapeutic diet menus available for a HHLS diet. -There was no therapeutic diet list posted for residents on therapeutic diets. Observation of the regular week-at-a-glance menu for Week 2 on Tuesday revealed apple glazed corned beef 3 ounces, new boiled potatoes 1/2 cup, braised cabbage and carrots 1/2 cup, 1 dinner roll, lime pineapple gelatin 1 2 X 2.5 square, 8 ounces 2% milk, hot tea or coffee. Observation of Resident #1's lunch meal service on 06/13/23 between 12:00pm and 12:15pm revealed: -Resident #1 was served chopped beef, a slice of bread, mixed peas and carrots, sliced pears, water, and milk. -Resident #1 consumed 100% of the meal. -It could not be determined if Resident #1 was served the correct therapeutic diet due to a HHLS menu was not available for staff guidance. Interview with Resident #1 on 06/13/23 at 12:55pm revealed: -He usually did not use extra salt with his meals. -He did not know he was on a HHLS diet, but he tried to watch his salt intake because of his heart condition. -It was difficult for him to determine how much sodium he ate without looking at food labels of food used in cooking his meals. Telephone interview with Resident #1's primary care provider (PCP) on 06/14/23 at 2:00pm revealed:	D 296	New orders will be reviewed by ED and MAs for diet changes daily and on going.	

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D 296	Continued From page 16 -A HHLS diet was the most appropriate diet for Resident #1. -He expected the facility to follow a menu for a HHLS diet for Resident #1. Refer to interview with a dietary aide on 06/13/23 at 2:53am. Refer to interview with a medication aide (MA) on 06/13/23 at 9:00am. Refer to interview with the Executive Director (ED) on 06/14/23 at 9:00am. 2. Review of Resident 4's current FL2 dated 02/14/23 revealed: -Diagnoses included diabetes mellitus and hyperlipidemia. -There was an order for a No Concentrated Sweets (NCS) diet. Observation of the kitchen on 06/13/23 at 12:05pm revealed: -There were no therapeutic diet menus available for a NCS diet. -There was no therapeutic diet list posted for residents on therapeutic diets. Observation of the regular week-at-a-glance menu for Week 2 on Tuesday revealed apple glazed corned beef 3 ounces, new boiled potatoes 1/2 cup, braised cabbage and carrots 1/2 cup, 1 dinner roll, lime pineapple gelatin 1 2 X 2.5 square, 8 ounces 2% milk, hot tea or coffee. Observation of Resident #4's lunch meal service on 06/13/23 between 12:00pm and 12:15pm revealed: -Resident #4 was served chopped beef, a slice of toast, mixed peas and carrots, sliced pears,	D 296		

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D 296	Continued From page 17	D 296		

water, and milk.
-Resident #4 consumed 100% of the meal.
-It could not be determined if Resident #4 was served the correct therapeutic diet due to a NCS menu was not available for staff guidance.

Interview with Resident #4 on 06/14/23 at 8:15am revealed:
-She was on a diabetic diet to control her blood sugars.
-She liked soda with sugar, but tried not to drink them.
-She was always served what other residents were served, just received smaller pieces of bread or pasta sometimes.

Telephone interview with Resident #4's primary care provider (PCP) on 06/14/23 at 2:00pm revealed:
-He expected for Resident #4 to be served a NCS diet as ordered according to a NCS menu.
-Resident #4's FSBS are better in the last 2 months, remaining under 300.
-He did not believe a controlled carbohydrate diet and a NCS diet to be the same.

Refer to interview with a dietary aide on 06/13/23 at 2:53am.

Refer to interview with a medication aide (MA) on 06/13/23 at 9:00am.

Refer to interview with the Executive Director (ED) on 06/14/23 at 9:00am

_____

Interview with a dietary aide on 06/13/23 at 2:53pm revealed:
-The ED completed the grocery orders for the facility and told her what residents had diabetic diets.

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D 296	Continued From page 18 -She did not keep a therapeutic diet list of residents in the kitchen. -She had only seen a controlled carbohydrate therapeutic menu available for guidance in preparing meals for residents who were on diabetic diets. -She followed the controlled carbohydrate diet menu for 4 residents who were on diabetic diets. -She would adjust portion sizes or serve sugar free desert according to the controlled carbohydrate menu instructions. -She did not know a NCS diet menu was different from a controlled carbohydrate diet menu and did not have a menu to prepare a NCS diet. -She did not know of resident that had an order for a HHLS diet and she did not have a menu to follow to prepare a HHLS diet. Interview with a MA on 06/13/23 at 9:00am revealed: -He knew the ED had only a controlled carbohydrate therapeutic diet menu prepared for the facility because there were diabetic residents. -The dietary staff had a list of diabetic residents and used the controlled carbohydrate menu to prepare plates. -He believed the controlled carbohydrate menu and NCS were prepared the same. -He did not know a resident had a HHLS diet order, but he knew Resident #1 had diagnoses with his heart. -There was not menu for a HHLS diet, he just removed the salt from the resident's table. Interview with the ED on 06/14/23 at 9:00am revealed: -She knew there should have been a matching therapeutic menu for each therapeutic diet order. -She was responsible for ensuring there were matching therapeutic menus available.	D 296		

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D 296	Continued From page 19 -She had a controlled carbohydrate therapeutic menu prepared because there were diabetic residents in the facility. -She thought the controlled carbohydrate diet was the same as a NCS diet. -She did not know a resident was to have a HHLS diet and did not have a menu prepared for a HHLS diet.	D 296		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop a program of activities designed to promote the residents' active involvement for 10 residents residing in the facility. The findings are: *Observation during the initial tour of the facility on* 06/13/22 revealed: -The activity calendar posted in the facility was labeled as May 2023. -The dates of 05/02/23 and 05/03/23 were blank on the calendar. -The dates of 05/01/23 and 05/04/23 through	D 315	ED is trying every effort to keep the activity program in place as per the rule. Due to the lack of staffing that ~~area~~ rule area got overlooked. ED and administrator of the facility created a Activity Calendar and ok	

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D 315	Continued From page 20 05/31/23 listed arts and crafts, game day, bingo, karaoke, movie night, church, prayer group, bible study, house discussions and guy/girl talk scheduled with no beginning or end times and no duration the activities were to last. Observations of the facility at various times on 06/13/23 between 9:00am and 4:45pm revealed: -No activities were offered to residents. -Residents sat in the living room and watched television. -Residents were in their rooms asleep or watching television. -Two residents were sitting outside listening to the radio and smoking cigarettes. Observation of the living room on 06/14/23 at 9:15am revealed there was a bookcase with books, games and puzzle books. Interviews with ten residents on 06/13/23 between 8:50am-4:05pm revealed: -They did not have activities at the facility. -They enjoyed going out to eat, shopping and watching movies. -They spent most of their time watching television, sitting outside or laying in their beds. -There were some books and games in the living room for residents to use on their own. -Staff did not ask them what they would like to do and did not offer group activities. Interview with the dietary aide on 06/14/23 at 8:35am revealed: -She was not sure who was responsible for the activities at the facility. -She had not seen activities conducted by staff at the facility since she began in March 2023. -The activities calendar was posted, but staff did not do activities with residents and there were	D 315	made it available for all the residents to participate in that Activity calendar is Posted in the hallway of the facility. 6/20/23 ED and staff will encourage daily participation in activities by residents. 6/20/23 and thereafter.	

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D 315	Continued From page 21 some books and puzzles in the living room available for residents. -Residents usually stayed in their rooms, sat outside, listened to music or watched TV. Telephone interview with the Executive Director (ED) on 06/14/23 at 9:00am revealed: -She was responsible to plan and conduct activities but had not been able to oversee the activities program as she had planned since taking over the facility. -She had not had enough staff to keep up with the activities calendar and to conduct activities with the residents.	D 315		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to an anti-anxiety medication and an anti-depressant medication. The findings are: Review of Resident #3's current FL-2 dated 06/12/23 revealed diagnoses included borderline	D 358	ED of the facility will do an audit of all the residents medication administration every day and ED will give instruction to the staff (med tech) not to pre pour the meds, since the pharmacy is dispensing in a dispill package since 6/20/23 All the staff were given instructions by the ED	

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D 358	Continued From page 22 intellectual functioning, oppositional defiant disorder, menorrhagia, insomnia, and stress reaction causing mixed disturbance of emotion and conduct. Interview with Resident #3 during the initial tour on 06/13/23 at 10:30am revealed: -She had not been at the facility for very long. -She returned to the facility on 06/09/23 from a mental health facility on 06/09/23. -She did not think she was getting her medications correctly. Review of Resident #3's packaging label used for medications dispensed by the contracted pharmacy provider dated 04/26/23 revealed: -Resident #3's medications were packaged in multi-dose bubbles prepacked with the medications scheduled for morning, afternoon, evening, and bedtime packaged together in a bubble for each time frame. -The package had the name of each medication, directions for dosing frequency, drug description, and 4 time slots with the number of tablets to administer for the medication indicated in each appropriate time slot. -The medication card label sheet had a handwritten grid of boxes drawn on the left side of the card with spaces created for documenting administration of each medication daily from 06/09/23 to 06/14/23 (medications scheduled more than one time daily were documented for the day administered but did not reflect the different times). Telephone interview with the pharmacist at the contracted pharmacy 06/14/23 at 10:10am revealed: -The pharmacy dispensed Resident #3's medications on 04/26/23 for the month of May	D 358	to administer the meds one resident at a time and sign off on the EMAR 6/20/23 ED will monitor every day for MAR and make sure ED will keep a log of the audit at the facility 6/20/23 ED will monitor every day the MAR is matching with the Physicians order and the dispill package from the Pharmacy ~~cstd~~ also 6/20/23 any changes in the orders after discharge -y any

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D 358	Continued From page 23 2023. -The pharmacy dispensed multidose bubble packages with one week (7 days equals 7 rows) of medications per card. -The pharmacy dispensed 4 weeks of Resident #3's current medications on 04/26/23 for May 2023 supply. -The pharmacy dispensed Resident #3's medications on individual bubble cards beginning 06/09/23. 1. Review of Resident #3's current FL-2 dated 06/12/23 revealed there was an order for hydroxyzine 50mg (used to treat anxiety) one capsule 3 times a day. Review of Resident #3's previous physician's orders revealed: -There was a physician's order dated 03/07/23 to increase hydroxyzine 50mg from 3 times a day to 4 times a day. -There was a physician's order dated 05/04/23 for hydroxyzine 50mg one as needed for anxiety. -There was a physician's order on the hospital discharge medication summary dated 06/09/23 ordering hydroxyzine 50mg one every 4 hours as needed for anxiety. Review of Resident #2's physician's order from 05/04/23 - 06/13/23 revealed there was no documentation the primary care provider (PCP) was notified to clarify hydroxyzine 50mg. Observation on 06/14/23 of medication on hand for administration to Resident #3 revealed there was a bingo card of hydroxyzine 50mg dispensed on 06/09/21 for a quantity of 90 capsules and labeled one capsule every 4 hours as needed with 85 of 90 capsules remaining.	D 358		

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D 358	Continued From page 24 Review of Resident #3's June 2023 MAR revealed there was no preprinted MAR for 06/01/23 - 06/12/23 available for review. Review of Resident #3's packaging label used for medications dispensed by the contracted pharmacy provider dated 04/26/23 revealed hydroxyzine 50mg was documented as administered morning (AM), afternoon (PM), evening (EV) and bedtime (Bd) from 06/09/23 to 06/14/23 in the handwritten boxes beside the medication's name. Telephone interview with the pharmacist at the contracted pharmacy 06/14/23 at 10:10am revealed: -The pharmacy provided pre-printed medication administration records (MARs) for the facility's residents in addition to dispensing pre-packaged multidose packages for the medications. -The pharmacy had an order dated 03/07/23 for 4 times a day as the previous order. -The pharmacy dispensed 4 weeks of hydroxyzine 50mg 4 times a day in the multidose package on 04/26/23 for May 2023 supply. -The pharmacy had not received subsequent orders for hydroxyzine until the new physician's order dated 06/09/23 for hydroxyzine 50mg one every 4 hours as needed. -The pharmacy dispensed 90 hydroxyzine 50mg on 06/09/23 labeled one capsule every 4 hours as needed. -The pharmacy received the new FL2 dated 06/12/23 with an order for hydroxyzine 50mg 3 times a day. -The pharmacy had not dispensed hydroxyzine 50mg with the new directions for administration. -There was no documentation Resident #3's order for hydroxyzine 50mg was clarified with the resident's mental health provider or primary care	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 provider (PCP). Interview with the medication aide/Supervisor (MAS) on 06/14/23 at 9:00am revealed: -He faxed the new physician's order dated 06/09/23 for hydroxyzine 50mg one capsule every 6 hours as needed. -Resident #3 had 3 days of medication remaining in the multi-dose prepacked packages from 04/26/23 when she went to the hospital on 05/27/23. -He used Resident #3's medications packaged in the multidose package when the resident returned from the hospital on 06/09/23 for 3 days (06/09/23, 06/10/23, and 06/11/23) to use up all her medications. -Hydroxyzine 50mg was administered scheduled 4 times a day (8:00am, 12:00pm, 4:00pm, and 8:00pm) as packaged in the multidose package on 06/09/23, 06/10/23, and 06/11/23. -He used 5 hydroxyzine 50mg capsules from 90 capsules packaged on single dose bingo cards dispensed on 06/09/23 from 06/12/23 to 06/14/23 but could not explain why he documented 4 capsules daily as administered on 06/12/23, and 06/13/23. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 06/14/23 at 2:10pm. Refer to the interview with the Executive Director (ED) on 06/13/23 at 4:00pm. Interview with the Executive Director on 06/13/23 at 4:00pm she did not know Resident #3 received hydroxyzine incorrectly (scheduled instead of as needed) from 06/09/23 -06/14/23. Attempted telephone interviews with Resident	D 358		

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D 358	Continued From page 26 #3's mental health PCP on 06/13/23 at 4:00pm and 06/14/23 at 9:30am were unsuccessful.. 2. Review of Resident #3's current FL-2 dated 06/12/23 revealed there was an order for gabapentin 300mg (used to treat depression and mood disorders) one capsule 3 times a day. Review of Resident #3's previous physician's orders revealed: -There was a physician's order dated 03/07/23 for gabapentin 600mg 3 times a day. -There was a hospital discharge summary dated 05/21/23 with an order for gabapentin 600mg 3 times a day. -There was a physician's order on the hospital discharge medication summary dated 06/09/23 for gabapentin 300mg 3 times a day. Observation on 06/14/23 of medication on hand for administration to Resident #3 revealed there was a bingo card gabapentin 300mg dispensed on 06/09/21 for a quantity of 90 capsules and labeled one capsule 3 times a day with 80 of 90 capsules remaining. Review of Resident #3's May 2023 medication administration record (MAR) revealed: -Gabapentin 600mg 3 times a day was listed, scheduled for administration at 8:00am, 2:00pm, and 8:00pm and documented as administered 3 times a day from 05/24/23 - 05/27/23. Review of Resident #3's June 2023 MAR revealed there was no preprinted MAR for 06/01/23 - 06/12/23 available for review. Review of Resident #3's packaging label used for medications dispensed by the contracted pharmacy provider dated 04/26/23 revealed	D 358		

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D 358	Continued From page 27	D 358		

gabapentin 600mg was documented as administered morning (AM), afternoon (PM), and bedtime (Bd)from 06/09/23 to 06/14/23 in the handwritten boxes beside the medication's name.

Telephone interview with the pharmacist at the contracted pharmacy 06/14/23 at 10:10am revealed:
-The pharmacy had an order dated 03/07/23 for gabapentin 600mg 3 times a day as the previous order.
-The pharmacy dispensed 4 weeks of gabapentin 600mg in the multidose package on 04/26/23 for May 2023 supply.
-The pharmacy received a new physician's order dated 06/09/23 for gabapentin 300mg 3 times a day.
-The pharmacy dispensed 90 gabapentin 300mg on 06/09/23 labeled one capsule 3 times a day.
-The pharmacy received the new FL2 dated 06/12/23 with an order for gabapentin 300mg 3 times a day.

Interview with the medication aide/Supervisor (MAS) on 06/14/23 at 9:00am revealed:
-He faxed the new physician's order dated 06/09/23 for gabapentin 300mg 3 times a day to the pharmacy provider.
-Resident #3 had 3 days of medication remaining in the multi-dose prepacked packages from 04/26/23 when she went to the hospital on 05/27/23.
-He used Resident #3's medications packaged in the multidose package when the resident returned from the hospital on 06/09/23 for 3 days (06/09/23, 06/10/23, and 06/11/23) to use up all her medications.
-Gabapentin 600mg was administered as scheduled 3 times a day (8:00am, 2:00pm, and 8:00pm) as packaged in the multi-dose package

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D 358	Continued From page 28 on 06/09/23, 06/10/23, and 06/11/23. -He used 10 gabapentin 300mg capsules from 90 capsules dispensed on 06/09/23 from 06/12/23 to 06/14/23 but could not explain why he documented 3 capsules of 600mg daily as administered on 06/12/23, and 06/13/23. -He documented gabapentin 300mg on 06/14/23 at 8:00am on a new MAR for June 2023 sent to the facility (by the pharmacy provider) on 06/12/23. Refer to the telephone interview with Resident #3's primary care provider (PCP) on 06/14/23 at 2:10pm. Refer to the interview with the Executive Director (ED) on 06/13/23 at 4:00pm. Interview with the Executive Director on 06/13/23 at 4:00pm revealed she did not know Resident #3 received gabapentin 600mg from previously provided medication from 06/09/23 -06/11/23. Attempted interviews with Resident #3's mental health PCP on 06/13/23 at 4:00pm and 06/14/23 at 9:30am were unsuccessful. Telephone interview with Resident #3's PCP on 06/14/23 at 2:10pm revealed: -He signed a new FL2 for Resident #3 on 06/12/23. -The MA/S sent a completed FL2 for him to sign. -He did not routinely order medications originally ordered by the mental health providers. -Resident #3 had been in the hospital and he did not want the resident to be without medications until she could be seen by her regular mental health PCP. Interview with the ED on 06/13/23 at 4:00pm	D 358		

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D 358	Continued From page 29 revealed: -The MA/S was responsible for ensuring all orders were faxed to the pharmacy when received. -The MA/S was responsible for ensuring medications were administered as ordered. -She did random audits of medications on hand for administration compared to the medication orders and the medications documented on the eMAR. -She had not audited Resident #3's medications for accuracy.	D 358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed *in a capped or sealed container*; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name;	D 363		

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D 363	Continued From page 30 (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared in advance were labeled with the resident name, name and strength of each medication until administered for 2 of 3 sampled residents (#1 and #4) on 06/13/23. The findings are: Observation of medication administration from 1:38pm to 1:45pm revealed: -A medication aide/Supervisor (MA/S) was administering afternoon medications to residents. -There was a basket sitting on top of the medication cart with 10 clear plastic medication cups whose lids were labeled with initials written on cloth bandage tape. -The MA removed three of the initialed containers. -At 1:38pm, the MA prepared 2:00pm afternoon medications for Resident #1, Resident #2, and Resident #4 at the same time. -The MA put the afternoon oral pills for Resident #1, Resident #2, and Resident #4 in clear plastic condiment cups labeled with the residents' initials.	D 363	Please refer page 22 + Page 23	

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D 363	Continued From page 31 -The medication cups were covered and protected from contamination or spillage. -There were no medication administration times labeled on the medication cups. -The names and strengths of the medications were not labeled on the cups. -After preparing the medications, the MA stacked the medication cups labeled with initials of Resident #1, Resident #2, and Resident #4 on top of each other and proceeded down the hall to the residents' rooms. -The MA administered the afternoon medications that were prepared in advance to the three residents from 1:38pm to 1:42pm. Interview with the MA/S on 06/13/23 at 1:50pm revealed: -He knew he was not supposed to prepare medications for more than one resident at a time but "It made administering the medications easier" than walking back and forth to the medication cart. -He routinely prepared the medications this same way. a. Review of Resident #1's current FL2 dated 05/29/23 revealed: -Diagnoses included prosthetic joint infection, chronic combined systolic and diastolic heart failure, alcohol abuse, essential hypertension, atrial flutter, acute kidney injury and history of coronary artery bypass graft x 3. -There was an order for buspirone 15mg(used to treat anxiety) three times a day. -There was an order for gabapentin 300mg (used to treat mood disorders and neuropathic pain) three times a day. -There was an order for hydroxyzine 50mg (used to treat anxiety) three times a day.	D 363		

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D 363	Continued From page 32 Observation of the medication aide/Supervisor (MA/S) administering afternoon medications on 06/13/23 revealed: -Resident #1's scheduled 2:00pm medications of buspirone 15mg, gabapentin 300mg, and hydroxyzine 50mg were prepared in advance with another residents' medications at 1:30pm. -The clear medication cups were capped but not labeled with the name of the medication, strength of the medication or the resident's name. -Medications were administered to Resident #1 at 1:38pm. Review of Resident #1's June 2023 medication administration record (MAR) revealed buspirone 15mg, gabapentin 300mg and hydroxyzine 50mg were ordered 3 times a day and scheduled at 2:00pm. Observation of the MA/S on 06/13/23 at 1:46pm revealed he documented administration of buspirone 15mg, gabapentin 300mg and hydroxyzine 50mg on the Resident #1's MAR after administering medications to 2 resident instead of immediately after administering Resident #1's medications. Refer to the interview with the Executive Director (ED) on 08/03/22 at 3:01pm. b. Review of Resident #4's current FL2 dated 02/14/23 revealed: -Diagnoses included schizoaffective disorder, diabetes, hypothyroidism, chronic kidney disease, hyperlipidemia, and history of right pinky finger fracture. -There was an order for amantadine (used to treat tremors) 100mg 3 times a day. Observation of the medication aide/Supervisor	D 363		

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D 363	Continued From page 33 (MA/S) administering afternoon medications on 06/13/23 revealed: -Medications were administered to Resident #4 at 1:42pm. -Resident #4's scheduled 2:00pm amatadine 100mg was prepared in advance with another residents' medications. -The clear medication cups were capped but not labeled with the name of the medication, strength of the medication or the resident's name. Review of Resident #4's June 2023 medication administration record (MAR) revealed amantadine 100mg was ordered 3 times a day and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. Observation of the MA/S on 06/13/23 at 1:46pm revealed he documented administration of amantadine 100mg on the Resident #4's MAR after administering medications to 2 resident instead of immediately after administering Resident #4's medications. Refer to the interview with the Executive Director (ED) on 08/03/22 at 3:01pm. Interview with the Executive Director on 08/03/22 at 3:01pm revealed: -She knew the MA/S had prepared medications in advance for two residents on 06/13/23. -The facility policy did not allow prepouring of medications. -The MAs knew they were not allowed to prepare medications for multiple residents at one time. -The MAs were supposed to prepare and administer one resident's medications at a time.	D 363		

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D 366	Continued From page 34	D 366		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide/Supervisor (MA/S) documented the administration of medications immediately following the administration and observation of the residents actually taking the medications, and prior to administration of another resident's medication for 3 of 3 residents (#1, #2, and #4) observed during the medication administration on 06/13/23. The findings are: Review of the facility's Medication Management Policy on 06/13/23 and 06/14/23 revealed there was no medication policy available for review. Observation of medication administration at the assisted living (AL) from 1:38pm to 1:45pm revealed: -A medication aide/Supervisor (MA/S) was administering afternoon medications to residents. -At 1:30pm, the MA prepared 2:00pm afternoon medications for Resident #1, Resident #2, and Resident #4 at the same time.	D 366	staff was given a review of Med administration training by the pharmacist 6/20/23 See page 22 and 23 also.	

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D 366	Continued From page 35 -The MA put the oral pills for Resident #1 and Resident #2, in clear plastic medication cups labeled with the residents' initials. -The MA administered the medications that were prepared in advance to the three residents from 1:38pm to 1:42pm. -The MA/S did not document medication administration after each resident. a. Review of Resident #1's current FL2 dated 05/29/23 revealed: -Diagnoses included prosthetic joint infection, chronic combined systolic and diastolic heart failure, alcohol abuse, essential hypertension, atrial flutter, acute kidney injury and history of coronary artery bypass graft x 3. -There was an order for buspirone 15mg(used to treat anxiety) three times a day. -There was an order for gabapentin 300mg (used to treat mood disorders and neuropathic pain) three times a day. -There was an order for hydroxyzine 50mg (used to treat anxiety) three times a day. Observation of the MA/S on 06/13/23 at 1:38pm revealed Resident #1's medications scheduled for 2:00pm (buspirone 15mg, gabapentin 300mg, and hydroxyzine 50mg that were prepared in advance with other residents' medications) were administered. Review of Resident #1's June 2023 medication administration record (MAR) revealed buspirone 15mg, gabapentin 300mg, and hydroxyzine 50mg were ordered 3 times a day and scheduled for 2:00pm administration. Observation of the MA/S on 06/13/23 at 1:46pm revealed he documented administration of buspirone 15mg, gabapentin 300mg and	D 366		

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D 366	Continued From page 36 hydroxyzine 50mg on the Resident #1's MAR after administering medications to 2 other residents and did not document administration immediately after administering Resident #1's medications. Refer to the interview with the MA/S on 06/14/23 at 3:05pm. Refer to the interview with the Executive Director on 08/03/22 at 3:01pm. b. Review of Resident #4's current FL2 dated 02/14/23 revealed: -Diagnoses included schizoaffective disorder, diabetes, hypothyroidism, chronic kidney disease, hyperlipidemia, and history of right pinky finger fracture. -There was an order for amantadine (used to treat tremors) 100mg 3 times a day. Observation of the MA/S on 06/13/23 at 1:42pm revealed Resident #4's amantadine 100mg, scheduled for 2:00pm and prepared in advance with other residents' medications and was administered to Resident #4. Review of Resident #4's June 2023 medication administration record (MAR) revealed amantadine 100mg (used to treat tremors) was ordered 3 times a day and scheduled for 2:00pm administration. Observation of the MA/S on 06/13/23 at 1:48pm revealed he documented administration of amantadine 100mg on Resident #4's MAR after administering medications to 2 other resident and did not document administration immediately after administering Resident #4's amantadine.	D 366		

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D 366	Continued From page 37 Refer to the interview with the Executive Director on 08/03/22 at 3:01pm. Refer to the interview with the MA/S on 06/14/23 at 3:05pm. c. Review of Resident #2's current FL2 dated 02/15/23 revealed: -Diagnoses included blindness due to cataract, chronic kidney disease stage 3, muscle weakness, incontinence, and metabolic encephalopathy. -There was an order for brimonidine solution 0.2% ophthalmic drops (used to reduce ocular pressure) one drop in each eye 3 times a day. Observation of the MA/S on 06/13/23 at 1:43pm revealed Resident #2's brimonidine solution 0.2% ophthalmic drops, scheduled for 2:00pm were administered. Review of Resident #2"s June 2023 medication administration record (MAR) revealed brimonidine solution 0.2% ophthalmic drops were ordered 3 times a day and scheduled for 2:00pm administration. Observation of the MA/S on 06/13/23 at 1:49pm revealed he documented administration of brimonidine solution 0.2% ophthalmic drops on Resident #2's MAR after administering medications to 2 other resident and not document administration immediately after administering Resident #2's eye drops. Refer to the interview with the Executive Director on 08/03/22 at 3:01pm. Refer to the interview with the MA/S on 06/14/23 at 3:05pm.	D 366		

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MOYER'S AGAPE ASSISTED LIVING	5767 HWY 135 STONEVILLE, NC 27048

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 38 Interview with the Executive Director on 08/03/22 at 3:01pm revealed: -The MAs were supposed to prepare and administer one resident's medications at a time. -The MAs were supposed to document on the MAR right after medications were administered to a resident, prior to going to the next resident. -She was not aware the MA/S was not documenting administration of medications on the MAR when the medications were administered. Interview with the MA/S on 06/14/23 at 3:05pm revealed: -He administered 3 residents' medications and subsequently documented administration of the medications when he had completed administration to all three. -He knew he should document administration of medications to a resident immediately after medications were administered and prior to administering medications to another resident. -He was the only medication aide working due to staffing shortages and was trying to save steps back and forth to the medication cart. -He had been trained to document each resident's medication administration prior to preparing and administering the next resident's medication.	D 366		