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
	HAL008042	A. BUILDING: ______ B. WING ______	R 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(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 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted a follow-up survey June 21, 2023 to June 23, 2023 with an exit conference via telephone on June 23, 2023.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide personal care based on resident's needs for 1 of 3 residents sampled (#2) related to draining open sores on his feet, toenails that were long, jagged, and curled. The findings are: Review of Resident #2's current FL-2 dated 11/09/22 revealed: -Diagnoses included epilepsy, cirrhosis of the liver, emphysema, and chronic obstructive pulmonary disease (COPD). -The resident was semi-ambulatory. Review of Resident #2's care plan dated 11/09/22 revealed:	D 269	Staff immediately provided personal care and foot care to Resident #2 and documentation on Resident #2 Personal Care Sheets were completed. Manager immediately discussed with PCA the concern on personal care being performed daily, observation of resident from head to toe, and reporting changes in a resident's condition immediately to the SIC or Facility Manager. Facility Manager had a mandatory staff meeting regarding personal care and supervision for all residents on 6/28/23. Facility Manager discussed the importance of staff being attentive to the residents condition, personal care needed that a resident may not be able to do themselves. Staff will provide extensive personal care such as nail care, foot care, and skin care daily. Administrator refreshed staff on how to perform an assessment from head to toe on 6/28/23. Facility Manager will ensure that staff document all ADL's according to the resident's care plan and according to the resident's level of care needed. Facility Manager will review Personal Care Sheets and Nurse's note daily. Facility Manager will follow up with staff on a daily basis for any changes of a resident's condition that may need to be reported. Facility Manager will report any changes to resident's PCP immediately. Facility Manager put a plan in place to ensure that Med Aides are responsible for communicating with PCP or other providers, document notes and print off all triage notes once received after communicating with PCP and other providers. Facility Manager will review Triage Note and Med Aide or Facility Manager will file in	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Monica Gibbs TITLE Administrator (X6) DATE 8/14/23

SJS Received via email 08/14/23
Reviewed and acknowledged 08/15/23

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D 269	Continued From page 1 -He required limited assistance with bathing, grooming, dressing, and toileting. -He required supervision with ambulating. Review of Resident #2's Resident Register dated 11/09/22 revealed he was admitted to the facility on 11/09/22. Observation of Resident #2 on 06/22/23 at 11:40am revealed: -He was lying in bed dressed and had socks on his feet. -There were light brown stains on areas on the bottom of his socks. -His feet were scaly and flaking around his toes, the bottom of his feet and the top of his feet. -There were brown spots and red spots on the bottom of both feet. -The cuticles on his toenails were overgrown on both feet. -His toenail on his great toe on his left foot was approximately ¼ inch long extended from his toenail, jagged and yellow. -The left third toenail curved over toward his skin but was not touching the skin of his toe. -He had several areas underneath his toes and in between his toes on his left foot that had cracked skin that had light brown drainage from the cracked areas. -The left great toe and second toe drainage that had hardened drainage areas where the drainage had dried into a clump of a hardened area that was dark brown. -There were areas under his second and fourth toes on his left foot that had a light brown drainage where the skin had cracked, and some areas of drainage had hardened. -There was a red open sore approximately ½ centimeter at the base of his second and third toe on the top of his feet.	D 269	resident's file/chart. Administrator has access to all Triage notes and receives via email from PCP. Administrator will f/u with Facility Manager that all documentation has been filed properly. Administrator checks resident files weekly to make sure notes are in resident's file. Administrator will ensure that the Facility Manager or SIC is performing staff and resident supervision during the weekly audit. Administrator will review all documentation on a weekly basis. Administrator will ensure that all staff receive any additional training if needed on personal care and supervision of residents. Date of Correction Completion: 6/25/2023	

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D 269	Continued From page 2 -There was a red open sore approximately ½ centimeter on the bottom of his foot above the left side of his heel. -His right foot had light brown drainage under each of his toes that had seeped from cracked skin. -Between the third and fourth toes an area of drainage had hardened and formed small, hardened areas of dark brown drainage. -There was an open wound approximately one centimeter at the bottom of his fourth toe with drainage -The right great toe was jagged, yellow, and extended approximately 1/8 inch from the tip of his toenail tip. -The right second, third, and fourth toenails were jagged and was approximately 1/8 inch long extended from the tip of his toenail. Review of Resident #2's primary care provider (PCP) visit note dated 03/15/23 revealed the PCP requested a podiatry referral for toenail dystrophy (toenails that are deformed, thickened or discolored). Review of Resident #2's May 2023 Activities of Daily Living (ADLs) revealed: -There was an entry for extensive assistance with bathing, extensive assistance for skin care which included washing the resident's feet and extensive assistance for nail care. -The bathing task was documented as completed daily from 05/25/23 to 05/31/23. -The skin care task was documented as completed daily from 05/25/23 to 05/31/23. -There was no documentation that nail care was provided from 05/25/23 to 05/31/23; there were no refusals documented. Review of Resident #2's June 2023 ADLs	D 269		

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revealed:
-There was an entry for extensive assistance with bathing, extensive assistance for skin care which included washing the resident's feet and extensive assistance for nail care.
-The bathing task was documented as completed daily from 06/01/23 to 06/21/23.
-The skin care task was documented as completed daily from 06/01/23 to 06/21/23.
-There was no documentation that nail care was provided from 06/01/23 to 06/21/23; there were no refusals documented.
-There was a handwritten note on the last page of the ADL sheet dated 06/05/23 that Resident #2 constantly had problems with his feet flaking and the skin was purplish.

Review of a shift report progress note dated 06/05/23 revealed a personal care aide (PCA) reported to a medication aide (MA) that Resident #2's feet were scaley, flakey, and the resident denied pain of his feet.

Review of a shift report progress note dated 06/19/23 revealed:
-A MA documented that a PCA applied lotion to Resident #2's feet due to the condition of his feet until the resident could be seen by a podiatrist.
-The Resident Care Coordinator (RCC) had been trying to get Resident #2 seen by a podiatrist, but local podiatrists did not have appointment availability and were not accepting new clients.

Review of an after visit summary for Resident #2 on 06/19/23 revealed the resident was diagnosed with hyperglycemia and started on Metformin (a medication used to treat diabetes).

Interview with Resident #2 on 06/22/23 at 11:48am revealed:

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D 269	Continued From page 4 -He did not know when he had last seen a podiatrist. -He did not have any pain in his feet. Interview with a personal care aide (PCA) on 06/22/23 at 12:10pm revealed: -She provided Resident #2 with a shower or bed bath during her morning shift. -Resident #2 needed assistance with his bathing because he was unable to bend down to reach his feet to clean them. -She bathed the resident yesterday and noticed his feet were flaky and he had areas of skin breakdown under his feet and between his toes. -She did not think that anything else could be done about the resident's feet and toenails until he saw a podiatrist, but she continued to wash his feet when she provided him a bath or shower. -She reported the condition of his feet to the Resident Care Coordinator (RCC) a few weeks ago and again on 06/19/23. Telephone interview with a MA on 06/23/23 at 1:47pm revealed: -Staff had not reported to her that Resident #2's feet had deteriorated. -PCAs were expected to report any concerns or changes to the MA or the RCC. -She provided the resident with a bath last month and noticed dry skin, but he did not have any sores or drainage on his feet at that time. -When a PCA reported a concern or change in condition of a resident she completed an incident report and then notified the RCC and the resident's PCP. Interview with the RCC on 06/22/23 at 5:07pm revealed: -She was not aware of the condition of Resident #2's feet until a PCA notified her on 06/19/23.	D 269		

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D 269	Continued From page 5 -The resident's toenails were cut when he was in the hospital on 05/22/23; she spoke with a registered nurse (RN) case manager who informed her the hospital cut the resident's toenails and cleaned his feet. -The resident went to the local emergency room on 06/19/23 and she figured staff at the hospital would take care of his feet. -She reviewed resident's ADL sheets weekly to ensure residents were receiving the care they needed and to see if there were any changes in condition. -She did not remember seeing communication on an ADL sheet about the resident's feet. Telephone interview with the RCC on 06/23/23 at 11:52am revealed: -PCAs were expected to trim resident toenails if they were not a diabetic. -PCAs were expected to notify her or the MA if there was a concern they identified when providing personal care. -She observed Resident #2's toenails approximately two weeks ago and they drastically changed when she observed them on 06/22/23. Interview with the Administrator on 06/22/23 at 5:10pm revealed that staff should have been more attentive to the condition of Resident #2's feet and staff should have reported their concerns sooner to a MA or the RCC. Telephone interview with Resident #2's PCP on 06/23/23 at 3:31pm revealed: -The RCC contacted her about the condition of Resident #2's feet on 06/22/23 and sent her pictures of his feet. -She prescribed an ointment on 06/22/23 for the resident's feet. -She expected the facility to notify her of changes	D 269		

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D 269	Continued From page 6 in condition of residents to ensure their safety and that they receive the care needed. -Resident #2 had recently been diagnosed with diabetes when he was at the local emergency department. -Due to Resident #2's diagnosis of diabetes the skin breakdown on his feet could easily progress. -Resident #2 was at an increased risk of amputation of toes or his feet, infection that could become septic and cause death.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#1,#2) related to failing to ensure scheduling of a podiatry appointment and failing to inform the primary care provider (PCP) of a change in condition (#2) and failed to contact a resident's psychiatrist that a medication for anxiety and insomnia was not available to administer to the resident (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 11/09/22 revealed: -Diagnoses included epilepsy, cirrhosis of the liver, emphysema, and chronic obstructive pulmonary disease (COPD).	D 273	Facility Manager will ensure to follow up on all referrals to meet the routine and acute health care needs of residents. Facility Manager will contact PCP or Psychiatrist of any changes in resident's condition. Facility Manager has communicated with the PCP challenges the facility has faced with facility's contracted podiatrist scheduling appointments. Facility Manager has coordinated with the PCP with assistance for scheduling Podiatrist appointments for residents.	

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D 273	Continued From page 7 -The resident was semi-ambulatory. Review of Resident #2's care plan dated 11/09/22 revealed: -He required limited assistance with bathing, grooming, dressing, and toileting. -He required supervision with ambulating. Review of Resident #2's Resident Register dated 11/09/22 revealed he was admitted to the facility on 11/09/22. Observation of Resident #2 on 06/22/23 at 11:40am revealed: -He was lying in bed dressed and had socks on his feet. -There were light brown stains on areas on the bottom of his socks. -His feet were scaly and flaking around his toes, the bottom of his feet and the top of his feet. -There were brown spots and red spots on the bottom of both feet. -The cuticles on his toenails were overgrown on both feet. -His toenail on his great toe on his left foot was approximately ¼ inch long extended from his toenail, jagged and yellow. -The left third toenail curved over toward his skin but was not touching the skin of his toe. -He had several areas underneath his toes and in between his toes on his left foot that had cracked skin that had drainage from the cracked areas. -The left great toe and second toe had crystalized into hardened areas where the drainage had dried into a clump of a hardened area that was dark brown. -There were areas under his second and fourth toes on his left foot that had a light brown drainage where the skin had cracked, and some areas of drainage had hardened.	D 273	Facility Manager will notify PCP and Psychiatrist if a resident is out of medications or delay in Pharmacy delivery. Med Aide B was instructed to report immediately when a resident is out of medications. The facility conducted an In-Service with Medication Aides on 8/4/23 and 8/5/23. Med Aide was instructed on making sure to follow up on any triage visitations with referral orders. Facility Manager will perform weekly audits by observing Med Aides will administering medications. Facility Manager will report job performance to Administrator in order to determine if additional training. Administrator will ensure that Facility Manager and Med Aides follow-up to meet the acute healthcare needs of the residents. Administrator will follow up by interviewing residents during weekly facility visits and audit residents files and documentation during weekly facility visits. Date of Correction Completion: 8/4/2023	

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-There was a red open sore approximately ½ centimeter at the base of his second and third toe on the top of his feet.
-There was a red open sore approximately ½ centimeter on the bottom of his foot above the left side of his heel.
-His right foot had light brown drainage under each of his toes that had seeped from cracked skin.
-Between the third and fourth toes an area of drainage had hardened and formed small, crystalized areas.
-There was an open wound approximately one centimeter at the bottom of his fourth toe with drainage
-The right great toe was jagged, yellow, and was approximately 1/8 inch long extended from his toenail.
-The right second, third, and fourth toenails were jagged and was approximately 1/8 inch long extended from his toenail.

Review of Resident #2's primary care provider (PCP) visit note dated 03/15/23 revealed the PCP requested a podiatry referral for toenail dystrophy (toenails that are deformed, thickened, or discolored).

Review of Resident #2's record revealed there was no documentation Resident #2 was seen by a podiatrist.

Review of Resident #2's June 2023 activities of daily living sheet (ADLs) revealed:
-There was an entry for extensive assistance with bathing, extensive assistance for skin care which included washing the resident's feet and extensive assistance for nail care.
-There was no documentation that nail care was provided from 06/01/23 to 06/21/23; there were

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no refusals documented.
-There was a handwritten note on the last page of the ADL sheet dated 06/05/23 that Resident #2 constantly had problems with his feet flaking and the skin was purplish.

Review of a shift report progress note dated 06/05/23 revealed a personal care aide (PCA) reported to a medication aide (MA) that Resident #2's feet were scaley, flakey, and the resident denied pain of his feet.

Review of a shift report progress note dated 06/19/23 revealed:
-A MA documented that a PCA applied lotion to Resident #2's feet due to the condition of his feet until the resident could be seen by a podiatrist.
-The Resident Care Coordinator (RCC) had been trying to get Resident #2 seen by a podiatrist, but local podiatrists did not have appointment availability and were not accepting new clients.

Review of an after visit summary for Resident #2 on 06/19/23 revealed the resident was diagnosed with hyperglycemia and started on Metformin (a medication used to treat diabetes).

Interview with Resident #2 on 06/22/23 at 11:48am revealed:
-He did not when he had last seen a podiatrist.
-He did not have any pain in his feet.

Interview with a personal care aide (PCA) on 06/22/23 at 12:10pm revealed:
-She provided the resident with a shower or bed bath during her morning shift.
-Resident #2 needed assistance with his bathing because he was unable to bend down to reach his feet to clean them.
-She bathed the resident yesterday and noticed

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D 273	Continued From page 10 his feet were flaky and he had areas of skin breakdown under his feet and between his toes. -She did not think that anything else could be done about the resident's feet and toenails until he saw a podiatrist, but she continued to wash his feet when she provided him a bath or shower. -She reported the condition of his feet to the RCC a few weeks ago and again on 06/19/23. Telephone interview with a MA on 06/23/23 at 1:47pm revealed: -Staff had not reported to her that Resident #2's feet had deteriorated. -PCAs were expected to report any concerns or changes to the MA or the RCC. -She provided the resident with a bath last month and noticed dry skin, but he did not have any sores or drainage on his feet at that time. -When a PCA reported a concern or change in condition of a resident she completed an incident report and then notified the RCC and the resident's PCP. Interview with the Resident Care Coordinator (RCC) on 06/22/23 at 12:05pm revealed: -She was not aware that Resident #2's feet had open wounds, drainage, and unkept toenails. -She knew that when the resident went to the emergency room on 06/19/23 that the emergency medical services (EMS) observed his feet and questioned the condition of his feet. -She had not reported any problems with the residents' feet to the PCP. -The facility's contracted podiatrist was scheduled to see Resident #2 on 06/24/23 but they called her earlier today and rescheduled for 07/15/23. Second interview with the RCC on 06/22/23 at 5:07pm revealed she was not aware of the condition of Resident #2's feet until a PCA notified	D 273		

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D 273	Continued From page 11 her on 06/19/23. Interview with the Administrator on 06/22/23 at 5:10pm revealed that staff should have been more attentive to the condition of Resident #2's feet and staff should have reported their concerns sooner to a MA or the RCC so the resident could have been seen by his PCP or another podiatrist in the area. Telephone interview with Resident #2's PCP on 06/23/23 at 3:31pm revealed: -The RCC contacted her about the condition of Resident #2's feet on 06/22/23. -She prescribed an ointment on 06/22/23 for the resident's feet. -She expected the facility to notify her of changes in condition of residents to ensure their safety and that they receive the care needed. -Resident #2 had recently been diagnosed with diabetes when he was at the local emergency department. -The MA or RCC should have notified her about the delay in the facility's contracted podiatrist being able to visit Resident #2 at the facility. -Due to Resident #2's diagnosis of diabetes the skin breakdown on his feet could easily become progressively worse. -Resident #2 was at an increased risk of amputation of toes or his feet, infection that could become septic and cause death. 2.Review of Resident #1's current FL2 dated 05/18/23 revealed: -Diagnoses included schizophrenia. -There was an order for Oxazepam 10mg to be administered every evening at bedtime. (Oxazepam is a medication used to treat anxiety.) Review of Resident #1's electronic medication	D 273		

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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 273	Continued From page 12 administration record (eMAR) for June 2023 revealed: -There was an entry for oxazepam 10mg to be administered each night at bedtime. -There was documentation oxazepam 10mg was administered at 8:00pm on 06/01/23 to 06/17/23. -There was documentation oxazepam 10mg was not administered on 06/18/23 and 06/19/23 because it was not recieved from the pharmacy. -There was documentation the medication had been discontinued. Interview with Resident #1 on 06/21/23 at 2:15pm revealed: -She had not been administered for a few nights but she was not sure exactly how many nights she was without it. -She had not slept very well and would lie awake worrying because she had not taken her medication. Interview with the Administrator on 06/21/23 at 3:12pm revealed: -There was no order to discontinue the oxazepam for Resident #1. -Oxazepam was on back order from the pharmacy and the pharmacy put discontinuation on the eMAR until the medication could be obtained. -She did not know if Resident #1's mental health provider had been notified the medication was not available. Telephone interview with the pharmacist with the facility's previously contracted pharmacy on 06/22/23 at 9:32am revealed: -Dispensing services were transfered to another pharmacy on 06/12/23. -They last dispensed a 30 day supply of oxazepam 10mg on 05/11/23 for Resident #1 and	D 273		

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D 273	Continued From page 13 the medication was currently not on back order. Telephone interview with the pharmacist for at the facility's contracted pharmacy on 06/22/23 at 4:15pm revealed: -They recieved Resident #1's order for Oxazepam 10mg on 05/25/23. -Oxazepam was currently on back order and had not been dispensed to the facility. Telephone interview with the nurse for Resident #1's mental health provider on 06/22/23 at 3:32pm revealed: -Resident #1 was quiet and had a lot of anxiety. -The facility contacted the provider's office on 06/21/23 with notification Resident #1's oxazepam was on back order. -She expected the facility to notify them a medication was not available as soon as they found out so the doctor could make changes to medications and control her anxiety. Telephone interview with Resident #1's psychiatrist on 06/22/23 at 4:30pm revealed: -He expected the facility to contact him as soon as they were aware the medication was on back order. -He recieved notification from the facility on 06/21/23 regarding the inability to obtain oxazepam for Resident #1. -He ordered a medication to substitute for the oxazepam 10mg but Resident #1 could exprience withdrawl symptoms such as decreased sleep, shaking and possible hallucinations. Interview with the Resident Care Coordinator (RCC) on 06/22/23 at 5:07pm revealed: -She had not notified the Administrator or Resident #1's psychiatrist of the oxazepam not being available for administration.	D 273		

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-She did not know she could or should have contacted the mental health provider regarding the medication not being available and she was not aware there were other options.
-She thought she "just had to wait for the medication".

Second interview with the Administrator on 06/22/23 at 5:07pm revealed:
-She was not aware Resident #1's oxazepam was on back order and had not been available for administration.
-She would have reached out to another pharmacy and notified the mental health provider if she had been informed.

The facility failed to ensure referral and follow-up to meet the acute health needs of 2 of 3 sampled residents (#1, #2) related to a resident with a new diagnosis of diabetes with open, draining sores on his feet, severe cracked skin and long, jagged and curved toenails who was placed at risk of an amputation, infection, becoming septic and possible death (#2) and failed to contact a resident's psychiatrist that a medication for anxiety and insomnia was not available to administer causing the resident to experience difficulties with anxiety and insomnia (#1).
The facility's failure to ensure referral and follow-up for acute health needs of residents was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

The facility provided a plan of correction in accordance with G.S. 131D-34 on 06/22/23 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 7, 2023.

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D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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 ensure implementation of orders for 2 of 3 sampled residents (#2, #3) related to not checking a resident's blood pressure prior to administering medications (#2) and failing to notify the primary care provider (PCP) that a resident's systolic blood pressure was greater than 140 (#3).

The findings are:

1. Review of Resident #3's current FL-2 dated 02/16/23 revealed:
-Diagnoses included renal failure, dementia, brain trauma, and aneurysm.
-There was an order for monthly blood pressure checks.
-There was an order for Amlodipine Besylate 10mg tablet. Take one tablet by mouth twice a day for hypertension. If systolic blood pressure is greater than 140 notify the primary care provider (PCP).

Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain vital signs daily,

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notify the PCP for systolic blood pressure if greater than 140 related to hypertension.
-There was an order for Amlodipine Besylate 10mg tablet. Take one tablet by mouth twice a day for hypertension. If systolic blood pressure is greater than 140 to notify the PCP.
-The systolic blood pressure was 142 on 06/05/23, and 142 on 06/19/23.
-There was no documentation the resident's PCP was notified on 06/05/23 or 06/19/23.

Interview with a medication aide (MA) on 06/22/23 at 3:05pm revealed:
-MAs were expected to follow physician orders.
-He was aware to complete daily blood pressure checks on Resident #3 prior to administering her blood pressure medication.
-He documented Resident #3's daily blood pressure value in the eMAR.
-He did not notify Resident #3's PCP when the systolic pressure was greater than 140 on 06/05/23 and 06/19/23.
-There was no documentation in the eMAR the resident's PCP was notified on 06/05/23 and 06/19/23.

Interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:58am revealed:
-MAs should have notified the PCP when Resident #3's systolic blood pressure was greater than 140.
-MAs had been trained on the importance of documentation and were expected to document communication with the PCP.
-She was not sure why the PCP was not contacted when Resident #3's systolic blood pressure was greater than 140.
-She expected the MAs to follow PCP orders to ensure the resident did not have an increased health problem or a health emergency.

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D 276	Continued From page 17 -The current PCP had not reviewed Resident #3's daily blood pressure checks. Telephone interview with the Administrator on 06/23/23 at 4:25pm revealed: -She expected the MAs to follow orders. -The MAs should have informed Resident #3's PCP systolic blood pressure was greater than 140. Interview with Resident #3 on 06/22/23 at 3:55pm revealed the MAs checked his blood pressure daily. 2. Review of Resident #2's current FL-2 dated 11/09/22 revealed diagnoses included epilepsy, cirrhosis of the liver, emphysema, and chronic obstructive pulmonary disease (COPD). Review of a physician visit note dated 01/19/23 revealed staff at the facility requested an order for Resident #2's blood pressure to be checked by staff prior to medication pass. Review of a physician order dated 01/19/23 revealed an order to check Resident #3's blood pressure before medication pass. Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed there was no entry for BP checks. Review of Resident #2's June 2023 eMAR revealed there was no entry for BP checks. Telephone interview with the Resident Care Coordinator on 06/23/23 at 11:58am revealed: -She was not aware that there was a physician order to check Resident #2's blood pressure prior to the administration of his medications. -She should have contacted the pharmacy to	D 276		

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D 276	Continued From page 18 have blood pressure checks added to his electronic treatment administration record (eTAR). -MAs were expected to follow PCP orders to ensure resident safety. Telephone interview with the Administrator on 06/23/23 at 4:25pm revealed: -The RCC should have contacted Resident #2's PCP to see if the PCP wanted to keep the order active for blood pressure checks prior to administration of medications. -The RCC conducted weekly audits to ensure all PCP orders were accurate and implemented. -The RCC was hired a few months ago and had missed the blood pressure order for Resident #2 when she completed weekly audits. Telephone interview with Resident #2's PCP on 06/23/23 at 3:31pm revealed: -Staff should have followed the previous PCP orders to check Resident #2's blood pressure prior to administering medications. -The resident was placed at risk of a hypertensive crisis which could lead to a stroke when his blood pressure was not monitored prior to the administration of medications.	D 276		
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	D 358	Facility Manager and Administrator immediately performed medication administration coaching with Med Aide 2. Facility Manager will perform a weekly medication administration pass. Facility Manager and Administration will perform a weekly Medication Cart audit vs MAR's to ensure Med Aides are administrating medications to residents as prescribed by PCP and Psychiatrist.	

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D 358	Continued From page 19 and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE B VIOLATION Based on these findings, the previously Unabated Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#1,#4) observed during the morning medication pass including errors with medications used to treat high cholesterol, support digestive health (#1), a cream and calming wash used to treat and alleviate itching of a rash and an antipsychotic medication (#4); and for 2 of 3 sampled residents for record review including errors with a medication used to treat anxiety (#1) and a medication used to treat seizures (#2). The findings are: 1. The medication error rate was 13% as evidenced by 5 errors out of 38 opportunities during the 8:00am medication administration pass on 06/21/23. a. Review of Resident #1's current FL2 dated 05/18/23 revealed: -There was a diagnoses of hyperlipidemia and colostomy. -Review of Resident #1's current FL2 dated 05/18/23 revelaed there was an order for fenofibrate 48mg to be administered each day with breakfast. (Fenofibrate is a medication used to treat high cholesterol.) Review of Resident #1's physician's order dated 05/31/23 revealed:	D 358	Facility Manager will immediately remove any Med Aide if any errors are continued to be found during Medication Administration Audit, re-train or remove from medication cart permanently. Administrator will perform weekly monitoring of Med Aide while administering medications. Date of Correction Completion: 7/21/2023	

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D 358	Continued From page 20 -Fenofibrate 48mg was to be discontinued. -Fenofibrate 145mg was to be administered each day. Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed: -Medications for the morning medication administration were packaged in a multidose pack. -The multidose package was labeled to include fenofibrate 48mg. -The pills contained in the multidose package were administered to Resident #1 at 8:24am. Review of Resident #1's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for fenofibrate 145mg to be administered every day with breakfast. -There was documentation fenofibrate 145mg was administered at 8:00am on 06/21/23. Observation of medications on hand for Resident #1 on 06/21/23 at 2:40pm revealed: -There was a multidose pack that contained fenofibrate 48mg. -Fenofibrate 145mg, 30 tablets were available in a bubble pack labeled for a quantity of 30 tablets with a fill date of 06/16/23. Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed: -He was not aware the dose of fenofibrate had increased. -He administered all medications in the multidose package to Resident #1 on 06/21/23 at 8:00am. -He did not read the label and compare the medication label to the eMAR as he should have at the time of administration because he was	D 358		

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rushing to administer medications.
-He did not know there was a card dispensed for fenofibrate 145mg that was on the cart and available for administration.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am.

Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm.

b. Review of Resident #1's current FL2 dated 05/18/23 revealed there was an order for Culturelle Digestive Health, 1 tablet to be administered each morning. (Culturelle Digestive Health is used support health digestion and minimize occasional diarrhea, gas, and bloating.)

Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed:
-Medications for the morning medication administration were packaged in a multidose pack.
-The pills contained in the multidose package were administered to Resident #1 at 8:24am.
-The multidose package did not include Culturelle.

Review of Resident #1's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for Culturelle Digestive Health, 1 tablet to be administered each morning.
-There was documentation Culturelle Digestive Health, 1 tablet was not administered at 8:00am on 06/21/23 because it was not in the facility.

Observation of medications on hand for Resident #1 on 06/21/23 at 2:40pm revealed there was a

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D 358	Continued From page 22 box of Culturelle labeled as dispensed on 05/24/23 for a quantity of 30 capsules. Interview with Resident #1 on 06/21/23 at 2:15pm revealed: -She was prescribed Culturelle to help with digestion due to having a colostomy. -She did not receive Culturelle that morning. Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed he overlooked the box if Culturelle that was on the cart that morning. Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am. Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm. c. Review of Resident #4's current FL2 dated 02/16/23 revealed there was a diagnoses included schizophrenia. Review of Resident #4's psychiatric progress note dated 06/05/23 revealed: -Resident #1 was responding to auditory hallucinations during the provider visit. -There was an order to discontinue Risperidone 1mg twice daily and to begin Risperidone 1mg, 1 tablet every morning and 1.5 tablets every evening. (Risperidone is a medication used to treat schizophrenia.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed: -Medications for the morning medication administration were packaged in a multidose pack. -The multidose pack did not contain Risperidone	D 358		

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1mg.

Review of Resident #4's electronic medication administration record (eMAR) for June 2023 revealed:
-There was an entry for Risperidone 1mg, 1 tablet to be administered each morning.
-There was documentation Risperidone 1mg was administered each morning on 06/06/23 to 06/21/23.

Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed:
-He administered all medications from the multidose package to Resident #4 on 06/21/23 at 8:00am.
-He did not know the multidose pack did not contain Risperidone 1mg.
-He did not read the label and compare the medication label to the eMAR as he should have at the time of administration because he was rushing to administer medications.

Observation of Resident #4's mdications on hand on 06/22/23 at 10:59 revealed Risperdone 1mg was not available for administration.

Interview with the Administrator on 06/22/23 at 5:07pm revealed she thought Risperidone 1mg was dispensed in the multidose pack with other medications.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am.

Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm.

d. Review of Resident #4's after visit summary from the local emergency department dated

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D 358	Continued From page 24 03/17/23 revealed he was diagnosed with a rash. Review of Resident #4's after visit summary from the local emergency department dated 03/17/23 revealed there was a physician's order for Eucerin Eczema Relief 2% wash, apply to affected area twice daily. (Eucerin Eczema Relief 2% is used to cleanse dry, itchy skin.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed Eucerin Eczema Relief 2% wash was not administered to Resident #4. Review of Resident #4's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for Eucerin Eczema Relief 2% wash to the affected area on the right knee twice daily for inflammation and scheduled for 8:00am and 8:00pm. -There was no documentation of administration on Eucerin Eczema Relief 2% wash on 06/01/23 to 06/20/23 at 8:00am. -There was documentation Resident #4 refused the Eucerin Eczema Relief 2% wash at 8:00pm on 06/20/23. -There was documentation Resident #4 was administered Eucerin Eczema Relief 2% wash at 8:00am on 06/21/23. Interview with Resident #4 on 06/21/23 at 3:48pm revealed: -He did not receive Eucerin Eczema Relief 2% wash. -He did not have a rash. -He did not have itchy skin. Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed:	D 358		

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D 358	Continued From page 25 -Eucerin Eczema Relief 2% wash was not administered to Resident #4 on 06/21/23 at 8:00am. -Resident #4 refuses to use the Eucerin Eczema Relief 2% wash and he documented that it was administered in error. Observation of Resident #4's mdications on hand on 06/22/23 at 10:59 revealed Eucerin Eczema Relief 2% wash was available for administration. Telephone interview with Resident #4's primary care provider on 06/23/23 at 3:31pm revealed Eucerin Eczema Relief 2% wash was typically prescribed for approximately 2 weeks or until symptoms resolved however, all ordered medications should be administered as prescribed. Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am. Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm. e. Review of Resident #4's after visit summary from the local emergency department dated 03/17/23 revealed there was a physician's order for hydrocortisone 2.5% cream to be applied to affected area twice daily. (Hydrocortisone cream is used to treat redness, itching, and swelling of the skin.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed hydrocortisone 2.5% cream was not administered to Resident #4. Review of Resident #4's electronic medication administration record (eMAR) for June 2023	D 358		

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revealed:
-There was an entry for hydrocortisone 2.5% cream to be applied to the affected area on the right knee twice daily for inflammation and scheduled for 8:00am and 8:00pm.
-There was no documentation of administration on hydrocortisone 2.5% cream on 06/01/23 to 06/20/23 at 8:00am.
-There was documentation Resident #4 refused the hydrocortisone 2.5% cream at 8:00pm on 06/20/23.
-There was documentation Resident #4 was administered hydrocortisone 2.5% cream at 8:00am on 06/21/23.

Interview with Resident #4 on 06/21/23 at 3:48pm revealed:
-He did not receive hydrocortisone 2.5% cream.
-He did not have a rash.
-He did not have itchy skin.

Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed:
-Hydrocortisone 2.5% cream was not administered to Resident #4 on 06/21/23 at 8:00am.
-Resident #4 refused to use the hydrocortisone 2.5% cream and he documented that it was administered in error.

Observation of Resident #4's mdications on hand on 06/22/23 at 10:59 revealed hydrocorisone 2.5% cream was available for administration.

Telephone interview with Resident #4's primary care provider on 06/23/23 at 3:31pm revealed hydrocortisone cream was typically prescribed for approximately 2 weeks or until symptoms resolved however, all ordered medications should be administered as prescribed.

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D 358	Continued From page 27 Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am. Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm. 2. Review of Resident #1's current FL2 dated 05/18/23 revealed: -Diagnoses included schizophrenia. -There was an order for Oxazepam 10mg to be administered every evening at bedtime. (Oxazepam is a medication used to treat anxiety.) Review of Resident #1's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for oxazepam 10mg to be administered each night at bedtime. -There was documentation oxazepam 10mg was administered at 8:00pm on 06/01/23 to 06/17/23. -There was documentation oxazepam 10mg was not administered on 06/18/23 and 06/19/23 because it was not received from the pharmacy. -There was documentation the medication had been discontinued. Interview with Resident #1 on 06/21/23 at 2:15pm revealed: -She had not been administered for a few nights, but she was not sure exactly how many nights she was without it. -She had not slept very well and lie awake worrying because she had not taken her medication. Interview with the Administrator on 06/21/23 at 3:12pm revealed: -There was no order to discontinue the oxazepam for Resident #1.	D 358		

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-Oxazepam was on back order from the pharmacy and the pharmacy put discontinuation on the eMAR until the medication could be obtained.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am.

Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm.

3. Review of Resident #2's current FL-2 dated 11/09/22 revealed diagnoses included epilepsy, cirrhosis of the liver, emphysema, and chronic obstructive pulmonary disease (COPD).

Review of Resident #2's physician order from the resident's neurologist dated 05/09/23 revealed there was an order for Dilantin every four weeks dose will decrease by 100mg, withdrawal scheduled for Dilantin from 05/10/23 to 06/10/23 administer 200mg daily and from 06/11/23 to 07/11/23 administer 100mg daily and then stop Dilantin. (Dilantin is a medication used to treat seizures).

Review of Resident #2's May 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Dilantin 100mg, take 2 capsules (200mg) 2 times a day at 8:00am and 8:00pm for seizures.
-There was documentation Dilantin 200mg was administered at 8:00am and 8:00pm on 05/25/23 to 05/31/23.

Review of Resident #2's June 2023 eMAR revealed:
-There was an entry for Dilantin 100mg, take 2 capsules (200mg) 2 times a day at 8:00am and

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8:00pm for seizures.
-There was documentation Dilantin 200mg was administered at 8:00am and 8:00pm on 06/01/23 to 06/19/23 and at 8:00am on 06/20/23.

Observation of medications on hand for Resident #2 on 06/22/23 at 2:40pm revealed:
-There was a multidose pack that contained Dilantin 100mg capsules, with directions to administer 3 capsules daily for seizures with a dispense date of 06/12/23, there were multidose packs dated 06/23/23 to 06/27/23.
-Dilantin 100mg capsules were available in a bubble pack labeled for a quantity of 120 tablets with a fill date of 06/24/23, with directions to administer 2 capsules twice a day for seizures.

Telephone interview with Resident #2's primary care provider (PCP) on 06/23/23 at 3:31pm revealed:
-She was not aware that Resident #2's neurologist had changed his Dilantin order.
-She expected the facility to send her any new orders by providers.
-Staff should ensure that medication was administered as ordered in order to treat the residents needs to prevent worsening of condition.
-Resident #2 was at risk of his seizures not being controlled properly after the neurologist order was not implemented as ordered.
-The facility had a lapse in communication which resulted in improper treatment for Resident #2.
-The facility needed to have additional education related to the importance of administering medications as ordered to prevent problems in the future.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am.

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D 358	Continued From page 30 Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm. ______ Telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am revealed: -She completed eMAR reviews with physician orders once a week. -MAs were expected to compare the eMAR with the prescription for accuracy, if they did not match they were expected to notify her so she could contact the pharmacy. -MAs were expected to correctly administer all medications as ordered. Telephone interview with the Administrator on 06/23/23 at 5:10pm revealed: -The RCC was expected to complete a cart audit with the eMARS to ensure medications orders are correct. -She expected all physician orders to match the eMARS. ______ The facility failed to administer medications as ordered for 2 of 3 residents (#1, #4) observed during the medication pass including a medication used to treat high cholesterol, support digestive health (#1), a cream and calming wash used to treat and alleviate itching of a rash and an antipsychotic medication (#4); and failed to administer the correct dose of a medication for 2 of 3 sampled residents which included failing to administer a medication used to treat anxiety which caused the resident to experience increased anxiety and inability to sleep (#1) and a medication used to treat seizures and increased the risk of seizure activity (#2). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an	D 358		

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D 358	Continued From page 31 Unabated Type B Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/21/23 for this violation.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration 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 observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate for 1 of 5 sampled residents (#4) including inaccurate documentation for a medication for	D 367	Facility Manager will ensure that Med Aide receives medication administration and documentation coaching weekly during weekly audits. Med Aides will review MAR's after each med pass for accuracy. Facility Manager will follow up on medication administration and documentation on a daily basis. Administrator will ensure that documentation and administration of medication are comparable to the residents MAR. Administrator will follow up with Facility Manager on a weekly basis or as needed. Date of Correction Completion: 7/21/2023	

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D 367	Continued From page 32 schizophrenia, and a cream and calming wash used to treat and alleviate itching of a rash. The findings are: The findings are: Review of Resident #4's current FL2 dated 02/16/23 revealed diagnoses included schizophrenia. 1. Review of Resident #4's psychiatric progress note dated 06/05/23 revealed: -Resident #1 was responding to auditory hallucinations during the provider visit. -There was an order to discontinue Risperidone 1mg twice daily and to begin Risperidone 1mg, 1 tablet every morning and 1.5 tablets every evening. (Risperidone is a medication used to treat schizophrenia.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed: -Medications for the morning medication administration were packaged in a multidose pack. -The multidose pack did not contain Risperidone 1mg. Review of Resident #4's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for Risperidone 1mg, 1 tablet to be administered each morning. -There was documentation Risperidone 1mg was administered each morning on 06/06/23 to 06/21/23. Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed:	D 367		

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D 367	Continued From page 33 -He administered all medications from the multidose package to Resident #4 on 06/21/23 at 8:00am. -He did not know the multidose pack did not contain Risperidone 1mg. -He did not read the label and compare the medication label to the eMAR as he should have at the time of administration because he was rushing to administer medications. Interview with the Administrator on 06/22/23 at 5:07pm revealed she thought Risperidone 1mg was dispensed in the multidose pack with other medications. 2. Review of Resident #4's after visit summary from the local emergency department dated 03/17/23 revealed he was diagnosed with a rash. Review of Resident #4's after visit summary from the local emergency department dated 03/17/23 revealed there was a physician's order for Eucerin Eczema Relief 2% wash, apply to affected area twice daily. (Eucerin Eczema Relief 2% is used to cleanse dry, itchy skin.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed Eucerin Eczema Relief 2% wash was not administered to Resident #4. Review of Resident #4's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for Eucerin Eczema Relief 2% wash to the affected area on the right knee twice daily for inflammation and scheduled for 8:00am and 8:00pm. -There was no documentation of administration on Eucerin Eczema Relief 2% wash on 06/01/23	D 367		

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to 06/20/23 at 8:00am.
-There was documentation Resident #4 refused the Eucerin Eczema Relief 2% wash at 8:00pm on 06/20/23.
-There was documentation Resident #4 was administered Eucerin Eczema Relief 2% wash at 8:00am on 06/21/23.

Interview with Resident #4 on 06/21/23 at 3:48pm revealed:
-He did not receive Eucerin Eczema Relief 2% wash.
-He did not have a rash.
-He did not have itchy skin.

Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed:
-Eucerin Eczema Relief 2% wash was not administered to Resident #4 on 06/21/23 at 8:00am.
-Resident #4 refuses to use the Eucerin Eczema Relief 2% wash and he documented that it was administered in error.

Telephone interview with Resident #4's primary care provider on 06/23/23 at 3:31pm revealed Eucerin Eczema Relief 2% wash is typically prescribed for approximately 2 weeks or until symptoms resolve however, all ordered medications should be administered as prescribed.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 06/23/23 at 11:52am.

Refer to telephone interview with the Administrator on 06/23/23 at 5:10pm.

3. Review of Resident #4's after visit summary from the local emergency department dated

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D 367	Continued From page 35 03/17/23 revealed there was a physician's order for hydrocortisone 2.5% cream to be applied to affected area twice daily. (Hydrocortisone cream is used to treat redness, itching, and swelling of the skin.) Observation of the 8:00am medication administration pass on 06/21/23 at 8:00am revealed hydrocortisone 2.5% cream was not administered to Resident #4. Review of Resident #4's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for hydrocortisone 2.5% cream to be applied to the affected area on the right knee twice daily for inflammation and scheduled for 8:00am and 8:00pm. -There was no documentation of administration on hydrocortisone 2.5% cream on 06/01/23 to 06/20/23 at 8:00am. -There was documentation Resident #4 refused the hydrocortisone 2.5% cream at 8:00pm on 06/20/23. -There was documentation Resident #4 was administered hydrocortisone 2.5% cream at 8:00am on 06/21/23. Interview with Resident #4 on 06/21/23 at 3:48pm revealed: -He did not receive hydrocortisone 2.5% cream. -He did not have a rash. -He did not have itchy skin. Interview with the medication aide (MA) on 06/22/23 at 10:59am revealed: -Hydrocortisone 2.5% cream was not administered to Resident #4 on 06/21/23 at 8:00am. -Resident #4 refuses to use the hydrocortisone	D 367		

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D 367	Continued From page 36 2.5% cream and he documented that it was administered in error. Telephone interview with Resident #4's primary care provider on 06/23/23 at 3:31pm revealed hydrocortisone cream is typically prescribed for approximately 2 weeks or until symptoms resolve however, all ordered medications should be administered as prescribed.	D 367		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure four prescription medications were locked in the medication room and a that was a schedule II controlled substance medication was secured and was kept under a double lock. The findings are: Observation of the medication room on 06/22/23 from 1:40pm to 1:43pm revealed:	D 393	Facility Manager will store controlled medications together in a common location or container under a double lock. Facility Manager or Med Aide will immediately return all expired medications including controlled medications back to pharmacy. Facility Manager will remove any Med Aide from Medication Cart immediately if medications are administered incorrectly. Facility Manager will monitor controlled medication and documentation vs MAR's on a daily basis. When medication cart is not attentive by Med Aide, the medication cart will remain locked in the locked medication room. We have the general lock on the med cart and a lock on the control box in the lock med cart. All medications that need to be returned to the pharmacy and stored in a locked cabinet in the locked med room. All controlled substances medications that need to be returned to the pharmacy will be locked in the locked box in the locked cabinet in the locked medication room. Controlled Substances will be stored under double lock at all times. Administrator will ensure that facility store all medications including controlled substances in secured location during weekly audit. Date of Correction Complication: 7/21/2023	

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WINSTON GARDENS	205 WEST WATSON STREET WINDSOR, NC 27983

(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 393	Continued From page 37 -The medication room was unlocked with the door open. -The medication room exited to the resident lobby near the front door. -Staff was not present in the medication room from 1:40pm to 1:43pm. -There was a brown paper bag folded over sitting on the counter to the left entrance of the medication room. -The brown paper bag had writing in a black marker "please send back to pharmacy." -The brown paper bag contained a bubble medication card with Morphine Sulfate TR 15mg, with 40 tablets in the bubble card (Morphine Sulfate TR is a schedule II controlled substance) and four additional bubble cards that contained four different prescription medications. -The medication aide (MA) was in the lobby when the medication room was unattended. Review of the facility's policy dated 06/22/23 revealed: -The purpose of the policy was to ensure accurate administration and record keeping of controlled substances, ensure proper storage of controlled substances, ensure knowledge of processes for expired, discontinued, or no longer required controlled substances, and ensure accurate documentation of controlled substances. -The facility should ensure there is a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. -The controlled substance should be stored together in a common location. -Schedule II medications should be stored together and should be under double lock. -All controlled substances that have expired, are discontinued, or are no longer required for the resident, shall be returned to the pharmacy within	D 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008042	A. BUILDING: ____ B. WING ____	R 06/23/2023

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D 393	Continued From page 38 90 days of the expiration or discontinuation or following the death of the resident. Interview with a MA on 06/22/23 at 1:43pm revealed: -He meant to lock the medication room when he went into the resident lobby. -He did not realize that there was a schedule II controlled substance in the brown paper bag to be returned to the pharmacy. Interview with the Resident Care Coordinator (RCC) on 06/22/23 at 1:35pm revealed: -She was aware that there was a bubble medication card in a brown paper bag with a bubble card of medication for Morphine Sulfate TR and four other bubble medication cards. -She was aware that the medications that were to be returned to the pharmacy were in a brown paper bag on top of a counter in the medication room. -She meant to put the Morphine Sulfate TR under double lock since it was a schedule II controlled substance. -She expected MAs to keep the medication room locked to ensure residents safety. Telephone interview with the Administrator on 06/23/23 at 4:25pm revealed: -She expected the medication room to be locked when unattended. -Any schedule II medications should be under double lock per the facility policy. -The MAs and RCC should have ensured the medication room was locked and the schedule II controlled substance was properly stored to ensure resident safety. Interview with the facility's primary care provider (PCP) on 06/23/23 at 3:10pm revealed MAs, the	D 393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 393	Continued From page 39 RCC and the Administrator were expected to keep medications secured to prevent residents from taking medications and to ensure resident safety.	D 393		