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
	HAL001141	A. BUILDING: _____ B. WING _____	R 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

(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 conducted a follow up survey on 08/01/23-08/02/23.	{D 000}		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) regulations pertaining to medication administration in adult care facilities; and (10)the facility's medication administration policy and procedures (b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department. (c) Verification of an individual's completion of the written examination and results can be obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at	D 156	1) DRC and BOM (Director of Resident Care and Business Office Manager) will audit staff files for all required trainings. Completion - 8/25/2023 2) RN to hold a fifteen hour class for all identified med techs, as well as all new med techs. Completion - 9/15/2023 3) RN to complete all necessary check offs for any identified staff and continue ongoing. This is to include LNPs. Completion - 9/15/2023 and ongoing - Completion - 9/15/2023	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Brindle — TITLE: Executive Director — (X6) DATE: 8/15/2023

Received, reviewed, and acknowledged on 08/28/23. kg

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D 156	Continued From page 1 https://mats.ncdhhs.gov/test-result. (d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter. (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following: (1) name of the staff and adult care home; (2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature; (3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and (4) staff and instructor signatures and date after completion of tasks. Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not transferable from one facility to another.	D 156		

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D 156	Continued From page 2 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 5 sampled staff who administered medications, completed a medication clinical skills checklist and had successfully passed the written state medication administration examination (Staff D), and completed the 5, 10, or 15-hour medication aide training course or had verification of previous employment (employee verification form) as a medication aide (MA) (Staff D and Staff E) before administering medication to residents. The findings are: 1. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff A was hired on 12/21/22. -There was no documentation Staff A had completed the medication clinical skills checklist. -There was a certificate dated 05/26/22 for completion of a 15-hour medication aide training from a previous employer. -There was no documentation Staff A completed the 5, 10, or 15-hour medication aide training since being hired on 12/21/22. -There was no documentation of previous employment verifications Staff A had worked as a MA. Telephone interview with Staff D on 08/02/23 at 6:08pm revealed: -She had not had anyone complete a medication clinical skills checklist on her through observing	D 156		

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D 156	Continued From page 3 her administer medications. -She had a 15-hour medication class at a previous facility but had not completed a 15-hour class at this facility. -She had passed medications at the previous facility but had not taken the medication exam before she changed jobs. -She had not taken the state medication administration exam; she needed to schedule that. Review of residents' May 2023-July 2023 electronic medication administration records (eMAR) revealed: -There was documentation Staff D administered medications on 7 days from 05/01/23-05/31/23. -There was documentation Staff D administered medications on 8 days from 06/01/23-06/30/23. -There was documentation Staff D administered medications on 7 days from 07/01/23-07/31/23. Interview with the Licensed Practical Nurse (LPN) on 08/02/23 at 5:21pm revealed: -Staff D was hired before she started to work at the facility in April 2023. -She knew Staff D needed to take the state medication administration exam. -She had not seen a medication clinical skills checklist for Staff D. Refer to the interview with the Administrator on 08/02/23 at 6:12pm. 2. Review of Staff E's, medication aide (MA,) personnel record revealed: -Staff E was hired on 05/14/23. -There was documentation Staff E had passed the state medication administration exam on 03/20/17. -There was no documentation Staff E completed	D 156		

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D 156	Continued From page 4	D 156		

the 5, 10, or 15-hour medication aide training.
-There was no documentation of previous employment verifications Staff E had worked as a MA.

Review of residents' May 2023-July 2023 electronic medication administration records (eMAR) revealed:
-There was documentation Staff E administered medications on 7 days from 05/23/23-05/31/23.
-There was documentation Staff E administered medications on 20 days from 06/01/23-06/30/23.
-There was documentation Staff E administered medications on 20 days from 07/01/23-07/31/23.

Telephone interview with Staff E on 08/03/23 at 2:03pm revealed:
-She had been a MA for five years.
-She independently administered medications to the residents.
-She had her 15-hour medication aide training at another facility, but no other medication administration training had been provided since she began working at the facility.
-She did not know if verification of her work as a MA had been obtained from her previous employer, but she had provided the facility with the information for her previous employers.

Interview with the Licensed Practical Nurse (LPN) on 08/02/23 at 5:21pm revealed:
-Staff E was supposed to bring her 15-hour training class from another facility where she had received the training because she had recently taken the 15-hour class.
-Staff E had completed the medical clinical skills checklist.

Refer to the interview with the Administrator on 08/02/23 at 6:12pm.

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D 156	Continued From page 5 Interview with the Administrator on 08/02/23 at 6:12pm revealed: -The LPN was responsible for ensuring the MAs had the required medication aide training. -Before the MA could be on the medication cart, the MA should have had the 15-hour medication aide training class. -The 15-hour medication class should be completed since being hired by the facility. -A 15-hour medication class certificate from a previous employer was not permissible. -No one had asked her if a 15-hour certificate from a previous employer could be used; she expected an employee verification form to have been obtained if the MA had worked as a MA at another facility. -She expected all MA training to be completed and verified before the MA administered medication. Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Unabated Type B Violation).	D 156		
{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:	{D 358}		

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{D 358}	Continued From page 6 FOLLOW UP TO A TYPE B VIOLATION Based on these findings, the previous Type B violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) related to an antibiotic, an antidepressant medication, a blood thinning medication, and a mild pain reliever. The findings are: Review of Resident #2's current FL-2 dated 06/08/23 revealed diagnoses included Alzheimer's disease, hypertension, and transient cerebral ischemia (mini-stroke). a. Review of Resident #2's emergency department (ED) after-visit summary dated 07/26/23 revealed: -Resident #2 was seen at the ED for altered mental status and was diagnosed with acute kidney injury and urinary tract infection (UTI). -There was an order for Cephalexin (an antibiotic used to treat UTIs) 500mg four times per day for 7 days. -The Cephalexin order had been sent to a [named] pharmacy. Review of an email communication from the facility's Wellness Coordinator to the Wellness Coordinator dated 07/27/23 at 11:49am revealed: -Resident #2's pharmacy stated they never received an order from the hospital for the antibiotic. -If you do not mind sending an order to them whenever you get around to Resident #2 that would be wonderful.	{D 358}	1) Complete med cart audits - mar to cart, Orders to mars by Wellness Secretary and DRC Completed by 8/11/2023 2) Identify any missed meds and reason not given. Utilize corrective actions when necessary to insure resident meds are given. Also, to identify if meds are not in house. DRC - Completed audit 8/31/2023 - and ongoing 3) Wellness Secretary to Complete med cart audits weekly opposite the meds techs doing audits. ongoing	

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{D 358}	Continued From page 7 Interviews with the Wellness Coordinator on 08/02/23 at 9:04am and 9:44am revealed: -She had received notification from a medication aide (MA) that Resident #2's Cephalexin was not on the cart, and it had been a couple of days, so she reached out to Resident #2's PCP by email. -She had not seen Resident #2's hospital discharge summary until today, 08/02/23, when she asked Resident #2's PCP's office to send a copy of the discharge summary. -When she came into work on 07/27/23 she was handed Resident #2's hospital discharge summary and she handed it to Resident #2's PCP before she had a chance to review them. -Today, 08/02/23, was the first time she had seen the order for Resident #2's antibiotic had been sent to the wrong pharmacy. Review of Resident #2's electronic medication administration record (eMAR) for July 2023 from 07/26/23-07/31/23 revealed: -There was an entry for Cephalexin 500mg take four times a day for UTI for 7 days until finished with a scheduled administration time of 9:00am, 1:00pm, 5:00pm, and 8:00pm; the start date was 07/27/23. -There was no documentation Cephalexin had been administered from 07/27/23-07/29/23 and 07/30/23 at 9:00am and 1:00pm. -There was documentation Cephalexin was administered for the first time on 07/30/23 at 5:00pm. Review of Resident #2's progress notes from 7/26/23-07/31/23 revealed: -On 07/27/23 at 8:54am and 1:17pm, there was documentation that Resident #2's Cephalexin was not in the facility. -On 07/27/23 at 7:25pm, there was	{D 358}	4) DRC to follow up daily on missed meds to be completed by 8/11/2023 and then ongoing 5) Insure progress notes are put in resident charts for all meds not in house, doctors notified, as well as families. to continue ongoing Completion - 9/2/2023	

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{D 358}	Continued From page 8 documentation the medication had not arrived from the pharmacy, and at 8:55pm there was documentation that the Cephalexin was not on the medication cart and should arrive tonight, 07/27/23. -On 07/28/23 at 8:06am, 1:19pm, 4:09pm, and 7:36pm, there was documentation the Cephalexin had not arrived at the facility. On 07/29/23, at 8:18am, 12:39pm, and 7:56pm there was documentation that the Cephalexin was not in the facility and was waiting on the pharmacy. -On 07/30/23 at 8:08am and 12:39pm, there was documentation that the Cephalexin was not in the facility. -There was no documentation the pharmacy had been notified. Review of Resident #2's eMAR for August 2023 for 08/01/23 revealed: -There was an entry for Cephalexin 500mg take four times a day for UTI for 7 days until finished with a scheduled administration time of 9:00am, 1:00pm, 5:00pm, and 8:00pm. -There was documentation Cephalexin was administered at 9:00am on 08/01/23. Observation of Resident #2's medications on hand on 08/01/23 at 11:33am revealed: -There was a punch card for Cephalexin 500mg dispensed on 07/30/23 for 28 tablets. -Twenty-one tablets remained in the medication card. Telephone interview with a pharmacy technician at Resident #2's pharmacy on 08/01/23 at 3:02pm revealed: -An order for Resident #2 was received on 07/29/23 for Cephalexin 500mg four times daily for 7 days; the medication was not dispensed.	{D 358}		

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{D 358}	Continued From page 9 -On 07/30/23, an order was received for Cephalexin 500mg capsules four times daily for 7 days and was sent out on 07/30/23 at 12:08pm. Telephone interview on 08/02/23 at 10:59am with the Pharmacist at the [named] pharmacy Resident #2's Cephalexin prescription had been sent by the hospital revealed: -She saw where a prescription for Resident #2's Cephalexin was received on 07/26/23. -There was a note that Resident #2 was no longer active in their system and had not been for a long time because the resident moved. -There was no documentation anyone had called about the prescription for Resident #2. -If someone would have called and requested, they would have sent the order to the correct facility. Telephone interview with another pharmacy technician at Resident #2's pharmacy on 08/02/23 at 1:46pm revealed: -There was no documentation in their system anyone had called about Resident #2's Cephalexin. -If a staff member from the facility had called about the Cephalexin not being delivered, they would have told the staff member to fax the hospital discharge summary to the pharmacy. -The order received on 07/29/23 for the Cephalexin was the first entry for the resident regarding Cephalexin. -If the hospital had sent the order for the Cephalexin to the wrong pharmacy, the facility staff could have either called the pharmacy it was sent to in error and asked for the prescription to be transferred or called Resident #2's pharmacy and they would have handled having the prescription transferred.	{D 358}		

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{D 358}	Continued From page 10 Telephone interview with Resident #2's family member on 08/01/23 at 5:52pm revealed: -She brought Resident #2 back to the facility on 07/26/23 after she had been at the ED "for hours." -She gave Resident #2's hospital discharge summary to a MA, but she did not know the MA's name. -When she visited Resident #2 on 07/29/23, she was told there was "the biggest mix-up" with Resident #2's medication and it had been sent to the wrong pharmacy by the hospital. -She was told the medication would be ordered immediately. -On Sunday, 07/30/23, the medication had finally been delivered and administered to Resident #2. -She was frustrated there had been a delay in Resident #2 receiving her antibiotic. -She told the MA if Resident #2's "gets worse and becomes septic, you are going to hear from me." Telephone interview with a representative at Resident #2's PCP's office on 08/02/23 at 9:12am revealed: -They received notification on 07/27/23, Resident #2 had returned from the ED, and Resident #2 was then scheduled to be seen by her PCP on 07/27/23. -There was no documentation in Resident #2's electronic record anyone had called about Resident #2's Cephalexin until 07/29/2023. -On 07/29/23, there was documentation the triage nurse had been called requesting a prescription for Cephalexin for Resident #2. -On 07/30/23, another call was received, the pharmacy needed the prescription for Cephalexin written for capsules, and the prescription for Cephalexin was rewritten. Review of Resident #2's PCP's triage note dated	{D 358}		

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{D 358}	Continued From page 11 07/29/23 revealed: -The reason Resident #2 was sent to the ED was listed as low blood pressure, gait was off, and the resident was confused. -Resident #2 returned from the hospital with an order for Cephalexin 500mg four times daily for 7 days and the resident had not received any. -An order was written for Cephalexin 500mg four times daily for seven days. -The triage note was electronically signed at 4:18pm by a medical assistant and at 7:22pm by a nurse practitioner. Review of Resident #2's PCP's triage note dated 07/30/23 revealed: -The pharmacy would not fill the order for Cephalexin 500mg four times daily unless the order was written for capsules and not tablets. -The insurance was rejecting the prescription due to not being written for capsules. -A prescription was written for Cephalexin 500mg one capsule four times daily as directed for 7 days. -The triage note was signed at 2:32pm. Interview with a MA on 08/02/23 at 9:46am revealed: -When she worked on 07/28/23, she saw Cephalexin listed on Resident #2's eMAR, but the antibiotic was not on the medication cart. -When she worked on 07/29/23, Resident #2's Cephalexin was still not available to be administered so she called Resident #2's PCP's office and spoke to someone in triage to have the order sent to the pharmacy. -When she worked on 07/30/23, Resident #2's Cephalexin was still not available, and she spoke to someone at the pharmacy and was told they needed a prescription specifying what was needed as the order did not specify tablet or	{D 358}		

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{D 358}	Continued From page 12 capsule. -Resident #2 had a progressive decline for about a week before going to the ED, and the week of 07/24/23 she declined further. -On 07/26/23, Resident #2 was having difficulty speaking, and her blood pressure was so low she had to sit down and was then sent to the ED to be evaluated. Telephone interview with Resident #2's PCP on 08/02/23 at 10:09am revealed: -Resident #2 had not been herself for a few weeks at the facility and she placed an order for staff to collect a urine sample to rule out a UTI on 07/13/23; staff had difficulty in obtaining a urine sample from the resident. -She saw Resident #2 on 07/27/23 and knew the resident had returned from the ED with a diagnosis of UTI and was started on an antibiotic. -She was given Resident #2's hospital discharge summary on 07/27/23 but was not given an original prescription for Cephalexin. -She did not know the discharge summary she was given had not been reviewed by the facility staff. -She did not know Resident #2 had not started on the Cephalexin when she saw the resident on 07/27/23. -No one had reported to her any issues with starting Resident #2's Cephalexin. -She could see in Resident #2's electronic record someone from the facility had called in to triage with the PCP's office on 07/29/23 and requested a prescription for Cephalexin 500mg and an order was sent to the pharmacy. -On 07/30/23, she could see someone had called back to triage with the PCP's office because Resident #2's insurance was rejecting the order for tablets and a new prescription for capsules was needed.	{D 358}		

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{D 358}	Continued From page 13 -She was concerned Resident #2 had a UTI and needed to be treated. -Because Resident #2 did not receive the Cephalexin until 4 days after the medication was ordered, it extended the time Resident #2 had the UTI and delayed the resident from feeling better. -An ongoing UTI also increased the resident's risk of falls. Telephone interview with another MA on 08/02/23 at 1:15pm revealed: -She worked on the third shift on 07/26/23. -She did not see or talk to Resident #2's family member on 07/26/23 when the resident returned from the ED. -She saw Resident #2's discharge summary laying on the desk at the nurse's station. -Whoever received the discharge summary was responsible for faxing it to the pharmacy. Interview with the facility's Licensed Practical Nurse (LPN) on 08/02/23 at 5:21pm revealed: -When a resident returned from the hospital, the discharge summary should be reviewed by the MA who received it and if no new orders, the discharge summary would be scanned to her or her assistant and scanned to the resident's electronic record. -Original prescriptions should be faxed to the pharmacy by whoever received the prescription. -She knew Resident #2 had returned from the hospital with an antibiotic order and had been diagnosed with a UTI. -No one had told her there was an issue receiving Resident #2's Cephalexin. -When a resident went to the ED, a medication list was sent with the resident, and the list should have the resident's pharmacy listed. -If the pharmacy was not listed, the hospital should have called to see which pharmacy to	{D 358}		

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{D 358}	Continued From page 14 send the prescription to. -She did not know Resident #2's prescription had been sent to the wrong pharmacy. -She worked as a MA in the SCU on 07/27/23 and did not see Resident #2's Cephalexin on the medication cart and thought it had not been delivered. -She asked the other MA when medications were usually delivered and was told the medications were delivered on the third shift. -She assumed Resident #2's Cephalexin would be delivered during the third shift on 07/27/23. -She worked again on Friday, 07/28/23, and saw Resident #2's Cephalexin was still not on the medication cart and assumed it would be delivered that night as sometimes it would take a couple of days depending on what time the order was received by the pharmacy. -She was not notified over the weekend, 07/29/23-07/30/23, the Cephalexin had not been received. -She would have expected the MA on the first shift to have called the pharmacy the next morning after returning from the hospital to make sure the prescription had been received. -When she returned to the facility on 08/01/23 she saw a preauthorization form for Resident #2's Cephalexin, and she checked with the MA and was told the medication had been delivered. -She was concerned there was a delay in Resident #2's receiving the Cephalexin and her UTI could have gotten worse. Interview with the Administrator on 08/02/23 at 6:12pm revealed: -Discharge summaries need to be given to the MA upon return to the facility. -The MA should give the discharge summary to the LPN the next day if received after hours. -The MA was responsible for looking over the	{D 358}		

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{D 358}	Continued From page 15 discharge summary for new orders and then process, which included faxing the orders to the pharmacy and entering the new order into the eMAR. -She did not know there was an issue with Resident #2's Cephalexin until 08/01/23 when she was told there had been an issue with insurance coverage but was told the medication had arrived and had been administered to Resident #2. -If there was an issue with the insurance, the MA should immediately contact the resident's PCP to let them know because they may want to send an alternative medication. -The MAs should have used the medication tracking form and when the Cephalexin did not come in the next day they should have been trying to find out why the medication had not been delivered. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted interview with the Wellness Coordinator on 08/02/23 at 4:22pm was unsuccessful. b. Review of Resident #2's physician's triage order dated 06/15/23 revealed an order to stop Fluoxetine (an antidepressant) 20mg/5ml and begin Fluoxetine 20mg one tablet daily. Review of Resident #2's physician's communication form dated 07/05/23 revealed: -The communication was initiated by a medication aide (MA). -There was a handwritten note that Resident #2's Fluoxetine had not arrived at the facility. -Pharmacy stated insurance would not cover	{D 358}		

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{D 358}	Continued From page 16 tablets but would cover capsules; please advise. -The Primary Care Provider (PCP) responded that capsules would be ordered and was signed on 07/06/23. Review of Resident #2's physician's triage order dated 07/06/23 revealed: -There was an order to start Fluoxetine 20mg take one capsule daily. -The order had a faxed confirmation from the PCP's office to the facility dated 07/06/23 at 9:23am. Review of Resident #2's physician's communication form dated 07/11/23 revealed: -The communication was initiated by a MA. -There was a handwritten note that the pharmacy had not received Resident #2's Fluoxetine order. -The resident's triage note from 07/06/23 was faxed to the pharmacy on 07/11/23; can you please send the order. -The PCP's response was she would send it electronically and was signed on 07/13/23. Review of Resident #2's physician's triage order dated 0713/23 revealed: -There was an order to start Fluoxetine 20mg take one capsule daily; there was documentation that the medication had a start date of 06/16/23. -The order had a faxed confirmation from the PCP's office to the facility dated 07/13/23 at 9:06am. Review of Resident #2's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for Fluoxetine 20mg/5ml give 5ml daily with a scheduled administration time of 2:00pm. -Fluoxetine 20mg/5ml was documented as	{D 358}		

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{D 358}	Continued From page 17 administered daily from 06/01/23-06/27/23 at 2:00pm. -There was documentation Fluoxetine 5ml was not administered on 06/28/23-06/29/23 with the exception as other and on 06/30/23 it was marked with an X. -There was no entry for Fluoxetine 20mg tablet daily and no documentation Fluoxetine 20mg tablet had been administered. Review of Resident #2's progress notes from 06/28/23 and 06/29/23 revealed there was documentation Resident #2's Fluoxetine 20mg/5ml was not administered because the medication was not in the facility. Review of Resident #2's eMAR for July 2023 revealed: -There was an entry for Fluoxetine 20mg tablet with a scheduled administration time of 8:00am. -There was documentation Fluoxetine 20mg was administered on 07/01/23-07/02/23 at 8:00am. -There was documentation Fluoxetine 20mg was not administered on 07/03/23-07/06/23 with an exception documented as other. -There was a second entry for Fluoxetine 20mg capsule with a scheduled administration time of 2:00pm. -There was documentation Fluoxetine 20mg was not administered on 07/06/23-07/11/23 and 07/13/23 with an exception documented as other. -There was documentation Fluoxetine 20mg was administered on 07/12/23 and 07/14/23-07/31/23 at 2:00pm. Review of Resident #2's progress notes from 7/01/23-07/31/23 revealed: -From 07/01/23- 07/05/23, on 07/07/23, on 07/09/23, and on 07/11/23 there was documentation Resident #2's Fluoxetine was not	{D 358}		

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{D 358}	Continued From page 18 in the facility. -On 07/06/23, there was documentation the medication was a new order and the medication had not arrived from the pharmacy. -On 07/10/23, there was documentation the medication was not in the facility and the pharmacy, and the PCP would be notified. On 07/13/23, there was documentation the medication was not in the facility and the PCP had been notified. Observation of Resident #2's medications on hand on 08/01/23 at 11:32am revealed 30 capsules of Fluoxetine 20mg was dispensed on 07/11/23; 14 tablets were available to be administered. Telephone interview with a pharmacy technician at Resident #2's pharmacy on 08/01/23 at 1:58pm revealed: -Resident #2 had been on liquid Fluoxetine and a new order was received on 06/15/23 to change the medication to tablets. -Seven tablets of Fluoxetine 20mg were sent to the facility on 06/15/23 with documentation the insurance would not cover the tablets. -The documentation included a prior authorization for the tablets or other alternatives for the medication, capsules instead of tablets. -On 07/11/23, an order was received for Fluoxetine 20mg capsules, and a 30-day supply was sent to the facility. Telephone interview with the Pharmacist at Resident #2's pharmacy on 08/01/23 at 2:27pm revealed: -Fluoxetine should not be stopped abruptly. -The resident could experience worsening mood and withdrawals from the medication including increased heart rate and blood pressure,	{D 358}		

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{D 358}	Continued From page 19 agitation, and headaches. Interview with a MA on 08/02/23 at 9:46am revealed: -Resident #2 was administered liquid Fluoxetine until the order for the Fluoxetine tablets could be fixed. -She did not recall when she first called the pharmacy about Resident #2's Fluoxetine not being available. -If a resident had a medication that was ordered and if the medication was not delivered in 1-2 days, she would call the pharmacy. -She left the communication form requesting the PCP write the order and change Resident #2's Fluoxetine from tablets to capsules in the PCP's folder on 07/05/23. -She had found that leaving information for the PCP in their folder was the best way to communicate because when she called, it often took a while for the PCP to get the message. -She may have called the PCP too, but she could not remember. -She did not recall if she documented anything about reaching out to the PCP, because the facility's Licensed Practical Nurse (LPN) usually handled that. Telephone interview with Resident #2's PCP on 08/02/23 at 10:09am revealed: -She wrote an order on 06/15/23 to change Resident #2's Fluoxetine from a liquid to a tablet. -Resident #2 was having problems with ongoing depression and she wanted to make sure the resident was getting the full dosage of Fluoxetine, and sometimes with liquid, the measuring could be more challenging for the MAs. -She had not received any notification there was a problem with obtaining Resident #2's Fluoxetine between 06/15/23-06/26/23.	{D 358}		

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{D 358}	Continued From page 20 -She went out of town the week of 06/26/23 but would have expected the facility staff to have called before she left town if there was a problem with obtaining the medication. -When she returned to the facility for her weekly visits on 07/06/23, there was a note in her folder related to Resident #2's Fluoxetine. -If there was an issue that needed to be addressed, she would prefer the issue to be addressed immediately and not put in her folder for her to review the next time she was at the facility. -She did not know what the facility's policy was to notify the PCP, but it seemed like they would have notified her before the following week. -On 07/13/23, she called the pharmacy herself about Resident #2's Fluoxetine and was told the medication had been delivered, but she wrote the order again just to make sure there was no further confusion about the order. -Her electronic orders showed that equivalent substitutions could be made, so she did not know why the pharmacy did not substitute the tablets with capsules, to begin with. -Her concern was Resident #2's Fluoxetine was abruptly stopped, and the resident went without the medication. -Even though the resident would still have some effects of the medication in her system, it would be at a lower dose and would not be as effective and the resident could have some breakthrough depression and altered thoughts, which Resident #2 had experienced. -She was not sure if the changes Resident #2 was having were because of medication not being as effective or because the resident had a urinary tract infection (UTI). -It would take 4-6 weeks to get the full benefit of the Fluoxetine.	{D 358}		

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{D 358}	Continued From page 21 Interview with the facility's LPN on 08/02/23 at 5:21pm revealed: -She was not aware Resident #2's Fluoxetine was not started when the order changed from liquid to tablet. -The MA who was working when the new order was received would have been responsible for processing the order, sending it to the pharmacy. -As soon as the medication was changed from one form to another, the new order should have been implemented. -If the new form of the medication was not in the facility, the MA should have called the pharmacy to see why the medication had not been delivered. -Sometimes it would take a day or two to get the medication to the facility, but a resident should not go without medication for 3 days. -If there was an issue with getting the medication and the MA was having difficulty getting the issue resolved she should have been told so she could have worked on it. -Resident #2's Fluoxetine should not be stopped abruptly because the resident could experience withdrawals. -She had seen a change in Resident #2 because she had always been really pleasant but was refusing to take her medications and she seemed more depressed. -She thought the changes with Resident #2 were because the resident had a UTI. Interview with the Administrator on 08/02/23 at 6:12pm revealed: -If there was an issue with the insurance, the MA should immediately contact the resident's PCP to let them know because they may want to send an alternative medication. -The MAs should have used the medication tracking form and when the Fluoxetine did not	{D 358}		

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{D 358}	Continued From page 22 come in the next day they should have been trying to find out why the medication had not been delivered. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. c. Review of Resident #2's current FL-2 dated 06/08/23 revealed an order for Aspirin (used to prevent heart attack or stroke) 81mg daily. Review of Resident #2's electronic medication administration record (eMAR) for July 2023 revealed: -There was an entry for Aspirin 81mg with a scheduled administration time of 8:00am. -There was documentation Aspirin had been administered from 07/01/23-07/16/23, 07/21/23, and 07/26/23-07/31/23. -There were exceptions documented for 07/17/23-07/2023 and 07/22/23-07/25/23 as other. Review of Resident #2's progress notes from 7/01/23-07/31/23 revealed on 07/17/23-07/20/23 and 07/22/23-07/25/23 there was documentation Resident #2's Aspirin was not available to be administered; there was no documentation the pharmacy had been notified. Observation of Resident #2's medications on hand on 08/01/23 at 11:32am revealed 30 tablets of Aspirin 81mg were dispensed on 07/24/23; 23 tablets were available to be administered. Telephone interview with a pharmacy technician at Resident #2's pharmacy on 08/01/23 at 1:58pm revealed: -Resident #2's Aspirin 81mg was dispensed on	{D 358}		

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{D 358}	Continued From page 23 05/08/23, 06/12/23, and 07/24/23, and each was a thirty-day supply. -The request for Resident #2's Aspirin was on 07/24/23 and was sent out for delivery on 07/25/23. -Resident #2's medications were not cycle filled and would need to be requested for a refill. Telephone interview with the Pharmacist at Resident #2's pharmacy on 08/01/23 at 2:27pm revealed: -Aspirin was used to prevent heart attacks and stroke by keeping the blood thinned out. -Missing 8 doses of Aspirin 81mg in a row would be concerning and put the resident at an increased risk of a mini-stroke. Telephone interview with Resident #2's Primary Care Provider (PCP) on 08/01/23 at 3:21pm revealed: -She was not notified Resident #2 had missed doses of Aspirin 81mg. -She did not write the initial order for Resident #2's Aspirin, but the medication was used to prevent cerebellar vascular or cardiac events. -If Resident #2 missed her Aspirin it put the resident at a higher risk for a cardiac event or stroke. -She expected Resident #2's Aspirin to be administered as ordered. Interview with a Medication Aide (MA) on 08/02/23 at 9:46am revealed: -She did not recall anything about Resident #2's Aspirin not being available on the medication cart for administration on 07/07/17/23-07/25/23. -Typically, if a medication was not on the medication cart, she would call the pharmacy to see what was going on and if there were no refills, she would leave a communication form for	{D 358}		

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{D 358}	Continued From page 24 the PCP to request a refill. -Medication should be reordered when there was a one-week supply left of the medication. Interview with the facility's Licensed Practical Nurse (LPN) on 08/02/23 at 10:37am and 5:21pm revealed: -Medications should never run out. -The MAs were responsible for reordering medication. -She expected medications to be reordered before the medication ran out to ensure the resident did not have to go without the medication until it was delivered. -Medication should be reordered when there was a 7-10-day supply remaining of the medication. -The MAs should be tracking to see when the medication had been delivered by keeping an eye on the medication cart and ensuring the medication had been delivered. -They usually did not have any issues with medication being available if it was ordered 7-10 days before it ran out. -It was usually only an issue when the medication was ordered at the last minute. -She expected medications to be re-ordered early, so if there was an issue, it could be figured out before the medication ran out. Interview with the Administrator on 08/02/23 at 6:12pm revealed: -There was no written policy as to when the MA should reorder the medication, but she expected it to be ordered 7days before the last dose because you had to allow time for the medication to get to the facility. -She expected medication to be available and to be administered as ordered. Based on observations, interviews, and record	{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 reviews, it was determined Resident #2 was not interviewable. d. Review of Resident #2's current FL-2 dated 06/08/23 revealed an order for Acetaminophen (used to treat mild pain) 325mg take 2 tablets twice daily. Review of Resident #2's electronic medication administration record (eMAR) for June 2023 revealed: -There was an entry for Acetaminophen 325mg take two tablets twice daily with a scheduled administration time of 8:00am and 7:00pm. -There was documentation Acetaminophen 325mg was administered twice daily from 06/01/23-06/30/23. Review of Resident #2's eMAR for July 2023 revealed: -There was an entry for Acetaminophen 325mg take two tablets twice daily with a scheduled administration time of 8:00am and 7:00pm. -There was documentation Acetaminophen 325mg was administered twice daily from 07/01/23-07/31/23 except for four exceptions. -Exceptions documented were on 07/10/23 for both the 8:00am and 7:00pm dose as refused, the 8:00am dose on 07/24/23 as refused, and the 7:00pm dose on 07/26/23 due to the resident being at the hospital. Review of Resident #2's eMAR for 08/01/23 revealed : -There was an entry for Acetaminophen 325mg take two tablets twice daily with a scheduled administration time of 8:00am and 7:00pm. -There was documentation that Acetaminophen 325mg was administered on 08/01/23 at 8:00am.	{D 358}		

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{D 358}	Continued From page 26 Observation of Resident #2's medications on hand on 08/01/23 at 11:33am revealed: -There was a medication card for Acetaminophen labeled as dispensed on 07/03/23 for 30 tablets and the card was card one of four; twenty-three tablets remained on the card. -There was a second medication card for Acetaminophen labeled as dispensed on 07/03/23 for 30 tablets and the card was card two of four; thirty tablets remained on the card. Telephone interview with a pharmacy technician at Resident #2's pharmacy on 08/01/23 at 1:58pm revealed: -Resident #2's Acetaminophen was dispensed on 04/20/23, 05/25/23, and 07/03/23 for a 30-day supply. -Resident #2's Acetaminophen was not requested to be refilled in June 2023 and therefore was not dispensed. Based on observations, interviews, and record reviews, Acetaminophen was documented as administered 53 times from 07/03/23-08/01/23. There should have been no more than 14 tablets of Acetaminophen remaining on 08/01/23 and 53 tablets were remaining. Telephone interview with the Pharmacist at Resident #2's pharmacy on 08/01/23 at 2:27pm revealed: -If Resident #2's Acetaminophen was not being administered as ordered, the resident was not being properly treated for pain. -If the resident was having pain and did not receive the Acetaminophen, she would have increased pain, which could also increase the resident's agitation. Telephone interview with Resident #2's Primary	{D 358}		

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{D 358}	Continued From page 27 Care Provider (PCP) on 08/01/23 at 3:21pm revealed: -Resident #2 had a diagnosis of osteoarthritis -If Resident #2's Acetaminophen was not administered as ordered, it could contribute to the resident's discomfort, especially in her knees and lower back. -She scheduled Resident #2's Acetaminophen because she knew Resident #2 would not remember to ask for the medication. Telephone interview with Resident #2's family member on 08/01/23 at 5:52pm revealed: -Resident #2 often complained of pain when she was visiting. -She would hear Resident #2 say "oooh and ahhh" when getting up from sitting and/or moving around and when she asked Resident #2 what was wrong, Resident #2 would say she was stiff or hurting. -She would ask Resident #2 if she had asked for anything for pain and the resident would not remember if she did or not. -She had been to the medication aide (MA) and asked if Resident #2 had been administered anything for pain and the MA would respond the resident had not asked for anything. -She told the MA she did not think Resident #2 would ask for pain medication. Interview with a MA on 08/02/23 at 9:46am revealed: -She did not know why there was more Acetaminophen available to be administered than there should be based on dispensed dates and documentation. -The facility did not use house stock for any medication. Interview with the facility's Licensed Practical	{D 358}		

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{D 358}	Continued From page 28 Nurse (LPN) on 08/02/23 at 5:21pm revealed: -Medications should never run out. -The MAs were responsible for reordering medication. -She expected medications to be reordered before the medication ran out to ensure the resident did not have to go without the medication until it was delivered. -She expected Resident #2's Acetaminophen to be administered as ordered. Interview with the Administrator on 08/02/23 at 6:12pm revealed she was concerned the MAs were documentation administering a medication that had not been administered and the resident could have been in pain and not received what she needed. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. The facility failed to ensure medications were administered as ordered for a resident (#2) who had a history of Alzheimer's disease and mini-strokes, had a change in condition and was sent to the ED, received an order for an antibiotic to treat a UTI, and the resident missed 14 doses of the antibiotic before the medication was started; missed at least 11 doses of an antidepressant medication that was changed from a liquid to a tablet and should not be abruptly stopped because it could result in worsening mood and withdrawals from the medication including increased heart rate and blood pressure, agitation, and headaches; and missed 9 doses of a medication used to prevent mini-strokes. This failure was detrimental to the health, safety, and welfare of the resident and constitutes an Unabated Type B Violation.	{D 358}		

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{D 358}	Continued From page 29 The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/02/23 for this violation.	{D 358}		
{D 377}	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that the residents' medications were stored in a safe and secure manner for 2 of 2 sampled resident (#5 and #7) who had over the counter (OTC) medications unsecured in the resident's room (#5) and who self-administered medications (#7). The findings are:	{D 377}	1) The Dec and Wellness secretary to do walk theagh of Suites to identify and address any meds seen Lying around in visual sight. Completed - 8/31/2023 2) Remove any meds in Suites that are not self admin and call family to pick up and address meds being braught in. Completed - 8/31/2023 by Dec	

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{D 377}	Continued From page 30 Review of the facility's Resident Self-Administration of Medications policy revealed residents capable of self-administration may store prescription and non-prescription medications on their person or in their apartment as long as they keep them safe and secure from other residents. Review of the facility's Medication Administration policy revealed: -Residents who engage in self-administration of medications may store medications in a secure area in their apartment. -Residents medications are to be stored in a locked storage area accessible to authorized personnel only. 1. Review of Resident #5's current FL2 dated 06/01/23 revealed: -Diagnoses included diabetes mellitus, atrial flutter and anxiety. -There was no information related to Resident #5's orientation status. -Medication orders included tamsulosin (used to treat enlarged prostate) 0.4mg daily, metoprolol (used to treat high blood pressure) 50mg daily, donepezil (used to treat dementia) 5mg at bedtime, apixaban (used to prevent blood clots) 5mg daily, lisinopril (used to treat high blood pressure) 5mg daily, sertraline (used to treat depression) 50mg daily, omeprazole (used to treat indigestion, heartburn, and acid reflux) 20mg daily, metformin (used to treat high blood glucose) 500mg 2 times a day, acetaminophen (used to treat pain) 1,000mg every 4 hours as needed and calcium carbonate (used to treat heart burn) 1 tablet as needed. -There was no order to self-administer any medications. Observation of Resident #5's room on 08/02/23 at	{D 377}	3) Insure all self med Residents are using their locked boxes appropriately and no meds left out in there Suite Completion 8/31/2023 4) DRC and Wellness Secretary to weekly do walk through of Suites to insure no meds are lying around. ongoing Completion - 9/15/2023	

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{D 377}	Continued From page 31 9:30am, 11:15am, 1:05pm and 3:30pm revealed: -Resident #5 was not in his room and the door was not locked. -There was a bottle of antidiarrheal medication, a tube of triple antibiotic ointment and 2 tubs of joint/muscle cream on the dresser beside the bed. Telephone interview with Resident #5's Primary Care Provider (PCP) on 08/02/23 at 3:44pm revealed: -Resident #5 had a diagnosis of dementia and was not able to self-administer any medications. -She did not know he had over the counter antibiotic ointment, muscle/joint creams and antidiarrheal medication in his room. -She thought his family may have brought the medications into the facility, because that was a frequent problem. -The medications he had in his room were harmless and she was not concerned if he had already taken/used any. -The staff should have informed her whenever a resident had any medications that were not ordered and she would consider ordering them for staff to administer if appropriate. Based on observation, record review and interview, it was determined Resident #5 was not interviewable. Interview with a personal care aide (PCA) on 08/02/23 at 1:35pm revealed: -She did not see medications in Resident #5's room. -She would report to the MA if she saw medications in a room. -She did not see Resident #5's medication sitting on the dresser by his bed.	{D 377}		

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{D 377}	Continued From page 32 Interview with a medication aide (MA) on 08/02/23 at 1:40pm revealed: -She noticed Resident #5's medication on the dresser by his bed. -She would not leave a prescription medication in Resident #5's room. -She did not think Resident #5 had self-administration orders. -She did not think residents needed orders for over-the-counter medications like antibiotic ointment, antidiarrheal liquid and lotions. Telephone interview with Resident #7's Primary Care Provider (PCP) on 08/02/23 at 3:44pm revealed: -She wrote a self-administration of medication order for Resident #7, and he was able to self-administer all his medications safely. -He had a lock box to secure his medications and he understood he was to do so, though he would be stubborn and do what he wanted. -She thought she wrote an order for a chewable antacid for him and believed him having it was not harm. -The staff should have informed her whenever a resident had any medications that weren't ordered, and she would consider ordering them for staff to administer if appropriate. Telephone interview with another MA on 08/02/23 at 3:50pm revealed: -Residents who self-administered medications must have an assessment to administer and their medications should have been kept in their lock box. -She did not know if Resident #5 had unsecured medications in his room. -She worked third shift (11:00pm-7:00am) and did not have to give him medications at night unless he requested them, so she would not have seen	{D 377}		

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{D 377}	Continued From page 33 OTC medications on his dresser. Interview with the Resident Care Director (RCD) on 08/02/23 at 5:20pm revealed: -Residents who self-administered medications had to be assessed to determine if they were capable to safely administer their own medications and should keep the medications in a locked box. -Resident #5 did not have a self-administration of medication order and should not have had any medications in his room. -She did not know Resident #5's had OTC medications in his room and thought his family must have given them to him. -Management had asked family/friends not to bring in medications without informing facility staff, but some continue to bring in medications they buy OTC. Interview with the Administrator on 08/02/23 at 6:05pm revealed: -Residents who self-administered medications should have medications stored in a locked box or locked drawer. -Resident #5 did not have self-administration of medication orders. -She did not know Resident #5 had OTC medications in his room and MAs should have removed any medications that were not ordered and from any resident that could not self-administer medications. 2. Review of Resident #7's current FL2 dated 06/01/23 revealed: -Diagnoses included hypertension, atrial flutter and anxiety. -Resident #7's orientation status was intermittently confused. -Medication orders included aspirin (used to	{D 377}		

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{D 377}	Continued From page 34 prevent blood clots) 81mg daily, vitamin B12 (used to treat B12 deficiency) 500 mcg 2 tablets daily, trazadone (used to treat insomnia) 50mg half tablet at bedtime, Cardizem (used to treat irregular heart rate) 120mg daily, meclizine (used to treat dizziness) 25mg every 6 hours as needed, omeprazole (used to treat indigestion, heartburn, and acid reflux) 10mg daily, senna (used to treat constipation) 8.6 mg at bedtime. Review of Resident #7's physician's orders revealed a self-administration order for all medications dated 11/01/21. Observation of Resident #7's room on 08/02/23 at 9:15am, 11:00am, 1:00pm and 3:40pm revealed: -Resident #7 was not in his room and the door was not locked. -There were 2 bottles of chewable antacid, one on a table beside his recliner and one on the dresser by his bed. Interview with a personal care aide (PCA) on 08/02/23 at 1:35pm revealed: -Resident #7 had always had medications in his room, and she thought he was allowed to have them. -She would report to the MA if she saw medications in a room of a resident who was not allowed to keep them. Interview with a medication aide (MA) on 08/02/23 at 1:40pm revealed: -Resident #7 had self-administration of medication orders. -Resident #7's kept his antacid medication at his bedside or his recliner. -Resident #7 had a locked box and kept all his other medication in it. -She did not think other residents wandered into	{D 377}		

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{D 377}	Continued From page 35 his room or would bother his antacid. Telephone interview with Resident #7's Primary Care Provider (PCP) on 08/02/23 at 3:44pm revealed: -She wrote a self-administration of medication order for Resident #7, and he was able to self-administer all his medications safely. -He had a locked box to secure his medications and he understood he was to do so, though he would be stubborn and do what he wanted. -She thought she wrote an order for a chewable antacid for Resident #7 and having the antacid was not harmful. -The staff should have informed her whenever a resident had any medications that were not ordered, and she would consider ordering them for staff to administer if appropriate. Telephone interview with another MA on 08/02/23 at 3:50pm revealed: -Residents who self-administered medications must have an assessment to administer and their medications should have been kept in their locked box. -She did not know if Resident #7 had unsecured medications in his room. -She worked third shift (11:00pm-7:00am) and did not have to give him medications at night unless he requested them, so she would not have seen OTC medications on his dresser. Interview with Resident #7 on 08/02/23 at 4:40pm revealed: -He kept and self-administered all his medications. -He had a locked box the facility gave him to store all his medications. -He did not lock his apartment door when he was out.	{D 377}		

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{D 377}	Continued From page 36 -He did not put his antacid in the locked box in case he needed one before/after eating. -He was out of his room frequently for meals, sitting on the porch or other activities. -He understood other confused residents could wander into his room, but he did not think that ever happened. Interview with the RCD on 08/02/23 at 5:20pm revealed: -Residents who self-administer medications must be assessed to determine if they are capable to safely administer their own medications and should keep the medications in a lock box. -Resident #7 had a self-administration of medication order and had a locked box. -She had spoken to Resident #7's on several occasions regarding leaving his medications out of his box, but he still did as he pleased and would not always put all of his medications in his locked box when he would leave the room. -MAs and PCAs should have reminded him to put his medication away each time they see any in view. Interview with the Administrator on 08/02/23 at 6:05pm revealed: -Residents who self-administer medications should have medications contained in a locked box. -Resident #7 had self-administration of medication orders and was given a lock box to store his medications in. -Resident #7 had been educated multiple times about keeping his medications out of site in his locked box, but he still just did whatever he wanted. -She expected MAs and PCAs to monitor for medications when they were in rooms each shift and ask the resident to secure them properly.	{D 377}		

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{D 451}	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to notify the County Department of Social Services (DSS) of incidents/accidents that required emergency medical evaluation for 2 of 5 residents (#5 and #6). The findings are: 1. Review of Resident #5's current FL2 dated 06/01/23 revealed diagnoses included diabetes mellitus, atrial fibrillation and anxiety. Review of Resident #5's accident/incident report dated 07/25/23 revealed: -The Incident/accident report was completed by the Resident Care Director on 07/25/23. -Resident #5 fell getting out of bed on 07/24/23 with no time noted. -Resident #5 complained of ankle pain. -Resident #5 was sent out by emergency medical services (EMS) to the local hospital. -Resident #5's family contact and Primary Care Provider (PCP) were notified. -Resident #5 returned from the hospital visit with orders for an ankle brace.	{D 451}	1) DRC to send in incident Report to DSS (County Monitor) next business day after incident. Completed 8/11/2023 2) Book located in ED office for all faxed reports. Completed 8/11/2023 3) Ongoing to be monitored by DRC and ED. 8/11/2023 Completion - 8/15/2023	

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{D 451}	Continued From page 38 Review of Resident #5's emergency department (ED) report dated 07/24/23 revealed: -Resident #5 was evaluated for a fall, face contusion and left ankle swelling. -His left ankle was sprained, but there were no fractures identified through imaging. -He was ordered to elevate his left ankle, to wear a compression bandage as needed on his left ankle and use acetaminophen for pain if needed. Telephone interview with the Adult Services Supervisor of the County Department of Social Services (DSS) on 08/02/23 at 12:00pm revealed the office did not receive an incident/accident report for Resident #5 for the ED visit on 07/24/23 due to a fall until 08/02/23. Refer to the interview with the Resident Care Director (RCD) on 08/02/23 at 2:45pm. Refer to the interview with the Administrator on 08/02/23 at 2:50pm. 2. Review of Resident #6's current FL2 dated 05/15/23 revealed diagnoses included dementia, hypertension and hypothyroidism. Review of Resident #6's accident/incident report dated 07/31/23 revealed: -The Incident/accident report was completed by the Director of Resident Care (DRC). -Resident #6 fell in her room unwitnessed on 07/29/23 with no time noted. -Resident #6 complained of right hip pain. -EMS was called and Resident #6 was transferred to the hospital. -Resident #6's family contact and Primary Care Provider (PCP) were notified. -Resident #6 had a broken right hip and was	{D 451}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001141	A. BUILDING: _____ B. WING _____	R 08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF BURLINGTON	118 ALAMANCE ROAD BURLINGTON, NC 27215

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{D 451}	Continued From page 39 hospitalized to have surgery that Sunday on 07/30/23. Telephone interview with the Adult Services Supervisor of the County Department of Social Services (DSS) on 08/02/23 at 12:00pm revealed the office did not receive an incident/accident report for Resident #6 for the hospital admission on 07/29/23 due to a fractured right hip related to a fall until 08/01/23. Refer to the interview with the Resident Care Director (RCD) on 08/02/23 at 2:45pm. Refer to the interview with the Administrator on 08/02/23 at 2:50pm. Interview with the Resident Care Director (RCD) on 08/02/23 at 2:45pm revealed: -She was responsible to send incident/accident reports that required emergency medical attention to the County DSS. -Resident #5's had a fall and was sent to the ED for evaluation on 07/24/23. -She just forgot to send Resident #5's incident/accident report to the County DSS on 07/24/23 but sent it today on 08/02/23. -Resident #6's incident/accident occurred on a Saturday, 07/29/23. -She would normally send it the first business day she was back in the office, which would have been 07/31/23. -She forgot to send Resident #6's incident/accident report to the County DSS on that Monday but sent it yesterday on 08/01/23. Interview with the Administrator on 08/02/23 at 2:50pm revealed: -The RCD was responsible for reporting incidents/accidents that required emergency	{D 451}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001141	A. BUILDING: _____ B. WING _____	R 08/02/2023

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{D 451}	Continued From page 40 medical attention to the County DSS. -She expected the RCD to report all incidents/accidents that required emergency medical attention to the County DSS.	{D 451}		