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	HAL066012	A. BUILDING: _____ B. WING _____	R 08/31/2023

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HAMPTON MANOR	320 BROUGHTON STREET GASTON, NC 27832

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D 000	Initial Comments The Adult Care Licensure Section and the Northampton County Department of Social Services conducted an annual survey, a follow-up survey, and a complaint investigation from August 29, 2023, to August 31, 2023, with an exit conference via telephone on August 31, 2023. The complaint investigations were initiated by the Northampton County Department of Social Servicees on August 10, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to maintain an environment which was free from chronic unpleasant odors. The findings are: Observation of the Special Care Unit (SCU) on 08/29/23 at 8:06am revealed there was a strong smell of urine upon entrance to the unit that permeated throughout the halls. Second observation of the SCU on 08/30/23 at 7:54am revealed: -There was a strong smell or urine upon entrance to the unit.	D 075	Hampton Manor shall ensure that the facility has no chronic unpleasant odors. Executive Director (ED) in-serviced staff on housekeeping expectations, the importance of daily decluttering of Resident rooms and ensuring cleanliness, consistent routines for toileting the incontinent Residents, and that soiled incontinent supplies should be secured in a sealed trashbag and disposed of promptly after providing incontinent care. ED in-serviced staff on Resident Rights. Care Managers will make unit rounds no less than twice daily to ensure the facility smells pleasant and clean. Any odors noted will be addressed immediately, finding the root cause, correcting the cause, and requesting housekeeping to refresh the area. ED/ or Designee will make facility	9/14/23 10/4/23 10/5/23 9/14/23 10/4/23 10/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Glenda Majette ED - 10-16-23

Reviewed and acknowledged 10/18/23 SJS

Glenda Majette 10-16-23

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D 075	Continued From page 1 -The strong smell of urine extended outside the locked SCU doors and onto the Assisted Living (AL) side of the facility. -There was a foul, pungent odor smell near the nursing station across from the dining hall. -There was a urine odor in and around a resident's room (room #133A) and throughout the unit. Third observation of the SCU on 08/30/23 at 8:17am revealed: -There were 24 residents in the dining room eating breakfast. -There was a strong smell of urine in the dining room. -There were no observations of unkempt residents or residents with soiled incontinent briefs. Fourth observation of the SCU on 08/30/23 at 1:33pm revealed there was a strong smell of urine upon entrance to the unit that permeated throughout the halls. Telephone interview with a resident's family member on 8/30/23 at 11:00 am revealed: -The smell on SCU hall was awful and made her gag. -The family member did not visit with the resident on the SCU hall because of the odor. -The family member visited with the resident in the sitting area of the assisted living hall in the front of the building. -The family member was concerned and did not know why the facility owner would not do something about the odor. Interview with a resident residing on the SCU on 08/30/23 at 10:18am revealed: -There was a strong smell of urine in the halls of	D 075	rounds no less than twice daily to ensure the facility smells pleasant and clean. Any odors noted will be addressed immediately, finding the root cause, correcting the cause, and requesting housekeeping staff to clean the area.	10/15/23

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D 075	Continued From page 2	D 075		

the SCU "just about every day".
-There were several residents on the SCU who had wandering behaviors and sometimes those residents urinated on the floor in the hallways.
-She once complained about the strong smell of urine to a medication aide (MA) who told her she would have someone from housekeeping come clean the area.

Interview with housekeeping staff on 08/23/23 at 8:29am revealed:
-There was one housekeeping staff assigned to clean the SCU and another housekeeping staff assigned to clean the AL side of the facility each day.
-It was the responsibility of the housekeeping staff to sweep and mop all floors daily in common areas and resident rooms and bathrooms.
-The housekeeping staff would repeat sweeping and mopping more frequently when needed.

Interview with a personal care aide (PCA) on 8/30/23 at 2:15 pm revealed:
-Some residents soiled their wheelchairs and needed a bath, some residents had urinary tract infections, and some residents were heavy wetters, contributing to the bad order on the SCU hall.
-The laundry for the residents does not begin until 9 pm at night.
-The soiled clothing stays in the resident's private hamper until it is ready to be transported for laundry.

Interview with a medication aide (MA) on 08/30/23 at 1:58pm revealed:
-She normally worked first shift on the SCU.
-There was usually a strong smell of urine on the SCU.
-Checks were performed on incontinent residents

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D 075	Continued From page 3 in the SCU every 2 hours. -If a resident was known to have more incontinent episodes SCU staff performed checks on those residents every hour. -She thought there was a strong smell of urine on the SCU because sometimes residents had incontinent accidents in their wheelchairs. -If a resident had an incontinent accident in their wheelchair, she would assist the resident with getting clean and then she would take the wheelchair to the shower and wash it. -There were some residents who would urinate in the floor on the SCU. -If a resident urinated in the floor on the SCU she would alert housekeeping staff to clean the area. -If housekeeping staff was not available to clean the area, she would clean the area. Telephone interview with the Special Care Coordinator (SCC) on 08/31/23 at 1:30pm revealed: -There was a strong smell of urine on the SCU. -The facility had been trying to get rid of the smell. -Sometimes soiled incontinent briefs were left in trash cans on the SCU or soiled laundry was left in the floor of a resident's room which contributed to the strong smell or urine. -There were residents on the SCU who sometimes urinated in the floor. -The facility had moved up checks on residents on the SCU who were incontinent to every 1 hour instead of every 2 hours. -Staff on the SCU were expected to remove any trash bags that contained soiled incontinence briefs immediately to help with the strong smell of urine. -Staff on the SCU were expected to remove any soiled laundry from a resident's room once they were done caring for that resident and tie them up in a bag and wash them immediately.	D 075		

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D 075	Continued From page 4 Telephone interview with the Administrator on 08/31/23 at 2:57pm revealed: -There was a smell of urine on the SCU. -She thought approximately 75-85 percent of the residents on the SCU were incontinent of urine which contributed to the smell. -Staff on the SCU were expected to immediately remove trash from the SCU which contained soiled incontinence briefs. -Staff on the SCU were expected to take any clothing that was soiled with urine to the laundry and wash it immediately. Telephone interview with the facility's primary care provider (PCP) on 08/30/23 at 3:01pm revealed: -There was a strong smell of urine on the SCU. -She had not addressed the strong smell of urine on the SCU with any staff at the facility. -The SCU did not smell clean. -She did not know why there was a strong smell or urine on the SCU. -Once she had the facility move a resident out of a room because the room "reeked" and it was not safe for the resident to remain in the room. -The strong odors on the SCU could cause the residents to have nasal irritation.	D 075		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.	D 079	Hampton Manor shall ensure the facility is maintained in an uncluttered, clean, and orderly manner, free of all obstr-uctions and hazards. Executive Director (ED) in-serviced 9/14/23 staff on housekeeping expectations, 10/4/23 the importance of daily decluttering of Resident rooms and ensuring clean- 10/5/23 liness. She in-serviced on ingestibles and hazards, and the importance of	

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D 079	Continued From page 5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards in nine resident rooms including toiletries, disposable razors, a prescription cream, and a box of insulin needles accessible to residents. The findings are: Review of the facility's census revealed the facility's census in the SCU was 37 residents. Review of the facility's policy for SCU Safety Measures for Accidental Ingestion dated September 2021 revealed: -The facility had a quality assurance program for accidental ingestion which included assessments to identify potential ingestion risks, and interventions to reduce the risks. -Facility staff would conduct periodic screening of personal items that could be ingested including all liquid personal items and aerosols were in a secure location until needed for resident use. -Resident rooms and care areas were inspected regularly for unsafe items that could be accidentally ingested or harmful. -All utility and laundry closets were to remain locked unless under direct supervision by staff. -All toxic substances should be secured in a locked area unless under direct supervision by staff. -Items used for activities which could be ingested would only be used while under direct supervision.	D 079	keeping these items secured in their designated areas away from Resident access. Staff were in-serviced on the importance of making a walk through at the end of their shifts, and that Care Managers will be completing rounds during the shift to ensure safety. ED in-serviced staff on Resident Rights. 9/14/23 10/4/23 Care Managers will make unit rounds no less than twice daily to ensure there are no hazards present, and all medical equipment is appropriately stored. Any noted concerns will be addressed immediately, followed by education with the staff. 10/13/23 ED will make facility rounds no less than twice daily to ensure there are no hazards present, and all medical equipment is appropriately stored. Any noted concerns will be addressed promptly with the respective Care Manager. 10/13/23	

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D 079	Continued From page 6 -Staff training included the identification and controlling of potential ingestible hazards which included monitoring the facility for substances that could be accidentally ingested. Observation of a resident's room on the Special Care Unit (SCU) on 08/29/23 at 9:37am revealed: -There was an unlocked closet to the left of the room. -The basket contained a pedicure kit which included a fingernail file, nail clippers, and three wooden sticks with a sharp point on the end. -There was an unlocked closet to the right of the room. -There was a bottle of lotion with a warning if swallowed get medical help or contact a poison control center. Observation of a second resident's room on the SCU on 08/29/23 at 10:01am revealed: -There was an unlocked closet. -There was one bottle of hand sanitizer with a warning to keep out of reach of children, keep out of eyes, avoid contact with broken skin, do not inhale, or ingest, and if swallowed get medical help or contact a poison control center. -There was one aerosol container of air freshener on the top shelf with a warning to use only as directed, intentional misuse by deliberately concentrating or inhaling the contents can be harmful or fatal, and to keep out of reach of children and pets. -There was a plastic tote with a handle located on the shelf of the closet without a secured top. -The tote included disposable razors, and denture cleaning tablets with a warning to not place tablets in mouth, keep out of reach of children, and in case of accidental ingestion seek professional assistance or contact a poison control center.	D 079		

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D 079	Continued From page 7 Observation of a third resident's room on the SCU on 08/29/23 at 10:02am revealed: -There was an unlocked closet. -There was a basket on the top shelf which contained shaving cream with a warning to keep out of reach of children, deodorant with a warning to keep out of reach of children, if swallowed, get medical help, or contact poison control center, and a disposable razor. Observation of a fourth resident's room on the SCU on 08/29/23 at 10:03am revealed: -There was an unlocked closet. -There was a bottle of mouthwash on the top shelf of the resident's closet with a warning to keep out of reach of children under 6 years of age, if more than used for rinsing is swallowed, get medical help, or contact poison control center. -There was an aerosol air freshener on the top shelf of the resident's closet with a warning to use only as directed, intentional misuse by deliberately concentrating or inhaling the contents can be harmful or fatal and to keep out of reach of children and pets. Observation of a fifth resident's room on the SCU on 08/29/23 at 10:11am revealed: -There was one resident in the room and a personal care aide (PCA). -The resident had a nightstand by her bed with two drawers. -The two drawers of the nightstand did not have a locking device on them and could not be locked. -The top drawer of the nightstand contained one box of approximately 32 single use insulin pen needles with the cover on them with a warning to keep out of reach of children and pets. -The top drawer of the nightstand contained a one fluid ounce over the counter eye drops with a	D 079		

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D 079	Continued From page 8 warning to keep out of reach of children, if swallowed seek medical help or contact a poison control center. -The top drawer of the nightstand contained a one fluid ounce facial moisturizer with a warning to keep out of reach of children, do not use on broken skin, keep out of eyes, if rash occurs discontinue use and if swallowed get medical help or contact a poison control center. -The top drawer of the nightstand contained a one ounce tube of Clotrimazole Cream 1% (Clotrimazole Cream is used to treat skin infections such as athlete's foot, jock itch, and ringworm) with a warning label to keep out of reach of children, avoid contact with eyes, and if accidental ingestion seek professional assistance or contact poison control center. Interview with the resident that resided in the room where hazardous items were in her nightstand drawer on 08/29/23 at 10:13am revealed: -She had recently moved from the assisted living (AL) side of the facility to the SCU. -She was not aware that the items in her nightstand needed to be secured. Observation of a sixth resident's room on the SCU on 08/29/23 at 10:13am revealed: -There were two unlocked closets. -There was a bottle of lotion located on the top shelf laying in a pink bucket in the first closet with a warning if swallowed get medical help or contact a poison control center. -There was one tub of petroleum jelly on the top shelf of the second unlocked closet with a warning to keep out of reach of children and if swallowed get medical help or contact poison control center.	D 079		

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D 079	Continued From page 9 Observation of a seventh resident's room on the SCU on 08/29/23 at 10:15am revealed: -There was an unlocked closet. -There was a tube of medicated body lotion with a warning to keep out of reach of children and two cans of foaming shave gel with a warning to keep out of reach of children on the top shelf of the closet. Observation of an eighth resident's room on the SCU on 08/29/23 at 10:16am revealed: -There were two unlocked closets. -There were two cans of aerosol shaving gel in the first closet with a warning label to keep out of reach of children. -There were fingernail files and a bottle of liquid nail polish remover in the second unlocked closet with a warning to keep out of reach of children, harmful if ingested, and in case of accidental ingestion contact a poison control center. -There was one tube of toothpaste in the second unlocked closet with a warning that if accidentally swallowed more than usual for brushing get medical help or contact a poison control center. -There was one deodorant in the second unlocked closet with a warning to keep out of reach of children and if swallowed get medical help or contact a poison control center. Observation of a ninth resident's room on the SCU on 08/29/23 at 10:17am revealed: -There were two unlocked closets. -There was one solid air freshener on the top shelf of the first unlocked closet with a warning to keep out of reach of children and pets. -There was one solid air freshener on the top shelf of the second unlocked closet with a warning to keep out of reach of children and pets. Observation of the SCU on 08/30/23 at 1:35pm	D 079		

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D 079	Continued From page 10 revealed: -A female resident wandered into a male resident's room. -The male resident was asleep in the bed. -The female resident adjusted the bed covers on the male resident's bed. -The female resident left the male resident's room at 1:36pm and wandered into another male resident's room. -The second male resident was asleep in a wheelchair. -The female resident wandered around the room picking up items and looking at them. -A PCA came to the second male resident's room at 1:37pm and redirected the female resident to her room. Interview with a resident on the SCU on 08/30/23 at 10:18am revealed: -She had been a resident on the SCU since 11/01/18. -There were several residents on the SCU who had wandering behaviors. -There were some residents who would wander into her room when she was not in the room and would move things. -Someone from the facility came in and removed all the toiletry items from her room yesterday, 08/29/23. -The items were removed from her room because there was a male resident on the SCU who would drink body wash. Interview with a personal care aide (PCA) on 08/29/23 at 9:48am revealed: -Toiletry items on the SCU were supposed to be locked in the resident's closets but the facility was "in the midst of" removing the locks from the closets. -It was important that toiletry items on the SCU be	D 079		

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D 079	Continued From page 11 locked away from residents because there were residents with wandering behaviors who may ingest them. -There were 5 residents on the SCU who had wandering behaviors. -She had never known of any of the residents on the SCU to ingest any toiletry items or injury themselves with any of them. Interview with a PCA on 08/29/23 at 12:51pm revealed: -The hygiene and toiletry supplies were stored in the closet in the common bathroom or in the residents' rooms. -The facility had residents that wandered into other resident rooms. -The PCA would redirect residents who wandered out of other resident rooms. -Resident closets should have been locked so residents would not be at risk of ingesting hazardous items. -Some resident closets were locked, but most were not. -She was not aware why they were not being locked. Confidential interview with a staff member on 08/29/23 at 1:06pm revealed: -The PCA staff was responsible for providing showers for the residents. -Shower supplies were stored in the residents' personal closet, common bathroom, and the Special Care Coordinator's (SCC) office. -There were residents in the SCU that wandered into other residents' rooms and would fumble through their belongings. -It was hazardous to keep razors in resident rooms as someone could injury himself, herself, or another resident. -She was not aware that certain residents had	D 079		

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D 079	Continued From page 12 razors in their rooms. -It was hazardous to store ingestible products in unsecure locations. -She was aware that hygiene products were ingestible products and were found in residents' closets. Interview with a medication aide (MA) on the SCU on 08/29/23 at 12:08pm revealed: -All ingestible products on the SCU should be secured in a locked area to prevent residents from accidentally ingesting the items. -Ingestible products were secured in the medication room on the SCU and locked. -When a PCA needed to shave a resident, they were expected to obtain a disposable razor from the MA on duty on the SCU and return the disposable razor to the MA once they completed personal care with that resident. -She was not aware that personal care items, razors, a prescription cream, and insulin needles were not secured on the SCU. Interview with a MA on the SCU on 08/30/23 at 1:58pm revealed: -There were residents with wandering behaviors on the SCU. -There was a male resident on the SCU who drunk body wash in the past. -She was not sure how long ago it was that the resident drank body wash, but it was "some months ago". -After the male resident drank body wash a plan was developed to keep all items that could be ingested locked in resident's closets. -She did not know why ingestible items were not locked in SCU resident's closets on 08/29/23. Telephone interview with a second MA on the SCU on 08/31/23 at 1:11pm revealed:	D 079		

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D 079	Continued From page 13 -All toiletry items on the SCU should be locked away so residents would not ingest them and become sick. -She was new on the SCU and did not know of any residents who had ingested any toiletry items. Telephone interview with the Special Care Coordinator (SCC) on 08/31/23 at 1:30pm revealed: -Toiletries for SCU residents were normally kept in a basket in the closet in their room. -The closets were not locked because it was a resident rights issue. -The closets in the SCU resident's room used to have locks on them but the locks were removed about 2 weeks ago. -It was important to keep toiletries locked on the SCU because a resident might eat them and get sick. -She was not aware of any residents ingesting any toiletry items on the SCU. Telephone interview with the Administrator on 08/31/23 at 2:57pm revealed: -Toiletry items on the SCU were not locked on 08/29/23 because staff had not locked them. -It was important for any ingestible hygiene items or needles to be locked because there were many residents on the SCU with dementia and wandering behaviors who might think the items were candy and ingest them. -She was not aware of any residents on the SCU ingesting any toiletry items. Telephone interview with the facility's PCP on 08/30/23 at 3:01pm revealed: -She expected any toiletry items that could be ingested by residents on the SCU to be locked away at all times. -Residents on the SCU were often confused and	D 079		

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D 079	Continued From page 14 if they had access to toiletry items such as soap and lotion they could eat them, drink them, or get them in their eyes. -She was not aware of any residents on the SCU ingesting any toiletry items, but another PCP may have been made aware. -She was not sure what the side effects of ingesting soap or lotion might be, but it would not be pleasant experience for the resident. -She was concerned that there were unlocked insulin pen needles found on the SCU because a resident could injure themselves with the needle. The facility failed to secure hazardous items to protect 37 residents who resided on the SCU with residents who had known wandering behaviors, including toiletries consisting of liquids, paste, lotions, deodorants, aerosols, fingernail clippers, disposable razors, a prescription cream, and insulin needles. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 08/29/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 13, 2023.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication	D 125	Hampton Manor shall ensure that staff who administer medications and their direct supervisors shall complete training, clinical skills validation, and pass the written exam within 60 days of completion of the 15 hour MA training class and the MA skills check-list.	10-15-23

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D 125	Continued From page 15 aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled medication aides (MA) (Staff B) passed the written MA examination within 60 days of completion of the MA skills checklist. The findings are: Review of Staff B's personnel record on 08/30/23 revealed: -Staff B's hire date was 10/07/21. -Staff B completed the MA skills checklist on 05/28/23. -There was no documentation Staff B had taken and passed the written MA examination within 60-days of completing the MA skills checklist. Observation of the 8:00am medication pass on 08/29/23 revealed: -Staff B administered 8 medications to a resident at 8:15am. -Staff B crushed 2 extended-release medications and administered them to the resident in applesauce.	D 125	Business Office Coordinator (BOC) will create a tickler system to note compliance/completion dates for required items for staff files, i.e. Med Tech State exam within 60 days. ED will sign off on all new hires once required documents are received, to approve that their file is complete.	10/15/23 10/15/23

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D 125	Continued From page 16 Review of a resident's August 2023 electronic medication administration record (eMAR) revealed Staff B administered medications to the resident on 08/18/23, 08/19/23, 08/20/23, and 08/28/23. Telephone interview with the Special Care Coordinator (SCC) on 08/31/23 at 1:30pm revealed: -When a MA was hired at the facility the MA observed another MA passing medications for about a week. -The facility's Area Clinical Director (ACD) then administered 2 handwritten tests she had created to MAs and watched them perform a medication pass on their own. -MAs should take the written MA examination within 60 days of completing the MA skills checklist. -The MA should know that they needed to take the written MA examination within 60 days of completing the checklist, but it was the Resident Care Coordinator's (RCC), SCC's, or Administrator's responsibility to make sure it was done. -If a MA had not taken and passed the written MA examination within 60 days of completing the MA skills checklist the RCC or SCC should report it to the Administrator who would remove the MA from the medication cart until the MA took the examination. -She became SCC at the facility on 08/24/23. -She did not know why the RCC, the prior SCC, or the Administrator did not realize that Staff B had not taken the written MA examination within 60 days of completing the MA skills checklist. -It was important that Staff B complete her written MA examination within 60 days of completing the MA skill checklist so the facility would know she was adequately trained to administer	D 125		

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D 125	Continued From page 17 medications. -Staff B not completing the written MA examination and continuing to administer medications to residents could be dangerous to residents because the MA might have administered the wrong medications to residents or missed medications that might have been ordered. Telephone interview with the Administrator on 08/31/23 at 2:57pm revealed: -MAs should take the written MA examination within 60 days of completing their MA skills checklist. -Once the MA had been checked off by the ACD it was her and the ACD's responsibility to remind the MA to register for the written MA examination and take the examination. -She tried to encourage MAs to take the written MA examination as soon as they possibly could do so. -It was ultimately the Administrator's responsibility to make sure MAs had completed and passed the written MA examination within 60 days of completing the MA skills checklist. -If a MA did not take or pass the written MA examination within 60 days of completing the MA skills checklist, she would remove the MA from the medication cart. -She was not aware that Staff B had not completed the written MA examination within 60 days of completing the MA skills checklist prior to being notified by the surveyor on 08/30/23. -If she had known Staff B had not completed the written MA examination, she would have removed her from the medication cart. Interview with the ACD on 08/30/23 at 2:51pm revealed: -She trained MAs at the facility on how to	D 125		

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D 125	Continued From page 18 administer medications and checked them off on the MA skills checklist. -She also administered 2 handmade tests to MAs. -It was the Administrator and business office manager's (BOM) responsibility to make sure MAs took and passed the written MA examination within 60 days of completing the MA skills checklist. Second interview with the ACD on 08/30/23 at 3:50pm revealed: -She checked off Staff B on the MA skills checklist on 05/25/23. -Staff B told facility staff on 08/30/23 that she took the written MA examination the prior week and failed it. -Staff B was scheduled to retake the written MA examination tomorrow, 08/31/23. -Staff B was working yesterday, 08/29/23, in the SCU administering medications to residents. -Staff B was outside of her 60-day time frame from being checked off, when she took and failed her written MA examination. -Staff B would need to be checked off again. -She was unable to locate proof of Staff B's failed test on the NC Adult Care Medication Aide Test website. -She knew the website would show when someone passed but was not sure if it showed failed attempts also. -Staff B was not found on the NC Adult Care Medication Aide Test site. Telephone interview with the facility's primary care provider (PCP) on 08/29/23 at 3:01pm revealed: -Extended-release medications should not be crushed before being administered to residents. -Extended-release medications were formulated to release medication over time.	D 125		

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D 125	Continued From page 19 -When an extended-release medication was crushed the resident received the whole dose of the medication at one time. -Because the resident received the whole dose of the medication at one time it meant the medication would be absorbed quicker and not last as long as it should. -She expected MAs to be properly trained to not crush extended-release medications. -She expected the facility to make sure MAs had been properly trained and had met all requirements prior to administering medications to residents. -If a MA did not meet all requirements to administer medications to residents, she expected the MA to be removed from the medication cart. -Not removing MAs from the medication cart if they had not met all requirements could cause the MA to make medication errors like the error made by Staff B on 08/29/23. Attempted telephone interview with Staff B on 08/31/23 at 1:30pm was unsuccessful.	D 125		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.	D 344	Hampton Manor shall ensure contact with the Resident's provider for verification or clarification of orders for medications and treatments. Area Clinical Director (ACD) in-serviced Care Managers and Med Techs on the 6 rights of medication administration, the importance of accurate medication management, the importance of contacting the Provider to clarify orders that are unclear or	9/13/23

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D 344	Continued From page 20 The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure clarification of medication orders for 1 of 5 sampled residents (#1) who had medication change orders after an emergency room (ER) visit. The findings are: Review of Resident #1's current FL-2, dated 06/13/23, revealed diagnoses including hypertension and diabetes. Review of an ER "After Visit Summary", dated 07/30/23, revealed: -Resident #1 returned to the facility from the ER following a fall which resulted "multiple contusions". -Changes to Resident #1's medication list included a new medication, Diclofenac (a medication used to treat pain and inflammation) 50mg, 1 tablet twice a day for 5 days. Review of Resident #1's July 2023 and August 2023 electronic medication administration record (eMAR) revealed there was no documentation the resident was administered Diclofenac. Interview with the Resident Care Coordinator (RCC) on 07/30/23 at 1:45pm revealed: -She reviewed the eMAR and stated the Diclofenac tablets was not administered to Resident #1. -The discharge summary did not include a physician's signature to meet requirements for signed physician's orders.	D 344	incomplete, and the importance of following up on that clarification and ensuring documentation. Med Techs in-serviced on the importance of notifying the Care Managers when there is any delay in getting an order clarified, getting a medication in the facility, or any other assistance is needed. Care Managers will monitor order processing folders daily to ensure there are not medication orders or referrals awaiting clarification. If such orders are present, Care Managers will work to assist in expediting the process. If the Resident has returned from an ER visit with new orders that are not accompanied by a prescription or have not been e-scribed directly to the pharmacy, Care Managers will promptly begin the process of order clarification with the Resident's PCP. Care Managers will ensure accuracy when approving orders, making sure to follow all directions given in the original physician's order. Care Managers will pull EMAR compliance reports daily to review for accuracy and compliance. The report will be reviewed and discussed daily with the ED during management meeting for any needed follow-up. Care Managers will complete a minimum of 2 chart audits weekly to ensure that all orders have been	10/15/23 10/15/23 10/15/23 10/15/23

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D 344	Continued From page 21 -There was no documentation the facility contacted Resident #1's primary care provider (PCP) to clarify the new medication list. -The former RCC should have contacted the resident's PCP to clarify the changes to the medication list, per the facility's policy. Interview with Resident 1's PCP on 07/30/23 at 3:22pm revealed: -She was aware Resident #1 had a fall and was sent to the ER but she was not aware of changes to Resident #1's medication. Interview with Resident #1 on 08/29/23 at 3:40pm revealed: -The resident had two falls about a month ago, during one fall she bumped her head and had to go to the ER.(this was the fall she was sent to ER for). -The Resident reported all of the injuries from the falls had resolved and were not causing her pain. - The pain she did currently have was from chronic back pain and she felt the current medications were managing her pain adequately and she reported no concerns. (I included this because the Diclofenac can be used for pain and inflammation. I didn't ask her about this medication specifically she only mentioned orders for Tramadol.)	D 344	processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance.	
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	D 358	Hampton Manor shall ensure the preparation and administration of medications and treatments by staff are according to Provider orders which are kept in the Resident's record, the facility's policies and procedures, and the rules of Section .1004(a).	

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D 358	Continued From page 22 which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#6) observed during the medication pass including errors with a blood pressure medication and a urinary frequency medication. The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 29 opportunities during the 8:00am medication pass on 08/29/23. Review of Resident #6's current FL-2 dated 07/25/23 revealed: -Diagnoses included vascular dementia and schizophrenia. -There was an order for Toprol XL extended release 24-hour (used to treat high blood pressure) 50mg one time a day do not crush. -There was an order for Detrol LA capsule extended release 24-hour (used to treat overactive bladder) 4mg one time a day. Review of Resident #6's physician order sheet dated 08/08/23 revealed: -There was an order for may crush medications as indicated. -There was an order for all medication may be given by mouth and/or crushed, check do not crush list, and placed in applesauce or pudding unless otherwise noted. -The diet order was for nectar thickened liquids	D 358	ACD in-serviced Care Managers and Med Techs on the 6 rights of medication administration, the importance of accurate medication management, the importance of contacting the Provider to clarify orders that are unclear or incomplete, and the importance of following up on that clarification and ensuring documentation. Med Techs in-serviced on the importance of notifying the Care Managers when there is any delay in getting an order clarified, getting a medication in the facility, or any other assistance is needed. ACD also provided in-servicing on Diabetes Management, Insulin Administration, Infection Control, and Resident Rights. Care Managers will ensure Do Not Crush lists are available on all medication carts for Med Tech use for safe and accurate med administration. Care Managers will pull Medication Compliance Reports daily to ensure medications are administered per MD orders. Report will be brought to management meeting daily for review with ED for compliance. Any noted areas of concern will have follow-up as appropriate, including MD notifications, clarifications, and any intervention needed. Care Managers will complete weekly QA cart audits to monitor for compliance of the medication cart. Results will be reviewed with the ED for any needed follow-up.	9/13/23 10/15/23 10/15/23 10/15/23

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D 358	Continued From page 23 and mechanical soft meats only. Observation of the 8:00am medication pass on 08/29/23 revealed: -The medication aide (MA) crushed Toprol XL 10mg and added it to applesauce. -The MA opened a capsule of Detrol LA 4mg and sprinkled the contents into applesauce. -The crushed Toprol XL 10mg and sprinkled Detrol LA were administered to Resident #6 at 8:15am. Review of Resident #6's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Toprol XL extended release 24-hour 50mg once daily scheduled for administration at 8:00am. -Toprol XL extended release 24-hour 50mg was documented as administered at 8:00am on 08/29/23. -There was an entry for Detrol LA extended release 24-hour 4mg once daily scheduled for administration at 8:00am. -Detrol LA extended release 24-hour 4mg was documented as administered at 8:00am on 08/29/23. Interview with the MA on 08/29/23 at 12:30pm revealed: -If a resident had an order that their medication could be crushed it showed up on the resident's eMAR. -She had never seen a do not crush list. -She did not know where a do not crush list was located in the facility. -She did not know that medications labeled as extended released should not be crushed. -She did not know that Resident #6's Toprol XL and Detrol LA should not be crushed.	D 358	ACD will complete random Med Tech observations during med passes to ensure at least 2 observations per month are completed. This will check compliance with giving medications correctly.	10/15/23

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D 358	Continued From page 24 -Resident #6 had an order that her medications could be crushed so she crushed all her medications unless they were in a capsule and then she sprinkled them into either applesauce or pudding. -Resident #6 had an order that her medications could be crushed, and she assumed all her medications could be crushed. -She had not noticed the order that Resident #6's medications could be crushed included instructions to check the do not crush list. -Resident #6 was on a special diet and that was why she crushed her medications and placed them in applesauce. Interview with the Special Care Coordinator (SCC) on 08/29/23 at 1:15pm revealed: -She had never seen a do not crush list posted at the facility. -There was a tab on the eMAR system that a MA could click on to see a do not crush list. -Normally if a resident's medication should not be crushed it would show up on the eMAR. -The instructions to not crush a resident's medications were placed on the eMAR by the facility's contracted pharmacy. -Extended-release medications should not be crushed. -The MA should know from her medication training that extended-release medications should not be crushed. -MAs received medication training from the Area Clinical Director (ACD) prior to passing medications to residents. -Resident #6 was on a thickened liquid and and mechanical soft meats only diet so if she had medications that could not be crushed the MA could place the whole tablet or capsule in pudding and administer it to the resident.	D 358		

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D 358	Continued From page 25 Interview with the Administrator on 08/29/23 at 3:15pm revealed: -There was no do not crush list posted in the facility's medication rooms. -There was a place on the eMAR system that a MA could check to see if a medication was on the do not crush list or not. -MAs should have been trained to look on the do not crush list on the eMAR prior to crushing any medications and administering them to a resident. -The ACD was who trained MAs on administering medications. Interview with the ACD on 08/30/29 at 3:40pm revealed: -She performed medication training for MAs at the facility. -Medication training included instructions that extended-release medications should not be crushed. -MAs were trained that if a medication had an abbreviation behind it such as XL or ER that meant it was an extended-release medication and it should not be crushed. -MAs were trained to look at a do not crush list before crushing any medications and administering them to a resident. -Crushing an extended-release medication and administering it to a resident could cause side effects with absorption. Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/29/23 at 12:54pm revealed: -Toprol XL and Detrol LA should not be crushed because they were extended-release medications. -Crushing an extended-release medication could cause a resident to have altered absorption of the	D 358		

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D 358	Continued From page 26 medication. -She did not know what the side effects of crushing Toprol XL or Detrol LA might be for a resident. -Resident's medication orders were placed on the eMAR by the pharmacy. -The pharmacy did not usually place do not crush on the eMAR if a medication should not be crushed. -She expected facility staff to check the do not crush list before crushing any medications and administering them to a resident. Telephone interview with Resident #6's primary care provider (PCP) on 08/29/23 at 3:01pm revealed: -Detrol LA and Toprol XL were extended-release medications so they should not be crushed before being administered to residents. -Extended-release medications were formulated to release medication over time. -When an extended-release medication was crushed the resident received the whole dose of the medication at one time. -Because the resident received the whole dose of the medication at one time it meant the medication would be absorbed quicker and not last as long as it should. -Resident #6 receiving Toprol XL which was crushed could cause her to have a profound drop in blood pressure or heart rate. -Resident #6 receiving Detrol LA which was crushed could also cause a drop in her blood pressure and dry mouth. -Resident #6's blood pressure was only checked once a month and the resident was not able to adequately communicate if she was not feeling well if her blood pressure were to drop after receiving medications that should not have been crushed.	D 358		

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D 358	Continued From page 27 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. The facility failed to ensure medications were administered as ordered for 1 of 4 residents (#6) observed during the medication pass including a resident who received a crushed extended-release medication to treat high blood pressure and a medication used to treat urinary frequency which should not have been crushed which could result in a profound drop in her blood pressure and heart rate. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/30/23 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED October 16, 2023.	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	D 367	Hampton Manor shall ensure the Resident's MAR is accurate for medication administration. ACD in-serviced Care Managers and Med Techs on the 6 rights of medication administration, the importance of accurate medication management, the importance of contacting the Provider to clarify orders that are unclear or incomplete, and ensuring appropriate documentation has occurred. ACD also provided in-servicing on	9/13/23

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D 367	Continued From page 28 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 the electronic medication administration records (eMAR) were accurate for 2 of 5 sampled residents (#3, #5) including inaccurate documentation of insulin (#5) and a wheelchair (WC) and bed alarm (#3). The findings are: 1. Review of Resident #5's current FL-2 dated 08/08/23 revealed: -Diagnoses included hypertension. -There was an order for Levemir (used to treat high blood sugars) 10 units at bedtime. Review of Resident #5's physician order sheet dated 08/18/23 revealed diagnoses included type 2 diabetes. Review of Resident #5's August 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Levemir 10 units at bedtime scheduled for administration at 8:00pm. -Levemir 10 units was documented as administered at 8:00pm on 08/01/23 to 08/03/23 and 08/05/23 to 08/25/23, and 08/27/23 to	D 367	Diabetes Management, Insulin Administration, Infection Control, and Resident Rights. Care Managers will ensure orders are complete and accurate, including orders for falls interventions that will require documentation when they are approving orders. 10/15/23 Med Techs will complete Mar to cart audits per facility schedule to account for medications on hand in the facility. Care Managers will follow-up on completed cart audits for compliance. 10/15/23 Med Techs will ensure that any medication, treatment, or intervention signed for on the Resident's MAR has been completed and verified prior to signing off. 10/15/23 Care Managers will complete weekly QA cart audits to monitor for compliance of the medication cart for safe medication administration. Results will be reviewed with the ED for any needed follow-up. 10/15/23	

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D 367	Continued From page 29 08/28/23. -Levemir 3 units was documented as administered at 8:00pm on 08/04/23. -Levemir 6 units was documented as administered at 8:00pm on 08/26/23. Interview with Resident #5 on 08/29/23 at 3:31pm revealed he received insulin every night, but he was not sure how much. Telephone interview with a former medication aide (MA) on 08/30/23 at 11:38AM revealed: -She knew that Resident #5 always received 10 units of Levemir at night. -She always administered 10 units of Levemir to Resident #5 at night. -The 3 units on Resident #5's eMAR on 08/04/23 was a typo. Interview with a second MA on 08/30/23 at 11:42am revealed: -She always administered 10 units of Levemir to Resident #5 at bedtime. -On 08/26/23 she administered 10 units of Levemir to Resident #5 but mistakenly typed in 6 units on the eMAR. Telephone interview with the Special Care Coordinator (SCC) on 08/31/23 at 1:30pm revealed it was important for MAs to accurately document Levemir on Resident #5's eMAR so staff would know that the resident was getting an accurate dosage of insulin. Telephone interview with the Administrator at 2:57pm revealed she expected MAs to accurately document medications on resident's eMARs. Telephone interview with Resident #5's primary care provider (PCP) on 08/30/23 at 3:01pm	D 367		

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D 367	Continued From page 30 revealed she expected MAs to accurately document the correct amount of Resident #5's Levemir to ensure he was receiving the correct dosage. 2. Review of Resident #3's current FL-2 dated 01/24/23 revealed: -Diagnoses included Alzheimer's disease, gastroesophageal reflux disease (GERD), asthma, and mood disorder. -She was admitted to the Special Care Unit (SCU) on 12/09/21. -She was constantly disoriented. -She was semi-ambulatory. -Speech was marked as her functional limitations. -Non-verbal was marked as her communication of needs. -She was incontinent of bowel and bladder. Review of Resident #3's physician order report dated 01/24/23 revealed: -There was an order for Resident #3 to have a wheelchair (WC) alarm and bed alarm. -The order description included ensure the alarm was working and in place on each shift. -The shifts were noted as 7:00AM-3:00PM, 3:00PM-11:00PM and 11:00PM-7:00AM. Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was an entry for wheelchair and bed alarm. -Special instructions on the eMAR included ensuring the alarm was working and in place on each shift. -It was documented, for this device to be checked, working and in place for the resident on 7AM-3PM, 3PM-11PM and 11PM -7AM shifts for the entire month of June 2023.	D 367		

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D 367	Continued From page 31 -There were no documented refusals. -The WC alarm and bed alarm were documented as in place and working on each shift on 06/01/23 to 06/30/23. Review of Resident #3's July 2023 eMAR revealed: -There was an entry for a wheelchair and bed alarm. -Special instructions on the eMAR included ensuring the alarm was working and in place on each shift. -It was documented, for this device to be checked, working and in place for the resident on 7AM-3PM, 3PM-11PM and 11PM-7AM shifts for the entire month of July 2023. -There were no documented refusals. -The WC alarm and bed alarm were documented as in place and working on each shift on 07/01/23 to 07/31/23. Review of Resident #3 August 2023 eMAR revealed: -There was an entry for a wheelchair and bed alarm. -Special instructions on the eMAR included ensuring the alarm was working and in place on each shift. -It was documented, for this device to be checked, working and in place for the resident on 7AM-3PM, 3PM-11PM and 11PM-7AM shifts from 08/01/23 to 08/28/23. -There were no documented refusals. -The WC alarm and bed alarm were documented as in place and working on each shift on 08/01/23 to 08/28/23. Observation of Resident #3 on 08/30/23 at 8:30am revealed: -Resident #3 was agitated.	D 367		

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D 367	Continued From page 32 -She was pushed in her WC by a personal care aide (PCA) from the dining hall to her room. -There was no alarm on the WC. Observation of Resident #3 on 08/30/23 at 4:30pm revealed: -She was laying in bed and a PCA was checking her for incontinent changes. -Her WC was against the wall. -There was no bed alarm or WC alarm found in her room. Interview with a medication aide (MA) on 08/30/23 at 4:35pm revealed: -She could not recall which residents had WC and bed alarms in the SCU. -She was new to working in the SCU. -She was not aware that Resident #3's WC and bed alarm was not in place today. -If Resident #3's device was missing than they would find it. Telephone interview with a second MA on 08/31/23 at 1:11pm revealed: -Resident #3 did not have a bed alarm but did have a WC alarm. -The device was being discontinued for Resident #3. -She was not certain if the order had been discontinued yet. -She checked Resident #3 on 08/31/23 at 1:22pm and there was no alarm on the resident's WC or on the resident's bed. -The eMAR would notify the MA if a resident had a WC or bed alarm during the medication pass. -The PCA, MA as well as Special Care Coordinator (SCC) and Resident Care Coordinator (RCC) would check to ensure bed alarms and WC alarms were working and in place.	D 367		

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D 367	Continued From page 33 -If the device was not working and not in place it should not be documented as so on the eMAR. -She was not sure why Resident #3's eMAR was documented that the device was working and in place if it was not being used. -It was important to document accurately on the eMAR to ensure the resident was getting the orders prescribed by the physician. Telephone interview with the SCC on 08/31/23 at 1:51pm revealed: -If a resident had an order for a WC alarm or bed alarm it would be listed on the resident's eMAR. -WC alarms and bed alarms were used for residents deemed a fall risk as a preventative tool to prevent future falls. -On each shift, the MA would be expected to check and ensure the device was working and in place. -The MA would then document on the eMAR. -The shifts on the eMAR were 7:00am-3:00pm 1st shift, 3:00pm-11:00pm 2nd Shift and 11pm-7:00am 3rd shift. -Resident #3 was not using a WC or bed alarm. -The SCC was working to locate the discontinue order for this device for Resident #3. -The SCC had only been working as the SCC since 08/24/23. -She believed the previous SCC obtained the discontinue order for this device. -She was not aware who wrote the discontinue order, so she was contacting the Primary Care Provider (PCP) and Physical Therapist (PT) to see if they wrote it. -She contacted the pharmacy regarding removal of the order from the eMAR and the pharmacy told her they were not the ones to remove this order from the eMAR. -The Administrator was the one who would remove this order from the eMAR.	D 367		

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D 367	Continued From page 34 -The facility had no copy of the discontinue order at this time. -If the device was missing, it was expected for the PCA to report to the MA and the MA to report to the SCC. -It was the expectation of the SCC that the MA accurately document on the eMAR system. -She was not aware that the MA staff was documenting the WC alarm and bed alarm was working and in place on each shift for Resident #3. -Since Resident #3 was not using a bed alarm or WC alarm that was inaccurate documentation of the eMAR system. -It was important to document accurately because if a resident had an order for and needed a bed alarm or WC alarm and it was not in place the resident could fall. Telephone interview with the Administrator on 08/31/23 at 4:54pm revealed: -Resident #3 no longer used a bed or WC alarm. -She had an order for it, but they stopped using it because the noise agitated her. -There should be a discontinue order for this device in Resident #3's file. -Resident #3 had not used the device in one to two months. -She was not aware that there was no discontinue order for the device. -She was not aware that the MA's were falsely documenting the eMAR for this device until today. -She did not expect facility staff to falsely document on the eMAR. -It was the expectation that the MA should have consulted the PCP and obtained a discontinue order for the device. -The MA could have also documented the eMAR system with an exception or refusal for this treatment since it agitated her, until the	D 367		

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D 367	Continued From page 35 discontinue order was obtained. Telephone interview with Resident #3's Primary Care Physician (PCP) on 08/30/23 at 3:01pm revealed: -The PCP was a new provider for Resident #3. -She had only had one face-to-face visit with Resident #3 and that was on 08/04/23. -She was agitated during the exam and no new orders were provided. -She was not aware of Resident #3 having a wheelchair alarm or bed alarm order.	D 367		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.	D 463	Hampton Manor shall ensure that admissions to the Special Care unit have an appropriate diagnosis on the FL2, a documented pre-admission screening by the facility, and a disclosure statement documented in the Resident's record. ED/ Care Manager/ or Designee will ensure preadmission screening and disclosure statement is completed on each SCU admission. 10/15/23 ED/ BOC will ensure SCU Resident's file is complete with a disclosure statement. ED will ensure that pre-admission screening has been completed and is documented on all SCU admissions. 10/15/23	

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D 463	Continued From page 36 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#2) residing in the Special Care Unit (SCU) had a pre-admission screening for appropriate placement. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed with a capacity of 82 residents with a Special Care Unit (SCU) capacity of 40 residents. Review of the facility's census on 08/29/23 revealed there were 37 residents in the SCU. Review of Resident #2's current FL-2 dated 08/24/23 revealed: -Diagnoses included Dandy Walker Syndrome (Dandy Walker Syndrome is a congenital (happening before birth) condition where the cerebellum does not develop normally), diabetes, hypertension, hypothyroidism, and hyperlipidemia. -She was semi ambulatory with a cane and was intermittently disoriented. -The current level of care was SCU. Review of Resident #2's care plan dated 08/24/23 revealed: -The resident required supervision and set up for bathing. -The resident required limited assistance with toileting, ambulation, dressing, grooming, and transferring. -The resident was oriented, and her memory was adequate. Interview with Resident #2 on 08/30/23 at 3:30pm	D 463		

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D 463	Continued From page 37 revealed: -She moved to the SCU from Assisted Living (AL) section of the facility approximately 1-2 weeks ago. -She enjoyed living on the SCU. Telephone interview with Resident #2's primary care provider (PCP) on 08/30/23 at 3:01pm revealed Resident #2 did not have a diagnosis of Alzheimer's or dementia; however, the resident had demonstrated some cognitive decline and would benefit from placement on the SCU to help decrease her falls. Interview with the Administrator on 08/29/23 at 2:03pm revealed: -Resident #2 had experienced a decline in cognitive functioning. -The resident had increased problems with following directions. -Resident #2 had a difficult time remembering to call for assistance when she got out of bed and had increased falls without injury. -She spoke with Resident #2's PCP provider to discuss a change in her level of care from Assisted Living to SCU. -She completed the SCU prescreening, disclosure, and resident profile for Resident #2 but did not realize that the resident did not have a qualifying diagnosis for placement on the SCU.	D 463		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility	D 611	Hampton Manor shall ensure that the facility's infection control policies and procedures are educated on and implemented appropriately by the staff. ACD in-serviced staff on diabetes	9/13/23

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	HAL066012	A. BUILDING: _____ B. WING _____	R 08/31/2023

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D 611	Continued From page 38 and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak.	D 611	management, infection control, and resident Rights. Staff was re-educated on the inportance of using proper PPE when performing any Resident care tasks that could have exposure to blood or body fluid, including FSBS, etc. They were educated on the portance of each diabetic Resident having their own individual diabetic kit which included their own glucometer, safety lancets, and safety insulin pens or needles. They were re-educated on the importance of using alcohol to cleanse the site before checking FSBS and before administering insulin, keeping these items secured when not in use, and notifying their Care Manager/ED when more supplies are needed. Care Managers will follow procedures for weekly Glucometer calibration and sanitization. They will also ensure that Med Techs are cleaning glucometers with alcohol after each use, and that each diabetic Resident has their own machine.	10/15/23

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D 611	Continued From page 39	D 611		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to implement infection control procedures for glucometers used to obtain fingerstick blood sugar (FSBS) readings for 1 of 5 sampled residents (#2) with an order for FSBS monitoring.

The findings are:

Review of the facility's glucometer care, maintenance and testing policy dated September 2021 revealed the facility's goal was to adhere to strict infection control practices based on Centers for Disease Control (CDC) guidelines.
-Glucometers should be sanitized weekly per manufacturers guidelines.

Review of manufacturer's user manual for Brand A glucometers revealed the device was intended for patient self-monitoring and should not be used to collect blood from more than one person as this posed a risk of transmitting blood borne pathogens such as Hepatitis B or HIV.

Review of Resident #2's current FL-2 dated 08/24/23 revealed diagnoses included diabetes.

Review of Resident #2's primary care provider (PCP) orders dated 08/24/23 revealed there was an order for FSBS checks three times a day at 8:00am, 12:00pm, and 5:00pm.

Observations of the medication cart on 08/29/23 at 12:28pm revealed:
-There was an unlabeled black pouch inside a

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D 611	Continued From page 40 clear plastic bag with Resident #2's last name written on the middle of the plastic bag. -The unlabeled black pouch contained a glucometer labeled with Resident #2's last name and a bottle of testing strips. Review of Resident #2's glucometer's history (Brand A) revealed: -Turning the glucometer on revealed the screen showed a current date of 08/29 and time of 12:28pm. -There was no year displayed with the date on the glucometer screen. -The following 4 FSBS results were shown consecutively on the glucometer following the result of 204: 204 at 4:04pm on 08/27, which matched Resident #2's August 2023 electronic medication administration record (eMAR) entry. 112 at 11:25am on 08/27, which matched Resident #2's August 2023 eMAR entry. 90 at 8:40am on 08/27, which did not match Resident #2's August 2023 eMAR entry. 342 at 8:32am on 08/27, which matched Resident #2's August 2023 eMAR entry. Review of Resident #2's August 2023 eMAR revealed: -There was an entry for FSBS three times a day. -On 08/27/23 at 8:32am a FSBS was documented as 342, which matched the FSBS recorded in the glucometer history. -On 08/27/23 at 8:40am there was not a FSBS documented as 90, which did not match the FSBS recorded in the glucometer history. Interview with a medication aide (MA) on 08/29/23 12:30pm revealed: -Resident #2's FSBS was 127 the morning on 08/29/23.	D 611		

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D 611	Continued From page 41 -A resident should not have two FSBS readings on the same day within minutes of each other. -The only reason she could think of that two FSBS readings would be on the same day within minutes of each other was that another MA used the same glucometer for more than one resident. -MAs were expected to only use the labeled glucometer for each resident, glucometers should not be shared between residents to prevent infection. Telephone interview with a medication aide (MA) on 08/30/23 at 1:12pm revealed: -The MAs should never share glucometers between residents; each resident's glucometer should be labeled. -MAs were expected to use a glucometer on only the resident it was labeled for to prevent the risk of infection. Telephone interview with the Special Care Coordinator (SCC) on 08/30/23 at 1:51pm revealed: -There should never be a reason that one resident's glucometer had two different readings within minutes of each other. -Obtaining two different blood sugar readings on a glucometer history within minutes of each other "raised a red flag" to her and she was concerned that a MA used the same glucometer which was shared between residents. -The MAs were expected to follow infection control guidelines and the glucometer guidelines and should never share a glucometer between residents. -She and the Resident Care Coordinator (RCC) cleared all glucometers and cleaned all glucometers every Monday. -MAs should never share a glucometer between residents due to the risk of infection.	D 611		

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D 611	Continued From page 42 Telephone interview with the Administrator on 08/30/23 at 4:45pm revealed: -Each resident had their own glucometer labeled on the medication cart. -The MAs should never share glucometers between residents. -Sharing glucometers increased the risk of spreading Hepatitis and other diseases. -She expected each MA to use the designated glucometer for each resident to decrease the risk of infection. Telephone interview with the facility's primary care provider (PCP) on 08/30/23 at 3:01pm revealed: -All residents glucometers and storage bags should be labeled to prevent MA's sharing glucometers between residents. -Glucometers should not be shared between residents, she expected each resident to have their own glucometer, -The MAs were expected to only use the designated and labeled glucometer for each resident to ensure they followed infection prevention guidelines to prevent possible spread of infection.	D 611		