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AHOSKIE ASSISTED LIVING	240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910

(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 an annual survey and complaint investigation on 10/24/23 to 10/25/23. The complaint investigation was initiated by the Hertford County Department of Social Services on 05/23/23 and 07/13/23.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: 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 five resident rooms including toiletries, three prescription medications and a prescription cream that were accessible to residents and ensure that the SCU residents were not exposed to cock roaches and cock roach excrement. The findings are: Review of the facility's census revealed the facility's census in the SCU was 33 residents. Review of the facility's ingestible assessment for residents on the SCU revealed: -Personal items that could be ingested were	D 079		

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maintained by staff in a secure location until needed for the resident's use.
-Resident rooms and care areas were inspected regularly for unsafe items that could be accidentally ingested or harmful.
-Staff routinely monitored residents for possible hoarding of substances that could be ingested.
-The state poison control telephone number was visibly posted at the medication station.
-All utility closets and laundry areas were locked unless under direct supervision.
-All toxic substances should remain in the original container and were secured in a locked area unless under direct supervision.
-Items for activities that could be ingested should only be used while under direct supervision.
-The facility provided staff training that included assessing residents for possible ingestion, initiating necessary emergency procedures, calling the poison control center if necessary, monitoring the facility and resident rooms for substances that could be accidentally ingested, notifying the resident's physician, responsible party, and other required parties a necessary.

1. Observation of a resident room #10 on the SCU on 10/24/23 at 9:50am revealed:
-There was 0.4 ounce bottle of nail polish in the windowsill 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 an 8 ounce container with body wash in the windowsill with a warning for external use only, may cause eye irritation, rinse eyes with water if contact occurred, consult physician if irritation persists, in rare instances of local sensitivity discontinue use.
-There were two 5.2 ounce tubes of charcoal toothpaste in the resident's bathroom with a

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warning to keep out of reach of children and a 4 ounce container of mouthwash with caution to not swallow and keep out of reach of children.

Second observation of a resident's room #10 on the SCU on 10/25/23 at 11:18am revealed:
-The 0.4 ounce of nail polish and 8 ounce container of body wash were observed in the windowsill.
-There were two 5.2 ounce tubes of charcoal toothpaste and a 4 ounce container of mouthwash in the resident's bathroom.

Observation of a second resident's room #6 on the SCU on 10/24/23 at 9:59am revealed there was an 8.8 ounce container of moisturizing balm for hair that was uncovered on top of the night stand with a warning to keep out of reach of children and avoid contact with eyes.

Observation of a third resident's room #4 on the SCU on 10/24/23 at 10:12am revealed there was an 8.5 ounce barrier cream container on top of the resident's dresser beside with a warning to keep out of reach of children, do not use on deep or puncture wounds or serious burns, and do not get product into eyes.

Observation of a fourth resident's room #2 on the SCU on 10/24/23 at 12:17pm revealed:
-There was an 80 gram container of Triamcinolone Acetonide Cream 0.1% (Triamcinolone Acetonide Cream is a topical steroid medication used to treat different skin conditions) on top of a pair of heel protectors on top of the resident's dresser.
-There was a warning on the container of Triamcinolone Acetonide Cream 0.1% to keep out of reach of children.

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D 079	Continued From page 3 Interview with a medication aide (MA) on 10/24/23 at 12:20pm revealed: -The Triamcinolone Acetonide Cream 0.1% that was on a pair of heel protectors had fallen out of her canvas bag that was on top of the resident's dresser. -She placed her bag in the resident's room #2 at approximately 7:00am on 10/24/23. -She left it in the resident's room shortly after she began her shift this morning because she had to help the personal care aides (PCAs) provide baths for the residents. -She placed her canvas bag on top of the resident's dresser because the resident who resided in the room would keep her canvas bag safe and would let her know if anyone tried to bother her canvas bag. -She usually kept her canvass bag under the chair across from the medication cart and had not been concerned about residents that wandered taking items from her bag. -She should have ensured that her bag was locked on the SCU because there were several items that could harm residents. -The residents on the SCU were at risk of dying if they took the medications she had in her bag, Metformin HCL and Rybelsus (medications used to treat diabetes), and Lisinopril (a medication used to treat high blood pressure) by accident. Second interview with the MA on 10/24/23 at 12:22pm revealed: -Residents on the SCU should not have access to items that they could accidently ingest. -There were at least 5 residents on the SCU that were known to wander into other resident's rooms, take items from the housekeeping cart, the medication cart, and other resident's rooms. -There were not any residents that had accidentally ingested items on the SCU.	D 079		

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-Residents with Alzheimer's disease were at a higher risk of ingesting something due to their inability to recognize that an item could be hazardous to them.
-Ingestible items should be secured and not accessible to residents due to the risk it could cause them by ingesting something they should not which could cause harm and make the resident very sick.
-The MA's and personal care aides (PCAs) completed searches of the SCU at least two times a week to ensure hazardous items were not accessible to residents.

Observation of a MA on 10/24/23 at 12:24pm revealed she removed the canvas bag from the resident's room and placed it on the floor under a chair in an alcove across from the medication cart.

Interview with the MA on 10/24/23 at 12:25pm revealed:
-She thought her canvas bag would be secure under the chair in the alcove across from the medication cart.
-She did not consider that her canvas bag needed to be locked so residents on the SCU were unable to access the items in her bag.
-She would place her canvas bag in the clinical office that she was able to lock.

Observation of a fifth resident's room on the SCU on 10/25/23 at 11:20am revealed there was a 10 ounce bottle of lotion with a warning if swallowed get medical help or contact a poison control center.

Observation of the SCU on 10/25/23 from 8:15am to 8:30am revealed:
-A female resident wandered into another female

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resident's room where the MA had her canvass bag located on 10/24/23.
-A PCA observed the resident wander into the wrong room and redirected the resident to the activity room.
-A second female resident paced the hallway.
-A third female resident walked down the hallway and stopped at the entrance of two resident's doors but did not enter the rooms.

Interview with a PCA on 10/25/23 at 8:31am revealed:
-There were four residents on the SCU that wandered.
-One resident walked the halls and would take items off the medication cart, the personal care cart, and would take any items from other residents' rooms.
-A second resident that wandered on the SCU would take items from the personal care cart when the PCAs were changing a resident, and the resident was known to hoard items.
-A third resident that wandered on the SCU would take items from other resident's rooms.
-A fourth resident that wandered on the SCU would hoard items that she found in other resident's rooms.
-The PCAs and MAs removed and secured any items that could be hazardous to residents on the SCU.
-She kept the personal care supply cart locked on the SCU in the laundry room.
-PCAs performed 15 minute checks to ensure residents did not have any hazards or ingestibles.
-Hazards and ingestibles should not be in resident rooms on the SCU.
-Staff must have missed removing items from resident's rooms earlier this morning.

Interview with the Administrator on 10/24/23 at

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D 079	Continued From page 6 2:30pm revealed: -All hazards and ingestibles should be locked on the SCU or in the staff locker room on the assisted living (AL) side of the building. -All staff were aware that hazards and ingestibles should not be accessible to residents due to the risk of ingestion which could cause harm to the residents. -An Ingestion Risk Assessment was completed for all residents on the SCU at admission and then quarterly. Telephone interview with the facility's primary care physician (PCP) on 10/25/23 at 2:58pm revealed: -The facility staff were expected to ensure that hazards and ingestibles were not accessible to residents due to the risk of resident's consuming hazardous items. -The Metformin HCL and Rybelsus medications that belonged to a MA should not have been accessible to residents because accidental consumption of either medication placed residents at risk of a hypoglycemia when a resident's blood sugar drops too low, which could cause dizziness, weakness, and falls. -The Lisinopril medication that belonged to a MA should not have been accessible to residents because accidental consumption could cause a hypotensive emergency resulting in a low blood pressure which could cause dizziness, fainting, and a resident could possibly need emergency care. -The Triamcinolone Acetonide Cream 0.1% if ingested by a resident could cause vomiting. 2. Observation of resident room #1 on the Special Care Unit (SCU) with a personal care aide (PCA) on 10/25/23 at 11:12am revealed: -There was a cookie on the floor in front of the nightstand by the resident's bed.	D 079		

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-There were two small cock roaches that crawled away from the cookie.
-The PCA opened the residents second drawer of her nightstand and three small cock roaches crawled to the far left of the drawer.

Observation of a second resident's room #3 on the SCU with a PCA on 10/25/23 at 11:20am revealed there were three cock roaches crawling on the floor near a resident's nightstand.

Observation of a third resident's room #5 on the SCU with a PCA on 10/25/23 at 11:22am revealed:
-The PCA opened the resident's first drawer of her nightstand and two small cock roaches crawled up the right side of the drawer.
-There was one small cock roach crawling on the floor in front of the nightstand.

Interview with a housekeeper on 10/24/23 at 9:20am revealed:
-He provided housekeeping duties for the SCU.
-He cleaned all rooms daily which including disposing of trash, mopping the floors, dusting the furniture and cleaning the bathrooms.
-Rooms were scheduled for deep cleaning on a rotation basis weekly.
-He had not noticed any problems with roaches on the SCU.
-The exterminator had treated the facility one or two months ago.

Interview with a PCA on 10/25/23 at 11:30am revealed:
-She had not observed cock roaches in resident rooms until today.
-The facility had an exterminator come recently to treat the facility for roaches.
-Residents had not complained to her about cock

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roaches.
-PCAs helped with housekeeping daily and the housekeeping staff deep cleaned rooms weekly.

Review of a pest control invoice dated 10/18/23 revealed the facility was treated for cock roaches on 10/18/23.

Interview with the Administrator on 10/25/23 at 5:15pm revealed:
-The facility's contracted exterminator treated the facility monthly from May 2023 to August 2023.
-The facility was scheduled to be treated during the month of September 2023; however, the exterminator company did not have staff available to treat the facility.
-The facility was treated in October 2023, and the next treatment was scheduled for November 7, 2023.
-The facility had a contract with the exterminator company for monthly treatment of the facility.
-Housekeeping staff completed weekly deep cleaning of rooms on a rotation basis.
-PCAs and MAs were expected to notify the Administrator if they noticed any roach activity in the facility.
-Residents on the SCU dropped food at times in their rooms and the dining room.
-The housekeeping staff and PCAs were expected to clean up any food that a resident dropped to prevent cock roaches.

Interview with the facility's primary care physician on 10/25/23 at 2:58pm revealed:
-Cock roaches and the excrement of cock roaches placed residents on the SCU at risk because cock roach droppings spread disease.
-Cock roaches and the excrement of cock roaches exacerbated symptoms of asthma.
-Residents on the SCU were at risk of cock

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D 079	Continued From page 9 roaches crawling into their ears and other open areas of their body. -Residents on the SCU were at risk of skin infections due to exposure to cock roach excrement, and if a resident had an open wound, they were at an increased risk of the open wound becoming infected. -Residents on the SCU were placed at an increased risk of infection due to their cognitive limitations and not reacting quickly enough to kill a roach when they saw one. _____ The facility failed to secure hazardous items to protect 33 residents who resided on the SCU with residents who had known wandering behaviors including a staff's prescription medications that if ingested by a resident could require emergency intervention and were protected from live cock roaches and cock roach excrement which could exacerbate symptoms of asthma and cause diseases. The 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 10/24/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 8, 2023.	D 079		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care	D 269		

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plans and attend to any other personal care needs residents may be unable to attend to for themselves.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide personal care based on the resident's accessed needs for 1 of 5 sampled residents (#1) related fingernails that were dirty, discolored, and long.

The findings are:

Review of Resident #1's current FL-2 dated 06/09/23 revealed diagnoses included vascular dementia, chronic pain syndrome, and shortness of breath and her recommended level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register dated 07/22/19 revealed he was admitted to the facility on 07/22/19.

Review of Resident #1's care plan dated 05/18/23 revealed:
-The resident required extensive assistance with eating.
-The resident was totally dependent for assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident's scheduled bath days were Sunday, Tuesday, Thursday, and Friday.
-The resident was scheduled for nail care to be completed once a week.

Observation of Resident #1's fingernails on 10/24/23 at 10:11am revealed:
-The resident was lying in bed, dressed, and eating a snack.
-There was a yellow stain on the resident's

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fingernails on both hands.
-There was a yellow and red substance matted on each side of her fingernail cuticles on both hands.
-The left thumb was approximately 3/4 inch long extended from the nailbed with a thick substance of various colors matted underneath her thumb nail.
-The left second, third, fourth and fifth fingernails were approximately 3/4 inch long extended from the nailbed.
-The right thumb was approximately 3/4 inch long extended from the nailbed with a thick substance of various colors matted underneath her thumb nail.
-The right second, third, fourth, and fifth fingernails were approximately 3/4 inch long extended from the nailbed.

Interview with Resident #1 on 10/24/23 at 10:00am revealed she liked her fingernails long but could not remember the last time someone cleaned her fingernails and trimmed them.

Review of Resident #1's September 2023 Activities of Daily Living (ADLs) revealed:
-There was an entry for extensive assistance with bathing each Sunday, Tuesday, Thursday, and Friday.
-The bathing task was documented as completed on all three shifts every day from 09/01/23 to 09/30/23.
-There was an entry for extensive assistance with grooming 7 days a week.
-The grooming task was documented as completed on all three shifts every day from 09/01/23 to 09/30/23.
-There was no documentation that the resident refused bathing or grooming assistance from 09/01/23 to 09/30/23.

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D 269	Continued From page 12 Review of Resident #1's October 2023 ADLs revealed: -There was an entry for extensive assistance with bathing each Sunday, Tuesday, Thursday, and Friday. -The bathing task was documented as completed on all three shifts every day from 10/01/23 to 10/24/23. -There was an entry for extensive assistance with grooming 7 days a week. -The grooming task was documented as completed on all three shifts every day from 10/01/23 to 10/24/23. -There was no documentation that the resident refused bathing or grooming assistance from 10/01/23 to 10/24/23. Interview with a personal care aide (PCA) on 10/25/23 at 8:25am revealed: -She cleaned the resident's fingernails when she provided the resident with a bath and daily when she provided grooming. -She had not noticed that Resident #1 had what appeared to be food matted underneath her fingernails. -She filed the resident's fingernails if the resident reported that her nails were too long. -Resident #1 liked her fingernails long and did not like to have her fingernails filed or trimmed. -She had not documented any refusals for nailcare from Resident #1 in the ADL log. Interview with a medication aide (MA) on 10/24/23 at 10:10am revealed: -Resident #1 preferred her fingernails long and did not like to have them trimmed. -The personal care aides (PCAs) were responsible for cleaning her fingernails each time she took a bath and daily when they provided	D 269		

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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 269	Continued From page 13 grooming for the resident. -She did not realize the resident's fingernails had food matted on the edges of the cuticles and underneath her fingernails. -The PCAs should have ensured the resident's fingernails were clean. -She had not documented that the resident refused to allow staff to trim her fingernails. Interview with the Administrator on 10/25/23 at 5:15pm revealed: -She expected the PCAs to follow the resident's care plan to ensure the resident received the personal care she required. -PCAs should have ensured the Resident #1's fingernails were clean and notified the MA if the resident refused nailcare so the MA could help provide nailcare to the resident. Telephone interview with the facility's primary care physician (PCP) on 10/25/23 at 2:58pm revealed: -Staff were expected to ensure the resident had clean fingernails as part of her bathing and grooming care. -Resident #1 was at a higher risk of scratching herself with her fingernails being too long, which could cause a skin infection and lead to cellulitis (cellulitis is a bacterial skin infection that if left untreated can spread into the lymph nodes and bloodstream).	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#2) by failing to notify the resident's primary care provider (PCP) of a 2 and 1/2 inch dark red circle on the right heel with a red inflamed area around the dark red circle.

The findings are:

Review of Resident #2's current FL-2 dated 10/02/23 revealed diagnosis included vascular dementia, diabetes, and chronic obstructive pulmonary disease (COPD).

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 08/25/23.

Review of Resident #2's care plan dated 09/28/23 revealed she required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #2 on 10/25/23 at 8:29am revealed:
-There was a pillow under the resident's feet that prevented her heels from touching the mattress.
-The resident's right heel had a 2 and 1/2 inch dark red circle with a red inflamed area around the dark red circle.

Interview with Resident #2 on 10/25/23 at 8:28am revealed her right heel hurt, she was uncomfortable and thought she had a sore on her right heel.

Interview with a personal care aide (PCA) on 10/25/23 at 8:30am revealed:
-The resident had a sore on her right heel and

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staff had placed a pillow under the resident's ankles to prevent her right heel from touching the mattress.
-She had noticed the sore sometime last week.
-She had reported the resident's sore on her right heel to the medication aide (MA) a few days ago.

Interview with a MA on 10/25/23 at 11:08am revealed:
-A PCA had informed her of a dark red area on Resident #2's right heel a few days ago.
-She could not remember if she had notified the resident's primary care provider (PCP) about the dark red area on the resident's heel.
-The MAs were responsible for notifying the PCP when a resident had a change in condition.

Interview with the Administrator on 10/25/23 at 5:15pm revealed:
-PCAs were expected to report any changes in condition to the MA.
-The MA should have reported the discoloration of Resident #2's right heel to the PCP.
-Resident #2's right heel needed to be assessed by the PCP to prevent further complications.

Telephone interview with the facility's primary care physician (PCP) on 10/25/23 at 2:58pm revealed:
-She began following Resident #2 on 10/20/23.
-She had not been notified of the discoloration to Resident #2's right heel.
-There was no documentation from the previous PCP that she had been notified of the discoloration to Resident #2's heel.
-The facility should have notified her of the discoloration of Resident #2's right heel so she could assess if the discoloration was a deep tissue injury, skin breakdown, or an infection.
-The resident could have needed an order for medication, heel protectors, a skin protectant

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D 273	Continued From page 16 cream, or a barrier cream. -Staff should have notified her or the PCP on call services of the change in the resident's heel to ensure the resident did not have further complications related to her right heel.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 5 sampled residents by ensuring a resident with bilateral edema had anti-embolism compression stockings implemented (#2) and a resident had heel protectors on to prevent skin breakdown (#1). The findings are: 1. Review of Resident #2's current FL-2 dated 10/02/23 revealed diagnosis included vascular dementia, diabetes, and chronic obstructive pulmonary disease (COPD). Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 08/25/23. Review of Resident #2's care plan dated 09/28/23	D 276		

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revealed she required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.

Observation of Resident #2 on 10/25/23 at 8:29am revealed:
-There was a pillow under the resident's feet that prevented her heels from touching the mattress.
-The resident was not wearing anti-embolism knee high compression stockings.

Interview with Resident #2 on 10/25/23 at 8:28am revealed her right heel hurt, she was uncomfortable and thought she had a sore on her right heel.

Review of Resident #2's primary care provider (PCP) visit note dated 09/21/23 revealed:
-The resident had worsening edema to her bilateral lower extremities, with her right lower extremity worse than the left.
-The PCP would complete an order for bilateral lower extremity knee high compression stockings to be placed on the resident every morning and removed each night.

Review of a physician order sheet for Resident #2 dated 10/02/23 revealed there was an order for anti-embolism knee high compression stockings to be applied every morning at 7:00am and removed at 7:00pm.

Review of Resident #2's record revealed there was a support hose measurement form signed by the PCP dated 09/22/23.

Interview with a personal care aide (PCA) on 10/25/23 at 8:30am revealed:
-Staff had a pillow underneath the resident's feet to help prevent her right heel from touching the

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mattress because she had a dark red area on her right heel.
-She thought Resident #2 was not supposed to wear her compression stockings because she had a dark red area on her right heel.
-She had not placed compression stockings on Resident #2 in the past two weeks.

Interview with a MA on 10/25/23 at 11:08am revealed:
-The PCAs placed compression stockings on the resident's legs each morning.
-She was not aware that the resident was not wearing compression stockings.
-The resident should be wearing compression stockings because the PCP had ordered her to wear them.
-The compression stockings were used to help the resident's bilateral edema.

Interview with the Administrator on 10/25/23 at 5:15pm revealed:
-The PCAs should place compression stockings on Resident #2 each morning and remove at night per the PCP order.
-Resident #2 needed compression stockings to prevent edema in her legs and feet.

Telephone interview with the facility's primary care physician (PCP) on 10/25/23 at 2:58pm revealed:
-She began following Resident #2 on 10/20/23.
-There was an order from Resident #2's previous PCP on 09/21/23 for the resident to wear compression stockings each morning and remove at night.
-Staff were expected to follow PCP orders to ensure the resident's edema did not progress.

2. Review of Resident #1's current FL-2 dated 06/09/23 revealed diagnoses included vascular

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dementia, chronic pain syndrome, and shortness of breath.

Review of Resident #1's Resident Register dated 07/22/19 revealed he was admitted to the facility on 7/22/19.

Review of Resident #1's care plan dated 05/18/23 revealed:
-The resident required extensive assistance with eating.
-The resident was totally dependent for assistance with toileting, ambulation, bathing, dressing, grooming, and transferring.
-The resident's scheduled bath days were Sunday, Tuesday, Thursday, and Friday.
-The resident was scheduled for nail care to be completed once a week.

Review of Resident #1's primary care provider (PCP) visit note dated 09/28/23 revealed:
-Staff reported concern about the resident's feet that had some redness earlier in the week.
-The PCP completed an order for heel protectors to be applied to both feet while the resident was in bed.

Review of Resident #1's PCP visit note dated 10/05/23 revealed:
-The resident complained of bilateral foot pain.
-There was no evidence of skin breakdown on the resident's feet.
-The facility was waiting for heel protectors to be delivered for the resident.

Review of facility progress notes for Resident #1 revealed:
-There was documentation on 10/09/23 that a medication aide (MA) contacted a local pharmacy to follow up on the heel protector order for

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Resident #1.
-There was documentation on 10/11/23 at 9:23am that heel protectors for Resident #1 were ordered and were expected to arrive on 10/12/23.

Observation of Resident #1 on 10/24/23 at 12:10pm revealed the resident was not wearing heel protectors on her feet, there was no skin breakdown on her feet or heels, and her feet were on the mattress.

Second observation of Resident #1 on 10/25/23 at 11:03am revealed the resident was not wearing heel protectors and her feet were on the mattress.

Interview with Resident #1 on 10/24/23 at 12:11pm revealed she did not have pain in her feet and she did not have heel protectors for her feet.

Interview with a personal care aide (PCA) on 10/25/23 at 11:03am revealed:
-Resident #1 wore heel protectors and she had forgotten to place them on the resident's feet this morning.
-The PCAs or MAs placed the residents heel protectors on each morning.
-She was unable to locate the resident's heel protectors but remembered she saw them yesterday in the resident's geri chair in the hallway yesterday afternoon.
-The resident did not like wearing heel protectors, but she encouraged the resident to wear them.

Interview with a MA on 10/25/23 at 11:08am revealed:
-She did not know where Resident #1's heel protectors were located.
-The resident did not like to wear heel protectors

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D 276	Continued From page 21 and often refused to wear them. -There was an order for the resident to wear heel protectors every day. -She had not notified Resident #1's PCP that the resident refused to wear heel protectors. -The MAs should ensure the resident wore heel protectors daily per the PCP order. -She should have notified the PCP that Resident #1 had refused to wear heel protectors. Interview with the Administrator on 10/25/23 at 5:15pm revealed: -The MAs should have ensured that Resident #1 wore heel protectors as ordered by the PCP for comfort and to prevent skin breakdown. -When the resident refused to wear the heel protectors, the MAs should notify the PCP. Telephone interview with the facility's primary care physician (PCP) on 10/25/23 at 2:58pm revealed: -She began following Resident #1 on 10/20/23. -Staff were expected to follow the previous PCP orders to apply heel protectors to the resident's feet each morning. -Heel protectors were ordered by the previous PCP due to staff reports that the resident had some redness on both feet. -The heel protectors would protect the resident from skin breakdown. -The resident was at an increased risk of skin breakdown because she stayed in bed and needed to wear heel protectors daily.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to 1 of 9 residents (#12, #13) observed during the medication pass including errors with a medication used to treat high blood pressure (#12) and a topical medication used to treat pain (#13).

The findings are:

The medication error rate was 7% as evidenced by 2 errors out of 26 opportunities during the 8:00am and 12:00pm medication passes on 10/24/23.

Review of the facility's medication policies and procedures dated 09/28/22 revealed medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders.

a. Review of Resident #12's current FL-2 dated 05/18/23 revealed:
-Diagnoses included vascular dementia and hypertension.
-There was an order for Coreg (used to treat high blood pressure) 6.25mg twice a day.

Observation of the 8:00am medication pass on 10/24/23 revealed:
-The medication aide (MA) placed Resident #12's medications in a medication cup.

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-The MA administered 9 ½ pills to Resident #12 at 9:11am.
-The MA did not administer Coreg 6.25mg to Resident #12.

Review of Resident #12's October 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Coreg 6.25mg twice a day scheduled for administration at 8:00am and 8:00pm.
-Coreg 6.25mg was documented as administered at 8:00am on 10/24/23.

Observation of Resident #12's medications on hand on 10/24/23 at 10:15am revealed:
-There was a bubble card containing 4 pills of Coreg 6.25mg.
-Fifty-six tablets of Coreg 6.25mg were dispensed with a start date of 09/28/23.
-There was no dispense date on the medication card containing Coreg 6.25mg.

Interview with the MA on 10/24/23 at 10:15am revealed:
-It had been a busy morning, and she must have missed administering Coreg 6.25mg to Resident #12.
-She must have scanned the medication card but not administered the medication.
-When the medication card was scanned it documented the medication as administered.

Interview with the Special Care Coordinator (SCC) on 10/24/23 at 4:35pm revealed:
-She expected MAs to read medication orders on the eMAR 3 times before administering medications to residents, so no medications were missed.
-Scanning a medication card marked the

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medication as administered on the eMAR.

Interview with the Administrator on 10/24/23 at 4:45pm revealed she expected MAs to administer all medications as ordered by the primary care provider (PCP).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/25/23 at 2:45pm revealed:
-Fifty-six tablets of Coreg 6.25mg were dispensed for Resident #12 on 09/21/23.
-The facility should have started administering Resident #12's Coreg 6.25mg that was dispensed on 09/21/23 whenever the previous medication card was empty.

Telephone interview with Resident #12's PCP on 10/25/23 at 2:58pm revealed:
-She was not familiar with Resident #12 because she took over for another PCP last week and she had not visited the facility yet, so she did not know why the resident's Coreg was ordered.
-Coreg could be used for cardiac disorders or to treat high blood pressure.
-Resident #12 missing one dose of Coreg would probably not have any adverse effects on the resident but she expected her to receive all medications as ordered.

Based on observations, interviews, and record reviews it was determined Resident #12 was not interviewable.

b. Review of Resident #13's current FL-2 dated 09/28/23 revealed:
-Diagnoses included type 2 diabetes, Alzheimer's dementia, and peripheral vascular disease.
-There was an order for diclofenac gel (used to treat pain) 1% apply 1 gram topically to bilateral

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D 358	Continued From page 25 knees three times a day. Observation of the 12:00pm medication pass on 10/24/23 revealed: -The medication aide (MA) measured out 1gm of diclofenac gel 1% and placed it in a medication cup. -The MA asked Resident #13 if the medication was supposed to be applied to the right knee and the resident stated it was. -The MA administered diclofenac gel 1% 1 gm to Resident #13's right knee at 12:35pm. -The MA did not administer diclofenac gel 1% 1 gm to Resident #13's left knee. Review of Resident #13's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for diclofenac gel 1% apply 1gm topically to bilateral knees 3 times a day scheduled for administration at 7:00am, 1:00pm, and 7:00pm. -Diclofenac gel 1% 1 gm was documented as administered at 1:00pm on 10/24/23. Interview with the MA on 10/24/23 at 4:42pm revealed: -She was also the Resident Care Coordinator (RCC) at the facility. -Resident #13 had orders for diclofenac gel 1% to be applied to both knees. -When Resident #13 said diclofenac gel was to be applied to her right knee, she did what the resident said. -She should not have listened to what Resident #13 said but should have applied the diclofenac gel to both knees as it was ordered. Interview with the Administrator on 10/24/23 at 4:45pm revealed she expected the MA to	D 358		

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D 358	Continued From page 26 administer Resident #13's diclofenac gel to both knees because that was how the medication was ordered to be administered. Telephone interview with Resident #13's primary care provider (PCP) on 10/25/23 at 2:58pm revealed: -She was not familiar with Resident #13 because she took over for another PCP last week and she had not visited the facility yet. -She expected Resident #13 to receive diclofenac gel to both knees because that was how it was ordered to be administered.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046020	A. BUILDING: _____ B. WING _____	10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 27 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 9 residents (#12) observed during the medication pass including errors with a medication used to treat high blood pressure. The findings are: Review of Resident #12's current FL-2 dated 05/18/23 revealed: -Diagnoses included vascular dementia and hypertension. -There was an order for Coreg (used to treat high blood pressure) 6.25mg twice a day. Observation of the 8:00am medication pass on 10/24/23 revealed: -The medication aide (MA) placed Resident #12's medications in a medication cup. -The MA administered 9 ½ pills to Resident #12 at 9:11am. -The MA did not administer Coreg 6.25mg to Resident #12. Review of Resident #12's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Coreg 6.25mg twice a day scheduled for administration at 8:00am and 8:00pm. -Coreg 6.25mg was documented as administered at 8:00am on 10/24/23. Interview with the MA on 10/24/23 at 10:15am revealed: -When a resident's medication card was scanned it documented the medication as administered.	D 367		

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D 367	Continued From page 28 -She must have scanned Resident #12's medication card containing Coreg but did not administer the medication. Interview with the Special Care Coordinator (SCC) on 10/24/23 at 4:35pm revealed: -Scanning a resident's medication card marked the medication as administered on the eMAR. -The MA should not have scanned Resident #12's Coreg if it was not administered. -The MA should have checked to make sure the eMAR looked correct before administering medications to Resident #12. Interview with the Administrator on 10/24/23 at 4:45pm revealed the MA should not have marked Resident #12's Coreg as administered if it was not administered to the resident.	D 367		
D 412	10A NCAC 13F .1010 (e) Pharmaceutical Services 10A NCAC 13F .1010 Pharmaceutical Services (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide pharmaceutical services that ensured accurate records of the receipt of medications were maintained in the facility for 1 of 5 sampled residents (#7). The findings are:	D 412		

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D 412	Continued From page 29 Review of Resident #7's current FL2 dated 03/02/23 revealed: -Diagnoses included acute kidney failure, suicidal behaviors, essential hypertension, heart value replacement, congestive heart failure, benign prostatic hyperplasia, and cerebral infraction. -There were physician orders for Amlodipine 10mg 1 tablet daily at 7:00am and Baclofen 10mg 1 tablet three times daily. Telephone interview with Resident #7 on 10/25/23 at 9:23am revealed: -He was admitted to the facility on 06/09/23. -He came with two medications, Amlodipine for his high blood pressure and Baclofen for pain. -He gave his medication to the staff when he was admitted. -The staff did not count his medication in his presence or review his medication with him when he was admitted. -He did not remember how many tablets he had for each medication when he was admitted. Telephone interview with the Pharmacist at the facility's local pharmacy on 10/25/23 at 2:46pm revealed: -Resident #7's Amlodipine 10mg was dispensed on 06/09/23 for 30 tablets. -Resident #7's Baclofen 20mg was dispensed on 06/09/23 for 90 tablets. Interview with the Resident Care Coordinator (RCC) on 10/25/23 at 5:20pm revealed: -She thought she had documented the count of Resident #7's medication when he was admitted. -Residents' medications were counted in their presence and logged at the time of their admission. -She would provide a copy of the medication	D 412		

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D 412	Continued From page 30 count log. Interview with the Administrator on 10/25/23 at 5:16pm revealed: -Resident #7's medication was counted at the time of his admission. -Resident #7 had two medications upon his admission. -The medication count was documented on the medication disposition log. -She would provide a copy of the medication count log. Interview with the Owner on 10/25/23 at 5:21pm revealed: -Resident #7's medications were not counted or logged during his admission. -The RCC was the person responsible for reviewing and counting the residents' medication upon admission.	D 412		