STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R-C 01/25/2024

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KINGSBRIDGE HOUSE	10 SUGAR LOAF ROAD BREVARD, NC 28712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted a follow-up survey on 01/23/24 to 01/25/24.	{D 000}		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff A's, personal care aide (PCA), personnel record revealed: -There was a hire date of 12/05/23. -There was no documentation of a HCPR check upon hire. Review of the HCPR check for Staff A on 01/24/24 revealed there were no substantiated findings. Refer to the interview with the Business Office Manager (BOM) on 01/24/24 at 2:08pm. Refer to the interview with the Administrator on	D 137		

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D 137	Continued From page 1 01/24/24 at 2:14pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -There was a hire date of 12/22/23. -There was no documentation of a HCPR check upon hire. Review of HCPR check for Staff C on 01/24/24 revealed there were no substantiated findings. Refer to the interview with the BOM on 01/24/24 at 2:08pm. Refer to the interview with the Administrator on 01/24/24 at 2:14pm. _____ Interview with the BOM on 01/24/24 at 2:08pm revealed: -She had been working in the facility for around 2 weeks. -She had never been told the process of her role in managing the HCPR. -She thought the cooperate office was responsible for completing personnel hiring information and sending it to the facility. Interview with the Administrator on 01/24/24 at 2:14pm revealed: -She or the BOM was responsible for completing HCPR checks. -She was not aware the HCPR checks were not completed for Staff A and C until 01/24/24. -Not completing HCPR checks must have been an oversight.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications	D 139		

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D 139	Continued From page 2 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) had a criminal background check completed upon hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 12/22/23. -Staff C worked as a medication aide (MA). -There was no criminal background check completed. Interview with the Business Office Manager (BOM) on 01/24/24 at 2:08pm revealed: -She had been working at the facility for around 2 weeks. -She knew to submit the background check request to the corporate office. -The corporate office would tell her if the staff were eligible for hire after the background check was completed. Interview with the Administrator on 01/24/24 at 2:14pm revealed: -The BOM was responsible for ensuring background checks got put in the system to the corporate office. -Results from the background checks would come back to corporate and corporate would tell the BOM if they were eligible for hire. -She was unaware background checks had not	D 139		

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D 139	Continued From page 3 been done Staff C until 01/24/24. -The background checks not being done was an oversight.	D 139		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 4 sampled residents (Resident # 5) who had a physician's order for double portions. The findings are: Review of Resident #5's current FL2 dated 04/14/23 revealed: -Diagnoses included dementia and anxiety. -The resident was constantly disoriented. Review of Resident #5's Care Plan dated 01/18/24 revealed the resident required limited assistance with meals. Review of Resident #5's Nurse Practitioner's (NP) order dated 01/11/24 revealed regular diet double portions. Review of the regular lunch meal menu for 01/23/24 revealed garlic herb roast pork, fresh cooked yams, peas and onions, baked roll beverage of choice, and grapes.	{D 310}		

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{D 310}	Continued From page 4 Observation of the lunch meal and beverage service on 01/23/24 revealed: -At 12:03pm, Resident #5 was served a pork chop with brown gravy, mashed potatoes, peas and onions, a roll, unsweetened tea with 2 packets of artificial sweetener, coffee, milk, and water. -At 12:19pm, Resident #5 was served fruit cocktail and a nutritional supplement shake. -At 12:28pm, Resident #5 had eaten 75% of the food items on the plate served to him at 12:03pm. Interview with the Dietary Manager (DM) on 01/23/24 at 12:25pm revealed: -She knew Resident #5 was supposed to receive double portions at meals. -There was a list of all current therapeutic diets available in the kitchen. -She served Resident #5 his lunch meal. -She served him a meal plate with regular portions. -She "forgot" to serve Resident #5 a double portion of all of the meal items. Interview with Resident #5 on 01/23/24 at 12:32pm revealed: -He did not like the pork chop served to him at lunch. -Staff did not serve him double portions of meal items. Interview with the Administrator on 01/24/24 at 4:10pm revealed: -There was a current list of therapeutic diets available in the kitchen for staff guidance. -Staff were trained to check the therapeutic diet list prior to serving residents. -Whomever delivered Resident #5's lunch meal to the table was responsible for ensuring they	{D 310}		

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{D 310}	Continued From page 5 were serving him the correct meal. -She would speak with all the staff to ensure they were made aware to give Resident #5 a double portion plate at all meals. Interview with Resident #5's NP on 01/25/24 at 9:35am revealed: -Resident #5 had a significant weight loss in October 2023 due to renal issues. -He wanted Resident #5 to receive double portions at all meals.	{D 310}		
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. 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 clarify medication orders for 1 of 5 sampled residents (Resident #1) related to self administration of medications in a special care unit. The findings are:	D 344		

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Review of the facility's policies and procedures on page 81 for medication administration dated 11/2018 revealed:
-If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or conditions, the facility personnel calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification.
-This interaction with the pharmacy and/or prescriber and the resulting order clarification are documented in the medical record as appropriate.

Review of the facility's policies and procedures for Resident Self-Management and Storage of Medications dated 09/2018 revealed residents with a diagnosis of memory impairment will not be permitted to self manage their medications.

Review of Resident #1's current FL2 for dated 01/11/24 revealed:
-Diagnoses included advanced dementia with behavioral disturbances, atrial fibrillation, benign prostatic hyperplasia.
-The resident was constantly disoriented.
-The recommended level of care was a SCU.
-There were orders for Vitamin D3 (Supplement) 2,000 units one capsule by mouth daily family to supply and self administer, ketoconazole shampoo (used to treat dandruff and other fungus of the skin) 2% apply a small amount topically to wet scalp, lather and leave on 5 minutes and rinse twice weekly, may self-administer and keep in room, Nystatin powder (used to treat fungal infections) 100,00 unit/gram apply topically to affected area every 6 hours as needed, may self-administer and keep in room, polyethylene glycol (used to treat constipation) 3350 17grams

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mix 1 capful to the indicated line in 8 ounces (oz.) fluid and take by mouth as needed, may keep at bedside and self-administer, hydrocortisone creme (topical steroid) 1% apply a small amount topically to facial rash once daily as needed, may keep at bedside, triple antibiotic ointment (antibiotic to treat minor skin injuries) 5,000 units apply topically to affected areas once daily as needed wrapped with Kerlix dressing applied to scabbing of bilateral upper extremities, may keep at bedside.

Review of Resident #1's current care plan dated 5/18/23 revealed the resident was constantly disoriented with significant memory loss.

Review of the December 2024 electronic medication record administration (eMAR) revealed:
-There was an entry for Vitamin D3 2,000 units one capsule by mouth daily family to supply and self administer.
-There was documentation of administration on 12/18/23 - 12/31/23.
-There was an entry for ketoconazole shampoo 2% apply a small amount topically to wet scalp, lather and leave on 5 minutes and rinse twice weekly, may self-administer and keep in room.
-There was documentation of administration on 12/20/23, 12/23/23, 12/26/23 and 12/29/23.
-There was an entry for Nystatin powder 100,00 unit/gram apply topically to affected area every 6 hours as needed, may self-administer and keep in room
-There was no documentation Nystatin powder was administered.
-There was an entry for polyethylene glycol 3350 17grams mix 1 capful to the indicated line in 8 ounces (oz.) fluid and take by mouth as needed, may keep at bedside and self-administer.

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D 344	Continued From page 8 -There was no documentation polyethylene glycol was administered. -There was an entry for hydrocortisone creme 1% apply a small amount topically to facial rash once daily as needed, may keep at bedside. -There was no documentation hydrocortisone creme was administered. -There was an entry for triple antibiotic ointment 5,000 units apply topically to affected areas once daily as needed wrapped with Kerlix dressing applied to scabbing of bilateral upper extremities, may keep at bedside. -There was no documentation of triple antibiotic ointment being administered. Review of the January 2024 eMAR revealed: -There was an entry for Vitamin D3 2,000 units one capsule by mouth daily family to supply and self administer. -There was documentation staff administered medication 01/01/24-01/23/24. -There was an entry for ketoconazole shampoo 2% apply a small amount topically to wet scalp, lather and leave on 5 minutes and rinse twice weekly, may self-administer and keep in room. -There was documentation of administration on 01/01/24, 01/04/24, 01/07/24, 01/10/24, 01/13/24, 01/16/24, 01/19/24, and 01/22/24. -There was an entry for Nystatin powder 100,00 unit/gram apply topically to affected area every 6 hours as needed, may self-administer and keep in room, polyethylene glycol 3350 17grams mix 1 capful to the indicated line in 8 ounces (oz.) fluid and take by mouth as needed, may keep at bedside and self-administer. -There was no documentation Nystatin powder or polyethylene glycol were administered. -There was an entry for hydrocortisone creme 1% apply a small amount topically to facial rash once daily as needed, may keep at bedside.	D 344		

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-There was no documentation hydrocortisone creme was administered.
-There was an entry for triple antibiotic ointment 5,000 units apply topically to affected areas once daily as needed wrapped with Kerlix dressing applied to scabbing of bilateral upper extremities, may keep at bedside.
-There was no documentation triple antibiotic ointment was administered.

Interview with a medication aide (MA) on 01/23/24 at 3:35pm revealed:
-The facility only administered a few of Resident #1's medications as the family kept the medications in his room and the family administered them.
-The family also brought in over the counter medications and supplies needed for Resident #1's care.

Interview with a private caregiver for Resident #1 on 01/23/24 at 4:04pm revealed:
-Resident #1 had medications in his room and they were kept in the closet.
-The caregivers staying with Resident #1 were directed by the family not to administer any of the medications in the closet.
-The family would administer medications kept in the closet in the resident's room.

Observation of Resident #1's medications kept in his closet on 01/23/24 at 4:02pm revealed:
-The caregiver retrieved the medications from the residents closet.
-There was a 30 count bottle of Vegan vitamin D chewable's 2,000 IU (supplement), ketoconazole 2% shampoo with a pharmacy label, a 17.9 oz bottle of Natural-lax with a pharmacy label, 3 opened bottles of nystatin powder 2 with pharmacy labels one did not have a pharmacy

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label, an opened 28.35 gram tube of hydrocortisone creme 1% (used to treat facial rash) with a pharmacy label, an opened 10 oz. tube of triple antibiotic creme with a pharmacy label and a 100gram tube of Voltaren gel 1% (used to treat arthritis) with a pharmacy label.

Interview with the Area Clinical Director (ACD) on 01/23/24 at 4:20pm revealed:
-The facility was a SCU and the residents were not allowed to have medications in their rooms.
-The staff should have contacted the physician and received a discontinue order for the medications kept in room and self-administered.

Interview with the primary care provider (PCP) for Resident #1 on 01/24/24 at 10:00am revealed:
-He had been unaware of the facility's policy for self administration and not being allowed to keep medications in the room due to residing in a SCU.
-He thought since the family was there with resident most of the day it would be ok.
-It was an oversight on his part.
-It could put other residents at risk if they ingested any of the medications.

Interview with the Administrator on 01/24/23 at 10:28am revealed:
-She was not aware of the medications in Resident #1's room until 01/23/24.
-She had been assured by the facility resident care coordinator (RCC) that there were no medications in any resident rooms the week of 01/15/24.
-There should not have been any medications in Resident #1's room.
-The RCC should have called the physician and explained Resident #1 was on a SCU and could not keep medications in the room nor self administer.

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D 344	Continued From page 11 Attempted interview with the RCC on 01/24/23 at 10:35am was unsuccessful.	D 344		
D 345	10A NCAC 13F .1002(b) Medication Orders 10A NCAC 13F .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to obtain physician orders for medications located in a residents (Resident #1) room for 1 of 5 sampled residents in a Special Care Unit (SCU). The findings are: Review of Resident #1's current FL2 for dated 01/11/24 revealed: -Diagnoses included advanced dementia with behavioral disturbances, atrial fibrillation, benign prostatic hyperplasia. -The resident was constantly disoriented. -The recommended level of care was a SCU. Review of Resident #1's current care plan dated 05/18/23 revealed the resident was always disoriented and had significant memory loss. Interview with a medication aide (MA) on 01/23/24 at 3:35pm revealed: -The facility only administered a few of Resident	D 345		

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#1's medications because the family kept the medications in his room and also administered them.
-The family also brought in over the counter medications and supplies needed for Resident #1's care and they were kept in the residents room..
-She was not aware of all the medications the family might have brought in for Resident #1.

Interview with a private caregiver for Resident #1 on 01/23/24 at 4:04pm revealed:
-Resident #1 did have medications in his room and they were kept in the closet.
-The caregivers staying with Resident #1 had been directed by the family not to administer any of the medications in the closet.
-The family would administer medications kept in the closet in Resident #1's room.
-The family was there in the morning and late evening and the caregivers were there from 1:00pm-5:00pm.
-No one stayed with the resident at night.

Observation of Resident #1's medications kept in his closet on 01/23/24 at 4:02pm revealed:
-He had a private room.
-The clothes closet was closed but not locked when the caregiver retrieved the medications from the closet.
-There was an unopened box containing 1 ounce (oz.) tube of antifungal creme, a 16 oz. bottle of Thera Breath oral rinse, a twin box of children's liquid acetaminophen 160mg per 5ml.(2- 4 oz. bottles), a new 1 oz. tube of athletes foot creme, a 32 oz. bottle mostly empty of hydrogen peroxide, a full 7.4 oz. bottle of saline wound wash, a 7.5 oz. bottle of health care antiseptic for perineal use, an opened 3 oz. bottle of zinc oxide skin protectant, N-Acetyl L-Cysteine powder

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600mg (dietary supplement), rinse free, foaming, shampoo and body wash.

Review of Resident #1's physician orders revealed there were no orders for a 1 ounce (oz.) tube of antifungal creme, a 16 oz. bottle of Thera Breath oral rinse, a twin box of children's liquid acetaminophen 160mg per 5ml.(2- 4 oz. bottles), a new 1 oz. tube of athletes foot creme, a 32 oz. of hydrogen peroxide, a full 7.4 oz. bottle of saline wound wash, a 7.5 oz. bottle of health care antiseptic for perineal use, a 3 oz. bottle of zinc oxide skin protectant, N-Acetyl L-Cysteine powder 600mg (dietary supplement), and rinse free, foaming, shampoo and body wash.

Review of the December 2024 electronic medication record administration (eMAR) revealed there were no entries for a 1 ounce (oz.) tube of antifungal creme, a 16 oz. bottle of Thera Breath oral rinse, a twin box of children's liquid acetaminophen 160mg per 5ml.(2- 4 oz. bottles), a new 1 oz. tube of athletes foot creme, a 32 oz. of hydrogen peroxide, a full 7.4 oz. bottle of saline wound wash, a 7.5 oz. bottle of health care antiseptic for perineal use, a 3 oz. bottle of zinc oxide skin protectant, N-Acetyl L-Cysteine powder 600mg (dietary supplement), and rinse free, foaming, shampoo and body wash.

Review of the January 2024 eMAR revealed there were no entries for a 1 ounce (oz.) tube of antifungal creme, a 16 oz. bottle of Thera Breath oral rinse, a twin box of children's liquid acetaminophen 160mg per 5ml.(2- 4 oz. bottles), a new 1 oz. tube of athletes foot creme, a 32 oz. of hydrogen peroxide, a full 7.4 oz. bottle of saline wound wash, a 7.5 oz. bottle of health care antiseptic for perineal use, a 3 oz. bottle of zinc oxide skin protectant, N-Acetyl L-Cysteine powder

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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 345	Continued From page 14 600mg (dietary supplement), and rinse free, foaming, shampoo and body wash. Interview with the primary care provider (PCP) for Resident #1 on 01/24/24 at 10:00am revealed: -He had not been notified of medications in the room without orders. -He would have wanted to know about the medications that did not have orders to ensure there were no negative interactions with Resident #1's other medications. -It could put other residents at risk if they ingested any of the medications. Interview with the Administrator on 01/24/23 at 10:28am revealed: -She was not aware of the medications in Resident #1's room until 01/23/24. -She had been assured by the facility resident care coordinator (RCC) that there were no medications in any resident rooms the week of 01/15/24. -The RCC was responsible to ensure there were no medications kept in the residents rooms and to obtain an order from a physician if a family member requested or brought a medication in for the residents. -There should not have been any medications in Resident #1's room. -Staff should have checked to see if there were other medications in the room and called the physician to obtain orders if other medications were discovered. Attempted interview with the RCC on 01/24/23 at 10:35am was unsuccessful.	D 345		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 15 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed 1 of 1 resident (Resident #5) take all prepared medication resulting in one medication being left unattended on the resident's television stand in his room. The findings are: Review of the facility's medication administration-general guidelines policy dated 11/2018 revealed: -When medications are administered by mobile cart and taken to the resident's location medications administered are administered at the time they are prepared. -The person who prepared the dose for administration is the person who administers the dose. Review of Resident #5's current FL2 dated 04/14/23 revealed: -Diagnoses included dementia and anxiety. -The resident was constantly disoriented. Review of Resident #5's Nurse Practitioner's (NP) order dated 12/28/23 revealed:	D 366		

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-Fiber gummies (used as a fiber supplement) chew two gummies daily.
-There was no order to self-administer the fiber gummies.

Review of Resident #5's NP order dated 01/11/24 revealed fiber gummies chew two gummies daily.

Observation during the initial facility tour on 01/23/24 at 9:06am revealed:
-There was a plastic medication cup with two orange gummies inside the medication cup on the television stand in Resident #5's room.
-The outside of the medication cup had a piece of masking tape affixed with Resident #5's first name written in pen on the outside of the medication cup.

Interview with Resident #5 on 01/23/24 at 9:07am revealed:
-The orange gummies in the medication cup on the television stand were fiber supplement gummies.
-He intended to take the gummies when he returned from his smoke break.
-The staff routinely watched him take his medications and did not leave them in the room.
-He had asked the medication aide (MA) who administered his medications that morning if he could wait to take his fiber gummies until he could put in his dentures after his smoke break.

Review of Resident #5's January 2024 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for fiber gummies chew two gummies once daily scheduled at 8:00am.
-The fiber gummies were documented as administered on 01/23/24 at 8:00am by the first shift (7:00am to 3:00pm) medication aide (MA).

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D 366	Continued From page 17 Interview with a medication aide (MA) on 01/23/24 at 9:15am revealed: -The third shift MA stayed over that morning to help administer the 8:00am medications. -The handwriting on the masking tape affixed to Resident #5's medication cup containing orange gummies looked like the third shift MA's handwriting. -"I guess" the third shift MA left the cup with the fiber gummies in Resident #5's room. Telephone interview with a second MA on 01/24/24 at 2:42pm revealed: -She assisted with the 8:00am medication pass on the morning of 01/23/24. -She was in the process of pouring Resident #5's fiber gummies into a medication cup when she and the first shift MA decided to switch hall assignments which meant exchanging medication carts. -She labeled the medication cup with the fiber gummies with Resident #5's name and the other MA took Resident #5's his 8:00am medications. -The MA said she would make sure Resident #5 took the fiber gummies. -She knew she should never pour a medication and let another MA administer it to the resident. -She knew to watch the residents take all of their medications before leaving the room. -She was trained to never leave medications in the room. -She assumed the other MA administered Resident #5's multidose pack of medications, but left the fiber gummies without watching Resident #5 take them. Interview with Resident #5's NP on 01/25/24 at 9:35am revealed: -He ordered the fiber gummies for Resident #5 to	D 366		

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D 366	Continued From page 18 treat constipation. -If Resident #5 was not administered one dose of the fiber gummies, the resident could experience constipation. Interview with the Administrator on 01/23/24 at 4:10pm revealed: -The MA should have taken the fiber gummies to Resident #5 and made sure he took them. -In the process of the MAs changing hall assignments, the day shift MA forgot to watch Resident #5 take the fiber gummies medication.	D 366		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	D 377		

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Based on observations, record review, and interviews, the facility failed to ensure medications were stored in a safe and secure manner for 1 of 5 sampled residents (Resident #1) who resided in a special care unit (SCU).

The findings are:

Review of the facility's policy Resident Self Management and Storage of Medications dated 09/2021 revealed:
-Residents with a diagnosis of memory impairment will not be permitted to self-manage their medications.
-All medications must be kept in a secure environment that is accessible only to the resident and the facility staff.
-Should a resident show an inability to manage his/her medications safely, Facility storage of the medications will be arranged.

Review of the daily census report for the SCU on 01/23/24 revealed a total census of 33.

Review of Resident #1's current FL2 for dated 01/11/24 revealed:
-Diagnoses included advanced dementia with behavioral disturbances, atrial fibrillation, benign prostatic hyperplasia.
-The resident was constantly disoriented.
-The recommended level of care was a SCU.

Review of Resident #1's current care plan dated 5/18/23 revealed the resident was always disoriented and had significant memory loss.

Observation of Resident #1's room on 01/23/24 at 9:25am revealed:
-The resident was awake and sitting up in his bed with a family member at his bedside.

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-The family member opened the resident's closet, which was not locked and retrieved a bottle of honey thick water.

Observation of the medications available for administration on 01/23/24 at 3:35pm revealed:
There was no Vitamin D available for administration.
-There was no ketoconazole shampoo available for administration.
-There was no calmoseptine available for administration.
-There was no polyethylene glycol available for administration.
-There was no Kerlix bandages available for administration.

Interview with a medication aide (MA) on 01/23/24 at 3:35pm revealed:
-The facility only administered a few of Resident #1's medications so they did not have the medications in the medication cart.
-The family kept the Vitamin D, calmoseptine, polyethylene glycol and Kerlix bandages in his room and the family administered them.
-The family also brought in over the counter medications and supplies needed for Resident #1's care.
-She was not aware of other medications the family may have in the room.

Interview with a private caregiver for Resident #1 on 01/23/24 at 4:04pm revealed:
-Resident #1 had medications in his room and they were kept in the closet.
-The closet was not kept locked.
-The caregivers staying with Resident #1 had been directed by the family not to administer any of the medications in the closet.
-The family would administer medications kept in

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the closet in Resident #1's room.

Observation of Resident #1's medications kept in his closet on 01/23/24 at 4:02pm revealed:
-The closet was closed but not locked when the caregiver retrieved the medications from the closet.
-There was an unopened box containing 1 ounce (oz.) tube of antifungal creme, a 16 oz. bottle of Thera Breath oral rinse, a twin box of children's liquid acetaminophen (used to treat pain) 160mg per 5ml.(2- 4 oz. bottles), a new 1 oz. tube of athletes foot creme (used to treat foot fungus), a 32 oz. bottle mostly empty of hydrogen peroxide (mild antiseptic used to treat minor scrapes of burns), a full 7.4 oz. bottle of saline wound wash, a 7.5 oz. bottle of health care antiseptic for perineal use, an opened 3 oz. bottle of zinc oxide skin protectant (used to treat rash related to wetness), N-Acetyl L-Cysteine powder 600mg (dietary supplement), rinse free, foaming, shampoo and body wash, a 30 count bottle of Vegan vitamin D chewable's 2,000 IU (supplement), ketoconazole 2% shampoo with a pharmacy label, a 17.9 oz bottle of Natural-lax (used to treat constipation)with a pharmacy label, 3 opened bottles of nystatin powder (used to treat fungus on the skin) 2 with pharmacy labels 1 did not have a pharmacy label, an opened 28.35 gram tube of hydrocortisone creme 1% (used to treat facial rash) with a pharmacy label, an opened 10 oz. tube of triple antibiotic creme (used to treat minor skin infections)with a pharmacy label and a 100gram tube of Voltaren gel 1% (used to treat arthritis) with a pharmacy label.

Interview with the Area Clinical Director (ACD) on 01/23/24 at 4:20pm revealed:
-The facility was a SCU and the residents were

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not allowed to have medications in their rooms.
-It was her understanding from the Administrator on 01/23/24 that the medications had been locked in the closet.

Interview with the Administrator on 01/24/23 at 10:28am revealed:
-She was not aware of the medications in Resident #1's room until 01/23/24.
-She had been assured by the facility resident care coordinator (RCC) that there were no medications in any resident rooms the week of 01/15/24.
-It was her understanding that the closet door was locked and only opened when the family was there to give the medication.
-There should not have been any medications in Resident #1's room.
-She was unaware the closet that contained the medications for Resident #1 was not locked.

Attempted interview with the RCC on 01/24/23 at 10:35am was unsuccessful.

_____

The facility failed to ensure medications were maintained under locked security or under the direct supervision of staff in charge of medication administration allowing medications to be left in a residents (Resident #1) room in a SCU putting them at risk for harm if they ingested them. 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 01/23/24 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 10, 2024.

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{D 465}	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure required staffing hours were met on all three shifts in the special care unit (SCU) based on a census of 32 to 36 residents for 15 out of 45 shifts. The findings are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was a licensed Special Care Unit (SCU) with a capacity of 60 residents. Review of the facility's census from 12/31/23 to 01/13/24 and 01/22/24 revealed there was a census of 32 to 36 residents which required 32 to 36 staff hours on first and second shifts, and 24 to 25 staff hours on third shift. Review of the staff time records from 12/31/23 to 01/13/24 and 01/22/24 revealed: -On 12/31/23, the census was 36 requiring 36 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 12 staff	{D 465}		

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hours.
-On 12/31/23, the census was 36 requiring 36 staff hours on second shift and a total 24 hours were provided leaving a shortage of 12 staff hours.
-On 12/31/23, the census was 36 requiring 25 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 9 staff hours.
-On 01/01/24, the census was 36 requiring 36 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 4 staff hours.
-On 01/01/24, the census was 36 requiring 25 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/02/24, the census was 35 requiring 25 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/03/24, the census was 35 requiring 36 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 4 staff hours.
-On 01/03/24, the census was 35 requiring 36 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 12 staff hours.
-On 01/04/24, the census was 35 requiring 36 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 4 staff hours.
-On 01/04/24, the census was 35 requiring 25 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/05/24, the census was 35 requiring 25 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/06/24, the census was 35 requiring 36 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 4 staff hours.
-On 01/06/24, the census was 35 requiring 25 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/08/24, the census was 34 requiring 25

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staff hours on third shift and a total of 24 hours were provided leaving a shortage of 1 staff hour.
-On 01/22/24, the census was 33 requiring 24 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 8 staff hours.

Interview with a medication aide (MA) on 01/23/24 at 9:40am revealed:
-She worked mostly on first shift (7:00am to 3:00pm) as an MA.
-She occasionally worked third shift (11pm to 7:00am) as an MA.
-"Most of the time" they were staffed to meet census.

Interview with a personal care aide (PCA) on 01/23/24 At 11:30am revealed:
-She usually worked first shift but she had been working night shift for the past week as the facility needed staff coverage.
-Staffing was challenging because staff were also doing the residents laundry.
-Sometimes oral care would not get completed.

Interview with a PCA on 01/23/24 at 11:35am revealed:
- She worked first shift as a PCA.
-The Supervision of the residents oral care were the two things that were still a problem because staff were having to do resident laundry.
-That would take the staff member off the floor for about 45 minutes each time they went to do a load of laundry leaving one less person on the floor.
-If you needed the staff member you would have to go to laundry to get them as you can not hear in the laundry room.

Interview with the Activity Director (AD) on 01/23/24 at 12:45pm revealed:

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{D 465}	Continued From page 26 -She was responsible for planning and facilitating activities in the facility. -She worked Monday through Friday 8:30am to 5:00pm. -She was trained as a personal care aide (PCA). -She would answer call lights when floor staff were busy. -She also worked one weekend a month. -The hours on the weekend would vary depending on what needed to be done. Telephone interview with a MA on 01/24/24 at 2:42pm revealed: -She routinely worked as a MA on third shift (11:00pm to 7:00am). -When there was one MA and two PCAs on third shift, it made it harder to get their assigned residents up and dressed for breakfast the next morning. -She was unable to help the two PCAs get residents up and dressed as she was responsible for doing a medication pass. -Third shift PCAs did their last incontinent round at 5:45am. -First shift PCAs often complained some of the incontinent residents were wet when they checked them on their first incontinent round starting at 8:00am. Observation in the facility living room on 01/24/24 at 3:35pm revealed the AD was outside on a covered porch with 4 residents who were smoking. Interview with the AD on 01/24/24 at 3:40pm revealed: -She did all of the resident smoking supervision during her 8:30am to 5:00pm shift. -She assisted the PCAs daily at lunch time by bringing residents to the dining room.	{D 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL088015	A. BUILDING: _____ B. WING _____	R-C 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{D 465}	Continued From page 27 -She also assisted the PCAs at lunch by ensuring residents who were eating in their rooms were eating and had what they needed. -She helped with the residents eating in their rooms to allow at least one PCAs to stay with the residents in the dining room during lunch at all times. Interview with the Administrator on 01/24/24 at 9:25am revealed she was aware they had been short staffed on some of the shifts based on census and they worked continuously to correct the issue.	{D 465}		