

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL100005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/22/2024
NAME OF PROVIDER OR SUPPLIER YANCEY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 4 COOPER LANE BURNSVILLE, NC 28714		
(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 and a follow up survey on 02/21/24 - 02/22/24.	D 000	Responses to the cited deficiencies do not constitute admission or agreement by the facility of the truth of the facts alleged or 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-358	10A NCAC 13F .1004(a) Medication Administration	D-358	10A NCAC 13F 1004(a) Medication Administration. An audit was completed on 3.7.24 of Physician's orders and a Cart audit was completed on 3.8.24 to ensure all ordered medications and treatments were available and medications administration record (MAR) reflects the applicable order. Any findings indicating medications or treatments were not available for administrations, or were not reflected on the MAR, were corrected, and the Physician/Provider was notified for any additional orders.	3.7.24
	10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1 and #5) related to medications used to treat high blood pressure, depression, stomach acid, constipation, and a vitamin supplement (Resident #1) and a medication used to treat post traumatic stress disorder (PTSD) (Resident #5). The findings are: Review of the facility's Medication Administration General Guidelines dated 11/2018 revealed: -Medications were administered in accordance with written orders of the PCP. -Staff that administered the medication documented the administration of the medication directly after the medication was given. 1. Review of Resident #1's current FL2 dated 08/31/23 revealed diagnoses included dementia		The Executive Director, Resident Care Coordinator, and Memory Care Coordinator/designee were retrained on the procedures assuring the preparation and administration of medication, prescriptions, and non-prescriptions, and the treatments ordered by a licensed prescribing practitioner and maintained in the MAR following State regulations and facility policies. The Resident Care Coordinator/Memory Care Coordinator/designee will run and review daily activity reports of MAR administration to determine medications were given and routine cart audits are performed to ensure medications are available. The Resident Care Coordinator/Memory Care Coordinator/designee will report during daily Standup meetings any areas of non-compliance. All Medication Techs will receive additional training on Medication Administration Procedures, including the importance of notifying the ED and/or the RCC/MCC for any medications that do not appear on the MAR during their medication pass, or any medication	3.15.24 3.15.24 3.15.24

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Grace Kewi Robinson**Administrator**3/15/24*

STATE FORM

6699

94TW11

If continuation sheet 1 of 17

Reviewed and acknowledged 03/18/24 RP

Division of Health Service Regulation

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D 358	Continued From page 1 and hypothyroidism. Review of Resident #1's physician's orders dated 02/15/24 revealed amlodipine (medication used to treat high blood pressure) 2.5mg daily, calcium carbonate (supplement) 600mg daily, escitalopram (medication used to treat depression) 20mg daily, stimulant laxative plus (medication used to treat constipation) 2 tablets twice daily, and vitamin D3 (supplement) 25mcg daily. a. Amlodipine 2.5mg daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for 02/01/24 - 02/21/24 revealed there was an entry for amlodipine 2.5mg daily with an administration time of 8:00am and documentation the amlodipine 2.5mg was administered on 02/21/24 at 8:00am. Observation of Resident #1's medications available for administration on 02/21/24 at 3:00pm revealed there was not any amlodipine 2.5mg available for administration. Interview with Resident #1's Primary Care Provider (PCP) on 02/22/24 at 9:24am revealed: -Resident #1 was prescribed amlodipine for high blood pressure. -She expected staff to fax the signed physician's order to the pharmacy and not to document they administered medications when they had not. Refer to the interview with the Special Care Coordinator (SCC) on 02/21/24 at 3:05pm and 02/22/24 at 7:30am. Refer to the telephone interview with the 3rd shift	D 358	cations that are not available for admin- istration. Medication Techs will be retrained on the 6 Rights of Medication Administra- tion and the legal and ethical responsibilities that require accurate administration and documentation of medications given.	

Division of Health Service Regulation

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D 358	Continued From page 2 Medication Aide (MA) on 02/21/24 at 6:45pm. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm.	D 358		
	Refer to the interview with the Administrator on 02/21/24 at 3:10pm.			
	b. Calcium carbonate 600mg daily. Review of Resident #1's eMAR for 02/01/24 - 02/21/24 revealed there was an entry for calcium carbonate 600mg daily with an administration time of 8:00am and documentation the calcium carbonate 600mg was administered on 02/21/24 at 8:00am. Observation of Resident #1's medications available for administration on 02/21/24 at 3:00pm revealed there was not any calcium carbonate 600mg available for administration. Interview with Resident #1's PCP on 02/22/24 at 9:24am revealed: -Resident #1 was prescribed calcium carbonate to treat stomach acid. -She expected staff to fax the signed physician's order to the pharmacy and not to document they administered medications when they had not. Refer to the interview with the SCC on 02/21/24 at 3:05pm and 02/22/24 at 7:30am. Refer to the telephone interview with the 3rd shift MA on 02/21/24 at 6:45pm. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm.			

Division of Health Service Regulation

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D 358	Continued From page 3 Refer to the interview with the Administrator on 02/21/24 at 3:10pm. c. Escitalopram 20mg daily.	D 358		
	Review of Resident #1's eMAR for 02/01/24 - 02/21/24 revealed there was an entry for escitalopram 20mg daily with an administration time of 8:00am and documentation the escitalopram 20mg was administered on 02/21/24 at 8:00am. Observation of Resident #1's medications available for administration on 02/21/24 at 3:00pm revealed there was not any escitalopram 20mg available for administration. Interview with Resident #1's PCP on 02/22/24 at 9:24am revealed: -Resident #1 was prescribed escitalopram to treat depression. -She expected staff to fax the signed physician's order to the pharmacy and not to document they administered medications when they had not. Refer to the interview with the SCC on 02/21/24 at 3:05pm and 02/22/24 at 7:30am. Refer to the telephone interview with the 3rd shift MA on 02/21/24 at 6:45pm. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm. Refer to the interview with the Administrator on 02/21/24 at 3:10pm. d. Stimulant laxative plus 8.6-50mg 2 tablets			

Division of Health Service Regulation

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D 358	Continued From page 4 twice daily. Review of Resident #1's eMAR for 02/01/24 - 02/21/24 revealed there was an entry for stimulant laxative plus 8.6-50mg 2 tablets daily with an administration time of 8:00am and documentation the stimulant laxative plus 8.6-50mg 2 tablets were administered on 02/21/24 at 8:00am. Observation of Resident #1's medications available for administration on 02/21/24 at 3:00pm revealed there was not any stimulant laxative plus 8.6-50mg available for administration. Interview with Resident #1's PCP on 02/22/24 at 9:24am revealed: -Resident #1 was prescribed stimulant laxative plus to treat constipation. -She expected staff to fax the signed physician's order to the pharmacy and not to document they administered medications when they had not. Refer to the interview with the SCC on 02/21/24 at 3:05pm and 02/22/24 at 7:30am. Refer to the telephone interview with the 3rd shift MA on 02/21/24 at 6:45pm. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm. Refer to the interview with the Administrator on 02/21/24 at 3:10pm. e. Vitamin D3 25mcg daily. Review of Resident #1's eMAR for 02/01/24 -	D 358			

Division of Health Service Regulation

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D 358	Continued From page 5 02/21/24 revealed there was an entry for vitamin D3 25mcg daily with an administration time of 8:00am and documentation the vitamin D3 25mcg was administered on 02/21/24 at 8:00am. Observation of Resident #1's medications available for administration on 02/21/24 at 3:00pm revealed there was not any vitamin D3 25mcg available for administration. Interview with Resident #1's PCP on 02/22/24 at 9:24am revealed: -Resident #1 was prescribed vitamin D3 because she had a vitamin D3 deficiency. -She expected staff to fax the signed physician's order to the pharmacy and not to document they administered medications when they had not. Refer to the interview with the SCC on 02/21/24 at 3:05pm and 02/22/24 at 7:30am. Refer to the telephone interview with the 3rd shift MA on 02/21/24 at 6:45pm. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm. Refer to the interview with the Administrator on 02/21/24 at 3:10pm. Based on observations, interviews and record review, Resident #1 was not interviewable.	D 358			

Division of Health Service Regulation

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D 358	Continued From page 6 2. Review of Resident #5's current FL2 dated 10/19/23 revealed: -Diagnoses included anxiety, chronic pain and Post-Traumatic Stress Disorder (PTSD). -An order for propranolol 40mg daily.	D 358		
	Review of Resident #5's January 2024 and February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for propranolol 40mg. -Propranolol 40mg was documented as administered 01/01/24 through 02/20/24. Observation of Resident #5's medications on hand on 02/22/24 at 8:48am revealed: -Resident #5's seven-day supply of medications were delivered from the pharmacy in a multi-dose pack and started on 02/21/24. -Propranolol 40mg was not included in the multi-dose pack. Interview with a medication aide (MA) on 02/22/24 at 8:50am and 10:13am revealed: -Resident #5 had been on propranolol for a long time and it was usually included in his multi-dose pack. -She noticed on 02/21/24 that Resident #5's propranolol was not in the multi-dose pack that was delivered on 02/20/24. -She meant to tell the Resident Care Coordinator (RCC) that it was not delivered but she must have forgotten. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/22/24 at 9:34am revealed: -On 09/17/24 the pharmacy stopped sending Resident #5's propranolol 40mg because they received a stop notice. -They normally received a verbal or written			

Division of Health Service Regulation

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D 358	Continued From page 7 discontinue order from the facility, not just a stop order. -The last time propranolol was sent to the facility was in the 09/14/23 multi-dose pack. -The pharmacy had no record of Resident #5's FL2 dated 10/19/23 with a propranolol 40mg order. -If the pharmacy had received a copy of the current FL2 they would have restarted the medication. Interview with the RCC on 02/22/24 at 9:29am and 9:45am revealed: -She always sent the new FL2s to the pharmacy so she did not know why they did not have a copy. -She conducted cart audits weekly and did not know how a lack of propranolol could have been missed. -MAs were trained to check all medications when they were administering from the multi-dose packs. Interview with Resident #5's primary care provider (PCP) on 02/22/24 revealed: -Resident #5 was originally prescribed propranolol 40mg by his mental health provider (MHP) for his night terrors related to his PTSD. -The MHP that wrote the original order no longer provided services to Resident #5 so she renewed the propranolol when she updated his FL2 on 10/19/23. Interview with the SCC on 02/21/24 at 3:05pm and 02/22/24 at 7:30am revealed: -She documented she administered Resident #1's 8:00am medications on 02/21/24 but she did not administer them. -The MA from 3rd shift administered the 8:00am medications with the 6:00am medications on	D 358		

Division of Health Service Regulation

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D 358	Continued From page 8 02/21/24 to Resident #1 to "help out" the day shift staff but she could not document the administration because it was too early to document the 8:00am medications on the eMAR. -She knew the MA should not have administered the 8:00am medications at that time because it was too early. -Resident #1's 8:00am medications were not available for administration because they were not delivered from the pharmacy the evening of 02/20/24 so the MA borrowed the 8:00am medications from other residents. -She faxed the physician's orders to the pharmacy 2 or 3 times in the past but they still were not delivered and she did not have the confirmation of the faxes. -She was responsible for conducting weekly medication cart audits to ensure medications were available and she did that weekly. Telephone interview with the 3rd shift MA on 02/21/24 at 6:45pm revealed: -She worked in the SCU on 3rd shift as a MA. -She did not administer Resident #1's 8:00am medications on 02/21/24 because there were not any medications available, but she had administered the 8:00am medications during her shift in the past to "help out" the day shift staff. -She was trained to only administer medications and document when they were on the eMAR to administer during her shift but she was trying to "help out". Telephone interview with a representative from the facility's contracted pharmacy on 02/21/24 at 3:29pm revealed: -Medications were delivered to the facility every Tuesday evening with the new supply of medications to begin Wednesday morning. -The last supply of Resident #1's 8:00am	D 358		

Division of Health Service Regulation

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D 358	Continued From page 9 medications were delivered 02/13/24 and that supply would have lasted through 02/20/24. -Resident #1's medications were not delivered the evening of 02/20/24 because the medications required new signed physician's orders and there would not have been any medications to administer at 8:00am on 02/21/24. -The pharmacy did not receive any communication from the facility about the medications until 02/21/24 when a fax was received with the signed physician's orders dated 02/15/24. Interview with the Administrator on 02/21/24 at 3:10pm revealed: -Staff should not have documented they administered medications when they did not. -Staff should not have administered medications earlier than the administration time as a "favor" to other staff. -The pharmacy delivered a 7 day supply of medications every Tuesday evening to be started on Wednesday morning. -There was a button on the eMAR for staff to request refills from the pharmacy. -The MAs and the SCC were responsible for faxing signed physician's orders to the pharmacy. -The MAs and the SCC could also telephone the PCP to get new prescription refills. -The SCC was responsible for conducting weekly medication cart audits. -She did not know why the physician's orders for Resident #1 were not faxed to the pharmacy.	D 358			
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration	D 367	An audit was completed on 3.7.24 of current Resident's MARs to determine accuracy of (1) resident name,(2) name of the medication or treatment order,(3) strength and dosage or quantity of medi-	3.7.24	

If continuation sheet 11 of 17

Division of Health Service Regulation

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D 367	Continued From page 11 February 2024 eMAR revealed: -There was an entry for propranolol 40mg. -Propranolol 40mg was documented as administered 01/01/24 through 02/20/24. Observation of Resident #5's medications on hand on 02/22/24 at 8:48am revealed: -Resident #5's seven-day supply of medications were delivered from the pharmacy in a multi-dose pack and started on 02/21/24. -Propranolol 40mg was not included in the multi-dose pack. Interview with a medication aide (MA) on 02/22/24 at 8:50am revealed she always confirmed the medications in the multi-dose pack were correct when she documented on the eMAR. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/22/24 at 9:34am revealed: -The last time propranolol was delivered to the facility was in the 09/14/23 multi-dose pack. -Propranolol 40mg was removed from the eMAR on 09/17/23 when a stop notice was received. -The current eMARs included propranolol 40mg because the RCC re-entered it on 09/18/23. -The pharmacy did not monitor eMAR entries done by the facility. Interview with the Resident Care Coordinator (RCC) on 02/22/24 at 9:29am and 9:45am revealed: -Resident #5 had an order for propranolol for a long time and she could only think that it was stopped at the pharmacy by accident. -If she re-entered propranolol 40mg on 09/18/23 it had to be because a MA informed her it had "fallen off the eMAR" and she was correcting it.	D 367	or initials of the person administering the medication following state regulations and facility policies. The RCC and MCC will report during daily stand up meetings any areas of non-compliance. All medication techs will receive additional training on Medication Administration assuring the resident's MAR is accurate with reagrds to (1) resident's name, (2) name of 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 the 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 omission, including refusals, (8) name or initials of the person administering the medications following State regulations and facility policies. Medication Techs will re-trained on the 6 Rights of Administration and the legal and ethical responsibilities that require accurate administration and documentation of medications given.	3.15.24

Division of Health Service Regulation

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D 367	Continued From page 12 Refer to interview with the RCC on 02/21/24 at 3:12pm. Refer to interview with the Administrator on 02/21/24 at 3:38pm. 2. Review of Resident #2's current FL2 dated 10/19/23 revealed diagnoses included diabetes type 2 and acute kidney failure. Review of Resident #2's physicians orders dated 01/31/24 revealed an order for Farxiga (used to treat diabetes) 10mg take 1 tablet daily. Review of Resident #2's February 2024 eMAR revealed: -There was an entry for Farxiga 10mg take 1 tablet daily at 8:00am. -There was documentation Farxiga was administered daily from 02/01/24 - 02/21/24. -There was an entry for Dapiglif Pro (a generic form of Farxiga) 10mg take 1 tablet daily at 8:00am. -There was documentation Dapiglif Pro was administered daily from 02/01/24 - 02/21/24. Observation of the medications on hand on 02/21/24 at 2:40pm revealed: -Farxiga 10mg tablets were available for administration. -Dapiglif Pro 10mg tablets were not available for administration. Interview with a medication aide (MA) on 02/21/24 at 2:43pm revealed: -She thought she had administered both the Farxiga and the Dapiglif Pro to Resident #2 during the morning medication pass on 02/21/24. -She was not aware the Farxiga and the Dapiglif	D 367		

Division of Health Service Regulation

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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 367	Continued From page 13 Pro were the same medication. -Farxiga was in the bubble pack and Dapiglif Pro was not. -When medications were in the bubble pack, it was easy to sign off without checking them against the eMAR. -She got in a hurry this morning and forgot to compare the bubble pack medication to the eMAR. -She documented on the eMAR she had administered the Dapiglif Pro multiple times during February 2024. Refer to interview with the RCC on 02/21/24 at 3:12pm. Refer to interview with the Administrator on 02/21/24 at 3:38pm. Telephone interview with a representative from the facility's contracted pharmacy on 02/22/24 at 8:41am revealed: -The Farxiga was active for Resident #2 in their system, not the Dapiglif Pro. -The pharmacy assistants put in orders that are received on the eMAR for the facility and the pharmacist verified the order. -There have been billing issues in the past and the Dapaglif Pro had to be used instead of the Farxiga. -The Dapaglif Pro should not have been listed on the February 2024 eMAR for Resident #2. _____ Interview with the Resident Care Coordinator (RCC) on 02/21/24 at 3:12pm revealed: -The MAs should be paying attention to what is listed on the bubble pack and comparing it to the eMAR. -The MAs were trained to compare the bubble	D 367			

Division of Health Service Regulation

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D 367	Continued From page 14 pack to the eMAR for correct medication and dosages. -The MAs should not be signing off on medications they did not administer.	D 367		
	Interview with the Administrator on 02/21/24 at 3:38pm revealed: -The MAs should always be checking the bubble pack of medications and comparing it to the eMAR as they are prepping for medication administration. -The MA should not document a medication that was not administered.			
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.	D 464	10A NCAC 13F.1307 Special Care Unit Res Profile and Care Plan An audit was completed on 3.7.24 of Resident Profile and Care Plans to ensure SCU Residents profile and care plan were completed and accurate within 30 days of admissions and quarterly thereafter. The ED,RCC,MCC/designee were re-trained on the procedures ensuring timely and accurate resident profile and care plan with in 30 days and quarterly thereafter, following State regulations and facility policies, in order to attain or maintain the maximum level of functioning possible to compensate for the lost abilities of residents. The RCC/MCC/designee will verify on admission that a resident profile is completed and uploaded into the electronic health record by running the Matrix Care Facility Observation Report for SCU resident profile and care plan daily, and bring to Daily standup meeting for review with ED. Any areas of non-compliance will be corrected to ensure the SCU resident profile is completed, then quarterly thereafter. Random monthly audits by ED/designee to	3.7.24 3.8.24 3.15.24

Division of Health Service Regulation

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D 464	Continued From page 15 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled residents (#1 and #4) had Special Care Unit (SCU) resident profiles updated on a quarterly basis. The findings are: 1. Review of Resident #1's current FL2 dated 08/31/23 revealed: -Diagnoses included dementia with behavioral disturbance. -The recommended level of care was SCU. Review of Resident #1's Resident Register revealed an admission date of 05/06/22. Review of Resident #1's record on 02/21/24 revealed: -There were SCU quarterly profiles completed on 01/29/23 and 06/20/23. -There was no additional documentation that SCU quarterly profiles were completed after 06/20/23. Refer to the interview with the Special Care Coordinator (SCC) on 02/22/24 at 9:15am. Refer to the interview with the Administrator on 02/22/24 at 8:45am. 2. Review of Resident #4's current FL2 dated 10/05/23 revealed: -Diagnoses included dementia without behavioral disturbance. -The recommended level of care was SCU. Review of Resident #4's Resident Register revealed an admission date of 10/02/23.	D 464	review for compliance following State regulations and facility policies.	

Division of Health Service Regulation

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D 464	Continued From page 16 Review of Resident #4's record on 02/21/24 revealed: -There was a SCU quarterly profile completed on 10/03/23. -There was no additional documentation that a SCU quarterly profile was completed after 10/03/23. Refer to the interview with the SCC on 02/22/24 at 9:15am. Refer to the interview with the Administrator on 02/22/24 at 8:45am. Interview with the SCC on 02/22/24 at 9:15am revealed: -She was responsible for ensuring the SCU quarterly profiles were completed. -She just "lost track of time" and did not complete the quarterly profiles timely. Interview with the Administrator on 02/22/24 at 8:45am revealed: -The SCC was responsible for ensuring the SCU quarterly profiles were completed. -She was responsible for following up with the SCC to ensure the documentation was complete. -She did not know why the SCC did not complete the SCU quarterly profiles.	D 464		