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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 01/10/24 and 01/11/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff who administered medications had successfully passed the state medication administration examination (Staff C) or completed the state-approved 5-hour,10-hour or 15-hour medication aide (MA) training courses as required (Staff F) prior to administering medications to residents for 2 of 5 sampled staff. The findings are: 1. Review of Staff C's , Medication Aide (MA), personnel record revealed: -Staff C was hired on 05/09/23 as a Personal Care Aide (PCA). -There was documentation that Staff C completed	D 125		

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the 15-hour medication aide training on 10/04/23.
-There was documentation of a medication clinical skills validation checklist completed for Staff C on 10/23/23.
-There was no documentation that Staff C had taken and passed the MA examination.

Review of resident's November 2023, December 2023, and January 01, 2024 through January 11, 2024 electronic medication administration (eMAR) records revealed:
-There was documentation that Staff C administered medications to residents on the first shift on 11/25/23.
-There was documentation that Staff C administered medications to residents on the first shift on 12/09/23, 12/10/23, 12/24/23, 12/25/23, and 12/29/23.
-There was documentation that Staff C administered medications to residents on the first shift on 01/09/24.

Interview with Staff C on 01/11/24 at 3:20pm revealed:
-She completed training a couple of months ago with the Registered Nurse (RN).
-She had demonstrated administering medications and the RN checked her off on her skills.
-She had not taken the state-approved MA examination.
-She attempted to take the test one time, but something happened, and she had to reschedule.
-The next time she attempted to take the test, something happened with the laptop, and she could not complete the test.
-She administered medications to the residents on occasion.

Interview with the Administrator on 01/11/24 at

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3:30pm revealed:
-He was aware Staff C had not completed the state-approved MA examination.
-Staff C administered medications to residents.
-Staff C scheduled a date to take the MA examination and there was an issue with the laptop not being compatible.
-He purchased a new laptop that was compatible so Staff C could complete the MA examination but she had not taken the test yet.

2. Review of Staff F's, Medication Aide (MA), personnel record revealed:
-Staff F was hired on 05/23/19 as a MA and Personal Care Aide (PCA).
-There was documentation of a medication clinical skills validation checklist completed for Staff F on 05/31/19.
-There was documentation Staff F had taken and passed the MA examination on 06/07/13.
-There was no documentation that Staff F completed the state-approved 5-hour, 10-hour or 15-hour medication aide training.

Observations on 01/10/24 and 01/11/24 at various times revealed Staff F was administering medications to the residents.

Review of residents' November 2023, December 2023 and Januray 01 through January 11, 2024 electronic medication administration records (eMAR) revealed
-There was documentation that Staff F administered medications to residents on the first shift 18 times in November 2023.
-There was documentation that Staff F administered medications to residents on the first shift 18 times in December 2023.
-There was documentation that Staff F administered medications to residents on the first

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D 125	Continued From page 3 shift 6 times from January 01 to January 11, 2024. Interview with a resident on 01/10/24 at 8:30am revealed Staff F frequently administered medications to residents. Interview with Staff F on 01/11/24 at 3:00pm revealed: -She passed her MA examination years ago in 2013. -She did not have documentation that she completed MA training -She worked at the facility full time as an MA and frequently administered medications to the residents. Interview with the Administrator on 01/11/24 at 3:30pm revealed: -Staff F was hired as an MA in 2019. -He would expect staff to be trained to administer medications. -He was not aware Staff F did not have documentation of the completed MA training. -He contacted the facility's contracted pharmacy, but they did not have documentation of Staff F's completed MA training. _____ The facility failed to ensure staff who administered medications had successfully passed the state medication administration examination (Staff C) or completed the state-approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required (Staff F) before administering medications to residents for which resulted in errors in medication administration. This failure was detrimental to the health, safety, and welfare of all residents and constitutes a Type B Violation.	D 125		

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D 125	Continued From page 4 A plan of protection was requested on 01/11/24 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 02/25/24.	D 125		
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 1 of 6 sampled staff (Staff E) had no substantiated findings on the North Carolina Health Care Personal Registry (HCPR) upon hire. The findings are: Review of Staff E's personnel record revealed: -Staff E was hired on 01/04/21 as a medication aide (MA). -There was no documentation a Health Care Personnel Registry (HCPR) review was completed upon hire. Interview with Staff E on 01/11/24 at 3:12pm revealed: -She had worked at the facility for three years. -She did not know what a HCPR was.	D 137		

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D 137	Continued From page 5 -She did not know if the facility checked the HCPR. Interview with the Administrator on 01/11/24 at 3:18pm revealed: -The previous Business Office Manager (BOM) was responsible for checking the HCPR for all employees. -Staff E's HCPR should have been checked by the previous BOM. -He is responsible for checking the HCPR for employees now. -He ran a check on Staff D today and there were no unsubstantiated findings on the HCPR.	D 137		
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: Based on observations, record review and interviews, the facility failed to ensure physician follow up was completed for 1 of 5 residents (#2) who had blood pressure readings outside the ordered parameters, The findings are: Review of Resident #2's current FL-2 dated 08/29/23 revealed: -Diagnoses included confusion, impaired balance, and acute kidney failure. -There was an order to check blood pressure (BP) daily and notify the Primary Care Provider (PCP) if greater than 140/90.	D 273		

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D 273	Continued From page 6 Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check BP daily and to notify PCP for BP reading greater than 140/90, scheduled daily at 8:00am. -On 11/02/23, the BP reading was 147/77; on 11/05/23, the BP reading was 143/75; on 11/06/23, the BP reading was 140/97; on 11/07/23, the BP reading was 141/70; on 11/13/23, the BP reading was 153/88; on 11/16/23, the BP reading was 144/82; on 11/17/23, the BP reading was 127/97, on 11/22/23, the BP reading was 149/80; and on 11/23/23, the BP reading was 141/86. -There was no documentation of BP readings on 11/11/23 and 11/15/23. -There was no documentation the PCP had been notified of BP readings greater than 140/90. Review of Resident #2's December 2023 eMAR revealed: -There was an entry to check BP daily and to notify PCP for BP reading greater than 140/90, scheduled daily at 8:00am. -On 12/02/23, the BP reading was 143/76; on 12/02/23, the BP reading was 149/81; on 12/14/23, the BP was 141/71; on 12/28/23, the BP was 148/78; on 12/29/23, the BP was 147/79; and on 12/30/23, the BP was 145/75. -There was no documentation of BP readings on 12/01/23, 12/13/23, 12/19/23, 12/26/23, and 12/27/23. -There was no documentation the PCP had been notified of BP readings greater than 140/90. Review of Resident #2's January 2024 eMAR from 01/01/24 to 01/10/24 revealed: -There was an entry to check BP daily and to notify PCP for BP reading greater than 140/90,	D 273		

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scheduled daily at 8:00am.
-On 01/02/24, the BP reading was 143/76; on 01/04/24, the BP reading was 149/88; and on 01/10/24 the BP readings was 145/89.
-There was no documentation the PCP had been notified of BP readings greater than 140/90.

Interview with Resident #2 on 01/10/24 at 8:30am revealed:
-He took medication for his blood pressure.
-The staff was supposed to check his blood pressure daily.
-He thought his BP was taken most days.

Interview with a medication aide (MA) on 01/11/24 at 1:45pm revealed:
-She had checked Resident #2's BP but had not needed to call the PCP about his BP being elevated.
-If she had to call the PCP, she would document on the nursing notes in the resident's record.
-If the PCP was in the facility, she would speak to the PCP, but would not document the conversation.

Interview with a second MA on 01/11/24 at 12:52pm revealed:
-She called the PCP if the resident's BP was outside the ordered range.
-She would document in the nursing notes in the resident's record each time she called the PCP.
-She did not recall having to call Resident #2's PCP regarding an elevated BP.

Telephone interview with the PCP on 01/11/24 at 1:42pm revealed:
-The facility had called her before regarding Resident #2's BP readings.
-She did not document each call she received regarding Resident #2's BP.

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-She did not know how often she received a call from the facility regarding Resident #2's BP.

Interview with the Resident Care Coordinator (RCC) on 01/11/24 at 2:17pm revealed:
-The MAs should notify the PCP of Resident #2's BP as ordered when out of range.
-The MAs should document when and why the PCP was notified in the nurses notes of Resident #2's record.

Interview with the Administrator on 01/11/24 at 3:18pm revealed:
-The MAs were expected to notify the PCP of BPs outside of ordered range.
-The MAs were expected to document each time they notified the PCP regarding BPs outside of the ordered range.

Based on observations, record reviews, and interviews, the facility failed to implement physician's orders for 1 of 6 sampled residents (#1) related to a dressing change order.

The findings are:

Review of Resident #1's current FL-2 revealed diagnoses included diabetes mellitus type 2, depression, chronic kidney disease, osteomyelitis, and toe amputation.

Review of a physician's order dated 01/02/24 revealed ensure resident has a dressing to left foot at all times.

Review of Resident #1's January 2024 electronic medication administration record (eMar) revealed:
-There was an entry for resident to have a dressing on left foot at all times at 8:00am and

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D 273	Continued From page 9 8:00pm. -There was documentation Resident #1 had a dressing to left foot at all times from 01/01/24 to 01/10/24. Observation on 01/10/24 at 8:30am revealed: -Resident #1's left foot had a wound to her left foot. -There was no dressing on the wound. -The wound had some healed areas. -The wound did not have any drainage. Interview with Resident #1 on 01/10/24 at 8:30am revealed: -She had her left great toe amputated and was seeing a podiatrist for the wound. -She was supposed to have a dressing on the wound. -She took a shower and the dressing was removed on Monday, 01/08/24. -There had not been a dressing on the wound since her shower Monday evening. -A nurse came to the facility to do the dressing change. Interview with a medication aide (MA) on 01/10/24 at 10:30am revealed: -Resident #1 had a wound to her left foot. -Resident #1 did not have a dressing on her left foot. -She was unsure when the dressing came off Resident #1's left foot. -There was a physician's order to keep a dressing to the left foot at all times. -She documented that she applied the dressing to the wound on 01/10/24 because she knew the home health nurse was coming to do the dressing change and she thought it was okay. -Resident #1 should have a dressing in place to her left foot.	D 273		

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D 273	Continued From page 10 Interview with a representative from Resident #1's podiatrist office on 01/11/24 at 10:15am revealed: -Resident #1 had a toe amputation and had an order for daily dressing changes. -Resident #1 should have a dressing to her left foot at all times. Interview with the Resident Care Director (RCD) on 01/11/24 at 2:00pm revealed: -Resident #1 did have an order for a dressing to her left foot to be on at all times. -She thought Resident #1 might have removed the dressing herself. -The MA should ensure there was a dressing to Resident #1's left foot at all times. Interview with the Administrator on 01/11/24 at 3:30pm revealed he expected physician's orders to be followed as written.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility	D 286		

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failed to ensure mealtime table service included a place setting consisting of a napkin, non-disposable knife, fork, spoon and cup.

The findings are:

1. Observation of the dining room on the Assisted Living (AL) side of the facility on 01/10/24 at 10:17am revealed:
-The dining room tables were preset for the lunch meal service.
-There were 25 place settings.
-There were two place settings with a plastic fork, knife and spoon.
-The dessert was served in a disposable bowl.

Observation of lunch meal on the Assisted Living (AL) side of the facility on 01/11/24 at 11:14am revealed:
-The dining room tables were preset for the lunch meal service.
-There were 26 place settings.
-There were two place settings with a plastic fork, knife and spoon.
-Four residents were served their beverages in disposable cups.

Interview with three residents on 01/10/24 at 12:08am revealed:
-They were given disposable cups, bowls, plastic forks, knives and spoons on occasion at meal times.
-They would prefer to use non-disposable table ware when eating their meals.
-It was difficult to eat with the plastic forks and knives.

Interview with the Kitchen Manager (KM) on 01/10/24 at 11:18am revealed:
-The Administrator ordered cups, knives, forks

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and spoons for the kitchen.
-She was responsible for telling the Administrator when the kitchen needed more equipment.
-She had requested the Administrator order more forks and knives about a week ago.
-She did not know she could not serve desserts in the disposable bowls she had provided.
-She did not have enough non-disposable glasses for the residents.
-She had not requested any to be ordered.

Refer to interview with the Administrator on 01/11/24 at 3:43pm.

2. Observation of the lunch service meal in the Memory Care Unit (MCU) on 01/10/24 at 11:19am revealed:
-There were paper towels placed on the dining room table for the residents to use as napkins at the lunch service meal.
-The staff provided 11 residents with a fork and 3 residents with a spoon to eat the lunch meal.
-One resident was observed holding the pork chop with her fingers and attempted to fork the pork chop with a spoon.
-Dessert was served to all residents in a Styrofoam bowl.

Observation of the dinner service meal in the MCU on 01/10/24 at 4:47pm revealed:
-There were 12 of 14 residents in the dining room eating the dinner service meal.
-The residents did not have a napkin at their place setting.
-Eleven of the 12 residents had a fork, and one of the 12 residents had a spoon.

Observation of the breakfast service meal in the MCU on 01/11/24 at 7:45am revealed:

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D 286	Continued From page 13 -Four residents were given a cocktail napkin after they had started eating. -Seven residents had a fork and a spoon, 3 residents had a fork, 2 residents had a plastic spoon, 1 resident had a Styrofoam cup, one resident had a Styrofoam bowl for cereal, and coffee was served in a glass instead of a coffee mug. Observation of the MCU dining room on 01/11/24 at 10:33am revealed: -There was a storage cabinet in the dining room. -There was an open package of 500 count cocktail napkins sitting on the counter. -There was a bin of reusable silverware in the cabinet including 26 knives and 10 spoons. -There were 13 six-ounce glasses and nine coffee cups in the cabinet. -There were 9 coffee cups and 7 reusable bowls on a shelf in the back of the cabinet. Interview with a resident's family member on 01/10/24 at 11:59am revealed: -The facility rarely placed napkins on the table for the residents. -When napkins were used the facility used cocktail napkins. -The residents were given paper towels to use as napkins at meals. -He did not recall seeing napkins used in the past 4 months. -The residents used plastic utensils until he addressed the issue with the management. -The staff give the residents silverware now, but only a fork or spoon; they do not receive a full place setting. Interview with the personal care aide (PCA) on 01/11/24 at 12:25pm revealed: -The kitchen staff sent utensils and napkins on	D 286		

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the food cart with the resident meals.
-The desserts were served in Styrofoam cups.
-She did not know why the desserts were served in Styrofoam cups.
-She did not have napkins to give the resident for lunch on 01/10/24.
-She gave the residents paper towels because they needed something to wipe their mouth with.
-We usually have cocktail napkins to give the residents; she did not know why there were no cocktail napkins on the food cart on 01/10/24.
-There were not enough forks on the food cart for lunch on 01/10/24, so she gave spoons to residents who did not have a utensil.
-She did not tell the kitchen staff; she thought there were not enough utensils for every to have a place setting.
-She did not give knives to the residents because they did not know how to use them.
-She used paper towel when she did not have napkins.
-She started passing out napkins for breakfast on 01/11/24.
-She had to stop to take a resident to the restroom.
-She did not know that all the residents did not get a napkin for breakfast on 01/11/24.
-She thought the MCC gave napkins to the other residents while she was out of the dining room.
-She served coffee in glasses this morning for breakfast, 01/11/24.
-She did not have enough mugs to use for coffee.
-She did not tell the kitchen staff that more coffee mugs were needed.
-She thought the MCC told the kitchen staff more coffee mugs were needed.

Interview with the Kitchen Manager (KN) on 01/11/24 at 10:17am revealed:
-There were only 15 coffee cups available for use

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in the AL dining room.
-The kitchen staff only took coffee to the MCU; the coffee cups were stored in a cabinet in the MCU unit.
-The coffee cups in the MCU were blue and red and the coffee cups used in the AL were white.
-The MCU returned dirty dishes to the kitchen where they were washed and returned to the MCU after every meal; including coffee cups and forks and knives.
-The MCC would send MCU staff to the kitchen to request additional equipment if needed.
-The kitchen staff delivered enough napkins for the entire day to the MCU in the morning when they delivered breakfast.
-The Administrator ordered the needed equipment for the kitchen when she needed more.

Interview with the Memory Care Coordinator (MCC) on 01/11/24 at 8:31am and 12:36pm revealed:
-There were not enough forks for every resident to have a fork for lunch on 01/10/24.
-Residents were not given knives because they may hurt themselves.
-There were enough spoons for each resident to have a spoon.
-There was no reason why each resident was not given a spoon.
-Paper towels were used for lunch on 01/10/24 because there were no napkins available.
-We give out of napkins the day before the truck delivery, so we use paper towels.
-The kitchen staff orders napkins; she had told a member of the kitchen staff that the MCU gave out of napkins.
-She did not pass out napkins for lunch on 01/11/24; the PCA puts the napkins on the tables for the residents.

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D 286	Continued From page 16 -The personal care aide (PCA) served the coffee in a glass instead of a coffee mug. -There were not enough coffee mugs to serve coffee to all the residents who wanted coffee. -She had not mentioned to the kitchen staff that more coffee mugs were needed in the MCU. -Styrofoam bowls and plates, and plastic utensils should not be used. -She did not know why Styrofoam and plastic items were being used. Refer to interview with the Administrator on 01/11/24 at 3:43pm. _____ Interview with the Administrator on 01/11/24 at 3:43am revealed: -The KM let him know when she needed him to order any small equipment for the kitchen. -She told him about two months ago they needed more forks. -He did not know they needed coffee cups. -The MCU staff and the kitchen staff decided what they needed for the units and worked it out. -There should have been enough coffee cups, forks, knives and spoons for each resident to have one at meals. -If he had known there was a need for cups, knives or forks he would have ordered them.	D 286		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#1 and #3) who had an order for a no concentrated sweets (NCS) diet.

The findings are:

Observation of the kitchen on 10/24/23 at 10:25am revealed the regular menus were posted on a bulletin board in the kitchen, but there were no therapeutic menus that matched the regular menus, available in the kitchen for staff guidance.

Review of the facility's week at a glance menu for the lunch meal on Wednesday, 01/10/24 revealed roasted chicken, corn, green, bred with margarine, cherry cream cheese bar water and choice of a beverage were to be served to the residents.

1. Review of Resident #1's current FL-2 dated 10/10/23 revealed diagnoses included type two diabetes, chronic kidney disease, toe amputation, osteomyelitis, and depression.

Review of Resident #1's record revealed a diet order dated 09/12/23 for no concentrated sweets (NCS) diet.

Observation of the lunch meal on 01/10/24 at 11:32am revealed:
-Resident #1 was served her meal in her room.
-She was served a peanut butter and jelly

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sandwich.
-She ate 100% of her meal.

Based on observation of the lunch meal service on 01/10/24, it could not be determined if Resident #1 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance.

Interview with Resident #1 on 01/10/24 at 12:08am revealed:
-Sometimes she was served sugar free items with her meals.
-She was served regular pancake syrup with her pancakes.
-He finger stick blood sugar results (FSBS) were usually high.
-She did not always eat what she was served for meals because she knew it had sugar in it.

Interview with Resident #1's primary care provider (PCP) on 01/11/24 at 1:41pm revealed:
-Resident #1 was ordered a NCS diet because she was diagnosed with diabetes.
-The NCS diet should include sugar free items and beverages but would depend on the [therapeutic] menu.
-The had not reviewed the facility's therapeutic menu.
-The expected the facility to follow Resident #1's NCS diet as ordered.

Refer to interview with the Kitchen Manager (KM) on 01/10/24 at 11:18am.

Refer to interview with the Administrator on 01/11/24 at 2:54pm.

2. Review of Resident #3's current fL-2 dated

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D 296	Continued From page 19 08/29/23 revealed: -Diagnoses included type two diabetes. -There was an order for a no concentrated sweets (NCS) diet. Review of Resident #3's record revealed a diet order dated 08/29/23 for a NCS diet. Observation of the lunch meal on 01/10/24 at 11:32am revealed: -Resident #3 was served a pork chop, corn, green beans, a slice of bread, water and lemonade. -She ate 100% of her meal but did not drink the lemonade. Based on observation of the lunch meal service on 01/10/24, it could not be determined if Resident #3 was served the correct therapeutic diet due to no therapeutic diet menu available for staff guidance. Interview with Resident #3 on 01/11/24 at 11:14am revealed: -She was diabetic and should not eat sweets. -She thought she was ordered a diabetic diet by her primary care provider (PCP). -She did not know if she was served cakes and other sweets with her meals. -She did not know if the items she was served were sugar free or not. Interview with Resident #3's PCP on 01/11/24 at 1:41pm revealed: -Resident #3 was ordered a NCS diet because she was diagnosed with diabetes. -The NCS diet should include sugar free items and beverages but would depend on the [therapeutic] menu.	D 296		

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D 296	Continued From page 20 -The had not reviewed the facility's therapeutic menu. -The expected the facility to follow Resident #3's NCS diet as ordered. Refer to interview with the Kitchen Manager (KM) on 01/10/24 at 11:18am. Refer to interview with the Administrator on 01/11/24 at 2:54pm. _____ Interview with the Kitchen Manager (KM) on 01/10/24 at 11:18am revealed: -She did not have a therapeutic diet menu for the NCS diet for reference when preparing meals. -She served the residents who were ordered a NCS diet sugar free items because they could not eat sweets. -The iced tea was unsweetened and "all sweets were sugar free". -The Administrator ordered all the food for the kitchen and he ordered sugar free items. Interview with the Administrator on 01/11/24 at 2:54pm revealed: -The facility's food vendor provided the week at a glance and therapeutic menus for the facility. -He provided the kitchen with a copy of the menus. -He ordered sugar free items for the kitchen to serve according to the NCS diet menu including sugar free jellies, syrups, cakes desserts and puddings.	D 296		
D 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes:	D 299		

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D 299	Continued From page 21 (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost.	D 299		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to ensure a serving of dairy was served three times daily to residents on the Assisted Living side of the facility.

The findings are:

Review of the facility's regular week at a glance menu for 01/10/24 revealed:
-Milk was listed to be served with the breakfast, and dinner meals only.
-Grilled cheese sandwiches were listed to be served for the dinner meal.

Review of the facility's regular week at a glance menu for 01/11/24 revealed:
-Milk was listed to be served with the breakfast, and dinner meals only.
-There were no dairy products listed to be served with meals during the day.

Observation of the lunch meal in the Assisted Living (AL) side of the facility on 01/10/24 from 11:32am to 12:08pm revealed the residents were

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not offered milk and there were no other dairy items served during the meal.

Observation of lunch meal on the Assisted Living (AL) side of the facility on 01/11/24 at 11:14am revealed no milk was offered to the residents and there were no dairy items offered.

Interview with three residents on 01/10/24 at 12:08am revealed:
-They were not served milk at all.
-They used to be served milk with cereal, but they were not served cereal anymore at breakfast.
-The had not had cereal or milk with breakfast in about a month.

Interview with the Kitchen Manager (KM) on 01/11/24 at 2:24pm revealed:
-Milk was offered to the residents by the kitchen staff at breakfast and dinner and served to the residents at lunch if they requested it in the AL.
-She did not know milk was not offered to the residents on 01/10/24 or 01/11/24.
-She knew it was required to offer milk at breakfast and dinner, but she was not aware dairy was to be served three times daily.

Interview with the Administrator on 01/11/24 at 2:54pm revealed:
-The facility's food vendor provided the week at a glance menu for the facility.
-He was not aware dairy items needed to be served three times daily.
-He thought milk was supposed to be served twice daily.
-He had not observed milk not being offered in the dining room with breakfast and dinner.
-He did frequent meal rounds in the AL but he had not had the chance to observe a meal since December 2023.

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 5 sampled residents (#2, #4, #5) including a medication for mood stabilization (#2); two medications to lower blood pressure were administered after being discontinued (#4); and an inhaler (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 03/06/23 revealed diagnoses included Alzheimer's disease, atrial fibrillation, heart failure, hypertension, and hyperlipidemia. a. Review of Resident #4's current FL-2 dated 03/06/23 revealed there was an order for furosemide (used to treat fluid retention) 40mg once daily. Review of Resident #4's primary care providers (PCP) after visit report dated 11/07/23 revealed Resident #4's blood pressures were documented as 112 systolic and 74 diastolic on 10/10/23 and	D 358		

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D 358	Continued From page 24 114 systolic and 72 diastolic on 11/07/23. Review of Resident #4's physician order dated 11/17/23 revealed an order to discontinue Resident #4's furosemide. Review of Resident #4's PCP after visit report dated 12/04/23 revealed: -Resident #4's blood pressure was documented as 77 systolic and 55 diastolic. -There was an order to discontinue Resident #4's furosemide due to low blood pressure results. Review of Resident #4's physician order dated 12/04/23 revealed an order to discontinue Resident #4's furosemide. Review of Resident #4's electronic medication administration record (eMAR) for November 2023 revealed: -There was an entry for furosemide 40mg once daily scheduled at 8:00am. -Furosemide 40mg was documented as administered once daily from 11/18/23 to 11/30/23. Review of Resident #4's eMAR for December 2023 from 12/01/23 to 12/04/23 revealed: -There was an entry for furosemide 40mg once daily scheduled at 8:00am. -Furosemide 40mg was documented as administered once daily from 12/01/2023 to 12/04/2023. Observation of Resident #4's medications on hand on 01/10/24 at 3:31pm revealed there was no furosemide 40mg available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/11/24 at	D 358		

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9:11am revealed:
-Resident #4 had an order for furosemide 40mg once daily until it was discontinued on 12/05/23.
-Resident #4 had a 28-day supply of furosemide dispensed on 09/15/2023, 10/15/2023, and 11/15/2023.
-Furosemide was used to reduce fluid retention and continued use of furosemide after being discontinued could cause dehydration, lightheadedness, dizziness, and lower blood pressure.

Telephone interview with Resident #4's PCP on 01/11/2024 at 1:59pm revealed:
- Furosemide was ordered for lowering blood pressure, hypertension, edema, and heart failure.
-Resident #4's furosemide was discontinued due to a decline in health and low blood pressure.
-The effects of continuing furosemide with other blood pressure medications after being discontinued included dizziness and falls.
-She expected the facility staff to follow her orders as written.

Interview with a medication aide (MA) on 01/11/24 at 12:40pm revealed:
-She had administered medications in the Special Care Unit (SCU).
-Discontinued orders were highlighted on the eMAR.
-She had administered Resident #4's furosemide in November 2023 per the eMAR.

Refer to telephone interview with Resident #4's family member on 01/11/2024 at 2:19pm.

Refer to interview with the Memory Care Coordinator (MCC) on 01/11/24 at 10:04am.

Refer to interview with RCC on 01/11/24 at

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D 358	Continued From page 26 10:18am. Refer to interview with the Administrator on 01/11/24 at 1:30pm. Based on observations, interviews and record reviews it was determinded Resident #4 was not interviewable. b. Review of Resident #4's current FL-2 dated 03/06/23 revealed there was an order for lisinopril (used to treat high blood pressure) 10mg once daily. Review of Resident #4's PCP after visit report dated 11/07/23 revealed Resident #4's blood pressures were documented as 112 systolic and 74 diastolic on 10/10/23 and 114 systolic and 72 diastolic on 11/07/23. Review of Resident #4's physician order dated 11/17/23 revealed an order to discontinue Resident #4's lisinopril. Review of Resident #4's PCP after visit report dated 12/04/23 revealed: -Resident #4's blood pressure was documented as 77 systolic and 55 diastolic. -There was an order to discontinue Resident #4's lisinopril due to low blood pressure results. Review of Resident #4's physician order dated 12/04/23 revealed an order to discontinue Resident #4's lisinopril. Review of Resident #4's eMAR for November 2023 revealed: -There was an entry for lisinopril 10mg once daily scheduled at 8:00am. -Lisinopril 10mg was documented as	D 358		

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administered once daily from 11/18/23 to 11/30/23.

Review of Resident #4's eMAR for December 2023 from 12/01/23 to 12/04/23 revealed:
-There was an entry for lisinopril 10mg once daily scheduled at 8:00am.
-Lisinopril 10mg was documented as administered once daily from 12/01/2023 to 12/04/2023; four of four opportunities.

Observation of Resident #4's medications on hand on 01/10/2024 at 3:31pm revealed there was no lisinopril 10mg available for administration.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 01/11/24 at 9:11am revealed:
-Resident #4 had an order for lisinopril 10mg once daily until it was discontinued on 12/05/23.
-A 28-day supply of Resident #4's lisinopril 10mg was dispensed on 09/15/2023, 10/15/2023, and 11/13/2023.
-Lisinopril was ordered to lower blood pressure and continued use of lisinopril after being discontinued could lead to lightheadedness and dizziness.

Telephone interview with Resident #4's PCP on 01/11/2024 at 1:59pm revealed:
-Resident #4 was ordered lisinopril 10mg to lower blood pressure, hypertension, and heart failure.
-Resident #4's lisinopril was discontinued due to a decline in health and low blood pressure.
-The effects of continuing lisinopril with other blood pressure medications after being discontinued included dizziness and falls.
-She expected to the facility to follow her orders as written.

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D 358	Continued From page 28 Interview with a MA on 01/11/24 at 12:40pm revealed: -She had administered medications in the Special Care Unit (SCU). -She administered Resident #4's lisinopril in November 2023 per the eMAR. Refer to telephone interview with Resident #4's family member on 01/11/2024 at 2:19pm. Refer to interview with the Memory Care Coordinator (MCC) on 01/11/24 at 10:04am. Refer to interview with RCC on 01/11/24 at 10:18am. Refer to interview with the Administrator on 01/11/24 at 1:30pm. Based on observations, interviews and record reviews it was determinded Resident #4 was not interviewable. _____ Telephone interview with Resident #4's family member on 01/11/2024 at 2:19pm revealed: -Resident #4 experienced falls and a drop-in blood pressure levels when standing. -She witnessed Resident #4 fainting and was able to catch her before she hit the floor in December 2023; the hospice nurse had just left Resident #4 and was called back immediately. -The hospice nurse took blood Resident #4's pressure and it was 77 systolic and 55 diastolic which led to second discontinue order for her blood pressure medications. Interview with the Memory Care Coordinator (MCC) on 01/11/24 at 10:04am revealed: -The Resident Care Coordinator (RCC) was	D 358		

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responsible for faxing medication orders to the pharmacy.
-She filed the medication orders in the residents' records after the RCC faxed them.
-She did not know the discontinue orders for Resident #4's medications had not been faxed when she filed them in November 2023.

Interview with RCC on 01/11/24 at 10:18am revealed:
-Medication orders were received overnight, and a printout was left for order review.
-She reviewed orders, sent them to the pharmacy and awaited approval.
-Discontinued medications were removed from the eMAR by the MAs and removed from the medication cart by the MCC.
-She thought the discontinue order for Resident #4's furosemide on 11/17/2023 was phoned into the pharmacy by the hospice nurse.
-The pharmacy did not receive the discontinue order until 12/05/2023 at which point the medications were discontinued.

Interview with the Administrator on 01/11/24 at 1:30pm revealed:
-The RCC or the PCP were responsible for faxing medication orders to the pharmacy.
-The RCC gave the orders to the MCC after she faxed them to the pharmacy.
-The MCC then filed the orders in the residents' records.
-The deleted orders were highlighted in yellow on the eMAR and would not allow the MAs to document on the eMAR.
-The hospice nurse must have given the discontinue orders to the MCC and she filed them before the RCC faxed them to the pharmacy; the MCC thought they had been faxed when she filed them.

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D 358	Continued From page 30 2. Review of Resident #5's current FL-2 dated 11/07/23 revealed: -Diagnoses included asthma, chronic obstructive pulmonary disease(COPD), history of pneumonia, fibromyalgia, and gastroesophageal reflux disorder. -There was an order for fluticasone furoate-vilanterol 100-25mcg/actuation inhaler (used to prevent and decrease symptoms (wheezing and trouble breathing) caused by asthma and ongoing lung disease) 1 puff daily. Review of Resident #5's November 2023 electronic medication administration (eMAR) revealed: -There was an entry for fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily. -There was documentation fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily was administered 11/07/23, 11/08/23, 11/09/23, 11/10/23, 11/12/23, 11/13/23, 11/14/23, 11/27/23, 11/28/23, 11/29/23, and 11/30/23. -There was documentation Resident #5 was out of the facility on 11/11/23, and 11/15/23 to 11/26/23. Review of Resident #5's December 2023 eMAR revealed: -There was an entry for fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily. - There was documentation fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily was administered from 12/01/23 to 12/31/23. Review of Resident #5's January eMAR from 01/01/24 to 01/10/24 revealed: -There was an entry for fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily.	D 358		

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D 358	Continued From page 31 - There was documentation fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily was administered from 01/01/24 to 01/10/24. Observations of Resident #5's medications on hand on 01/10/24 at 3:30pm revealed there was no fluticasone-vilanterol inhaler available for administration on the medication cart. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/11/24 at 9:12am revealed: -There was not an active order for Resident #5 for fluticasone-vilanterol 100-25 inhale 1 puff into the lungs daily dated. -There was an order dated 11/06/23 for fluticasone-vilanterol inhaler that was discontinued because it was not reordered. -The fluticasone-vilanterol inhaler was dispensed and sent to the facility on 11/06/23. -The fluticasone-vilanterol inhaler contained a 30-day supply. -The fluticasone-vilanterol inhaler was not a part of the facility's cycle fill medications; it had to be reordered by the facility. -Fluticasone-vilanterol inhaler was used to open the lungs to aid in breathing. Interview with Resident #5 on 01/10/24 at 3:53pm revealed: -She used fluticasone-vilanterol daily. -She ran out of the medication several days ago and let the staff know. Interview with a medication aide (MA) on 01//11/24 at 8:54am revealed: -She reordered the fluticasone-vilanterol inhaler 01/11/24 because Resident #5 told her she ran out. -She made sure Resident #5 used the inhaler	D 358		

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each day.
-She did not know Resident #5 ran out of the medication.

Interview with Resident #5's primary care provider (PCP) on 01/11/24 at 1:40pm revealed:
-Resident #5 had asthma and COPD and was prescribed fluticasone-vilanterol inhaler to treat those disorders.
-Resident #5 had a history of COVID-19 pneumonia.
-It was important for Resident #5 to have the physician ordered medication daily.
-Resident #5 could have chest tightness and difficulty breathing if she did not use the medication daily.

Interview with the Resident Care Coordinator (RCC) on 01/11/24 at 2:00pm revealed:
-Resident #5 had an order for fluticasone-vilanterol inhaler for breathing problems and shortness of breath.
-The medication would have to be reordered by the MA when it was low; it was not part of the pharmacy's cycle fill.
-Resident #5 could experience shortness of breath or difficulty breathing without the medication.

Interview with the Administrator on 01/11/24 at 3:30pm revealed it was his expectation medications be administered as ordered by the physician.

3. Review of Resident #2's current FL-2 dated 08/29/23 revealed:
-Diagnosis included confusion.
-There was an order for clonazepam 1mg (used to treat panic disorder) three times daily.

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Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation clonazepam was administered three times daily from 11/01/23 to 11/22/23 and from 11/25/23 to 11/30/23, on 11/23/23 at 8:00am, and on 11/24/23 at 2:00pm and 8:00pm.
-There were exceptions on 11/23/23 at 2:00pm and 8:00pm and on 11/24/23 at 8:00am; the exception was out of facility.

Review of Resident #2's December 2023 eMAR revealed:
-There was an entry for clonazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation clonazepam was administered three times daily from 12/01/23 to 12/24/23 and from 12/28/23 to 12/31/23, on 12/25/23 at 8:00am and 2:00pm, and on 12/27/23 at 8:00pm.
-There were exceptions on 12/25/23 at 8:00pm, 12/26/23 at 8:00am, 2:00pm and 8:00pm, and on 12/27/23 at 8:00am and 2:00pm; the exception was out of facility.

Review of Resident #2's January 2024 eMAR from 01/01/24 to 01/10/24 revealed:
-There was an entry for clonazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation clonazepam was administered three times daily from 01/01/24 to 01/09/24 and on 01/10/24 at 8:00am.

Observation of medication on hand for Resident

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#2 on 01/10/24 at 2:34pm revealed:
-There was a bubble pack of clonazepam 0.5mg dispensed on 12/09/23 available for administration.
-There were 42 of 90 clonazepam 0.5mg tablets remaining in the bubble pack.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 01/10/24 at 1:45pm revealed:
-The pharmacy had a new order for clonazepam 0.5mg three times daily dated 08/25/23.
-The pharmacy had an order to discontinue clonazepam 1mg three times daily dated 08/25/23.
-The pharmacy received Resident #2's FL-2 dated 08/29/23.
-She did not realize clonazepam 1mg was on the FL-2.
-She knew a new order was faxed to the pharmacy on 08/25/23 to decrease clonazepam to 0.5mg three times daily.
-The pharmacy dispensed 90 clonazepam 0.5mg tablets on 10/18/23, 11/20/23 and 12/19/23.

Interview with the Primary Care Provider (PCP) on 01/11/24 at 1:42pm revealed:
-The FL-2 was completed by the Administrator or the Resident Care Coordinator (RCC) and was given to her to sign.
-The FL-2 should be correct when given to her for her signature.
-She did not order the clonazepam for Resident #2; the Mental Health Provider (MHP) managed that medication.

Interview with the RCC on 01/11/24 at 2:17pm revealed:
-She completed the FL-2's for the PCPs to sign.
-She reviewed the physician orders to complete

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D 358	Continued From page 35 the FL-2s. -She missed the clonazepam 0.5mg order when she completed the FL-2. -It was an oversight that she missed the change in the clonazepam order. Interview with the Administrator on 01/11/23 at 3:18pm revealed: -The RCC completed the FL-2s for the facility. -The RCC referred to the medication records and physician's order to complete the FL-2. -The RCC was expected to complete the FL-2 accurately. Attempted telephone interview with Resident #2's MHP on 01/11/24 at 2:17pm was unsuccessful. The facility failed to ensure two medications were discontinued as ordered for a resident who had low blood pressure readings, and continued to receive the two medications for an additional 3 weeks, when the residents blood pressure reading was 77/44 (#4). The facility's failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/11/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 02/25/24.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the	D 366		

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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, record reviews, and interviews, the facility failed to ensure staff documented on the electronic administration medication record immediately after administering medication for 2 of 6 sampled residents (#2, #6).

The findings are:

1. Review of the facility's medication administration policy revealed the recording of the administration of the medication administration record shall be by the staff person who administered the medication immediately following administration of the medication to the resident

Review of Resident #2's current FL-2 dated 08/29/23 revealed:
-Diagnoses included confusion, impaired balance, and acute kidney infection.
-There was an order for hydroxyzine 50mg (used to treat anxiety) every 8 hours as needed (PRN) for episodic outbursts.

Review of Resident #2's November 2023 electronic medication administration record (eMAR) from 11/14/23 to 11/30/23 revealed:
-There was an entry for hydroxyzine 50mg every 8 hours PRN for episodic outbursts.
-There was documentation hydroxyzine was administered 13 times from 11/13/23 to 11/30/23.

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D 366	Continued From page 37 Review of Resident #2's December 2023 eMAR revealed: -There was an entry for hydroxyzine 50mg every 8 hours PRN for episodic outbursts. -There was documentation hydroxyzine was administered 15 times from 12/01/23 to 12/31/23. Review of Resident #2's January 2024 eMAR from 01/01/24 to 01/10/24 revealed: -There was an entry for hydroxyzine 50mg every 8 hours as PRN for episodic outbursts. -There was documentation hydroxyzine was administered 8 time from 01/01/24 to 01/10/24. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 01/10/24 at 1:45pm revealed: -The pharmacy had an order for hydroxyzine 50mg every 8 hours PRN for episodic outburst dated 07/25/23. -The pharmacy dispensed 90 hydroxyzine 50mg tablets on 11/13/23. Review of medications on hand on 01/10/23 at 2:15pm revealed: -There were two bubble packs of hydroxyzine 50mg; one bubble pack contained one capsule and the second bubble pack contained 30 capsules. -The bubble packs were dispensed on 11/13/23. Based on eMAR review, interviews, and medication on hand it was determine that 90 capsules were dispensed on 11/13/23 with 31 capsules remaining with only 36 capsules documented as administered and 23 capsules unaccounted for. Interview with the medication aide (MA) on	D 366		

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D 366	Continued From page 38 01/11/24 at 1:45pm revealed: -Resident #2 asked for hydroxyzine when he needed it. -She documented the PRN medication on the eMAR each time she administered the medication. -The oncoming shift would not know the last time the medication was given if it was not documented. -If the medication was not documented and the next shift administered the medication, not knowing it had already been administered, could be dangerous for the resident. -She did not know why there were more tablets missing than was documented on Resident #2's eMAR. Interview with the Resident Care Coordinator (RCC) on 01/11/24 at 2:17pm revealed: -The MAs should document on the eMAR each time a PRN medication was administered. -She did not know there were more hydroxyzine missing that documented as administered. -It appeared the MAs were not documenting each time Resident #2 was administered the PRN medication. -The on-coming MA needed to know the last time the PRN medication was administered to prevent administering the PRN too soon. Interview with the Administrator on 01/11/24 at 3:18pm revealed: -The MAs should document on the eMAR each time a PRN medication was administered. -He expected the MAs to document PRN administration on the eMAR. 2. Review of the facility's medication administration policy revealed the facility shall ensure that only staff meeting the requirements of	D 366		

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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 366	Continued From page 39 Qualifications of a Medication Aide shall administer medications to residents. Review of Resident #6's current FL-2 dated 09/05/23 revealed: -Diagnoses included dementia, major depressive disorder, mood disorder, anxiety, mild intellectual disabilities, chronic obstructive pulmonary disease (COPD) hypothyroidism, hyperlipidemia, and muscle weakness. -There was an order for diclofenac sodium 1% gel (used for arthritic pain) 4 grams to lower back and left shoulder twice daily. Observation of Resident #6's room on 01/10/24 at 8:54am revealed there was a medication cup with a white cream about ½ full on Resident #6's rollator. Interview with Resident #6 on 01/10/24 at 8:54am revealed: -The medication in the medicine cup was for her back and neck. -She had arthritis and the medication helped with the pain. -The medication aide (MA) left the medicated cream in her room on shower days. -After she takes her shower the personal care aide (PCA) would apply the medication to her back and neck. Review of Resident #6's January 2024 eMAR on 01/10/24 revealed: -There was an entry for diclofenac sodium 1% apply 4 grams to lower back and left shoulder twice daily with a scheduled administration time of 8:00am. -There was documentation diclofenac sodium was administered to Resident #6 on 01/10/24 at 8:00am.	D 366		

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	HAL001134	A. BUILDING: _____ B. WING _____	R 01/11/2024

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D 366	Continued From page 40 Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 01/11/24 at 10:37am revealed: -The pharmacy had an order for diclofenac sodium 1% apply 4 grams to lower back and left shoulder twice daily dated 02/14/23. -Diclofenac sodium was used for arthritis pain. Interview with the medication aide (MA) on 01/11/24 at 1:45pm revealed: -She prepared diclofenac sodium 1% and placed it in a medication cup. -She would give the medicated cream to the PCA to apply to Resident #6's back, shoulders, and neck after the PCA had completed Resident #6's shower. -She did not leave the medicated cream at Resident #6's bedside; she gave it to the PCA. -She did not administer the medicated cream to Resident #6. -She did not observe the medication cream being administered to Resident #6. Interview with the Resident Care Coordinator (RCC) on 01/11/24 at 2:17pm revealed: -The MAs should apply medicated creams to Resident #6's shoulders, back, and neck. -Medication should not be left at the bedside for the PCA to administer. -The MA should administer all medications to residents. Interview with the Administrator on 01/11/24 at 3:18pm revealed: -The medication cream should not have been left at Resident #6's bedside. -Another resident could have walked in her room and took the medication. -He expected the MAs to administer all	D 366		

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D 366	Continued From page 41 medications, including creams.	D 366		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 2 of 2 sampled residents had physician's orders to self-administer extra strength Tylenol used to treat pain (#1), and fluticasone-vilanterol and albuterol used to treat shortness of breath (#5). The findings are: Review of the facility's policy for self-administration of medications revealed "it is the policy of this facility to allow medications to be stored at bedside if the physician has written "may self-administer" order and the Administrator has agreed that the resident meets the facility's qualifications for self-medication."	D 375		

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D 375	Continued From page 42 1. Observation of Resident #1's bedroom on 01/10/24 at 8:30am and 01/11/24 at revealed -There was a bottle of extra strength Tylenol 500mg per tablet on the nightstand beside her bed. -There were less than 10 tablets in the bottle. Interview with Resident #1 on 01/11/24 at 8:15am revealed: -She took the extra strength Tylenol for her arthritis pain. -She took the extra strength Tylenol mostly at night. -She did not take the extra strength Tylenol every night. -The Primary Care Provider (PCP) knew about it. -She came to the facility with the extra strength Tylenol. Review of Resident #1's current FL-2 dated 10/10/23 revealed: -Diagnoses included chronic kidney disease, diabetes mellitus, toe amputation, and osteomyelitis. -There was not an order for extra strength Tylenol. Review of Resident #1's Resident Register revealed she was admitted to the facility on 09/11/23. Review of Resident #1's physician's orders dated 10/10/23 revealed: -Diagnoses included osteomyelitis. -There was not an order for extra strength Tylenol. -There was not an order for Resident #1 to self-administer medications.	D 375		

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D 375	Continued From page 43 Interview with the medication aide (MA) on 01/11/24 at 8:54am revealed: -Resident #1 did not have an order to self-administer medications. -Resident #1 did not have an order for extra strength Tylenol. -She was unaware Resident #1 had a bottle of extra strength Tylenol in her room. -Resident #1 should not have medications at her bedside. Interview with the Resident Care Director (RCD) on 01/11/24 at 2:00pm revealed: -Resident #1 did not have an order to self-administer medications. -Resident #1 did not have an order for extra strength Tylenol. -Resident #1 should not have medications at her bedside. -All staff were responsible for checking rooms to make sure there were no medications left out. -Resident #1 has been told she cannot have medications left out at the bedside. Interview with Resident #1's PCP on 01/11/24 at 1:40pm revealed: -Resident #1 was not a candidate for self-administration of medications because she didn't know all the medications she took. -Resident #1 went to the store and bought medications and did not tell the staff. -Resident #1 was at risk of taking too much medication if left at the bedside. -Resident #1 knew she should not have medications at the bedside. Interview with the Administrator on 01/11/24 at 3:30pm revealed: -He was unaware Resident #1 had extra strength Tylenol at the bedside.	D 375		

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D 375	Continued From page 44 -Resident #1 should not have medications at the bedside if she did not have an order to self-administer medications. -All staff members are responsible for making sure medications are not left out at the bedside and, if found, should be taken to the MA. 2. Observation of Resident #5's bedroom on 01/10/94 at 3:53pm revealed: -Four vials of 3 milliliter albuterol for use with a nebulizer machine were on Resident #5's nightstand. -An albuterol 90mcg/actuation inhaler with no label was on Resident #5's nightstand. Review of Resident #5's current FL-2 revealed: -Diagnoses included asthma, chronic obstructive pulmonary disease, history of pneumonia, fibromyalgia, and gastroesophageal reflux disorder. -There was an order for albuterol 90mcg/actuation inhaler 2 puffs every four hours as needed. -There was an order for fluticasone furoate-vilanterol 100-25mcg/actuation inhaler 1 puff daily. -There was an order for albuterol 2.5mg/ml 0.08% 3 ml's every four hours as needed. Review of Resident #5's record revealed no physician's order to self-administer medications. Interview with Resident #5 on 01/10/94 at 3:53pm revealed -She self-administered her rescue inhaler (albuterol), her albuterol nebulizer treatments, and her fluticasone furoate-vilanterol. -The staff were aware she had medications at the bedside. -She used the albuterol inhaler and the albuterol	D 375		

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D 375	Continued From page 45	D 375		

via nebulizer as needed.
-She used fluticasone furoate-vilanterol daily, but she was currently out of it.

Interview with a MA on 01/11/24 on 8:54am revealed:
-Resident #5 did not have a physician's order to self-administer medications.
-She left the vials of albuterol for Resident #5 to use when she was ready.
-She left the albuterol inhaler in Resident #5's room because she had recently returned from the hospital for breathing problems and had recently had COVID.

Interview with the Resident Care Director (RCD) on 01/11/24 at 2:00pm revealed:
-Resident #5 did not have an order to self-administer medications.
-Resident #5 should not have medications at her bedside.
-All staff were responsible for checking rooms to make sure there were no medications left out.
-Resident #5 has been told she cannot have medications left out at the bedside.

Interview with the Administrator on 01/11/24 at 3:30pm revealed:
-He was unaware Resident #5 had medications at the bedside.
-Resident #1 should not have medications at the bedside if she did not have an order to self-administer medications.
-He was unsure if Resident #5 had an order to self-administer medications.
-All staff members are responsible for making sure medications are not left out at the bedside and, if found, should be taken to the MA.

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D 377	Continued From page 46	D 377		
D 377	10A NCAC 13F .1006(a) Medication Storage 10A NCAC 13F .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the adult care home's medication storage policy and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents medications were stored in a safe and secure manner for 2 of 2 sampled residents who had medications at the bedside (#1, #5). The findings are: Review of the facility's Medication Storage policy for residents revealed: -A secure area for storage of medications will be available for bedside medication so that other residents do not have access to the drug. -Medications were to be stored in the resident's room in a locked drawer or locked box. 1. Review of Resident #1's current FL-2 dated 10/10/23 revealed: -Diagnoses included diabetes mellitus type 2, chronic kidney disease, osteomyelitis, toe amputation, and depression. -There was no order for Resident #1 for self-administration of medications. Observation of Resident #1's bedroom on 01/10/24 at 8:30am and 01/11/24 at revealed: -There was a bottle of extra strength Tylenol 500mg per tablet on the nightstand beside her bed. -There were less than 10 tablets in the bottle.	D 377		

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D 377	Continued From page 47 Interview with Resident #1 on 01/11/24 at 8:15am revealed: -She took the extra strength Tylenol for her arthritis pain. -She took the extra strength Tylenol mostly at night. -She did not take the extra strength Tylenol every night. -The Primary Care Provider (PCP) knew about it. -She came to the facility with the extra strength Tylenol. Interview with the medication aide (MA) on 01/11/24 at 8:54am revealed: -She administered Resident #1's medications to her in her room. -Resident #1's medications were stored on the medication cart. -She did not see the bottle of extra strength Tylenol on Resident #1's nightstand. -Resident #1 should not have medications at her bedside. Interview with the Resident Care Director (RCD) on 01/11/24 at 2:00pm revealed: -Resident #1 did not have an order to self-administer medications. -Resident #1's medications should be kept locked on the medication cart. --Resident #1 should not have medications at her bedside. -All staff were responsible for checking rooms to make sure there were no medications left out. -Resident #1 has been told she cannot have medications left out at the bedside. Refer to the Administrator on 01/11/24 at 3:30pm. 2. Review of Resident #5's current FL-2 revealed:	D 377		

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D 377	Continued From page 48 -Diagnoses included asthma, chronic obstructive pulmonary disease, history of pneumonia, fibromyalgia, and gastroesophageal reflux disorder. -There was an order for albuterol 90mcg/actuation inhaler 2 puffs every four hours as needed. -There was an order for fluticasone furoate-vilanterol 100-25mcg/actuation inhaler 1 puff daily. -There was an order for albuterol 2.5mg/ml 0.08% 3 ml's every four hours as needed. Review of Resident #5's record revealed no physician's order to self-administer medications. Observation of Resident #5's bedroom on 01/10/94 at 3:53pm revealed: -Four vials of 3 milliliter albuterol for use with a nebulizer machine were on Resident #5's nightstand. -An albuterol 90mcg/actuation inhaler with no label was on Resident #5's nightstand. Interview with Resident #5 on 01/10/94 at 3:53pm revealed -She self-administered her rescue inhaler (albuterol), her albuterol nebulizer treatments, and her fluticasone furoate-vilanterol. -The staff were aware she had medications at the bedside. -She used the albuterol inhaler and the albuterol via nebulizer as needed. -She used fluticasone furoate-vilanterol daily, but she was currently out of it. Interview with a MA on 01/11/24 on 8:54am revealed: -Resident #5 did not have a physician's order to self-administer medications.	D 377		

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D 377	Continued From page 49 -She left the vials of albuterol for Resident #5 to use when she was ready. -She left the albuterol inhaler in Resident #5's room because she had recently returned from the hospital for breathing problems and had recently had COVID. Interview with the Resident Care Director (RCD) on 01/11/24 at 2:00pm revealed: -Resident #5 did not have an order to self-administer medications. -Resident #5 should not have medications at her bedside. -Resident #5's medications should be locked on the medication cart. -All staff were responsible for checking rooms to make sure there were no medications left out. -Resident #5 has been told she cannot have medications left out at the bedside. Interview with the Administrator on 01/11/24 at 3:30pm revealed: -Residents should not have medications at the bedside if there was no an order to self-administer medications. -Medications at the bedside were to be stored in a locked box. -All staff members are responsible for making sure medications are not left out at the bedside and, if found, should be taken to the MA.	D 377		