recieved via e-mail 07/09/24

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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041010	A. BUILDING: _____ B. WING _____	C 05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services (DSS) conducted and annual survey and complaint investigation on May 08, 2024 through May 10, 2024. Complaints were initiated by the Guilford County Department of Social Services from 03/20/24 to 04/25/24.	D 000		
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305Physical Environment (d) The requirements for the bedroom are: (1) The number of resident beds set up shall not exceed the licensed capacity of the facility; (2) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, any live-in staff and other persons living in the home. Residents shall not share bedrooms with staff or other live-in non-residents; (3) Only rooms authorized as bedrooms shall be used for residents' bedrooms; (4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom; (5) There shall be a minimum area of 100 square feet excluding vestibule, closet or wardrobe space in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two people; (6) The total number of residents assigned to a bedroom shall not exceed the number authorized for that particular bedroom; (7) A bedroom may not be occupied by more than two residents. (8) Resident bedrooms shall be designed to	D 049	Maintenance or designee will check all Windows on or before 6/1/24 To ensure they are in good repair. Window alarms Will be ordered and installed by Maintenance or designee Maintenance and or designee Will monitor the windows monthly And ongoing.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 06.24.24

STATE FORM 6899 39SE11 If continuation sheet 1 of 103

reviwed and acknowledged 07/09/24

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D 049	Continued From page 1 accommodate all required furnishings; (9) Each resident bedroom shall be ventilated with one or more windows which are maintained operable and well lighted. The window area shall be equivalent to at least eight percent of the floor space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and (10) Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the window openings in the Special Care Unit (SCU) residents' bedrooms were restricted to 6 inches to prevent elopement or suicide. The findings are: Observation of the windows in the SCU on 05/08/24 between 10:05am and 10:45am revealed: -There were 14 resident rooms with 1 window in each room. -There were 10 closed windows with closures in the locked position. -There were 4 windows that were unlocked and opened with the lower pane openings ranging from one-half inch to 12 inches. A second observation of the windows in the SCU	D 049		

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D 049	Continued From page 2 on 05/10/24 between 10:51am and 11:20am revealed: -The lower pane of 1 window could be raised 9 inches. -The lower panes of 7 windows could be raised 12 inches. -One of the lower panes that raised to 12 inches slammed close after it was raised. -The lower pane of 1 window could be raised 21 inches. -The window openings were large enough for a resident to pass through to the outside or for someone to come in from the outside. -One window had no screen. -All 14 windows had alarms in place, but only 2 of the alarms sounded when the lower pane was raised. -It took staff 2 minutes to respond to the window alarm and staff appeared baffled as to what the alarm sound was. Observation of the outside area of the SCU on 05/10/24 at 10:57am revealed: -The area outside of the SCU was bordered by vinyl ranch rail fencing. -The fencing separated the facility from the lawn and a wooded area on the side of the SCU. -One end of the fencing opened to a wooded area. -The other end of the fencing curved around the facility and opened to the facility's parking lot. Interview with a SCU resident on 05/08/24 at 10:40am revealed: -He cracked his window open "to let the funk out" because it got hot in his room due to his air conditioner not working. -He had to crack his window open by stuffing a piece of paper between the lower window pane and the window sill because the window slammed	D 049		

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D 049	Continued From page 3 shut and would not stay up. Interview with a medication aide (MA) on 05/10/24 at 11:25am revealed: -The windows were lifted in the SCU residents' rooms so that the residents could get some air. -The air conditioner unit in most of the rooms did not have control knobs and she did not know how to turn the units on. -Sometimes the staff raised the windows and sometimes the residents raised the windows. -She did not know if the windows were closed during the night when the residents were asleep. Interview with a personal care aide (PCA) on 05/10/24 at 11:27am revealed: -Some windows were raised in the SCU residents' rooms because the residents were hot. -She did not know some windows raised 12 inches and one of them raised 21 inches. -She did not raise the residents' windows and guessed the residents raised them. Interview with a second PCA on 05/10/24 at 11:40am revealed she did not know the windows were not supposed to open more than six inches. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:36pm revealed: -It was warm in the SCU and staff raised the windows in some of the residents' rooms. -There were no sounding devices on the windows in the SCU that she knew of. -She did not know if there had been training on security of the SCU. -She did not know if staff closed the windows in the bedrooms of the SCU at night. -She did not know the windows raised allowed enough space for a resident to get through the window opening.	D 049		

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D 049	Continued From page 4 Interview with the Administrator on 05/10/24 at 5:24pm revealed: -The heating system was in the attic and blew warm air throughout the facility; the system had not been adjusted yet to stop blowing warm air. -She did not know about the windows being raised in the SCU. -There were alarms on the windows in the SCU, but she did not know they were not working. -She had been told by a monitoring agency (date unknown) to apply screws to the windows at 12 inches. -After the screws had been placed at 12 inches a resident attempted to raise the window, was unable to raise it, and broke the window. -She was told by a different monitoring agency to take the screws out of the window because it was a violation of residents' rights. -The fire marshal got involved and that the screws needed to be removed because they were a safety hazard. Attempted interview with the maintenance staff on 05/10/24 at 10:30am was unsuccessful.	D 049		
D 057	10A NCAC 13F .0305(f)(5) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (5) Handwashing facilities with wrist type lever handles shall be provided immediately adjacent to the drug storage area; This Rule is not met as evidenced by: Based on observations and interviews, the facility	D 057	Location of med room Will be changed to be in compliance to the rule RCC or designee will Monitor med room placement Weekly and ongoing.	

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D 057	Continued From page 5 failed to ensure the medication storage area for 3 of 3 medication carts in the assisted living unit were immediately adjacent to a handwashing sink. The findings are: Observation during the initial tour on 05/08/24 revealed the facility had an assisted living (AL) unit and a Special Care Unit (SCU). Observation during medication administration on 05/09/24 from 7:30am to 8:00am in the AL unit revealed: -The facility had 3 halls for residents' rooms in the AL unit (100 hall, 300 hall, and 400 hall). -There were 3 medication carts used to administer medications for residents in the AL unit stored on a front hall that did not have assigned residents' rooms. -The medication cart storage room did not have a handwashing sink. -There was an employee bathroom with a handwashing sink and toilet near the 100 hall located 50 feet from the medication cart storage room. -There were residents' rooms on the 300 hall located 30 feet from the medication cart storage room. Observation of the 300 hall to 400 hall on 05/09/24 at 12:00pm revealed: -The 300 hall and 400 hall adjoined each other on one side of the AL unit. -There was an open foyer area between the 300 hall and 400 hall. -Between the end of the 300 hall and at the beginning of the 400 hall, there were 2 rooms not occupied by residents. -One room was the Maintenance Director's office.	D 057		

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D 057	Continued From page 6 -The second room was used for storage of a few extra portable oxygen tanks and various equipment, and included a handwashing sink. Observation of the 100 hall on 05/09/24 at 12:10pm revealed: -There was a foyer area at the back side of the 100 hall next to the entrance to the SCU with a desk and 2 rooms as well as the SCU entrance. -There was a room that was not a resident's room with a full size refrigerator containing residents' nutrition supplements. -There was a second room that was not a resident's room with a small refrigerator containing overstock medications for AL unit residents, resident records, and some overstock medications; including a handwashing sink. Interview with a medication aide (MA) on 05/09/24 at 3:00pm revealed: -Residents from the 300 hall and 400 hall routinely came by the medication cart storage room on the way to the dining room. -The MAs administered most of the resident's medications in the hallway just outside of the medication cart storage room. -The medication carts were stored in the room on the front hall after the medication passes. Interview with the Business Office Manager (BOM) on 05/09/24 at 3:00pm revealed: -She did not know the medication storage area had to be located adjacent to a handwashing facility (sink). -The facility Owner had rearranged offices and medication cart locations late last summer 2023. -The medication carts for the AL unit were moved to the current medication cart storage room around August 2023. -The 100 hall medication cart was previously	D 057		

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D 057	Continued From page 7 stored in the room at the end of the 100 hall along with the small medication refrigerator and residents' records. -The 300 hall and 400 hall medication carts were previously stored in the medication room between the 300 hall and 400 hall which had a handwashing sink inside the room. Interview with the Administrator on 05/10/24 at 5:00pm revealed: -The facility Owner had implemented changes in the facility's offices and medication cart storage room early last fall (August 2023.) -She did not realize there was a requirement for a handwashing sink immediately adjacent to medication storage. -She would inform the facility Owner about the requirement for a handwashing sink in or adjacent to the medication storage area. -She would ensure the medication carts were moved back to the rooms with handwashing sinks as originally designed.	D 057		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the air conditioning/heating units in the Special Care Unit (SCU) were maintained in an operating condition. The findings are:	D 105	Knobs for PTAC units Will be ordered for all PTAC so the temperature in the unit can be Adjusted on or before 6/1/24 Temperature in The unit will be monitored by MCC and/ or designee monthly and Ongoing.	

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D 105	Continued From page 8 Observation of the Special Care Unit (SCU) on 05/08/24 between 10:05am and 10:40am revealed: -There were 14 occupied rooms, but 1 resident was out of the facility in the hospital. -All the rooms had wall air conditioning/heating units. -Five of the rooms had air conditioning/heating units with push button controls. -Nine of the rooms had air conditioning/heating units that with knob controls. -In the 9 rooms where the air conditioning/heating units that were to be turned on and adjusted using knobs, there should have been 2 knobs to turn on and control the air and both knobs were missing in all 9 rooms. -It was warm in the SCU including in resident rooms. -None of the air conditioning/heating units were turned on. -There was not a thermostat or thermometer in the SCU. Interview with an outside provider on 05/08/24 at 10:29am revealed: -She was visiting with a resident in the SCU on 05/08/24. -It was pretty warm in the resident's room and she noticed there were no knobs on the air conditioning/heating unit to turn on or adjust the temperature. -She was just about to go ask staff about the air in the resident's room. Interview with a resident in the SCU on 05/08/24 at 10:14am revealed: -It got too hot in his room and he could not turn on the air conditioning unit. -He opened his bedroom door and opened his	D 105		

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D 105	Continued From page 9 window so that he could get cool air. Interview with a second resident in the SCU on 05/08/24 at 10:35am revealed: -He cracked the window "to let the funk out." -The air conditioning did not work, and it got hot in his room. -"We need new ones (air conditioning units) to replace these because they do not have knobs." Interview with the maintenance staff on 05/08/24 at 10:40am revealed: -He removed the knobs on the air conditioning/heating units because the residents pulled them off. -He did not have any of the missing knobs for the air conditioning/heating units and had to take the cover off the units to turn the air or heat on and to adjust the temperatures. -He tried to look for replacement knobs to order, but he could not find any for the air conditioning/heating units. -When it was warm outside, he adjusted the temperatures in the residents' rooms if they asked. -He showed the medication aides (MA) how to hit the reset button located under the unit for times when he was not in the facility. -There were 2 reset buttons, one to turn on the air and one to turn on the heat, but the temperatures could not be controlled unless the cover was taken off and the inside devices were manually manipulated. -All the air conditioning/heating units worked in the resident rooms. Observation in the SCU on 05/08/24 at 10:40am revealed: -The maintenance staff removed the cover from one of the air conditioning/heating units and	D 105		

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D 105	Continued From page 10 manipulated a device on the inside to turn the air conditioner on. -The air conditioning unit came on. Interview with a MA on 05/10/24 at 11:25am revealed: -Residents have complained about it being hot in their rooms and in the common areas. -The knobs were missing on some of the air conditioning/heating units and she did not know how to turn the unit on. -The SCU staff has told the maintenance staff about the SCU residents being hot. -"Management knows the units in the rooms don't work." Interview with a personal care aide (PCA) in the SCU on 05/10/24 at 11:27am revealed: -She did not know how to turn the air conditioning/heating units on. -There was one staff in the SCU who knew how to turn the units on. Interview with a PCA in SCU on 05/10/24 at 11:40am revealed: -When it got hot in the residents' rooms, she did not turn on the air because she did not know how. -She was not sure if anyone knew how to turn on the air. Observation of the SCU on 05/10/24 at 12:14pm revealed: -There were 11 residents seated in chairs in the common area. -The Activity Director was talking to the residents. -The common area was opened to the dining area. -There were 2 air conditioning/heating units in the common area. -There were no air conditioning /heating units in	D 105		

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D 105	Continued From page 11 the dining area. -There was a slim, standing and oscillating fan in the dining area Interview with the Activity Director in the SCU on 05/10/24 at 12:15pm. -There were two air conditioning/heating units in the common area. -One of the air conditioning/heating units did not work and it got hot in the common area. -She sometimes had to open a side door to the secured patio area to try to let air into the common area. -She could not do any physically strenuous activities with the residents because it got so hot in the common area. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:36pm revealed: -She did not know if all the air conditioning/heating units in the residents' rooms worked. -She had not been in the residents' rooms to try to turn the units on and she did not know how to turn the units on. -She did not know who was able to turn the units on. -Staff raised the windows in residents' rooms if it got too hot. -It was warm in the common area. -She did not know if both air conditioning/heating units worked in the common area, but there was a fan in the dining area. -If residents got too hot in the common area, staff opened the side door to the secured patio area. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -Some of the air conditioning/heating units in the SCU unit were older.	D 105		

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D 105	Continued From page 12 -Some of the units did not having operating knobs and she did not know who was taking the knobs off the units. -She thought the maintenance staff had a master knob to use to turn on all the air conditioning units and left the master knob in the maintenance office for staff to use when he was not there. -It was warm in the SCU because the heating system in the attic and blew warm air throughout the facility; the system had not been adjusted yet to stop blowing warm air.	D 105		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 residents sampled (Resident #3) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #3's current FL-2 dated	D 234	All resident charts will be reviewed to Ensure every resident has a TB-test On or before 6/1/24 by admin or designee Upon admission resident documentation Will be reviewed admin or designee to ensure resident has had all necessary immunizations.	

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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 234	Continued From page 13 11/09/23 revealed diagnoses included dementia, right below the knee amputation, third left toe amputation, and osteomyelitis. Review of Resident #3's Resident Register revealed there was an admission date of 10/24/23. Review of Resident #3's record for a tuberculosis (TB) skin test revealed: -There was documentation of a TB skin test administered on 05/09/24, but no date read was provided. -There was no documentation of a second TB skin test for Resident #3. Review of Resident #3's record revealed, there was no physician's order or documentation for a second step TB test to be administered. Interview with the Administrator on 05/10/24 at 10:58am revealed: -She did not audit residents' admission paperwork for TB compliance. -The facility's Nurse was responsible to ensure all residents received two TB skin tests upon admission. -The facility's Nurse was responsible to audit residents' admission paperwork for TB compliance. -The facility did not currently have a facility Nurse. -The last date of residents' records audit was unknown. -The previous Nurse left the facility on 4/25/24. Interview with Resident #3 on 05/10/24 at 11:03am revealed: -She received a TB skin test on 5/9/2024. -She previously received a TB skin test at her previous facility.	D 234		

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D 234	Continued From page 14 Interview with the Business Office Manager (BOM) Assistant on 05/10/24 at 11:05am revealed: -She did not audit residents' admission paperwork for TB compliance. -The facility's Nurse was responsible to ensure all residents received two TB skin tests upon admission. -The facility's Nurse was responsible to audit residents' admission paperwork for TB compliance. -The facility did not currently have a facility Nurse. -The last date of residents' records audit was unknown.	D 234		
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 reviews, and interviews the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 6 sampled residents (Resident #6) related to notifying the primary care provider (PCP) for refused doses of sliding scale insulin (SSI). The findings are: Review of Resident #6's current FL2 dated 06/22/23 revealed: -Diagnoses included diabetes and dementia. -There was an order for Humalog (a rapid acting insulin used to lower elevated blood sugar levels) 100units/ml subcutaneously 3 times a day using	D 273	Admin or designee will implement A paper notification system for the physician on or before 6/1/24. Admin And or designee Will do routine monitoring of the system	

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D 273	Continued From page 15 sliding scale insulin (SSI): 0-200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than 450 notify physician (MD). Review of Resident #6's signed physician orders dated 01/11/24 revealed there was an order for Humalog Kwikpen 100 units/ml, check fingerstick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. Review of Resident #6's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100 units/ml, check finger stick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. -FSBS and Humalog SSI were scheduled for administration at 6:00am, 11:00am, and 4:00pm daily. -The FSBS values ranged from 60 to 332. -There were 23 doses documented as not administered as ordered with 8 refused doses documented on the eMAR. -Examples of refused FSBS check and Humalog administration documented as refused included: On 03/08/24 at 11:00am and 4:00pm, on 03/10/24 at 4:00pm, on 03/13/24 at 11:00am, on 03/26/24 at 4:00pm, and on 03/27/24 at 11:00am. -There was no documentation of physician notification of refused FSBS checks and Humalog administration.	D 273		

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D 273	Continued From page 16 Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Humalog Kwikpen 100 units/ml, check finger stick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. -FSBS and Humalog SSI were scheduled for administration at 6:00am, 11:00am, and 4:00pm daily. -The FSBS values ranged from 60 to 332. -There were 21 doses documented as not administered as ordered with 6 refused Humalog doses documented on the eMAR. -Examples of refused FSBS checks and Humalog SSI administration documented as refused included: On 04/09/24 at 6:00am, on 04/20/24 at 12:00pm, on 04/22/24 at 4:00pm, and on 04/24/24 at 12:00pm. -There was no documentation of physician notification of refused FSBS and Humalog administration. Review of Resident #6's May 2024 eMAR from 05/01/24 to 05/10/24 revealed: -There was an entry for Humalog Kwikpen 100 units/ml, check finger stick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. -FSBS and Humalog SSI was scheduled for administration at 6:00am, 11::00am, and 4:00pm daily. -The FSBS values ranged from 72 to 380. -There were 6 refused FSBS checks and Humalog SSI administration documented	D 273		

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documented on the eMAR.
-Examples of refused FSBS checks and Humalog administration documented as refused included: On 05/02/24 at 4:00pm, on 05/03/24 at 11:00am, and on 05/05/24 at 11:00am and 4:00pm.
-There was no documentation for physician notification of refused FSBS and Humalog administration.

Observation of medication on hand for administration on 05/09/24 at 12:20pm revealed Resident #6 had a partial Humalog Kwikpen 100u/ml used to administer Humalog SSI that was labeled as opened on 04/21/24.

Review of Resident #6's notifications to the primary care provider (PCP) documentation from February 2024 to May 2024 revealed:
-There was one document dated 04/04/24.
-The document was a pre-printed cover sheet with spaces to enter the resident's name and date.
-There was a pre-printed statement "Please review the attached MARs for recent missed doses. Please provide any new orders or recommendations below".
-The document included a thank you with the name of the former Resident Care Coordinator (RCC) pre-printed.
-Attached to the document was the printed eMAR for March 2024 with no direct indication which medications, days missed, or times missed were being included for notification.
-The new orders section was documented for medications reviewed; no changes in current medication regimen signed and dated 04/04/24 by the PCP.

Interview with Resident #6's PCP on 05/09/24 at

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D 273	Continued From page 18 11:05am revealed: -She did not know Resident #6 had multiple missed doses of Humalog SSI. -The facility's Nurse was filling out a cover sheet and attaching it to the printed eMAR for residents, and stacking the sheet and eMARs in a big stack for her to review when she came to the facility on her routine weekly visit. -She would have wanted to be made aware of refusals in a timely manner and not waiting several weeks. Interview with Resident #6 on 05/10/24 at 3:30pm revealed he did not recall if he refused his insulin on any occasion. Attempted telephone interview with the Resident Care Coordinator (RCC) on 05/10/24 at 2:00pm was unsuccessful. Interview with the BOM on 05/10/24 at 12:00pm revealed: -She had temporarily assumed some of the former RCC's duties until a replacement was in place. -The RCC was responsible for medication audits, but she was not sure if they were completed. -The facility did not have a policy for missed medication administration or refusals for review. -Best practice was notification to the PCP after three refusals. -Best practice for missed medication administration was immediate notification to the PCP. Interview with the SCUC on 5/10/24 at 4:38pm revealed: -She had been employed at the facility since April 2024. -The RCC was responsible for medication audits,	D 273		

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D 273	Continued From page 19 but she was not sure if they were completed. -The facility did not have a policy for missed medication administration or refusals available for review. Interview with the Administrator on 05/10/24 at 4:45pm revealed: -The facility's Nurse was the RCC for the facility. -The RCC was responsible for auditing the eMARs for medication administration, including refused medications. -There was no documentation the RCC had routinely reported residents were refusing medications to the PCP. -The MAs were responsible for reporting refused medications to the RCC. Second interview with the Administrator on 05/10/24 at 5:24pm revealed the facility did not have a policy for provider notification for refused or missed medications for review.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 6 sampled residents (#3 and #6) related to implementing a treatment	D 276	Admin or designee will review the MARS to ensure orders are being Administrated as ordered on or before 6/1/24 And then monthly and ongoing Any orders that are not being administrated Will be addressed immediately. Admin or designee will monitor weekly For four weeks and then ongoing	

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for soaking and dressing of the toe on the left foot (#3) and fingerstick blood sugars (FSBS) (#3 and #6) .

The findings are:

1. Review of Resident #3's current FL2 dated 11/09/23 revealed diagnoses included dementia, right below the knee amputation, third left toe amputation, and osteomyelitis.

a. Review of Resident #3's local hospital emergency room (ER) discharge summary dated 05/03/24 revealed:
-Resident #3 was seen for a toe injury.
-There was an order to soak the feet with Epsom Salt water 2 to 3 times a day as the toenail grows back, after soaking be sure to dry the foot, apply antibiotic ointment, and dress the wound to maintain cleanliness.

Review of Resident #3's May 2024 electronic medication administration record (eMAR) & electronic treatment administration record (eTAR) revealed there were no entries for an order to soak the feet with Epsom Salt water 2 to 3 times a day as the toenail grows back, after soaking be sure to dry the foot, apply antibiotic ointment, and dress the wound to maintain cleanliness on the eMAR or eTAR.

Interview with Resident #3 on 05/09/24 at 12:30pm revealed her toe/foot had been soaked by the medication aides (MA) once a day every other day since being discharged from the local emergency room (ER) on 05/03/24.

Interview with a MA on 05/09/24 at 4:09pm revealed:
-She was not aware of the treatment order for

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D 276	Continued From page 21 Resident #3. -She was not able to locate the treatment order on the eMAR or eTAR. -She was unable to locate the dressing supplies indicated for use on the treatment order from the resident's hospital discharge summary. Telephone interview with a representative from the contracted pharmacy on 05/10/24 at 3:57pm revealed: -The pharmacy entered the treatment order if the treatment involved a medication, not if the order was only directions for the care staff. -The facility should enter that order on the eTAR. Interview with the Administrator on 05/10/24 at 6:13pm revealed: -It was her understanding that pharmacy was responsible for entering treatments on the eMAR or eTAR. -She was not aware that the treatments were not entered on the eMAR or eTAR from Resident #3's hospital discharge. -She was not aware staff were not completing the treatment order for Resident #3. -The Resident Care Coordinator (RCC) was responsible for ensuring orders for treatments were implemented. -The RCC left employment in late April 2024. -The Business Office Manager (BOM) and the Special Care Unit Coordinator (SCUC) were responsible for reviewing medication and treatment orders until a new RCC assumed the responsibility. -Her expectation was for all treatments to be implemented according to the residents' orders. Interview with the BOM on 05/10/24 at 6:17pm revealed: -The facility did not currently have a RCC.	D 276		

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D 276	Continued From page 22 -It was her understanding that sometimes the facility and sometimes the pharmacy was responsible for entering treatments on the eMAR or eTAR. -She was not sure of she was supposed to be auditing treatments. -She was not aware that the treatments were not entered on the eMAR or eTAR from Resident #3's hospital discharge. -She was not aware the staff were not completing the treatment order for Resident #3. -Her expectation was for all treatments to be implemented according to the residents' orders. Interview with SCUC on 05/10/24 at 6:23pm revealed: -She did not know Resident #3 was not receiving the treatment order for her foot from the hospital discharge on 05/03/24. -The RCC was routinely responsible for medication audits, but she was not sure if they were completed since the RCC no longer was employed at the facility. -She was not sure who was responsible for receiving orders after a resident returned to the facility from the ER when the BOM was not present. b. Review of Resident #3's signed physician orders dated 02/08/24 revealed there was an order to check fingerstick blood sugar (FSBS) three times daily before each meal and at bedtime. Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for check FSBS three times daily before each meal and at bedtime. -FSBS was scheduled to be checked at 6:30am,	D 276		

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D 276	Continued From page 23 11:30am and 4:30pm, and then at bedtime 7:00pm. -There were 6 of 124 opportunities in March 2024 when no FSBS was documented as checked. -Examples of missed FSBS checks included on 03/03/24 at 7:00pm, on 03/18/24 at 4:30pm, on 03/22/24 at 4:30pm, and on 03/24/24 at 4:30pm. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for check FSBS three times daily before each meal and at bedtime. -FSBS was scheduled to be checked at 6:30am, 11:30am and 4:30pm, and then at bedtime 7:00pm. -There were 6 of 124 opportunities in April 2024 when no FSBS was documented as checked. -Examples of missed FSBS checks included on 04/01/24 at 7:00pm, on 04/06/24 at 11:30am and 4:30pm, on 04/9/24 at 6:30am, and on 04/16/24 at 6:30am. Interview with Resident #3's primary care provider (PCP) on 05/10/24 at 10:09am revealed: -She was not aware Resident #3 was sent to a local ER and returned on 05/03/24 until 05/07/24 when she visited the facility for a non-routine visit. -The order from the hospital visit summary on 05/03/25 should have been on the resident's eTAR. -She expected the treatment order for soaking the foot to be started as ordered. -Without implementation of the order the resident could develop further infection or develop sepsis. Attempted telephone interview with the Resident Care Coordinator (RCC) on 05/10/24 at 2:00pm was unsuccessful. Refer to the interview with a morning medication	D 276		

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D 276	Continued From page 24 aide (MA) on 05/09/24 at 11:00am. Refer to the interview with the Business Office Manager (BOM) on 05/10/24 at 12:00pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 5/10/24 at 4:38pm. Refer to the interview with the Administrator on 05/10/24 at 4:45pm. 2. Review of Resident #6's current FL2 dated 06/22/23 revealed diagnoses included diabetes and dementia. Review of Resident #6's signed physician orders dated 01/11/24 revealed there was an order for check fingerstick blood sugar (FSBS) three times daily before each meal. Review of Resident #6's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for check FSBS three times daily before each meal. -FSBS was scheduled to be checked at 6:00am, 11:00am, and 4:00pm daily. -The FSBS values ranged from 60 to 332. -There were 15 occurrences with no FSBS documented as checked. -Examples of missed FSBS checks included: On 03/20/24 at 4:00pm, from 03/21/24 to 03/24/24 at 6:00am, 11:00am, and 4:00pm, and on 03/26/24 at 6:00am. Review of Resident #6's April 2024 eMAR revealed: -There was an entry for check FSBS three times daily before each meal. -FSBS was scheduled to be checked at 6:00am,	D 276		

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D 276	Continued From page 25 11:00am, and 4:00pm daily. -The FSBS values ranged from 60 to 332. -There were 7 occurrences with no FSBS documented as checked. -Examples of missed FSBS checks included: On 04/06/24 at 11:00am and 4:00pm and on 04/10/24 at 11:00am and 4:00pm. Review of Resident #6's May 2024 eMAR from 05/01/24 to 05/10/24 revealed: -There was an entry for check FSBS three times daily before each meal. -FSBS was scheduled to be checked at 6:00am, 11:00am, and 4:00pm daily. -The FSBS values ranged from 72 to 380. -On 05/08/24 at 4:00pm, there was no FSBS documented. Interview with Resident #6's PCP on 5/09/24 at 9:20am revealed: -She would have wanted to be made aware of missed FSBS checks in a timely manner. -The Administrator told her that she would be notified within "one month" of errors/concerns. -High levels of blood sugar could lead to organ failure in the long term. -She expected all orders, including orders for FSBS, to be implemented when ordered. -If the orders were not implemented, she should be notified promptly. Attempted telephone interview with the Resident Care Coordinator (RCC) on 05/10/24 at 2:00pm was unsuccessful. Refer to the interview with a morning medication aide (MA) on 05/09/24 at 11:00am. Refer to the interview with the Business Office Manager (BOM) on 05/10/24 at 12:00pm.	D 276		

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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 276	Continued From page 26 Refer to the interview with the Special Care Unit Coordinator (SCUC) on 5/10/24 at 4:38pm. Refer to the interview with the Administrator on 05/10/24 at 4:45pm. Interview with a morning medication aide (MA) on 05/09/24 at 11:00am revealed: -The MA were responsible to administer medications and implement orders as they appeared on the eMARs and eTARs. -The MAs did not enter orders on the eMARs or the eTARs. -The former RCC or the SCUC routinely checked behind MAs by auditing the eMARs for missed documentation of FSBS and treatments. -She was not sure who was auditing the eMARs since the RCC left a few weeks ago. Interview with the BOM on 05/10/24 at 12:00pm revealed: -The MAs were responsible to implement all orders as they appeared on the eMAR and eTAR. -She had temporarily assumed some of the former RCC's duties until a replacement was in place. -She thought the contracted pharmacy's staff entered the orders on the eMAR and eTAR. -She did not know the RCC was responsible to enter some orders on the eTAR. -She did not know residents' orders for FSBS were not being implemented. Interview with the SCUC on 5/10/24 at 4:38pm revealed: -She had been employed at the facility since April 2024. -Staff should notify the Administrator or BOM if orders or treatments were not implemented.	D 276		

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D 276	Continued From page 27 Interview with the Administrator on 05/10/24 at 4:45pm revealed: -The facility's Nurse was the RCC for the facility. -The RCC was responsible for ensuring orders were implemented, and documented correctly on the eMARs and eTARs. -The RCC had left employment less than 2 weeks ago (04/23/24). -The RCC was responsible for auditing the eMARs for medication and treatment administration, including FSBS and orders for wound care. -The RCC had monthly reported residents were refusing medications to the PCP but she had not mentioned any residents' orders that were not implemented. -The MAs were responsible for reporting any orders or treatments not implemented to the RCC.	D 276		
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	Dietary staff will be retrained on proper place Settings by admin or designee on or before 6/1/24. Admin or designee will monitor quarterly for two quarters and ongoing.	

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D 286	Continued From page 28 failed to ensure table service included a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers for all residents and non-disposable utensils for residents in the Special Care Unit (SCU). The findings are: Review of the facility's census revealed a census of 61 residents, 39 in the Assisted Living (AL) unit and 22 in SCU. Observation of the facility's non-disposable utensils on 05/09/24 at 4:33pm revealed there were more than 61 knives, more than 61 forks, and more than 61 spoons available. 1. Observation of the AL dining room on 05/08/24 at 12:35pm revealed: -There were 32 place settings on the tables. -There was 1 place setting without a spoon or fork. -There were 4 place settings without a knife. -There were 3 place settings without a spoon. -There were 3 place settings without a fork. Interview with a personal care aide (PCA) on 05/09/24 at 8:51am revealed: -She assisted in the AL dining hall for the lunch meal service on 05/08/24 and placed silverware on the tables for residents. -All residents should have had a knife, fork, and spoon. -There was enough silverware available in the kitchen for each resident in the AL to have a knife, fork, and a spoon. -A knife, fork, and spoon were not provided at each place setting because staff were rushing with trying to get residents served.	D 286		

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D 286	Continued From page 29 Interview with 4 residents on 05/10/24 between 4:00pm and 4:25pm revealed: -One resident did not usually get a knife, a spoon, and a fork with her place setting and would like to get all 3 utensils. -A second resident did not receive a knife, a spoon, and a fork with his place setting and would like to be able to use all 3 utensils. -A third resident usually had a fork and a spoon at her place setting and found it hard to eat meats without a knife. -A fourth resident usually got a fork with her meal, but she preferred to have a fork, a spoon, and a knife. Refer to interview with a cook on 05/09/24 at 9:02am. Refer to interview with a second cook on 05/09/24 at 9:17am. Refer to interview with the Executive Director (ED) on 05/10/24 at 5:24pm. 2. Observation of the breakfast service in the Special Care Unit (SCU) on 05/08/24 at 9:30am revealed: -There were 16 residents in the dining room. -There were 16 place settings prepared for residents and none of the prepared place settings included non-disposable utensils, beverage container or a napkin. -The breakfast menu served was a boiled egg, crème of rice, toast, water and apple juice. -There were 8 residents who were given plastic disposable spoons. -There were 8 residents who were given plastic disposable forks. -There were 16 residents served beverages in	D 286		

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D 286	Continued From page 30 Styrofoam cups. Observation of the lunch service in the SCU on 05/08/24 at 12:35pm revealed: -The lunch menu served was chicken, mashed cauliflower, baked breaded tomatoes and cornbread. -There were 16 residents in the dining room. -There were 16 place settings prepared for residents and none of the prepared place settings included non-disposable utensil and a napkin. -There were 8 residents who were given non-disposable spoons and no knives or fork were provided. -There were 8 residents who were given non-disposable forks and no spoons or knives were provided. -There were three residents who were given napkins during the meal service. Observation of the breakfast service in the Special Care Unit (SCU) on 05/09/2024 at 7:30am revealed: -There were 8 residents in the dining room. -There were 8 place settings prepared for residents and none of the prepared place settings included non-disposable utensils or a napkin. -The breakfast menu served was a sausage patty, oatmeal, toast and applesauce. -There were 8 residents who were given non-disposable spoons and no knives or fork were provided. -Two residents who were given non-disposable spoons, picked up the sausage patty and ate it with their hands -The two residents who ate the sausage patty with their hands were not interviewable. -One resident said it was hard to eat the sausage with the spoon. -There were no other residents in the SCU who	D 286		

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D 286	Continued From page 31 were interviewable. Interview with a personal care aide (PCA) in the SCU on 05/09/24 at 10:25am reveal: -She did not know each place setting had to have a napkin. -She would give a napkin to residents if they needed one or would wipe their faces for them. -She did not know residents had to have non-disposable flatware and cups. -She provided residents with whatever utensils the kitchen sent with the food. -If residents needed assistance cutting their food up, the staff would do it for them. Interview with a medication aide (MA) in the SCU on 05/09/24 at 10:25 am reveal: -She was not aware the residents were supposed to have non-disposable flatware and a place setting with a napkin. -The residents used to get non-disposable flatware but for the past few months the kitchen sent plastic forks or spoons and some Styrofoam cups. -If a resident needed assistance cutting their food up, she would help them. Refer to interview with a cook on 05/09/24 at 9:02am. Refer to interview with a second cook on 05/09/24 at 9:17am. Refer to interview with the Administrator on 05/10/24 at 5:24pm. Interview with a cook on 05/09/24 at 9:02am revealed: -There were enough knives, spoons, and forks, for all residents to have a complete set of	D 286		

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D 286	Continued From page 32 silverware in the AL and SCU. -He did not know all residents in the AL and SCU did not have a complete set of non-disposable silverware or that plastic utensils were used in the SCU. Interview with a second cook on 05/09/24 at 9:17am revealed: -Dietary aides usually set the tables for meals. -Dietary aides called off from work and PCAs had been assisting with setting the tables. -There were enough knives, spoons, and forks for each resident in the AL and SCU to receive a complete set of silverware. -He did not know residents were eating with non-disposable utensils in the SCU. -The PCAs should have known to set the tables with a knife, spoon, and fork. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -There should have been a spoon, fork, knife, 3 beverage cups, a coffee cup, and a napkin on the table for each resident in the AL and SCU. -She did not know all residents did not receive a full set of silverware or that some residents in the SCU were provided plastic utensils to eat with.	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	Dietary staff will be retrained on or Before 6/1/24 on diet orders and Menu variation by Admin or designee. Admin or designee will monitor monthly For two months and ongoing	

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D 296	Continued From page 33	D 296		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for 6 of 6 (#3, #6, #9, #10, #11, and #12) sampled residents who had physician's orders for a no concentrated sweets (NCS) diet (#3, #6, and #12), a NCS diet chopped diet (#11), a no added salt (NAS) chopped diet (#10), and a pureed diet (#9).

The findings are:

1. Review of Resident #3's current FL2 dated 11/09/23 revealed:
-Diagnoses included diabetes mellitus.
-There was no diet order.

Review of Resident #3's diet order sheet dated 04/30/24 revealed an order for a no concentrated sweets (NCS) diet.

Review of the facility's undated therapeutic diet list posted on the wall in the kitchen on 05/09/24 revealed Resident #3 was be served a NCS diet

Review of the facility's menus revealed there were no therapeutic diet menus available for a NCS diet.

Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served.

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D 296	Continued From page 34 Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #3 was served chicken, mashed cauliflower, breaded tomatoes, cornbread, fat free ice cream, and coffee. -Resident #3 ate 10% of her meal. Based on observation of the lunch meal service on 05/08/24, it could not be determined if Resident #3 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Interview with Resident #3 on 05/10/214 at 4:01pm revealed: -She was diabetic, but she was served the same meals as the other residents. -She was served the same desserts as other residents, but she received unsweetened tea. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. 2. Review of Resident #6's current FL2 dated 06/22/23 revealed: -Diagnoses included diabetes and dementia. -There was no diet order. Review of Resident 6's diet order sheet dated 04/30/24 revealed an order for a no concentrated sweets (NCS) diet.	D 296		

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D 296	Continued From page 35 Review of the facility's undated therapeutic diet list posted on the wall in the kitchen on 05/09/24 revealed Resident #6 was to be served a NCS diet. Review of the facility's menus revealed there were no therapeutic diet menus available for a NCS diet. Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served. Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #6 was served chicken, mashed cauliflower, breaded tomatoes, cornbread, fat free ice cream, and coffee. -Resident #6 ate 100% of his meal. Based on observation of the lunch meal service on 05/08/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Review of the facility's daily menu for the breakfast meal service on 05/09/24 for regular diets revealed oatmeal, fresh whole apple, sausage patty, peach pancakes, margarine, syrup, coffee, milk, and apple juice were to be served. Observation of the breakfast meal service on 05/09/24 between 7:35am and 8:40am revealed: -Resident #6 was served a sausage patty, toast,	D 296		

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D 296	Continued From page 36 oatmeal, unsweetened apple sauce, and juice. -Resident #6 consumed 95% of his meal. Based on observation of the breakfast meal service on 05/09/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Interview with Resident #6 on 05/10/214 at 4:01pm revealed: -He was not on a special diet, but he was diabetic. -He was served the same meals as the other residents including the same desserts and sweetened beverages. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. 3. Review of Resident #9's current FL2 dated 08/10/23 revealed: -Diagnoses included cerebral palsy and dysphagia. -There was no diet order. Review of Resident 9's diet order sheet dated 04/30/24 revealed an order for a pureed diet and nectar thickened liquids. Review of the facility's undated therapeutic diet	D 296		

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D 296	Continued From page 37 list posted on the wall in the kitchen on 05/09/24 revealed Resident #9 was be served a pureed diet. Review of the facility's menus revealed there were no therapeutic diet menus available for a pureed diet. Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served. Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #9 was served a pureed white food item, a pureed brown food item, a pureed tan food item, a pureed green food item, and nectar thickened water. -Resident #9 ate 100% of her meal. Based on observation of the lunch meal service on 05/08/24, it could not be determined if Resident #9 was served the appropriate therapeutic diet due to no pureed diet menu available for staff guidance. Review of the facility's daily menu for the breakfast meal service on 05/09/24 for regular diets revealed oatmeal, fresh whole apple, sausage patty, peach pancakes, margarine, syrup, coffee, milk, and apple juice were to be served. Observation of the breakfast meal service on 05/09/24 between 7:35am and 8:40am revealed: -Resident #9 was served pureed oatmeal, vanilla pudding, thickened water, and nectar thickened	D 296		

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D 296	Continued From page 38 coffee. -Resident #9 consumed 100% of her meal. Based on observation of the breakfast meal service on 05/09/24, it could not be determined if Resident #9 was served the appropriate therapeutic diet due to no pureed diet menu available for staff guidance. Observation of the kitchen on 05/10/24 at 4:41pm revealed: -There was a bag of shredded lettuce, a bag of uncooked shredded carrots, and a bag of uncooked purple cabbage sitting on a counter. -Lettuce, carrots, and purple cabbage had been blended in a food processor with water. -There were visible chunks of lettuce, carrots, and purple cabbage. -The mixture had the appearance of slaw rather than a pureed food item. Interview with a cook on 05/09/24 at 4:41pm revealed: -She pureed salad for Resident #9 in a food processor for the dinner meal. -She did not know that raw foods were not able to be pureed. -She had not seen a menu for a pureed diet. -She pureed food items from the regular menu for Resident #9 and did not know if there were foods that could or could not be pureed because she did not have a pureed diet menu. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on	D 296		

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D 296	Continued From page 39 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. 4. Review of Resident #10's current FL2 dated 08/10/23 revealed: -Diagnoses included dementia, dysphagia, muscle weakness, and cognitive communication deficit. -There was no diet order. Review of Resident 10's diet order sheet dated 04/30/24 revealed an order for a no added salt (NAS) diet chopped. Review of the facility's undated therapeutic diet list posted on the wall in the kitchen on 05/09/24 revealed Resident #10 was to be served a NAS diet chopped. Review of the facility's menus revealed there were no therapeutic diet menus available for NAS diet chopped. Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served. Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #10 was served chicken cut into 1-inch portions, mashed cauliflower, breaded tomatoes, and milk. -Resident #10 ate 75% of her meal. Based on observation of the lunch meal service	D 296		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIEDMONT CHRISTIAN HOME	1510 DEEP RIVER ROAD HIGH POINT, NC 27265

(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 296	Continued From page 40 on 05/08/24, it could not be determined if Resident #10 was served the appropriate therapeutic diet due to no NAS diet chopped menu available for staff guidance. Review of the facility's daily menu for the breakfast meal service on 05/09/24 for regular diets revealed oatmeal, fresh whole apple, sausage patty, peach pancakes, margarine, syrup, coffee, milk, and apple juice were to be served. Observation of the breakfast meal service in the Special Care Unit (SCU) on 05/09/24 between 7:30am and 8:30am revealed: -Resident #10 was served chopped sausage, oatmeal, toast, applesauce and apple juice. -Resident #10 consumed 75% of her meal. Based on observation of the breakfast meal service on 05/09/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no NAS diet chopped menu available for staff guidance. Based on observations, interviews, and record reviews, it was determined Resident #10 was not interviewable. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm.	D 296		

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D 296	Continued From page 41 5. Review of Resident #11's current FL2 dated 11/29/23 revealed: -Diagnoses included dementia, hypothyroidism, hyperlipidemia, hypertension, and dysphagia. -There was no diet order. Review of Resident #11's diet order sheet dated 04/30/24 revealed an order for a no concentrated sweets (NCS) diet chopped. Review of the facility's undated therapeutic diet list posted on the wall in the kitchen on 05/09/24 revealed Resident #11 was on the list for NCS and chopped diet. Review of the facility's menus revealed there were no therapeutic diet menus available for a NCS diet chopped. Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served. Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #11 was served chicken cut into 1-inch portions, mashed cauliflower, breaded tomatoes, coffee, fat free ice cream, coffee, and tea. -Resident #11 ate 80% of her meal. Based on observation of the lunch meal service on 05/08/24, it could not be determined if Resident #11 was served the appropriate therapeutic diet due to no NCS diet chopped menu available for staff guidance.	D 296		

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D 296	Continued From page 42 Review of the facility's daily menu for the breakfast meal service on 05/09/24 for regular diets revealed oatmeal, fresh whole apple, sausage patty, peach pancakes, margarine, syrup, coffee, milk, and apple juice were to be served. Observation of the breakfast meal service on 05/09/24 between 7:35am and 8:40am revealed: -Resident #11 was served chopped sausage, oatmeal, toast, applesauce and apple juice. -Resident #11 consumed 75% of her meal. Based on observation of the breakfast meal service on 05/09/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no NCS diet chopped menu available for staff guidance. Interview with Resident #11 on 05/09/24 at 4:17pm revealed: -She did not think she was on a special diet. -She was served the same meal as the other residents. -Staff did not chop meat for her, but her meat was chopped for the breakfast meal on 05/09/24. -She chopped her own meat if she needed to. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm.	D 296		

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D 296	Continued From page 43 6. Review of Resident #12's current FL2 dated 10/02/23 revealed: -Diagnoses included diabetes mellitus. -There was no diet order. Review of Resident 12's diet order sheet dated 04/30/24 revealed an order for a no concentrated sweets (NCS) diet chopped. Review of the facility's undated therapeutic diet list posted on the wall in the kitchen on 05/09/24 revealed Resident #12 was to be served a NCS diet. Review of the facility's menus revealed there were no therapeutic diet menus available for a NCS diet chopped. Review of the facility's week at a glance menu for the lunch meal service on 05/08/24 for regular diets revealed baked chicken, garlic mashed cauliflower, breaded tomatoes, cornbread, margarine, assorted ice cream, milk, and coffee were to be served. Observation of the lunch meal service on 05/08/24 between 12:30pm and 1:30pm revealed: -Resident #12 was served chicken, mashed cauliflower, breaded tomatoes, and unsweetened tea. -Resident #12 ate 100% of his meal. Based on observation of the lunch meal service on 05/08/24, it could not be determined if Resident #12 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Review of the facility's daily menu for the breakfast meal service on 05/09/24 for regular	D 296		

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D 296	Continued From page 44 diets revealed oatmeal, fresh whole apple, sausage patty, peach pancakes, margarine, syrup, coffee, milk, and apple juice were to be served. Observation of the breakfast meal service on 05/09/24 between 7:35am and 8:40am revealed: -Resident #12 was served chopped sausage, oatmeal, toast, and applesauce and apple juice. -Resident #12 consumed 50% of his meal. Based on observation of the breakfast meal service on 05/09/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Based on observations, interviews, and record reviews, it was determined Resident #12 was not interviewable. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 4:41pm. Refer to the interview with a third cook on 05/09/24 at 4:41pm. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. Interview with a cook on 05/09/24 at 9:02am revealed: -He prepared all residents' meals using the regular menus. -He had not seen any therapeutic menus. -He did not cook meals with salt and did not add any sugar to his meals.	D 296		

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D 296	Continued From page 45 -He usually chopped the meat in the food processor and added water and thickener as needed to the pureed food items. -He did not know who was responsible for ensuring menus were available for staff guidance when preparing meals. Interview with a second cook on 05/09/24 at 9:17am revealed: -He used the regular menu to prepare all residents' meals. -He chopped the meats in the food processor for residents who had orders for chopped; chopped meats were to be bite-sized. -For residents who had orders for NAS, he did not give salt at the table. -For residents who had orders for NCS, he provided sugar free options and if sugar free options were not available, he served a half serving of dessert and a half serving of bread. -He had not been provided a therapeutic menu for therapeutic diets for guidance in preparing their meals. -He was trained by the former Dietary Manager. Interview with a third cook on 05/09/24 at 4:41pm revealed: -She served all residents according to the regular menu. -She made no changes to any of the food items on the regular menu except she pureed meals for the resident who had a pureed diet. -She did not chop any food items for any of the residents. -She had not seen a therapeutic diet list until 05/09/24; she was told by other dietary staff that it was posted in the kitchen on 05/08/24. -She had not been properly trained to prepare meals for the residents.	D 296		

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D 296	Continued From page 46 Interview with the Administrator on 05/10/24 at 5:24pm revealed: -The DM was responsible for ensuring there were therapeutic diet menus in the facility. -She currently did not have a dietary manager. -She thought the former DM had therapeutic menus in place and dietary staff were using them. -She did not know therapeutic diet menus were not available and not being used for staff guidance in preparing meals. -She expected for the menus to be available and for dietary staff to use them.	D 296		
D 297	10A NCAC 13F .0904(d)(1) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there were at least 10 hours between the breakfast and dinner meals. The findings are: Interview with the former Dietary Manager (DM) on 03/21/24 at 10:35am revealed:	D 297	Dietary staff will be retrained On meal times by admin And/or designee on or before 6/1/24. Admin or designee will Monitor meal times monthly For three months ongoing.	

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D 297	Continued From page 47 -The kitchen staff consisted of the former DM, two cooks, and three dietary aides. -The kitchen cook did not report for work on 03/11/24. -The former DM came in to serve breakfast to residents on 03/11/24 at 8:00 am. -Breakfast was to be served at 7:00am and dinner at 5:00pm, in accordance with the facility's meal schedule. -He was not aware there should have been 10 hours between the breakfast and dinner meals. -On 03/11/24, breakfast was served at 8:30am and dinner was served at 5:00pm allowing 8.5 hours between the breakfast and dinner meal service instead of at least 10 hours between meals. -The cook failed to report to work as scheduled on 03/21/24 and breakfast was served at 8:30am. Interview with the Resident Care Coordinator (RCC) on 03/21/24 at 10:30am revealed: -On 3/11/24, the opening cook was supposed to come in at 6:00am; but he did not show up for work. -The RCC received a text from the former DM at 7:37am on 03/11/24 that he was going in to open the kitchen. -Breakfast began around 8:30am on 03/11/24. -Dinner was served at 5:00pm on 03/11/24. -She was aware there should have been 10 hours between the breakfast and dinner meals. Interview with a medication aide (MA) on 03/21/24 at 10:42am revealed: -She assisted with late breakfast served on 03/11/24 and 03/21/24. -Breakfast was served at 8:30 am on 03/11/24 and 03/21/24. -She recalled no other times that breakfast had been late this month.	D 297		

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D 297	Continued From page 48 -Dinner was served at 5:00pm on 03/11/24. Interview with a resident on 03/21/24 at 11:09am revealed: -Breakfast was late often and was usually served after 8:00 am. -Breakfast was late on 03/21/24 and was served at 8:30am. -Dinner was served at 5:00 pm on 03/11/24. Interview with a second resident on 03/21/24 at 11:15am revealed: -Breakfast was served late after 8:00am on 03/21/24. -She did not usually eat breakfast because she would have to get up at 6:30am. -Breakfast was also served late the week prior to 03/21/24, however, she could not recall the day/date. -Dinner was served at 5:00 pm. -Dinner was served at 5:00 on 03/11/24. Interview with a third resident on 03/21/24 at 11:22am revealed: -Breakfast was always served late. -Breakfast did not arrive to her room until after 10:00 am on 03/21/24. -Dinner was normally served at 5:00 pm. Interview with a fourth Resident on 03/21/24 at 11:30am revealed: -Breakfast had been late on several occasions; however, he could not recall specific dates. -Dinner was normally served at 5:00 pm. Interview with a fifth Resident on 03/21/24 at 12:15pm revealed: -Breakfast and other meals were always late. -Late breakfast times vary between 8:30 am and 10:00 am.	D 297		

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D 297	Continued From page 49 -On 03/11/24, breakfast was served at 8:30 am. Observation on 03/21/24 at 5:00 pm revealed dinner was served at 5:00pm. Interview with a MA on 04/02/24 at 9:29am revealed: -Breakfast should be served at 7:00am. -Breakfast usually started late around 7:30am or later. -She believed breakfast began later due to residents not being up. -She was not present on 03/11/24 when breakfast began late but she was aware it occurred. Interview with housekeeping staff on 04/02/24 at 10:33am revealed breakfast was late on 03/29/24 because there was no staff present in the kitchen until 9:00am. Interview with a sixth Resident on 04/02/24 at 10:42am revealed: -Breakfast was served at 10:00am on 03/29/24. -Dinner was served at 5:00pm. Interview with personal care aide (PCA) on 04/02/24 at 10:48am revealed: -Breakfast was normally served between 7:30am and 8:00am. -One day last week (not specified); breakfast was served at 10:00am due to a lack of kitchen staffing. -Dinner was served at 5:00pm. Interview with a cook on 04/02/24 at 12:38 pm revealed: -Breakfast was usually served between 7:00am-7:30am. -She came in at 6:00am on scheduled days to prepare meals.	D 297		

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D 297	Continued From page 50 -Breakfast was not often late. -She was unable to speak to allegations of late serving times. -Dinner was served at approximately at 5:00pm each day. Observation of the breakfast meal service in the assisted living dining room on 05/08/24 from 8:45am to 9:00am revealed: -Residents were sitting at the table awaiting breakfast to be served. -The first resident was served breakfast at approximately 8:55am. Interview with a second cook on 05/08/24 at 9:00am revealed: -This was his third day of employment at the facility. -He was unable to get into the locked kitchen area to prepare breakfast until 7:30am and 8:00am. -He had no dietary aides to provide assistance.	D 297		
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: (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	Dietary staff will Be educated and retrained on Proper milk servings at meals by Admin or designee on or before 6/1/24 Admin and or designee monitoring and ongoing.	

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D 299	Continued From page 51	D 299		

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to residents in the Assisted Living (AL) and Special Care Unit (SCU).

The findings are:

Review of the facility's census revealed a census of 61 residents, 39 in AL and 22 in SCU.

Review of the facility's daily menu for 05/08/24 and 05/09/24 revealed:
-Milk was listed to be served for the breakfast, lunch, and dinner meal service.
-There were no equivalent dairy products listed on the menu to be served on 05/08/24 or 05/09/24.

Observation of the kitchen on 05/08/24 revealed there were 14 unopened gallons of milk and 2 gallons of milk that had been opened in the reach-in refrigerators.

1. Observation of the lunch meal service in the AL on 05/09/24 between 12:30pm and 1:30pm revealed:
-There were 28 residents present in the dining room.
-All residents were served coffee.
-At 1:02pm, after some of the residents had eaten their meals, staff went around and asked residents if they wanted tea.
-No residents were offered or served milk.

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D 299	Continued From page 52 Interview with a personal care aide (PCA) on 05/09/24 at 8:51am revealed: -She served beverages to residents in the AL during the lunch meal service on 05/08/24 and the breakfast meal service on 05/09/24. -Milk was not served to residents during lunch on 05/08/24 or breakfast on 05/09/24. -The dietary staff prepared the beverage cart and the PCAs served the beverages. -If milk was not on the beverage cart, it was not served to residents. -Milk was usually only served with the breakfast meal. -She did not know milk was on the menu to be served with each meal. -She had not been told to serve any other dairy products in place of milk. Interview with a cook on 05/09/24 at 9:02am revealed: -The PCAs served beverages to the residents for the lunch meal on 05/08/24 and the breakfast meal on 05/09/24. -He did not know milk was not served in the in the AL or SCU for the lunch meal on 05/08/24 or for the breakfast meal on 05/09/24. -Milk should have been served at each meal. Interview with a second cook on 05/09/24 at 9:17am revealed: -It was chaotic on 05/08/24 in the kitchen because the dietary aide did not show up to work for the breakfast meal. -Milk was on the menu to be served with breakfast, lunch, and dinner daily. -He did not know SCU residents were not served milk and AL residents were not offered or served milk with the lunch meal on 05/08/24. Interview with 4 residents on 05/10/24 between	D 299		

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D 299	Continued From page 53 4:00 and 4:25pm revealed: -One resident was not offered milk 3 times daily with each meal. -A second resident was not offered milk 3 times daily with each meal, but he would drink milk if it was offered to him. -A third resident was not offered milk 3 times daily with each meal, but she would drink milk if it was offered to her. -A fourth resident was not offered milk 3 times daily, but was sometimes offered milk with breakfast. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. 2. Observation of the breakfast service in the Special Care Unit (SCU) on 05/08/24 at 9:30am revealed: -There were 16 residents in the dining room. -There were 16 residents who were not served milk. Observation of the breakfast service in the SCU on 05/09/24 at 7:45am revealed: -There were 17 residents in the dining room. -There were 17 place settings prepared for residents. -None of the prepared place settings included milk. -Milk was offered to 12 of 17 residents during the meal service. -Four residents had completed their meal before milk was offered. Interview with a personal care aide (PCA) in the SCU on 05/09/24 at 10:25am revealed: -She did not know milk and one other beverage should be served at each meal. -She did not know residents in the SCU should	D 299		

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D 299	Continued From page 54 have milk set on front of them at the beginning of each meal. -No one every told her to offer the milk to the resident verses setting it in front of them. Interview with a medication aide (MA) in the SCU on 05/09/24 at 10:25am revealed: -She thought staff only had to offer milk to the residents. -She did not know people with dementia should have the milk sat in front of them at each meal. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:36pm revealed: -She knew milk should have been served with each meal to residents in the SCU. -She did not know milk was not served with the lunch meal service on 05/08/24 or with the breakfast meals service on 05/09/24. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -The Dietary Manager (DM), a cook, and a dietary aide resigned this week. -She expected milk to be offered to all residents in the AL. -She expected milk to be served, and not just offered to the resident in the SCU during each meal. -She did not know milk was not offered or served to each resident in the AL and the SCU.	D 299		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 306		

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D 306	Continued From page 55 (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure water was served in addition to other beverages to each resident in the Assisted Living (AL) and Special Care Unit (SCU). The findings are: Review of the facility's census revealed a census of 61 residents, 39 in AL and 22 in SCU. Review of the facility's daily menu for 05/08/24 and 05/09/24 revealed water was not listed to be served with breakfast, lunch, or dinner. 1. Observation of the lunch meal service in the AL on 05/08/24 between 12:30pm and 1:30pm revealed: -There were 28 residents present in the dining room. -All residents were served coffee. -At 1:02pm, after some of the residents had eaten their meals, staff went around and asked residents if they wanted tea. -One resident who had a physician's order for thickened liquids was served thickened water. -No other residents were served water. Observation of the breakfast meal service in AL on 05/09/24 between 7:35am and 8:40am	D 306	Dietary staff will be Retrained on serving water at mealtime On or before 6/1/24. Admin and or designee Will monitor routinely and ongoing.	

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D 306	Continued From page 56 revealed: -There were 21 residents present in the dining room. -Staff pushed a beverage carton throughout the dining room which contained milk, coffee, and apple juice. -All residents were served apple juice and offered milk. -One resident who had a physician's order for nectar thickened liquids was served nectar thickened water. -No other residents were served water. Interview with a personal care aide (PCA) on 05/09/24 at 8:51am revealed: -She served beverages to residents in the AL during the lunch meal service on 05/08/24 and the breakfast meal service on 05/09/24. -She knew water should have been served to residents at each meal. -She did not realize water was not served to residents during the lunch meal on 05/08/24 or the breakfast meal on 05/09/24. -Water was usually already on the table when she came in the dining hall to assist with serving residents. -She usually assisted with serving plates, but the kitchen was short staffed, so she assisted with serving beverages on 05/08/24 and 05/09/24. -The dietary staff prepared the beverage cart and the PCAs served the beverages. -She did not think about asking the dietary staff for water to serve the residents. Interview with 3 residents between 4:00pm and 4:25pm revealed: -One resident was not always served water with each meal, but she would drink water with each meal if it was served. -Another resident did not get water with each	D 306		

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D 306	Continued From page 57 meal and had to ask for it; he would drink water with each meal if it was served. -A third resident was not served water with each meal and sometimes had to ask for it; she would drink water with each meal if it was served. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 9:17am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. 2. Observation of the breakfast service in the Special Care Unit (SCU) 05/08/24 at 9:30am revealed: -There were 16 residents in the dining room. -There were 16 residents served water. Observation of lunch the service in the SCU on 05/08/24 at 12:35pm revealed: -There were 16 residents in the dining room. -There were 16 place settings prepared for residents and none of the prepared place settings included water. -There were 16 residents who were not served water during the meal service. -One resident began to cough and requested and received water. Observation of the breakfast service in the SCU on 05/09/24 at 7:45am revealed: -There were 17 place settings prepared for residents and none of the prepared place settings included water. -There were 17 residents who were not served water during the meal service.	D 306		

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D 306	Continued From page 58 Interview a personal care aide (PCA) in the SCU on 05/09/24 at 10:25am reveal: -She did not know water should be served at each meal. -She did not know residents in the SCU should have beverages set on front of them at the beginning of each meal. -She thought it was "okay" to just offer the beverage to the resident verses setting it in front of them. -She did not think about all beverages being placed on front of them because of their dementia diagnosis. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:36pm revealed: -She knew water should have been served with each meal to residents in the SCU. -She did not know water was not served with the lunch meal service on 05/08/24 or with the breakfast meals service on 05/09/24. Refer to the interview with a cook on 05/09/24 at 9:02am. Refer to the interview with a second cook on 05/09/24 at 9:17am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. Interview with a cook on 05/09/24 at 9:02am revealed: -The PCAs served beverages to the residents for the lunch meal on 05/08/24 and the breakfast meal on 05/09/24. -He did not know water was not served in the in the AL or SCU for the lunch meal on 05/08/24. -He put apple juice, coffee, and milk on the beverage cart to be served for the breakfast meal	D 306		

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D 306	Continued From page 59 on 05/09/24. -He forgot to put water on the beverage cart. -Water should have been placed on the tables for all residents at each meal. Interview with a second cook on 05/09/24 at 9:17am revealed: -It was chaotic on 05/08/24 in the kitchen because the dietary aide did not show up to work for the breakfast meal. -Water should have been served to all residents in the AL and SCU with each meal. -He did not know SCU and AL residents were not served water with the lunch meal service on 05/08/24 or with the breakfast meal service on 05/09/24 or why it was not served. -The dietary staff usually prepared the beverage cart. -He did not know why water was not served with the breakfast meal and lunch meal. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -The Dietary Manager (DM), a cook, and a dietary aide resigned this week. -She expected water to be placed on the table for each resident during each meal. -She did not know water was not placed on the table for each resident in the AL and the SCU during the lunch meal on 05/08/24 and the breakfast meal on 05/09/24.	D 306		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338	Staff will be retained by admin and or designee On resident rights on or before 6/1/24 Admin or designee will monitor routinely And ongoing.	

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D 338	Continued From page 60	D 338		

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents were treated with consideration, respect, dignity, and full recognition of his or her individuality and right to privacy related to female and male residents residing in bedrooms sharing adjoining bathrooms.

The findings are:

Observation of the Special Care Unit (SCU) on 05/10/24 between 11:20am and 11:50am revealed:
-There were 2 female residents in a room (#206) who shared a connecting bathroom with 2 male residents who resided in a room (#207) on the other side of the bathroom.
-There were 2 female residents in room (#212) who shared a connecting bathroom with 1 male resident who resided in a room (#211) on the other side of the bathroom.
-There were 2 doors in the bathroom, one giving access to the female residents and the other giving access the male residents.
-The bathroom doors locked from the inside of the bathroom, but the doors did not lock on the inside of the residents' rooms.

Interview with a medication aide (MA) in the SCU on 05/10/24 at 11:25am revealed:
-When one of the female residents in room #206 could not get into the shared bathroom because the door was locked from the inside, she went through the males' room #207 to get into the bathroom.
-She did not know if the bathroom doors stayed opened or closed between the rooms to give the

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D 338	Continued From page 61 female residents and male residents privacy while in the bathroom and while in their rooms. Interview with one of the female residents who resided in room #206 on 05/10/24 at 11:32am revealed: -She did not like sharing a bathroom with 2 males. -Sometimes the males did not flush the toilet, urinated on the floor, and had tissue paper on the floor. -She did not like that the door locked from the inside of the bathroom and that the male residents had access to her room from the bathroom. -She tried to keep the bathroom door closed on her side of the room. Interview with a family member of one of the female residents who resided in room #206 revealed: -The facility staff changed the resident's room and did not tell her they were changing the room. -She did not know that the resident was sharing a common bathroom with male residents who resided in the room on the other side of the bathroom. -The female resident would not know to close or lock the bathroom door when she used it. Interview with one of the male residents who resided in room #207 on 05/10/24 at 11:37am revealed: -He did not like sharing a bathroom with female residents. -The females should have their own bathroom so that it would be sanitary. -Sometimes his roommate went into the bathroom and urinated all over the floor and the female residents did not like that.	D 338		

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D 338	Continued From page 62 -Sometimes, one of the female residents did not lock the bathroom door and his roommate walked in on the female resident. -Sometimes, the female resident left the door open when she used the bathroom. -Sometimes both doors to the shared bathroom were open during the day and night. -The doors only locked from the inside of the bathroom. Interview with a family member of one of the female residents in room #212 on 05/10/24 at 11:47am revealed: -The resident did not like sharing a bathroom with a male resident. -Sometimes the resident locked the door when she used the bathroom and sometimes, she did not. -She was afraid the male resident was going to walk in on the resident while she was using the bathroom. -The resident had walked in on the male resident before. Interview with one of the female residents who resided in room #212 on 05/10/24 at 11:56am revealed: -"There was a man on the other side of the bathroom." -She preferred to share a bathroom with a woman. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 6:05pm revealed she did not know there were male residents and female residents who shared a common bathroom between their rooms. Interview with the Administrator on 05/10/24 at 5:24pm revealed:	D 338		

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D 338	Continued From page 63 -She did not know there were male residents and female residents sharing a bathroom with access to each other's rooms. -The night staff moved residents' rooms without management's knowledge or consent. -She told staff to stop moving residents' rooms. -Male and female residents should not share adjoining bathrooms.	D 338		
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 interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 3 of 6 sampled residents (Resident #6, #3, and #2) related to sliding scale insulin (SSI) (#6, #3), and an allergy, cholesterol, anti-seizure, anti-depressant, anti-anxiety, and mood stabilizer medications (#2). The findings are: 1. Review of Resident #6's current FL2 dated 06/22/23 revealed: -Diagnoses included diabetes and dementia.	D 358	MAR's will be audited by admin Or designee weekly for three weeks, Monthly for two months and then quartley For two quarters by admin or designee. Any Issues found with Medication administration will be Addressed immediately. To begin on 6/24/24	

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D 358	Continued From page 64 -There was an order for Humalog (a rapid acting insulin used to lower elevated blood sugar levels) 100units/ml subcutaneously 3 times a day using sliding scale insulin (SSI): 0-200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than 450 notify physician (MD). Review of Resident #6's signed physician orders dated 01/11/24 revealed there was an order for Humalog Kwikpen 100 units/ml, check fingerstick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. Review of Resident #6's April 2024 eMAR revealed: -There was an entry for Humalog Kwikpen 100 units/ml, check FSBS three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. -Humalog SSI was scheduled for administration at 6:00am, 11:30am, and 4:00pm daily. -The FSBS values ranged from 60 to 332. -There were 7 doses of Humalog documented as "faxed and called pharmacy to deliver stat" documented on the eMAR. -Examples of missed FSBS values and Humalog administration documented as faxed and called pharmacy to deliver stat included: On 04/09/24 at 11:45am and 4:00pm; on 04/19/24 at 6:00am, 11:30am, and 4:00pm; and on 04/20/24 at 6:00am. Review of Resident #6's May 2024 eMAR from 05/01/24 to 05/10/24 revealed:	D 358		

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D 358	Continued From page 65 -There was an entry for Humalog Kwikpen 100 units/ml, check finger stick blood sugar (FSBS) three times daily before each meal and inject per SSI: 0-150= 0 units, 151-200= 4 units, 201-250 = 8 units, 251-300 = 12 units, 301-350 = 16 units, 351-400 = 18 units, 401-450= 22 units, greater than 450 notify MD. -Humalog SSI was scheduled for administration at 6:00am, 11:30am, and 4:00pm daily. -The FSBS values ranged from 72 to 380. -On 05/04/24 at 11:30am, Humalog SSI was documented as not administered for the reason "withheld per doctor's orders".. Review of Resident #6's record revealed there was one Hemoglobin A1C (HgbA1C) value (a laboratory value use to measure blood sugar concentration over an extended period time) of 10.6 documented for a test result dated 01/17/24. According to the Centers for Disease Control and Prevention a HgbA1C value of less than 5.7 is normal and higher values increase risk for long-term organ damage. Telephone interview with a representative from the facility's contracted pharmacy on 05/10/24 at 3:57pm revealed: -On 12/10/23, Resident #6 was dispensed 5 Humalog Kwikpen with each containing 300 units of insulin. -On 03/21/24, Resident #6 was dispensed 5 Humalog Kwikpen with each containing 300 units of insulin. -How long each pen lasted was determined by the amount of SSI administered with each dose up to the 300 units or 28 days after first using the Kwikpen. Observation of Resident #6's medication on hand	D 358		

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D 358	Continued From page 66 for administration on 05/09/24 at 12:20pm revealed Resident #6 had a partial Humalog Kwikpen 100u/ml used to administer Humalog SSI labeled as opened on 04/21/24. Interview with Resident #6's primary care provider (PCP) on 05/09/24 at 11:05am revealed: -She had been his PCP from since around March 2024. -She did not know Resident #6 had multiple undocumented doses of Humalog SSI. -The facility should be administering Resident #6's Humalog SSI as ordered. -The facility's Nurse was filling out a cover sheet and attaching to the printed eMAR for residents, and stacking the sheet and eMARs in a big stack for her to review when she came to the facility on her routine weekly visit. -She would have wanted to be made aware of the errors, refusals or not administered for any reason, in a timely manner. -High levels of blood sugar could lead to organ failure in the long term, but several doses periodically would not have caused any detriment. Interview with Resident #6 on 05/10/24 at 3:30pm revealed: -He received his insulin most of the time. -Some medication aides (MAs) did not come to check his FSBS when they were supposed to. -He did not know if he had been out of insulin on any occasion. Interview with the Administrator on 05/10/24 at 4:45pm revealed: -The facility Nurse was the Resident Care Coordinator (RCC) for the facility. -The RCC was responsible for ensuring medications were administered on time, correctly, and documented correctly on the eMARs.	D 358		

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D 358	Continued From page 67 -The RCC was responsible for auditing the eMARs for medication administration. -The RCC had left abruptly less than 2 weeks ago (04/23/24). -There were no routine audits of the eMARs for medications administered as ordered by the providers. -The RCC had not reported residents were missing administration of medications. -The MAs were responsible for reporting missed medication administration to the RCC. Second interview with the Administrator on 05/10/24 at 5:24pm revealed: -The former nurse/RCC conducted eMAR reviews monthly, but now she conducted eMAR reviews and notified the facility PCP if there were any medications not administered as ordered. -She expected MAs to follow up with the pharmacy regarding any medication issues and to administer medications as ordered. Attempted telephone interview with the RCC on 05/10/24 at 3:00pm was unsuccessful. 2. Review of Resident #3's current FL2 dated 11/9/24 revealed: -Diagnoses included dementia, right below the knee amputation, third left toe amputation, and osteomyelitis. a. Review of Resident #3's current FL2 dated 11/9/24 revealed there was an order for Humalog (a rapid acting insulin used to lower elevated blood sugar levels) 100units/ml subcutaneously 3 times a day using sliding scale insulin (SSI): less than (<) 200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than (>) or =400=10 units and notify physician (MD).	D 358		

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D 358	Continued From page 68 Review of Resident #3's signed physician orders dated 02/08/24 revealed: -There was an order to check fingerstick blood sugar (FSBS) three times daily before each meal and at bedtime. -There was an order for Humalog Kwikpen 100 units, inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and contact primary care provider (PCP). Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100 units, check FSBS three times daily before each meal and at bedtime and inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and contact MD. -Humalog SSI was scheduled for administration at 6:30am, 11:30am and 4:30pm, and then at bedtime 7:00pm. -The FSBS values ranged from 153-500. -There was one dose with the incorrect amount of Humalog SSI documented as administered. -On 03/6/24 at 7:00pm, the resident's FSBS was 355 and 8 units of SSI should have been administered but 10 units was documented as administered. -There were 5 out of 124 opportunities when there was no FSBS value documented and Humalog SSI was documented as administered. -Examples of Humalog SSI administered with no corresponding FSBS value documented included: -On 03/05/24 at 4:30pm, 14 units of Humalog SSI was documented as administered with no FSBS documented.	D 358		

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D 358	Continued From page 69 -On 03/11/24 at 4:30pm, 14 units of Humalog SSI was documented as administered with no FSBS documented. -On 03/12/24 at 4:30pm, 14 units of Humalog SSI was documented as administered with no FSBS documented. -On 03/13/24 at 4:30pm, 14 units of Humalog SSI was documented as administered with no FSBS documented. -On 03/30/24 at 4:30pm, 14 units of Humalog SSI was documented as administered with no FSBS documented. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Humalog Kwikpen 100 units, check FSBS three times daily before each meal and at bedtime and inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and MD. -Humalog SSI was scheduled for administration at 6:30am, 11:30am and 4:30pm, and then at bedtime 7:00pm. -The FSBS values ranged from 128-403. -On 04/29/24 at 11:30am, the resident's FSBS was 261 and she received 8 units when she should have received 4 units. -There were 7 out of 120 opportunities when there was no FSBS value documented and Humalog SSI was documented as administered. -Examples of Humalog SSI administered with no corresponding FSBS value documented included: -On 04/01/24 at 4:30pm, 16 units of Humalog SSI was documented as administered with no corresponding FSBS. -On 04/03/24 at 4:30pm, 16 units of Humalog SSI was documented as administered with no corresponding FSBS. -On 04/04/24 at 4:30pm, 16 units of Humalog SSI	D 358		

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D 358	Continued From page 70 was documented as administered with no corresponding FSBS. -On 04/05/24 at 4:30pm, 16 units of Humalog SSI was documented as administered with no corresponding FSBS. -On 04/09/24 at 11:30am, 14 units of Humalog SSI was documented as administered with no corresponding FSBS. Review of Resident #3's record revealed there was one Hemoglobin A1C (HgbA1C) value (a laboratory value use to measure blood sugar concentration over an extended period time) of 10.4 documented for a test result dated 04/24/24. According to the Centers for Disease Control and Prevention (CDC) a HgbA1C value of less than 5.7 is normal and higher values increase risk for long-term organ damage. Telephone interview with a representative from the facility's contracted pharmacy on 05/10/24 at 3:57pm revealed: -On 2/2/24, Resident #3 was dispensed 5 Humalog Kwikpen with each containing 300 units of insulin. -On 2/26/24, Resident #3 was dispensed 5 Humalog Kwikpen with each containing 300 units of insulin. -On 3/25/24, Resident #3 was dispensed 5 Humalog Kwikpen with each containing 300 units of insulin. -How long each pen lasted was determined by the amount of SSI administered with each dose up to the 300 units or 28 days after first using the Kwikpen. b. Review of Resident #3's current FL2 dated 11/09/23 revealed: -There was an order for Humalog (a rapid acting	D 358		

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D 358	Continued From page 71 insulin used to lower elevated blood sugar levels) 100units/ml subcutaneously 3 times a day using sliding scale insulin (SSI): less than (<) 200= 0 units, 201-250= 2 units, 251-300= 4 units, 301-350= 6 units, 351-400= 8 units, greater than (>) or =400=10 units and notify physician (MD). Review of Resident #3's signed physician orders dated 02/08/24 revealed: -There was an order to check fingerstick blood sugar (FSBS) three times daily before each meal and at bedtime. -There was an order for Humalog Kwikpen 100 units, inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and contact primary care provider (PCP). Review of Resident #3's March 2024 electronic Medication Administration Record (eMAR) revealed: - There was an entry for Humalog Kwikpen 100 units, check FSBS three times daily before each meal and at bedtime and inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and contact MD. -Humalog SSI was scheduled for administration at 6:30am, 11:30am and 4:30pm, and at bedtime 7:00pm. -There were 5 out of 124 opportunities when 10 or more units of Humalog SSI was documented as administered with no FSBS value documented for the corresponding days. -Examples of Humalog SSI greater than 10 units administered were as follows: -On 03/05/24 at 4:30pm, 14 units of Humalog SSI was documented as administered. -On 03/11/24 at 4:30pm, 14 units of Humalog SSI	D 358		

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D 358	Continued From page 72 was documented as administered. -On 03/12/24 at 4:30pm, 14 units of Humalog SSI was documented as administered. -On 03/13/24 at 4:30pm, 14 units of Humalog SSI was documented as administered. -On 03/30/24 at 4:30pm, 14 units of Humalog SSI was documented as administered. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for Humalog Kwikpen 100 units, check FSBS three times daily before each meal and at bedtime and inject per sliding scale: FSBS: <200 = 0 units, 201-250 = 2 units, 251-300 = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 400=10 units and MD. -Humalog SSI was scheduled for administration at 6:30am, 11:30am and 4:30pm, and at bedtime 7:00pm. -There were 7 out of 120 opportunities when 10 or more units of Humalog SSI was documented as administered with no FSBS values documented for the corresponding days. -Examples of Humalog SSI greater than 10 units documented as administered included: -On 04/01/24 at 4:30pm, 16 units of Humalog SSI was documented as administered. -On 04/03/24 at 4:30pm, 16 units of Humalog SSI was documented as administered. -On 04/04/24 at 4:30pm, 16 units of Humalog SSI was documented as administered. -On 04/05/24 at 4:30pm, 16 units of Humalog SSI was documented as administered. -On 04/09/24 at 11:30am, 14 units of Humalog SSI was documented as administered. Interview with Resident #3's PCP on 05/09/24 at 9:20am revealed: -She had been the resident's PCP from March 2024 to present.	D 358		

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D 358	Continued From page 73 -High levels of blood sugar could lead to organ failure in the long term, but several doses periodically would not have caused any detriment including but not limited to hypoglycemia, memory loss, metabolic issues, coma, unstable patient, and death. -She was not able to locate documentation in the PCP notes for the facility contacting the PCP for administering the additional Humalog SSI. -The Administrator informed the PCP that she would be notified within "one month" of errors/concerns. -Moving forward she was requesting the facility to notify her after 2 missed medication administrations or per SSI orders for FSBS greater than 400. Interview with Resident #3 on 05/09/24 at 12:30pm revealed she was unaware if she received incorrect doses of Humalog SSI. Interview with the Administrator on 05/10/24 at 11:50am revealed: -She was not aware Resident #3 received incorrect sliding scale insulin. -She interviewed staff about entering 0 (zero) on the eMAR for FSBS values, and administering dosage not on the SSI order. -Staff reported they received directions via telephone from the PCP, but there was no documentation or order form completed for the contact or for orders related to additional SSI documented as administered. -Audits were not being done on a regular basis until April 2024, after the RCC left employment. Interview with Resident #3 on 04/02/24 at 10:23am revealed: -She did not receive her evening medications on the night of 04/01/24.	D 358		

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D 358	Continued From page 74 -She had missed medications on more than one occasion. Interview with a medication aide (MA) on 04/02/24 at 10:48am revealed: -Medications had been missed on different occasions when she came in for a shift. -She did not administer medications showing missed by the previous shift. Interview with a second MA on 04/03/24 at 9:48am revealed: -There had been times medications were missed and she did not go back and administer if it was prior to her shift. -She did not always notify administration of residents' missed medications. -She believed the Administrator was aware of missed medications for residents. Interview with Resident #3's PCP on 05/09/24 at 9:20am revealed: -She had been her PCP from March 2024 to present. -She was not made aware of any sliding scale insulin errors for Resident #3. -She would have wanted to be made aware of the errors. -The Administrator stated that she would be notified within one month of errors/concerns. -High levels of blood sugar could lead to organ failure in the long term, but several missed doses periodically would not have caused any detriment including but not limited to hypoglycemia, memory loss, metabolic issues, coma, unstable patient, and death. Interview with a MA on 5/09/24 at 10:55am revealed when administering insulin, staff were to follow the order listed on the eMAR for SSI and if	D 358		

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D 358	Continued From page 75 needed contact the resident's provider, document on a facility form in the care notes binder and place the sheet in the resident's record. Interview with the Administrator on 05/10/24 at 11:50am revealed: -She was not aware Resident #3 received incorrect sliding scale insulin. -She interviewed staff about not documenting FSBS values and administering dosages of insulin not on the SSI order. -Staff reported that they received directions via telephone from the PCP but there was no documentation or order form completed for the contact and directives. -She did not receive a medication error report which documented when the PCP was made aware. -Audits were not being done on a regular basis until April 2024. -Her expectation was for all medications to be given according to the PCP orders. Interview with the Business Office Manager (BOM) on 05/10/24 at 12:00pm revealed: -She had temporarily assumed some of the duties of the RCC since the -She was not aware Resident #3 was given the incorrect sliding scale insulin dose according to what was ordered. -She did not receive a medication error report on Resident #3. -The Resident Care Coordinator (RCC) was responsible for medication audits, but she was not sure if they were completed. -The facility did not have a policy for missed medication administration or refusals. -Best practice was notification to the PCP after three refusals. -Best practice for missed medication	D 358		

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D 358	Continued From page 76 administration was immediate notification to the PCP. Interview with Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:38pm revealed: -She had been employed at the facility since April 2024. -She was not aware Resident #3 was given the incorrect sliding scale insulin dose according to what was ordered. -She did not receive a medication error report on Resident #3. -The RCC was responsible for medication audits, but she was not sure if they were completed. -The facility did not have a policy for missed medication administration. -Staff should contact the pharmacy for backup medications if not received after request more than 1 day. -Staff should notify the Administrator or BOM when medications were not received as requested. 3. Review of Resident #2's current FL2 dated 04/24/24 revealed diagnoses included dementia, epilepsy, goiter, and traumatic brain injury. a. Review of Resident #2's FL2 dated 01/25/24 revealed an order for loratadine (used to treat allergies) 10mg 1 tablet daily. Review of Resident #2's eMAR for March 2024 revealed: -There was an entry for loratadine 10mg 1 tablet daily scheduled for administration at 8:00am. -There was documentation loratadine was not administered for 6 of 31 opportunities on 03/13/24, 03/18/24, 03/19/24, 03/22/24, 03/28/24, and 03/29/24 due to faxed and called pharmacy to deliver.	D 358		

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D 358	Continued From page 77	D 358		

Review of Resident #2's eMAR for April 2024 revealed:
-There was an entry for loratadine 10mg 1 tablet daily scheduled for administration at 8:00pm.
-There was documentation loratadine was not administered for 11 of 30 opportunities on 04/01/24, 04/02/24, 04/05/24, 04/15/24, 04/16/24, 04/19/24, 04/21/24, 04/23/24, 04/24/24, 04/29/24 and 04/30/24 due to faxed and called pharmacy to deliver and on 04/21/24 due to resident refused.

Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed loratadine 10mg was not available.

Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed:
-Resident #2's loratadine 10mg 1 tablet daily was dispensed to the facility on 02/12/24 boxed with a quantity of 300 tablets.
-Loratadine should have lasted 300 days.

Interview with a medication aide (MA) on 05/09/24 at 11:46am revealed:
-She reordered medication 3 days before the medication ran out.
-Once reordered, the medication was usually delivered from the pharmacy that same night.
-If the medication was not delivered, the MAs were to reorder and call the pharmacy again.
-She had not had trouble with reordering medication or with medications being delivered.
-She did not know Resident #2 did not have loratadine available on the medication cart.

Interview with a second MA on 05/10/24 at

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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 358	Continued From page 78 3:39pm revealed: -Loratadine was a boxed medication and should have been on the medication cart and available for administration. -She did not know why loratadine was not on the medication cart or why MAs documented that loratadine was administered when it was not on the medication cart. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 4:36pm. -She worked as the SCUC and administered medication when needed in the Special Care Unit (SCU) as well as the Assisted Living Unit of the facility. -She administered medications on 05/10/24, but Resident #2 was in the hospital so she did not administer her medications. -She called the pharmacy when she noticed loratadine was not on the medication cart in April 2024. -The pharmacy told her that they sent out boxed loratadine and it was too early to reorder. -She had not talked to the Administrator or any other facility staff about loratadine not being available for administration in April 2024. -She did not know loratadine was still not on the medication cart for Resident #2. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -She did not know loratadine was not available for Resident #2 on the medication cart. -A new MA could have been putting new medication on the medication cart and may have accidentally pulled the box of loratadine and sent it back to the pharmacy. -If loratadine was not available on the medication cart, the MA should have contacted the pharmacy.	D 358		

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D 358	Continued From page 79 Interview with Resident #2's primary care provider (PCP) on 05/09/24 at 8:39am revealed: -Loratadine was used to treat allergy symptoms. -Missed doses of loratadine could cause Resident #2 to experience increased allergy symptoms. Refer to the interview with a MA on 05/10/24 at 3:39pm. Refer to the interview with the SCUC on 05/10/24 at 4:36pm. Refer to the interview with Resident #2's PCP on 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. b. Review of Resident #2's FL2 dated 01/25/24 revealed an order for atorvastatin (used to treat high triglycerides levels) 40mg 1 tablet daily. Review of Resident #2's electronic medication administration record (eMAR) for March 2024 revealed: -There was an entry for atorvastatin 40mg 1 tablet every evening at 6:00pm scheduled for administration at 6:00pm. -There was documentation atorvastatin was not administered for 2 of 31 opportunities on 03/01/24 and 03/31/24 due to faxed and called pharmacy to deliver. Review of Resident #2's eMAR for April 2024 revealed: -There was an entry for atorvastatin 40mg 1 tablet every evening at 6:00pm scheduled for administration at 6:00pm. -There was documentation atorvastatin was not	D 358		

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D 358	Continued From page 80 administered for 17 of 30 opportunities on 04/01/24 through 01/05/24, 04/09/24, 04/15/24, 04/16/24, 04/19/24, 04/22/24, 04/23/24, and 04/27/24 through 04/30/24 due to faxed and called pharmacy to deliver and on 04/21/24 due to resident refused. Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed: -There was a bubble pack of atorvastatin 40mg dispensed from the pharmacy on 04/30/24 with a quantity of 28 tablets. -There were 22 tablets remaining. Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed: -Resident #2's atorvastatin 40mg 1 tablet every evening at 6:00pm was dispensed to the facility on 03/05/24 and on 04/30/24 with a quantity of 28 tablets each time. -Atorvastatin should have lasted 28 days with each dispense date. Interview with Resident #2's PCP on 05/09/24 at 8:39am revealed: -Atorvastatin was used to treat high triglycerides levels. -Missed doses of atorvastatin could cause Resident #2's triglycerides levels to increase and place her at risk for stroke and cardiovascular disease. Refer to the interview with a MA on 05/10/24 at 3:39pm. Refer to the interview with the SCUC on 05/10/24 at 4:36pm.	D 358		

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D 358	Continued From page 81 Refer to the interview with Resident #2's PCP on 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. c. Review of Resident #2's FL2 dated 01/25/24 revealed an order for divalproex (used to treat manic depressive illness) 500mg 2 tablets twice daily. Review of Resident #2's eMAR for March 2024 revealed: -There was an entry for divalproex 500mg 2 tablets twice daily at 7:00am and 7:00pm. -There was documentation divalproex was not administered for 3 of 31 opportunities at 7:00am on 03/28/24, 03/29/24, and 03/31/24 due to faxed and called pharmacy to deliver. -There was documentation divalproex was not administered for 2 of 31 times at 7:00pm on 03/27/24 and 03/31/24 due to faxed and called pharmacy to deliver. Review of Resident #2's eMAR for April 2024 revealed: -There was an entry for divalproex 500mg 2 tablets twice daily at 7:00am and 7:00pm. -There was documentation divalproex was not administered for 2 of 30 opportunities at 7:00am on 04/01/24 and 04/02/24 due to faxed and called pharmacy to deliver and on 04/21/24 due to resident refused. Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed: -There was a bubble pack of divalproex 500mg dispensed from the pharmacy on 05/06/24 with a quantity of 112 tablets packaged with 2 tablets in	D 358		

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D 358	Continued From page 82 each bubble. -There was one bubble pack on the cart with 54 tablets remaining. Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed: -Resident #2's divalproex 500mg 2 tablets twice daily was dispensed to the facility on 03/31/24 and on 05/04/24 with a quantity of 112 tablets each time. -Divalproex should have lasted 30 days with each dispense date. Interview with Resident #2's mental health provider (MHP) on 05/10/24 at 10:20am revealed: -She reviewed Resident #2's eMARs each time she saw her. -She noticed in March 2024 that Resident #2's mental health medications had not been administered as ordered and talked to the facility staff about medication administration. -She wanted to know if Resident #2 missed prescribed medications because if they were not administered at least 50% of the time they were not effective and probably needed to be discontinued. -Resident #2 had experienced mood instability and agitation since March 2024 and not administering her prescribed medications, including divalproex, as ordered could have contributed to her behaviors. Refer to the interview with a MA on 05/10/24 at 3:39pm. Refer to the interview with the SCUC on 05/10/24 at 4:36pm. Refer to the interview with Resident #2's PCP on	D 358		

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D 358	Continued From page 83 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. d. Review of Resident #2's FL2 dated 01/25/24 revealed an order for hydroxyzine (used to treat anxiety disorders) 25mg 3 times daily. Review of Resident #2's eMAR for March 2024 revealed: -There was an entry for hydroxyzine 25mg 1 tablet 3 times daily scheduled for administration at 7:00am, 1:00pm, and 7:00pm. -There was documentation hydroxyzine was not administered for 3 of 31 opportunities at 7:00am on 03/28/24, 03/29/24, and 03/31/24 due to faxed and called pharmacy to deliver. -There was documentation hydroxyzine was not administered for 1 of 31 opportunities at 1:00pm on 03/28/24 due to faxed and called pharmacy to deliver. -There was documentation hydroxyzine was not administered for 4 of 31 opportunities at 7:00pm on 03/27/24, 03/29/24, 03/30/24, and 03/31/24 due to faxed and called pharmacy to deliver. Review of Resident #2's eMAR for April 2024 revealed: -There was an entry for hydroxyzine 25mg 1 tablet 3 times daily scheduled for administration at 7:00am, 1:00pm, and 7:00pm. -There was documentation hydroxyzine was not administered for 2 of 30 opportunities at 7:00am on 04/01/24 and 04/02/24 due to faxed and called pharmacy to deliver. -There was documentation hydroxyzine was not administered for 1 of 30 opportunities at 1:00pm due to faxed and called pharmacy to deliver. -There was documentation hydroxyzine was not	D 358		

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D 358	Continued From page 84 administered for 2 of 30 opportunities at 7:00pm on 04/01/24 due to faxed and called pharmacy to deliver and 04/21/24 due to resident refused. Review of Resident #2's physician's orders dated 05/01/24 revealed an order to discontinue hydroxyzine 25mg 1 tablet 3 times daily. Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed hydroxyzine 25mg was not available. Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed: -Resident #2's hydroxyzine 25mg 1 tablet 3 times daily was dispensed to the facility on 03/31/24 with a quantity of 84 tablets. -Divalproex should have lasted 28 days. -Resident #2's hydroxyzine was discontinued on 05/01/24. Interview with Resident #2's mental health provider (MHP) on 05/10/24 at 10:20am revealed: -She reviewed Resident #2's eMARs each time she saw her. -She noticed in March 2024 that Resident #2's mental health medications had not been administered as ordered and talked to the facility staff about medication administration. -She wanted to know if Resident #2 missed prescribed medications because if they were not administered at least 50% of the time they were not effective and probably needed to be discontinued. -Resident #2 had experienced mood instability and agitation since March 2024 and not administering her prescribed medications, including hydroxyzine, as ordered could have	D 358		

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D 358	Continued From page 85 contributed to her behaviors. Refer to the interview with a MA on 05/10/24 at 3:39pm. Refer to the interview with the SCUC on 05/10/24 at 4:36pm. Refer to the interview with Resident #2's PCP on 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. e. Review of Resident #2's FL2 dated 01/25/24 revealed an order for levetiracetam (used to treat seizures) 250mg 2 tablets twice daily. Review of Resident #2's eMAR for March 2024 revealed: -There was an entry for levetiracetam 250mg 2 tablets twice daily scheduled for administration at 7:00am and 7:00pm. -There was documentation levetiracetam was not administered for 3 of 31 opportunities at 7:00am on 03/28/24, 03/29/24, and 03/31/24 due to faxed and called pharmacy to deliver. -There was documentation levetiracetam was not administered for 4 of 31 opportunities at 7:00pm on 03/27/24, 03/29/24, 03/30/24, and 03/31/24 due to faxed and called pharmacy to deliver. Review of Resident #2's eMAR for April 2024 revealed: -There was an entry for levetiracetam 250mg 2 tablets twice daily scheduled for administration at 7:00am and 7:00pm. -There was documentation levetiracetam was not administered for 2 of 30 opportunities at 7:00am on 04/01/24 and 04/02/24 due to faxed and called	D 358		

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pharmacy to deliver.
-There was documentation hydroxyzine was not administered for 2 of 30 opportunities at 7:00pm on 04/01/24 faxed and called pharmacy to deliver and 04/21/24 due to resident refused.

Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed:
-There was a bubble pack of levetiracetam 250mg dispensed from the pharmacy on 05/06/24 with a quantity of 112 tablets packaged with 2 tablets in each bubble.
-There was one bubble pack on the cart with 54 tablets remaining.

Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed:
-Resident #2's levetiracetam 250mg 2 tablets twice daily was dispensed to the facility on 03/31/24 and on 05/04/24 with a quantity of 112 tablets each time.
-Levetiracetam should have lasted 30 days with each dispense date.

Interview with Resident #2's PCP on 05/09/24 at 8:39am revealed:
-Levetiracetam was used to treat seizures.
-Missed doses of levetiracetam could have placed Resident #2 at increased risk of experiencing seizures.

Refer to the interview with a MA on 05/10/24 at 3:39pm.

Refer to the interview with the SCUC on 05/10/24 at 4:36pm.

Refer to the interview with Resident #2's PCP on

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D 358	Continued From page 87 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. f. Review of Resident #2's FL2 dated 01/25/24 revealed an order for sertraline (used to treat anxiety and depression) 50mg 1 tablet daily. Review of Resident #2's eMAR for March 2024 revealed: -There was an entry for sertraline 50mg 1 tablet daily scheduled for administration at 7:00am. -There was documentation sertraline was not administered for 6 of 31 opportunities on 03/09/24, 03/13/24, 03/18/24, 03/28/24, 03/29/24, and 03/31/24 due to faxed and called pharmacy to deliver. Review of Resident #2's eMAR for April 2024 revealed: -There was an entry for sertraline 50mg 1 tablet daily for administration at 7:00am. -There was documentation sertraline was not administered for 2 of 30 opportunities on 04/01/24 and 04/02/24 due to faxed and called pharmacy to deliver. Observation of Resident #2's medications available for administration on 05/09/24 at 11:40am revealed: -There was a bubble pack of sertraline 50mg dispensed from the pharmacy on 05/04/24 with a quantity of 28 tablets. -There were 24 tablets remaining. Interview with a representative from the facility's contracted pharmacy on 05/10/24 at 8:33am revealed: -Resident #2's sertraline 50mg 1 tablet daily was	D 358		

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D 358	Continued From page 88 dispensed to the facility on 03/13/24, 04/01/24, and 05/0/24 with a quantity of 28 tablets each time. -Sertraline should have lasted 28 days with each dispense date. Interview with Resident #2's mental health provider (MHP) on 05/10/24 at 10:20am revealed: -She reviewed Resident #2's eMARs each time she saw her. -She noticed in March 2024 that Resident #2's mental health medications had not been administered as ordered and talked to the facility staff about medication administration. -She wanted to know if Resident #2 missed prescribed medications because if they were not administered at least 50% of the time they were not effective and probably needed to be discontinued. -Resident #2 had experienced mood instability and agitation since March 2024 and not administering her prescribed medications, including sertraline, as ordered could have contributed to her behaviors. Refer to the interview with a MA on 05/10/24 at 3:39pm. Refer to the interview with the SCUC on 05/10/24 at 4:36pm. Refer to the interview with Resident #2's PCP on 05/09/24 at 8:39am. Refer to the interview with the Administrator on 05/10/24 at 5:24pm. Interview with a MA on 05/10/24 at 3:39pm revealed: -When she documented faxed and called	D 358		

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pharmacy to deliver, it meant that the medication was not on the medication cart.
-All residents' medications were automatically dispensed from the pharmacy each month and should be on the medication cart.
-She documented faxed and called the pharmacy to deliver some of Resident #2's medications in April 2024; she faxed a request for medication to the pharmacy, but she did not call because she was told some of Resident #2's medications were not available due to financial issues.
-She told the SCUC the medication was not on the medication cart after she faxed the pharmacy in April 2024.

Interview with the SCUC on 05/10/24 at 4:36pm revealed:
-She thought MAs clicked the button to document faxed and called pharmacy to deliver thinking that the button reordered a medication when it was out.
-There was a separate button to click when a medication needed to be reordered.
-When a medication was out, MAs should have clicked the pharmacy reorder button and then called the pharmacy to ensure they received the request to reorder.
-If the medication was still not on the medication cart, the MA should have contacted the pharmacy to see why the medication was not delivered.
-She was trying to review a few of the residents MARs every day.
-She had noticed medication had not been administered documented by MA's initials being circled and documentation of faxed and called pharmacy to deliver.
-She called the pharmacy about the medications and thought the medications had been delivered.

Interview with Resident #2's PCP on 05/09/24 at

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D 358	Continued From page 90 8:39am revealed: -She was notified 2 weeks ago that MAs were not reordering medications and medications were not on the cart for residents, including Resident #2. -Staff informed her that Resident #2 did not have money to purchase all her prescribed medications and asked if she could discontinue medications. -She discontinued Resident #2's supplements, but she could not discontinue the medications she was currently administered. -She expected for MAs to reorder Resident #2's medications before they ran out and expected for her medications to be administered as ordered. Interview with the Administrator on 05/10/24 at 5:24pm revealed: -When there was documentation on the eMAR faxed and called pharmacy to deliver, it meant that the medication was not in the facility. -If a medication was not in the facility, the MA should have called the pharmacy to reorder or to see why the medication had not been delivered. -The former nurse was conducting eMAR reviews, but now she conducted eMAR reviews and notified the facility PCP if there were any issues. -She expected MAs to follow up with the pharmacy regarding any medication issues and to administer medications as ordered. The facility failed to ensure medications were administered to 2 residents who received insulin (#6 and #3) which resulted in the residents continuing to have elevated FSBS readings placing the residents at increased risk for organ failure; and a resident (#2)who had multiple missed doses of medications to treat mental health disorders, allergies, elevated triglycerides and seizures placing the resident at increased risk for behaviors, depressive episodes, seizures,	D 358		

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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 358	Continued From page 91 and allergy symptoms. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 24, 2024.	D 358		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of a controlled substance for 2 of 4 sampled residents (#1, #5) who received a controlled substance for pain.. The findings are: 1. Review of Resident #1's current FL-2 dated 10/26/23 revealed diagnoses included dementia, hyperlipidemia (HLD) and basal cell carcinoma. Review of Resident #1's physician's orders revealed an order dated 03/01/24 for morphine concentrate 100 mg/5ml (20 mg/ml) Oral Solution	D 392	Staff will be retrained on the Proper administration, documentation And disposal of narcotics on or before 6/1/24 By Admin or Designee. Staff will be trained on How to receive narcotic medications From the pharmacy and how To properly retuen them By Admin or designee. RCC and or designee will monitor Monthly and ongoing.	

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D 392	Continued From page 92 0.5 ml every 2 hour(s) as needed (PRN) for pain or agitation (prefilled syringe) (morphine is a Schedule II controlled substance used to control moderate to severe pain). Interview with a representative from the facility's contracted pharmacy on 05/09/24 at 9:00am for Resident #1's morphine concentrate revealed: -Resident #1 was dispensed 15 ml (30 doses) of morphine concentrate on 04/09/24. -The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document administration for inventory control. Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for morphine concentrate 20mg/ml oral solution take 0.5ml(10mg) every 2 hours as needed for pain or agitation and scheduled administration as needed (prn). - Morphine 20mg/ML oral solution was documented as administered 4 doses on 4/13/24, 4/16/24, and 2 times on 4/25/24. Review of Resident #1's CSCS for morphine concentrate 100 mg/5ml (20 mg/ml) Oral Solution 0.5 ml every 2 hour(s) as needed for pain or agitation (prefilled syringes) dispensed on 04/09/24 revealed the sheet listed 30 pre-filled syringes as the beginning quantity and 11 doses signed out as administered from 04/09/24 to 05/05/24. Review of Resident #1's CSCS for morphine 20mg/ML oral Solution dispensed on 04/09/24 compared to Resident #1's April 2024 eMAR revealed: -There were 7 doses signed out on the CSCS as	D 392		

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D 392	Continued From page 93 administered that were not documented as administered on the eMAR. -Examples of doses signed out as administered on the CSCS but not documented on the eMAR included: -On 04/10/24 at 1:30 (not am or pm noted), one dose was documented as administered on the CSCS. -On 04/18/24 at 8:00pm, one dose was documented as administered on the CSCS. -On 04/18/24 at 10:00pm, one dose was documented as administered on the CSCS. -On 04/29/24 at 10:00pm, one dose was documented as administered on the CSCS. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for Morphine 20mg/ml oral solution take 0.5ml(10mg) every 2 hours as needed for pain or agitation and scheduled administration as needed (prn). -Morphine 20mg/ML oral solution was documented as administered 1 dose on 05/05/24. Review of Resident #1's CSCS for morphine concentrate 20mg/mL oral Solution dispensed on 04/09/24 compared to Resident #1's May 2024 eMAR revealed one dose was signed out on the CSCS and documented as administered on the eMAR. Observation of medication on hand for administration for Resident #1 on 05/10/24 at 4:15pm revealed there were 19 pre-filled syringes of morphine 20mg/ml oral solution pre-filled syringes dispensed on 04/09/24 for prn administration matching the quantity indicated on the CSCS. Based on observations, interviews, and record	D 392		

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D 392	Continued From page 94 review it was determined Resident #1 was not interviewable. Interview with a medication aide (MA) on 4/2/24 at 8:20pm revealed: -The facility had been aware of controlled substances "being off" for a while now. -When the previous Special Care Unit Coordinator (SCUC) was here she would go through the CSCS book routinely to ensure accuracy. -The CSCS and counts became inaccurate more once new staff started on the medication carts. Interview with a second MA on 04/2/24 at 10:26am revealed: -Some MAs were not signing the CSCS nor entering the counts. -The MAs should mark the eMAR when a controlled medication was given scheduled or as needed (prn). Interview with a third MA on 4/3/24 at 11:25am revealed: -The MA did not have an in-service on how to count and record controlled substances. -There was an online training staff completed on controlled substance documentation through the contracted pharmacy. Interview with a fourth MA on 4/3/24 at 11:27am revealed: -Issues with control counts and missed medication administration were brought to the attention of the Resident Care Coordinator (RCC) and she would track down the discrepancy. -The RCC was aware of errors in the Control logbooks. -There was no documentation of control counts at shift changes.	D 392		

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D 392	Continued From page 95 Interview with a fifth MA on 4/3/24 at 5:26pm revealed: -She was aware of missed medication administration on 3/20/24. -She made the Resident Care Coordinator (RCC) aware of missed medications flagged on the eMAR and discrepancies on the control medication counts. The RCC was not available for interview from 05/08/24 to 05/10/24. Refer to the interview with a medication aide (MA) on 05/10/24 at 9:53am. Refer to the interview with the Business Office Manager (BOM) on 05/09/24 at 11:00am. Refer to the interview with a MA on 05/10/24 at 3:00pm. Refer to the interview with the Administrator on 05/10/24 at 5:40pm. 2. Review of Resident #1's physician's orders revealed an order dated 03/04/24 for oxycodone 10mg (Oxycodone a Schedule II controlled substance used to control moderate to severe pain) one tablet 4 times a day as needed for pain. Interview with a representative of the facility's contracted pharmacy on 05/09/24 at 9:00am revealed: -The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document administration for inventory control. -On 03/04/24, oxycodone 10mg was dispensed for a quantity of 30 tablets.	D 392		

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D 392	Continued From page 96 -On 03/13/24, oxycodone 10mg was dispensed for a quantity of 30 tablets. -On 03/27/24, oxycodone 10mg was dispensed for a quantity of 30 tablets. -On 04/11/24, oxycodone 10mg was dispensed for a quantity of 30 tablets. -On 04/23/24, oxycodone 10mg was dispensed for a quantity of 30 tablets. -On 04/30/24, oxycodone 10mg was dispensed for a quantity of 31 tablets. Review of Resident #5's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours as needed for pain that was schedule for as needed (prn) administration. -Oxycodone 10mg was documented as administered for 53 doses on the eMAR from 03/05/24 through 03/31/24. -On 03/28/24 at 9:56am, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding time. Review of Resident #5's CSCS for oxycodone 10mg tablets dispensed for 30 tablets on 03/04/24, 03/13/24, and 8 of 30 tablets dispensed 03/27/24 (for total of 68 tablets) compared to the March 2024 eMAR revealed there was an incorrect accounting for 11 doses as follows: -There were 4 doses subtracted as administered without documentation for date, time and staff that administered the medication with the inventory decreased by one tablet as follows: between 03/05/24 and 03/06/24, between 03/11/24 and 3/12/24, between 03/14/24 at 2:00pm and 03/14/24 at 11:00pm a line, and between 03/20/24 at 10:00am and 03/20/24 at 9:00pm.	D 392		

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D 392	Continued From page 97 -There were 7 doses signed out for administration on the CSCS but not documented as administered on the eMAR with examples including: -On 03/07/24 at 5:00pm a dose was signed out on the CSCS. -On 03/15/24 at 3:15pm a dose was signed out on the CSCS. -On 03/18/24 at 11:00am a dose was signed out on the CSCS. -On 03/24/24 at 5:00pm a dose was signed out on the CSCS. Review of Resident #5's April 2024 eMAR revealed: -There was an entry for oxycodone 10mg one tablet every 4 hours as needed for pain that was schedule for as needed (prn) administration. -Oxycodone 10mg was documented as administered for 64 doses on the eMAR from 04/01/24 through 04/30/24. -On 04/14/24 at 7:00pm, there was one dose documented as administered on the eMAR but not signed out on the CSCS. Review of Resident #5's CSCS for oxycodone 10mg tablets for 22 of 30 tablets dispensed on 03/27/24, 30 tablets dispensed on 04/11/24, and 18 of 30 tablets dispensed on 04/23/24 (for total of 70 doses) compared to the April 2024 eMAR revealed there was an incorrect accounting for 6 doses as follows: -There were 6 doses signed out for administration on the CSCS but not documented as administered on the eMAR with examples including: -On 04/13/24 at 12:00am, a dose was signed out on the CSCS. -On 04/14/24 at 7:00pm, a dose was signed out on the CSCS.	D 392		

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D 392	Continued From page 98 -On 04/19/24 at 12:00am, a dose was signed out on the CSCS. -On 04/20/24 at 5:00pm, a dose was signed out on the CSCS. -On 04/24/24 at 12:00am, a dose was signed out on the CSCS. -On 04/27/24 at 10:30pm, a dose was signed out on the CSCS. Observation of oxycodone 10mg on hand for administration on 05/10/24 at 3:00pm revealed there were 18 doses remaining on a bingo card dispensed for 31 on 04/30/24. Interview with Resident #5 on 05/10/24 at 4:00pm revealed: -She had a pain medication she could request up to 4 times a day, -She usually asked for the medication 2 maybe 3 times a day. The RCC was not available for interview from 05/08/24 to 05/10/24. Refer to the interview with a medication aide (MA) on 05/10/24 at 9:53am. Refer to the interview with the Business Office Manager (BOM) on 05/09/24 at 11:00am. Refer to the interview with a MA on 05/10/24 at 3:00pm. Refer to the interview with the Executive Director (ED) on 05/10/24 at 5:40pm. Interview with a medication aide (MA) on 05/10/24 at 9:53am revealed: -The MAs were responsible to sign the CSCS logs, check the count and document.	D 392		

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D 392	Continued From page 99 -Some MAs were not completing the documentation per policy. -Some MAs documented on the eMAR, but not document on the CSCS on a consist basis. Interview with the Business Office Manager (BOM) on 05/09/24 at 11:00am revealed: -The RCC was in charge of the controlled substance auditing for documentation for administration, security, and returns to the contracted pharmacy. -The RCC had left employment on 04/23/24 without notice. -The BOM was currently maintaining the CSCS log filing. -A new locking file cabinet had been obtained and all controlled substances overstock was locked in the cabinet, in the locked office, within the management building. -The BOM had the key to the filing cabinet with controlled substances. -The BOM had not audited CSCS compared to the Resident's eMARs for controlled medication accountability. Interview with a MA on 05/10/24 at 3:00pm revealed: -The staff counted controlled medications at shift changes before exchanging the medication cart keys. -The oncoming MA was not to accept the medication cart keys until the controlled medications on hand were verified with the CSCS to match. -If the count did not match, the SCUC, the Resident Care Coordinator (RCC), or the Executive Director (ED) were supposed to approve the key exchange and audit the eMAR and CSCS to correct the difference. -There was a controlled count log sheet in the	D 392		

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D 392	Continued From page 100 front of the binder used to store current CSCS that was located on the medication cart. Interview with the Administrator on 05/10/24 at 5:40pm revealed: -The former RCC was responsible for ensuring controlled substances (medications) ordered and received for residents were properly accounted for. -The BOM and the SCUC were assuming the monitoring of controlled medications until a new RCC was employed.	D 392		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for	D 454	Admin or designee will reeducate staff On incident reports or before 6/1/24. Rcc will monitor routinly and ongoing.	

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D 454	Continued From page 101 elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to notify a resident's Guardian within 24 hours for 1 of 5 sampled residents (Resident #1) related to a confrontation between the resident and his roommate, resulting in the resident being evaluated by his local Hospice nurse. The findings are: Review of Resident #1's current FL2 dated 10/26/23 revealed: -Diagnoses included malignant melanoma, cognitive and behavioral changes, mixed hyperlipidemia, right femoral fracture. -There was documentation that he was constantly disoriented. -The level of care was documented as a Special Care Unit (SCU). Interview with the Resident #1's Guardian on 4/15/24 at 2:42pm revealed: -Resident #1 was in the SCU due to his behaviors. -Monthly visits were done by the Guardian to Resident #1. -The Administrator reported to her that staff in the SCU were not under the impression they had to contact the Guardian. -Going forward, the Administrator assured the Guardian that she would be notified as well as Hospice. -The staff thought only Hospice was to be notified for incidents or accidents.	D 454		

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D 454	Continued From page 102 -She was upset that the facility had failed to send incident reports when Resident #1 went out to the hospital from accidents or altercations that happened in the facility. -She wanted better communication from the facility and hospice going forward and would reach out to the ED and hospice directly. Review of Resident #1's Accident/Incident (A/I) Report dated 04/09/24 revealed: -Resident #1 had a physical altercation with their roommate at 9:30am in his bedroom. -Resident #1 did not obtain any physical injuries nor did his roommate. -Hospice was notified of the incident on 04/09/24 at 9:35am. -There was no documentation that Resident #1 Guardian was notified of the incident. Review of Resident #1's Hospice notes dated 04/12/24 revealed there documentation related to Resident #1 involved in a physical altercation (no date given) that resulted in him being punched in the head where his wound (malignant melanoma). Interview with the Administrator on 4/16/24 at 11:11am revealed: -Staff followed the written rules when it came to reporting accidents/incidents. -Staff did not report the incident on 04/09/24 with Resident #1 and his roommate to the Guardian. -After the altercation involving Resident #1, he was immediately moved to a private room on 04/09/24. -Any resident involved in an altercation was moved to another room.	D 454		