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PRINTED: 06/06/2024
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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
	HAL068036	A. BUILDING: _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 000	Initial Comments The Adult Care License Section conducted an annual survey on May 21-22, 2024. 10A NCAC 13F .0311(d) Other Requirements	D 000		
D 113	10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F on one section of the 100 hall for 1 the sink fixture and 1 tub fixture in the common spa, and 4 of 4 fixtures (4 sinks) located in residents' rooms and used by the residents. The findings are: Observation of the hot water temperature in the 100 hall common spa on 05/21/24 at 9:15am revealed the hot water temperature was 124 degrees F at the sink and tub. Observation of the hot water temperature at the bathroom sink of resident room 101 on 05/21/24 at 9:20am revealed the hot water temperature	D 113	The hot water will be monitored and checked weekly and as needed by the Maintenance Director in several places throughout the building. If the temperature is above 116 it will be adjusted and the Maintenance Director will continue to monitor. A log will be kept of weekly temperatures.	July 5, 2024

RN 6/20/24 hrp

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D 113	Continued From page 1 was 124 degrees F. Interview with the resident who resided in resident room 101 on 07/25/23 at 9:22am revealed: -She used the sink independently. -Staff adjusted the shower water to a comfortable temperature. -She never had an issue where the water temperature was too hot because she adjusted the water temperature by mixing in some cold water when using the sink. -She had never been burned by hot water. Observation of the hot water temperature at the shared resident bathroom sink between resident room 104 and resident room106 on 05/21/24 at 9:25am revealed the hot water temperature was 124 degrees F. No steam was visible. Observation of the hot water temperature at the bathroom sink in resident room 107 on 05/21/24 at 9:28am revealed the hot water temperature was 128 degrees F. No steam was visible. Interview with the resident who resided in resident room 107 on 05/21/24 at 11:00am revealed: -He knew the hot water temperature was "pretty hot". -He adjusted the hot and cold water to be comfortable. -He had not been burned by the hot water. -He had not seen a staff checking the hot water temperature. Observation of the hot water temperature at the shared bathroom sink between room 109 and room111 on 05/21/24 at 9:25am revealed the hot water temperature was 129 degrees F. No steam was visible.	D 113		

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D 113	Continued From page 2 Interview with a resident who resided in resident room 109 on 05/21/24 at 9:43am revealed: -She used the sinkfrequently. -She knew the hot water temperature was "really hot". -She never had an issue where the water temperature was too hot because she adjusted the water temperature by mixing in some cold water when using the sink. -She had never been burned by hot water. -She had not told any staff member about the hot water being too hot. Interview with a resident who resided in resident room 111 on 05/21/24 at 11:20am revealed: -She used the sink occasionally. -She knew the hot water temperature was "hot". -She never had an issue where the water temperature was too hot because she adjusted the water temperature by mixing in some cold water when using the sink. -She had never been burned by hot water. -Facility staff check the hot water temperature occasionally. -She had not told any staff about the hot water being too hot. On 09/21/24 at 9:40am the Administrator and Maintenance Director (MD) were informed of elevated hot water temperature on the 100 hall from the common spa to room 111 and were requested to post signs in the residents' bathrooms and the common spa alerting residents of the elevated hot water temperature. The residents should request staff assistance with using the water. Interview with the Administrator on 05/21/24 at 10:15am revealed: -She had made signs for posting in the	D 113		

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D 113	Continued From page 3 bathrooms of the residents residing on the 100 hall section affected by elevated hot water temperatures. -The common spa also had a sign on the door to alert residents of the elevated hot water temperatures. -She would inform the medications aides (MA) and personal care aides (PCA) to be on alert for residents needing assistance with the hot water adjustments. -The MD was working on finding the hot water heater for the affected rooms and would adjust temperatures to the 100-116 degrees F range. -A plumber would be called if the MD could not get the hot water temperature corrected. -The Administrator was informed she needed to inform the surveyor when the hot water temperatures were ready to be rechecked for compliance. On 05/21/24 at 11:10am, the surveyor's thermometer was calibrated using an ice water slurry with a reading of 32 degrees F registered on the thermometer. Interview with the MD on 05/21/24 at 10:30am revealed: -He thought the elevated hot water temperatures were coming from one hot water heater. -He would adjust the hot water heater temperature, flow the hot water and inform the surveyor when hot water temperatures were within the 100 to 116 degrees F range. -He checked hot water temperature routinely. Interview with a PCA on 05/21/24 at 11:00am revealed no resident on the 100 hall complained to her regarding elevated hot water temperatures. Second interview with the MD on 05/21/24 at	D 113		

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D 113	Continued From page 4 12:05pm revealed: -He checked hot water temperature randomly, 2 times a month, throughout the facility and had hot water temperature logs for review. -He only checked hot water temperatures one time this month. -The facility had 7 to 8 hot water heaters located throughout the facility rather than a large boiler. -Each water heater provided hot water for a select group of rooms. -The facility owner replaced individual hot water heaters over the last 2 years. -There had been hot water temperatures that were below 100 degrees F on the affected section of the 100 hall a few weeks ago. -The hot water heater was turned way past 116 degrees F but he did not change the temperature and was not sure if someone working replacing hot water heaters in a different section of the facility changed the setting. -He returned the thermostat setting to less than 116 degrees F setting. Review of the available hot water temperature log on 05/21/24 revealed: -On 05/03/23, there were 4 hot water temperatures documented for residents' rooms ranging from 100 to 103 degrees F. -On 04/22/24, there were 4 hot water temperatures documented for residents' rooms ranging from 100 to 102 degrees F. -On 04/08/24, there were 4 hot water temperatures documented for residents' rooms ranging from 105 to 110 degrees F. -On 03/25/24, there were 3 hot water temperatures documented for residents' rooms ranging from 103 to 105 degrees F. -On 03/11/24, there were 3 hot water temperatures documented for residents' rooms ranging from 101 to 110 degrees F.	D 113		

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D 113	Continued From page 5 A recheck of the bathroom sink and tub in the common bathroom/spa on 05/21/24 at 1:10pm revealed the hot water temperature was 110 degrees F. A recheck of the bathroom sink in resident room 101 on 05/21/24 at 1:15pm revealed the hot water temperature was 110 degrees F. A recheck of the bathroom sink between resident room 104 to 106 on 05/21/24 at 1:17pm revealed the hot water temperature was 110 degrees F. A recheck of the bathroom sink in resident room 107 on 05/21/24 at 1:20pm revealed the hot water temperature was 110 degrees F. A recheck of the bathroom sink between resident rooms 109 and 111 on 05/21/24 at 1:28pm revealed the hot water temperature was 110 degrees F. On 05/21/24 at 11:30am, the MD was informed hot water temperatures were within 100 to 116 degrees F and signs in residents' room related to elevated hot water temperatures could be removed. The facility failed to ensure hot water temperatures for 6 fixtures used by residents were maintained between 100-116 degrees F related to hot water temperatures checked that ranged from 124-129 degrees F. A hot water temperature of 129 degrees F could result in a first degree burn in less than 30 seconds and a second degree burn in 1 minute. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.	D 113		

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D 113	Continued From page 6 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/21/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 5, 2024.	D 113		
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: Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#6 and #7) observed during the morning medication pass on 05/23/24. The findings are: The medication error rate was 8% as evidenced by 2 errors out of 25 opportunities during the 8:00am medication pass on 05/22//24. 1. Review of Resident #6's current FL2 dated 04/01/24 revealed: -Diagnoses included autism disorder and schizophrenia. -There was an order for Sertraline (used to treat various mental disorders) 100mg daily.	D 358	All Medication Aids will be in-serviced on Medication Administration by RN Nurse Consultant. Staff will administer as prescribed by the Doctor and EMAR. They will perform the 6 rights and 3 checks with each resident as they give out medication, according to policy. The RCC will monitor EMAR once a week to ensure all medications are being given and that they are available. Any problems found will be corrected immediately through training and continued monitoring.	July 5, 2024

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D 358	Continued From page 7 Observation of the morning medication aide (MA) during the medication pass on 05/22/24 at 7:32am revealed: -The MA displayed the morning medications scheduled for 8:00am administration for Resident #6 on the electronic medication administration record (eMAR) computer monitor. -The MA consulted the eMAR computer monitor several times while preparing Resident #6's medications. -The MA prepared 10 oral medications from bingo packaged medication cards, and prepared one dose of reconstituted liquid medication for Resident #6. -The MA observed Resident #6 take the medications. -The MA returned to the medication cart and documented the medication administration by clicking record on the eMAR computer screen. -Sertraline 100mg was not included in the medications prepared and observed administered to Resident #6 at 7:32am. Review of Resident #6's May 2024 eMAR on 05/22/24 at 8:20am revealed: -There was an entry for sertraline 100mg one tablet daily and scheduled for administration at 8:00am daily. -Sertraline 100mg was documented as administered at 8:00am on 05/22/24. Observation of Resident #6's medications on hand for administration on 05/22/23 at 8:55am revealed there was a bingo packaged medication card labeled for sertraline 100mg dispensed for 30 tablets on 04/24/24 with 12 tablets remaining located at the front of the area designated for Resident #6's medications.	D 358		

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D 358	Continued From page 8 Interview with the morning MA at 8:55am revealed: -She consulted the eMAR computer screen as she prepared the residents' medications. -Resident #6 had a lot of medications. -She had returned all the medications prepared for Resident #6 grouped together to the drawer space designated for Resident #6 after she prepared the medications for administration earlier in the day, except a controlled medication which she returned to the locked drawer of the medication cart, and an empty bingo card. -She must have overlooked preparing Resident #6's sertraline 100mg since it was not grouped with the other medications. Interview with the Administrator on 05/22/24 at 9:00am revealed the MA must have overlooked sertraline 100mg and documented as administered along with the resident's other 8:00am medications. Interview with Resident #6's primary care physician (PCP) on 05/22/24 at 10:00am revealed: -MAs should be administering medications as ordered, and not have missed a dose of sertraline 100mg for Resident #6 this morning. -Not receiving sertraline 100mg as ordered could cause changes in mood and/or behaviors with increased anxiety or depression. -Resident #6's sertraline 100mg was ordered once a day and could be administered now (10:00am) to ensure the resident received his medication. Interview with the Resident Care Coordinator (RCC) on 05/22/24 at 4:00pm revealed she was informed the morning MA omitted Resident #6's sertraline 100mg during the 8:00am medication	D 358		

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D 358	Continued From page 9 pass by the Administrator around 10:30am. Based on observations, interviews, and record review it was determined that Resident #6 was a poor historian. Refer to the interview with the Administrator on 05/22/24 at 9:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 05/22/24 at 4:00pm. 2. Review of Resident #7's current FL2 dated 07/26/23 revealed: -Diagnoses Type 2 Diabetes Mellitus. -There was an order for metformin 500mg (used to treat elevated blood sugar in diabetes) two times a day. Review of Resident #7's signed physician's order dated 01/29/24 revealed: -There was an order for metformin 1000mg daily in the morning with meals. -There was an order for metformin 500mg in the evening with meals. Observation of the morning medication aide (MA) during the medication pass on 05/22/24 at 7:40am revealed: -The MA displayed the morning medications scheduled for 8:00am administration for Resident #7 on the electronic medication administration record (eMAR) computer monitor. -The MA consulted the eMAR computer monitor several times while preparing Resident #7's medications. -The MA prepared 4 oral medications from bingo packaged medication cards for Resident #7. -The MA punched one metformin 500mg tablet from a bingo packaged medication card labeled	D 358		

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D 358	Continued From page 10 as dispensed on 04/24/24 for 30 tablets with 16 tablets remaining. (The bingo card had a green auxiliary sticker with "evening" affixed to the front upper right hand corner of the card). -The MA observed Resident #7 take the medications and proceed into the dining room for breakfast. -The MA returned to the medication cart and documented the medication administration by clicking record on the eMAR computer screen. Interview with the morning MA on 05/22/24 at 7:41am revealed Resident #7 had 2 bingo packaged medication cards in the drawer for administration and both were for metformin, so she was going to use the one labeled evening because she already pulled the card from the drawer. Interview with Resident #7 on 05/22/24 at 7:43am revealed: -He depended on the medication staff to administer his medications like they were ordered. -He did not know the strengths of his medications or how his diabetes medication was ordered. Review of Resident #7's May 2024 eMAR on 05/22/24 at 8:30am revealed: -There was an entry for metformin 1000mg one tablet once daily in the morning with meals and scheduled for administration at 8:00am daily. -Metformin 1000mg was documented as administered at 8:00am on 05/22/24. Observation of Resident #7's medications on hand for administration on 05/22/23 at 8:55am revealed: -There was a partial bingo packaged medication card labeled for metformin 1000mg for one tablet	D 358		

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D 358	Continued From page 11 daily in the morning with meals, dispensed for 30 tablets on 04/24/24. -There was a bingo packaged medication card labeled for metformin 500mg one tablet every evening with meals dispensed for 30 tablets on 04/24/24, with 16 tablets remaining located at the front of the area designated for Resident #7's medications. Interview with the morning MA at 9:10am revealed: -She consulted the eMAR computer screen as she prepared the residents' medications. -Resident #7 had two bingo cards for metformin tablets in his medication on hand for administration. -She did not realize Resident 7's morning metformin was 1000mg and his evening metformin was 500mg. -She remembered Resident #7's metformin administered during the 8:00am medication pass today (05/22/24) had the green evening sticker at the upper right corner. -She overlooked comparing the strength of the metformin on the eMAR computer monitor to the bingo card's metformin 500mg strength. Interview with the Administrator on 05/22/24 at 9:00am revealed the MA must have overlooked Resident #7's metformin orders were for 1000mg in the morning and 500mg in the evening with bingo cards for each dose on the medication cart. Interview with Resident #7's primary care physician (PCP) on 05/22/24 at 10:05am revealed: -MAs should be administering medications as ordered and administered metformin 1000mg for Resident #7 this morning instead of 500mg. -Not receiving metformin as ordered could result	D 358		

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D 358	Continued From page 12 in higher blood glucose levels and poor diabetes control. -Resident #7's could receive another dose of metformin 500mg now to equal the 1000mg dose ordered in the morning. Review of Resident #7's record revealed a laboratory test result for hemoglobin A1C (a test used to measure blood glucose levels over an extended period of time) level of 8.8 with a range of 4.8 to 5.6 being considered normal. Refer to the interview with the Administrator on 05/22/24 at 9:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 05/22/24 at 4:00pm. Interview with the Administrator on 05/22/24 at 9:00am revealed: -The MAs were supposed to administer medications by consulting the eMAR computer monitor as the medications were prepared, check the medications as prepared on the computer display, administer medications, and then click record on the eMAR computer screen to document administration. -The facility's contracted PCP was scheduled to come to the facility today (05/22/24) and would be contacted immediately upon arrival. Interview with the RCC on 05/22/24 at 4:00pm revealed: -The MAs were trained by the RCC or Administrator. -The facility's procedure for administering medications was to administer medications by consulting the eMAR computer monitor as the medications were prepared, check the medications as prepared on the computer	D 358		

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D358	Continued From page 13 display, administer medications, and then click record on the eMAR computer screen to document administration. -She was informed the morning MA omitted Resident #6's sertraline 100mg during the 8:00am medication pass.	D358		
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 1 of 5 sampled residents (#3) who received a controlled substance for pain. The findings are: Review of Resident #3's current FL2 dated 04/08/24 revealed: -Diagnoses included essential hypertension, hypothyroidism, CVA with left hemiparesis non dominant side, encephalopathy, and type 2 diabetes mellitus without complications. Review of Resident #3's physician's orders dated 04/05/24 revealed an order for pregabalin 75mg (a Schedule V controlled substance used to treat moderate to severe pain) one tablet a day for	D392	All Medication Aids will be in-serviced on Medication Administration by RN Nurse Consultant. Staff and they will administer as prescribed by the Doctor and EMAR. They will sign the narcotic prescribed out on EMAR and Narcotic sheets , according to policy..the RCC will monitor EMAR and Narcotic sheets for compliance once a week to ensure all medications are being given and that they are available. Any problems found will be corrected immediately through training and continued monitoring.	July 5, 2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068036	A. BUILDING: _____ B. WING _____	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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D 392	Continued From page 14 pain. Interview with a representative from the facility's contracted pharmacy on 05/22/24 at 11:35am revealed: -The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document administration for inventory control. -On 03/18/24, pregabalin 75mg was dispensed for a quantity of 30 tablets. -On 04/18/24, pregabalin 75mg was dispensed for a quantity of 30 tablets. -On 05/18/24, pregabalin 75mg was delivered for a quantity of 30 tablets. Review of Resident #3's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for pregabalin 75mg scheduled daily at 8:00pm. -Pregabalin 75mg was documented as administered on 03/25/24 at 8:00pm on the eMAR but not signed out on the CSCS for the corresponding time. -Pregabalin 75mg was documented as administered for 13 doses from 03/19/24 through 03/31/24. Review of Resident #3's CSCS for pregabalin 75mg dispensed on 03/19/24 (30) revealed 12 out of 30 doses were signed out with no missing medications, compared to the March 2024 eMAR documentation of 13 administered doses. Review of Resident #3's April 2024 eMAR revealed: -There was an entry for pregabalin 75mg scheduled daily at 8:00pm. -Pregabalin 75mg was documented as	D 392		

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D 392	Continued From page 15 administered for 30 doses from 04/01/24 through 04/30/24. -On 04/12/24, one dose of pregabalin 75mg was documented as administered on the eMAR but not signed out on the CSCS for the corresponding time. -On 04/20/24, one dose of pregabalin 75mg was documented as administered on the MAR but not signed out on the CSCS for the corresponding time. Review of Resident #3's CSCS for pregabalin 75mg dispensed on 04/19/24 (30) revealed 28 out of 30 doses were signed out with no missing medications, compared to the March 2024 eMAR documentation of 30 administered doses. Review of Resident #3's May 2024 eMAR revealed: -There was an entry for pregabalin 75mg schedule daily at 8:00pm. - Pregabalin 75mg was documented as administered for 20 doses from 05/01/24 through 05/20/24. -On 05/16/24, one dose for pregabalin 75mg scheduled for 8:00pm was documented as administered on the eMAR but documented as "not pulled" on the CSCS for the corresponding time. Review of Resident #3's CSCS for pregabalin 75mg dispensed on 05/18/24 (30) revealed from 05/01/24 through 05/20/24, there were 19 out of 30 doses that were signed out with no missing medications, compared to the March 2024 eMAR documentation of 20 administered doses. Observation of the medication on hand revealed 19 out of 30 doses were dispensed from 05/01/24 through 05/20/22; which corresponded with the	D 392		

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D 392	Continued From page 16 CSCS. Interview with Resident #3 on 05/22/24 at 2:25pm revealed: -The medication aide (MA) brought her medications to her every day in a cup, and she took the medication with water. -She was not sure of the names of the medications. -She did not know she was taking pregabalin. -She was not in pain. Interview with a medication aide (MA) on 05/22/24 at 2:45pm revealed: -When a controlled medication was administered, she pulled the medication card from the medication cart and administered the medication to the resident. -She documented that it was given on the eMAR and signed the controlled substance logbook with the date and time given. Interview with a second MA on 05/22/2023 at 3:00pm revealed: -When a controlled medication was administered, she would find the resident's name in the MAR, check the medication listed and dosage to see if it matched the medication on hand and administered the medication to the resident. -She would document the medication was administered on the eMAR and in the controlled substance logbook. -She would not document until the medication was administered because the resident might refuse. Interview with the Resident Care Coordinator (RCC) on 05/22/24 at 3:35pm revealed: -Her expectation would be for all MAs to follow the correct protocol for administration of all	D 392		

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D 392	Continued From page 17 medications. -The MAs should make sure they have the controlled substance logbook out before administering controlled medications, so they do not forget to document they administered the medication. -The protocol was to administer the medication to the resident, record the administration of the medication on the eMAR and in the controlled substance logbook. -All MAs were trained on this protocol, and she would expect all of them to follow this protocol. Interview with Administrator on 05/22/24 at 4:00pm revealed: -Her expectation was the MAs should not record in the eMAR or controlled substance logbook until after the medications were administered. -All MAs should pull the medication, administer it to the resident and then document it in the eMAR. -If it was a controlled medication, it should be documented on the eMAR and in the controlled substance logbook. -There was a system in place to check for medication errors in the logbook and the eMAR. -The Administrator would check the logbook line-by-line for errors and compare it to what was documented as administered in the eMAR. -The Administrator was not aware of the errors made on the eMAR on 04/12/24, 04/20/24 and 05/10/24 because she had not reviewed the controlled substance logbook or MAR for the month of April or May 2024.	D 392		

Patricia A. Bell RN BSN 6/20/2024