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JOHNSON BETTER CARE FACILITY	HWY 301 NORTH DUNN, NC 28335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 4, 2024 through June 5, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the environment was free of hazards related to oxygen tanks not being secured in a resident's (#2) room. Review of Resident #2's FL-2 dated 11/08/23 revealed diagnosis included chronic obstructive pulmonary disease. Review of Resident #2's Resident Register dated 11/01/23 revealed he was admitted to the facility on 11/01/23. Review of Resident #2's physician's order sheet dated 02/12/24 revealed an entry for oxygen (O2) at 4 liters via nasal cannula continuously. Observation of Resident #2's room on 06/04/24 at 9:48am revealed eight oxygen tanks on the floor in the resident's room; they were not in a rack or no-tip container.	D 079		

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D 079	Continued From page 1 Interview with Resident #2 on 06/04/24 at 3:15pm revealed: -There had never been a rack in his room for his oxygen tanks. -The oxygen tanks were usually stored in his closet. -There was no rack for the oxygen tanks in his closet. Interview with a medication aide (MA) on 06/04/24 at 10:15am revealed: -Resident #2's oxygen tanks had always been on the floor. -The oxygen tanks had also been stored in the closet. -Resident #2 had never had a storage rack for his oxygen tanks. Interview with the Resident Care Coordinator (RCC) on 06/04/22 at 10:20am revealed: -All oxygen tanks were to always be secured in a container or rack. -There should not be an oxygen tank sitting on the floor unsecured in the residents' rooms. -There should have been a rack in the resident's room for the oxygen tanks. -She was aware unsecured oxygen tanks were a safety concern. -All staff were responsible for ensuring oxygen tanks were secured. Interview with the Administrator on 06/04/24 at 10:25am revealed: -Resident #2 had not had an oxygen rack in his room to her knowledge. -There should never be unsecured oxygen tanks on the floor in the residents' rooms. -She was aware unsecured oxygen tanks were a safety concern.	D 079		

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D 079	Continued From page 2 -The Administrator and the RCC were responsible for ensuring the facility was free from hazards. -She and the RCC failed to ensure the facility was free from hazards by making sure oxygen tanks were secure once they were delivered to the facility. -The facility did not have a policy for hazards.	D 079		
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, interviews, and record reviews, the facility failed to meet the acute health care needs for 1 of 5 residents (#3) sampled related to a referral for dental and ears, nose, and throat (ENT) specialist evaluations. The findings are: Review of Resident #3's current FL-2 dated 08/23/23 revealed diagnoses included hypertension, gastro-esophageal reflux disease, migraines, anxiety, dementia, and Huntington's disease. Review of Resident #3's current care plan assessment dated 08/23/23 revealed: -Resident #3 was oriented. -Resident #3 required assistance with all activities of daily living, including eating at times due to her diagnoses of Huntington's disease. Review of a hospital discharge summary for Resident #3 dated 03/21/24 revealed:	D 273		

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-The resident was admitted on 03/19/24 with a diagnosis of altered mental status.
-The resident was able to follow commands and say yes and no in response to questioning.
-Swelling of the right lower jaw was noted by emergency medical services.
-There was noted poor dentition as well as swelling and erythema (redness) in the right buccal (inner cheek) area.
-The resident was treated for a buccal infection/abscess and urinary tract infection.
-The resident was discharged back to the facility on 03/21/24.
-The outpatient follow-up included ENT and dentist.

a. Review of a local hospital After Visit Summary for Resident #3 dated for 03/19/24 - 03/21/24 revealed an ambulatory referral to dentistry.

Review of Resident #3's primary care provider (PCP) notes dated 03/25/24 revealed an order to follow up with dentist.

Review of Resident #3's record revealed there were no reports of dentist visits for the resident.

Observations of Resident #3 on 06/04/24 between 11:45am and 12:25pm revealed:
-Resident #3 was seated in a wheelchair at a table in the dining room.
-The resident was served her lunch meal in the dining room at 11:58am.
-The resident fed herself.
-The resident did not complain of any discomfort while eating the lunch meal of cauliflower, rice, ground pork meat, oatmeal cookie, and a roll.
-The resident drank sweet tea with her meal.

Observations of Resident #3 on 06/05/24 at

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4:47pm revealed:
-The resident was in the dining room preparing for the dinner meal.
-The personal care aide (PCA) provided Resident #3 with her beverage in the resident's sippy cup.
-The resident began drinking from her beverage cup without any noted difficulty.
-The resident's dinner meal included creamed potatoes, turkey meat, brussel-sprouts, and a dessert which she ate without any noted difficulties or complaints.

Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 12:00pm revealed documentation of any appointment visits would be in the residents' record.

Interview with the RCC on 06/05/24 at 5:00pm revealed she did not know Resident #3 was supposed to be scheduled for a dental appointment until 06/05/24 when the surveyor brought it to her attention.

Telephone interview with a representative for a local dentist office on 06/05/24 at 4:23pm revealed:
-A dental appointment was scheduled for Resident #3 at another location for 07/26/24.
-She could not access information for when the appointment was requested.

Attempted telephone interview with second local dental office on 06/05/24 at 4:26pm was unsuccessful.

Attempted telephone interview with the primary care provider (PCP) for Resident #3 on 06/05/24 at 4:15pm and 4:32pm were unsuccessful.

Refer to the interview with Resident #3 on

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D 273	Continued From page 5 06/05/24 at 5:10pm. Refer to the interview with the personal care aide (PCA) on 06/05/24 at 4:48pm. Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/24 at 5:00pm. Refer to the interview with the Administrator on 06/05/24 at 5:05pm. b. Review of a local hospital After Visit Summary for Resident #3 dated for 03/19/24 - 03/21/24 revealed: -There was an ambulatory referral to an ear, nose, and throat specialist (ENT). -There was a new patient appointment scheduled for 03/25/24 with a local ENT provider. Review of physician orders for Resident #3 dated 03/25/24 revealed an order for ENT follow up. Review of Resident #3's record revealed there were no report of an ENT visit for the resident. Interview with the RCC on 06/05/24 at 12:00pm revealed documentation of any appointment visits would be in the residents' record. Interview with the RCC on 06/05/24 at 2:34pm revealed: -Resident #3 returned to the facility from a hospital admission on 03/21/24. -The resident was "still sick, still weak" and she (RCC) called and canceled the ENT appointment that had been scheduled prior to the hospital discharge. -She forgot about the appointment until 06/05/24 when the surveyor mentioned it. -On 06/05/24, she rescheduled the ENT	D 273		

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appointment for 06/19/24.
-She was responsible for scheduling resident appointments.

Attempted telephone interview with the ENT physician's office on 06/05/24 at 4:28pm was unsuccessful.

Attempted telephone interview with the primary care provider (PCP) for Resident #3 on 06/05/24 at 4:15pm and 4:32pm were unsuccessful.

Refer to the interview with Resident #3 on 06/05/24 at 5:10pm.

Refer to the interview with the personal care aide (PCA) on 06/05/24 at 4:48pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/05/24 at 5:00pm.

Refer to the interview with the Administrator on 06/05/24 at 5:05pm.

_____

Interview with Resident #3 on 06/05/24 at 5:10pm revealed:
-She felt good.
-She denied pain in her ears, nose, and teeth.

Interview with a personal care aide (PCA) in the dining room on 06/05/24 at 4:48pm revealed:
-Resident #3 liked to eat.
-The resident did not talk much.
-If Resident #3 was hurting, she would lay her head down.
-The resident did not look any different and "seems to be fine".

Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 5:00pm revealed she had

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D 273	Continued From page 7 not received any reports of Resident #3 complaining of pain. Interview with the Administrator on 06/05/24 at 5:05pm revealed: -Resident #3 communicated in a way that staff could understand her and used one-word phrases. -She was not aware of Resident #3 making any complaints of pain. -Staff would tell the administrative staff if the resident complained or if the resident's behaviors were different from her normal. -She (Administrator) expected resident appointments to be made. -The RCC was responsible for scheduling resident appointments. -The RCC received all the paperwork that came back with a resident returning from a hospital visit.	D 273		
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 reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents (#2, #5, #6) observed during the medication pass	D 358		

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including errors with a medication used to help with digestion of food (#6), a nebulizer medication for breathing problems (#2), and a controlled substance used for moderate to severe pain (#5).

The findings are:

The medication error rate was 10% as evidenced by 3 errors out of 29 opportunities during the 8:00am medication pass on 06/05/24.

a. Review of Resident #6's current FL-2 dated 01/24/24 revealed:
-Diagnoses included gastroesophageal reflux disease, seizure disorder, hypertension, anxiety, schizophrenia, major depressive disorder, chronic kidney disease, tremors, peripheral vascular disease, and osteoarthritis.
-There was an order for Creon DR 12,000 units take 1 capsule 3 times a day with meals; hold if resident is not eating meal. (Creon DR is pancreatic enzymes used to aid in digestion of food. Creon should be administered with food to work as expected by mixing with food and entering the stomach and small intestines at the same time.)

Observation of the 8:00am medication pass on 06/05/24 revealed:
-The medication aide (MA) prepared and administered Creon DR 12,000 units capsule to Resident #6 at 7:48am.
-The resident was in bed and had not eaten breakfast.
-The MA did not ask the resident if he was planning to eat breakfast.

Observation of Resident #6 at the front desk on 06/05/24 at 8:15am revealed:
-The resident was standing at the front desk with

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an orange soda in his hand.
-The resident told a staff member that he was not eating breakfast.

Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 8:16am revealed Resident #6 did not usually eat breakfast.

Review of Resident #6's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Creon DR 12,000 units take 1 capsule 3 times a day with meals (hold if resident not eating meal) scheduled at 8:00am, 12:30pm, and 5:30pm.
-Creon DR was documented as administered from 06/01/24 - 06/05/24.

Observation of Resident #6's medications on hand on 06/05/24 at 12:08pm revealed:
-There was a supply of Creon DR 12,000 units capsules dispensed on 05/27/24.
-The instructions on the label were to take 1 capsule 3 times a day with meals (hold if resident not eating meal).

Interview with Resident #6 on 06/05/24 at 10:15am revealed:
-He did not eat breakfast every day.
-He did not eat breakfast that morning, 06/05/24.
-He denied any current symptoms of stomach discomfort or pain.

Interview with the MA on 06/05/24 at 12:08pm revealed:
-Breakfast was usually served about 8:00am every morning.
-She should have asked Resident #6 if he was planning to eat breakfast before she administered the Creon DR that morning, 06/05/24.

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-Most of the time, she asked the resident if he was going to eat breakfast.
-Resident #6 had not complained of any stomach pain or discomfort.

Interview with the RCC on 06/05/24 at 12:28pm revealed:
-Resident #6 did not usually eat breakfast.
-If a medication was ordered with a meal, it should be administered when the resident was eating.
-She needed to check with the primary care provider (PCP) about Resident #6 not eating breakfast routinely.

Interview with the Administrator on 06/05/24 at 12:28pm revealed:
-Medications ordered with meals should be administered when the resident was eating or right after the resident had finished eating.
-Resident #6's Creon DR should have been held and not administered if the resident did not eat breakfast.

Attempted telephone interview with Resident #6's PCP on 06/05/24 at 4:15pm was unsuccessful.

b. Review of Resident #2's current FL-2 dated 11/08/23 revealed diagnoses included acute chronic respiratory failure, chronic obstructive pulmonary disease, pneumonia, pulmonary embolism, atrial fibrillation, hypertension, anemia, and colon cancer.

Review of Resident #2's physician's orders dated 02/12/24 revealed an order for Budesonide 0.5mg/2ml use 1 vial via nebulizer every 12 hours, rinse mouth after each use. (Budesonide is an inhaled steroid used to treat inflammation and breathing problems. The mouth should be

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rinsed after using Budesonide to prevent irritation and infections of the mouth.)

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Budesonide 0.5mg/2ml use 1 vial via nebulizer every 12 hours, rinse mouth after each use.
-Budesonide was scheduled to be administered at 8:00am and 8:00pm.

Observation of the 8:00am medication pass on 06/05/24 revealed:
-The medication aide (MA) put the contents of 1 vial of Budesonide 0.5mg/2ml into Resident #2's nebulizer machine.
-The MA turned on the nebulizer machine and handed the mouthpiece device to the resident at 7:59am.
-The MA left the room and did not observe Resident #2 take the Budesonide nebulizer treatment.
-The MA did not instruct the resident to inhale the medication and she did not instruct the resident to rinse his mouth after using the Budesonide.

Observation of Resident #2's room on 06/05/24 at 9:15am revealed:
-The resident was lying in bed.
-The nebulizer mouthpiece with medication chamber was on top of the nebulizer machine on the bedside table.
-There was a small amount of liquid residue on the inside of the medication chamber.

Interview with Resident #2 on 06/05/24 at 9:15am revealed:
-He used all the medication in the nebulizer machine that morning, 06/05/24.

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D 358	Continued From page 12 -The medication helped with his breathing. Interview with Resident #2 on 06/05/24 at 10:19am revealed: -He had shortness of breath all the time, especially when he moved around. -The MAs did not usually observe him take the nebulizer treatment; they would leave him and let him do it. -He sometimes rinsed his mouth with water after using the nebulizer treatment. -He did not recall if he rinsed his mouth that morning, 06/05/24. Observation of Resident #2's medications on hand on 06/05/24 at 12:13pm revealed: -There was a supply of Budesonide 0.5mg/ml vials dispensed on 02/20/24. -The instructions on the label were to use 1 vial via nebulizer every 12 hours, rinse mouth after each use. Interview with the MA on 06/05/24 at 12:12pm revealed: -She usually set up the nebulizer machine and put the medication in the chamber for Resident #2. -She made a mistake that morning, 06/05/24, and forgot to go back and check on the resident while he was doing the nebulizer treatment. -She did not know if the resident got the full amount of Budesonide that morning, 06/05/24. -She forgot to have the resident rinse his mouth with water after the Budesonide treatment that morning, 06/05/24. -The resident had not reported any issues with mouth irritation. Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 12:28pm revealed:	D 358		

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-Resident #2 had shortness of breath all the time.
-The MAs should observe all residents take their medications, including nebulizer medications.
-The MA should have instructed and assisted Resident #2 with rinsing his mouth after using the Budesonide.
-The resident could get oral thrush (mouth infection) if he did not rinse his mouth after using the Budesonide.

Interview with the Administrator on 06/05/24 at 12:28pm revealed:
-The MA should have stayed in the room and observed Resident #2 take the nebulizer treatment.
-The MA should have made sure the resident rinsed his mouth after the nebulizer treatment.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/05/24 at 4:15pm was unsuccessful.

c. Review of Resident #5's current FL-2 dated 08/23/23 revealed:
-Diagnoses included type 2 diabetes mellitus, chronic kidney disease, chronic obstructive pulmonary disease, hypertension, gout, and peripheral vascular disease.
-There was an order for Tramadol 50mg take 1 tablet every 5 hours as needed (prn) for pain, maximum daily dose of 5 tablets. (Tramadol is a controlled substance used to treat moderate to severe pain.)

Review of Resident #5's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 50mg take 1 tablet every 5 hours as needed (prn) for pain maximum daily dose of 5 tablets.

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D 358	Continued From page 14 -Tramadol was documented as administered as needed on 12 occasions (3 times a day) from 06/01/24 - 06/04/24. Observation of the 8:00am medication pass on 06/05/24 revealed: -The medication aide (MA) prepared and administered Tramadol 50mg to Resident #5 at 8:10am when she administered the resident's medications scheduled for 8:00am. -Resident #5 did not request Tramadol or state she was in pain. Observation of Resident #5's medications on hand on 06/05/24 at 12:19pm revealed: -There was a supply of Tramadol 50mg tablets dispensed on 5/06/24. -The instructions were to take 1 tablet every 5 hours as needed for pain, maximum daily dose of 5 tablets. Interview with Resident #5 on 06/05/24 at 10:10am revealed: -She took Tramadol for leg pain 3 times a day. -She usually got the Tramadol every morning with her morning medications. -She usually asked for Tramadol most mornings. -Tramadol helped with her pain. Interview with the MA on 06/05/24 at 12:19pm revealed: -Resident #5 usually looked for Tramadol when she handed the resident the medication cup in the mornings. -If Tramadol was not in the medication cup, the resident usually asked for it. -She should have asked the resident if she needed the Tramadol before she prepared it since it was prn and not scheduled.	D 358		

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D 358	Continued From page 15 Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 12:28pm revealed: -A resident was supposed to ask for prn medication. -The MA should not administer a prn medication unless the resident asked for it. -Resident #5 would tell the MAs when she needed the Tramadol. Interview with the Administrator on 06/05/24 at 12:28pm revealed: -The MA should not administer a prn medication as a scheduled medication. -The resident needed to ask for prn medication when they needed it for their symptoms. Telephone interview with a medical assistant at Resident #5's pain clinic provider's office on 06/05/24 at 4:21pm revealed: -Resident #5's Tramadol was supposed to be administered every 5 hours if needed. -The resident took Tramadol for chronic lower back and leg pain.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure that the medication administration record was accurate for 1 of 5 sampled residents (#4) related to documentation of the administration of a blood thinner.

The findings are:

Review of Resident #4's current FL-2 dated 03/11/24 revealed diagnoses included atrial fibrillation, cardiovascular disease, congestive heart failure, cerebral infarction, and mechanical heart valve.

Review of Resident #4's physician's orders revealed:
-There was an order dated 03/18/24 for Warfarin 6mg for 1 dose then take 3mg once daily. (Warfarin is a blood thinner used to prevent heart attacks and blood clots. INR (international normalized ratio) is a blood test used to determine how long it takes the blood to clot and to determine if Warfarin dosages need to be adjusted.)
-There was an order dated 04/01/24 to increase Warfarin to 4mg once a day.
-There was an order dated 04/03/24 to increase Warfarin to 5mg once day.

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D 367	Continued From page 17 Review of Resident #4's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Warfarin 3mg take 1 tablet once a day. -Warfarin 3mg was documented as administered at 8:00pm on 04/01/24 and 04/02/24. -There was a stop date of 04/03/24 for Warfarin 3mg. -There was a second entry for Warfarin 4mg take 1 tablet once a day. -Warfarin 4mg was documented as administered at 8:00pm on 04/01/24 and 04/02/24. -There was a stop date of 04/03/24 for Warfarin 4mg. -A total of Warfarin 7mg was documented as administered on 04/01/24 and 04/02/24 when only 4mg was ordered to be administered. Review of Resident #4's labwork dated 04/06/24 revealed the resident's INR was 2.6 (reference range for mechanical heart valve was 2.5 - 3.5), within normal range. Interview with Resident #4 on 06/05/24 at 4:48pm revealed: -He usually received Warfarin every day. -They kept his blood work checked frequently and sometimes his dosage of Warfarin changed. -He was not sure how much Warfarin he received. -He denied any current symptoms of unusual bleeding or bruising. Interview with a medication aide (MA) on 06/05/24 at 11:13am revealed: -She would not have administered both a 3mg tablet and a 4mg tablet of Warfarin to Resident #4 in April 2024.	D 367		

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D 367	Continued From page 18 -She was not sure why she documented administration of both dosages of Warfarin. Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 11:16am revealed: -The MAs should have let her know there were two entries for Warfarin on 04/01/24 and 04/02/24. -The facility's contracted pharmacy entered the orders into the eMAR system and she or the MAs were responsible for reviewing and accepting the orders in the eMAR system. -When a medication was discontinued, she pulled the discontinued medication from the medication cart herself. -She would have pulled the Warfarin 3mg tablets from the medication cart when the order changed to 4mg on 04/01/24. -Warfarin 3mg tablets would not have been available for the MAs to administer on 04/01/24 and 04/02/24. -It was a documentation error.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the medication pass on 06/05/24 by 1 of 1 medication aides observed	D 371		

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who failed to wash or sanitize their hands prior to preparing and after administering medications to 3 residents, including multiple oral medications, a nasal spray, and a nebulizer treatment.

The findings are:

Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 06/05/24 from 7:45am - 8:10am revealed:
-There was no hand sanitizer on the North Hall medication cart.
-At 7:45am, the MA was wearing gloves and started preparing medications for a resident who lived on the North Hall.
-The MA did not wash or sanitize her hands or change gloves prior to preparing the resident's medications.
-The MA administered medications to the resident, including oral medications at 7:48am, and a nasal spray at 7:49am.
-The MA returned to the medication cart and used her gloved hands to enter documentation into the computer system.
-The MA did not remove the gloves and sanitize or wash her hands after administering the medications and prior to preparing medications for the next resident.
-The MA prepared medication for a second resident who resided on the North Hall and administered oral medications to the resident at 7:58am.
-The MA prepared a nebulizer treatment and handed the mouthpiece with her gloved hand to the resident at 7:59am.
-The MA returned to the medication cart and used her gloved hands to enter documentation into the computer system.
-The MA did not remove the gloves and sanitize

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or wash her hands after administering the medications and prior to preparing medications for the next resident.
-The MA prepared medication for a third resident who resided on the North Hall and administered oral medications to the resident at 8:10am.
-The MA returned to the medication cart and used her gloved hands to enter documentation into the computer system.
-The MA did not remove the gloves and sanitize or wash her hands after administering the medications.
-The MA continued down the hall with the medication cart to administer more medications without changing her gloves and sanitizing or washing her hands.

Interview with the MA on 06/05/24 at 12:19pm revealed:
-She usually used hand sanitizer between each resident when administering medications or sometimes she washed her hands with soap and water.
-She used gloves during the medication pass that morning on 06/05/24, because there was no sanitizer on the medication cart.
-She did not know why there was no hand sanitizer on the medication cart that morning.
-There was usually hand sanitizer on the medication cart.
-She just found some hand sanitizer a few minutes ago in the treatment cart.

Observation of the medication and treatment carts on 06/05/24 at 12:19pm revealed:
-The MA found some bottles of hand sanitizer in the treatment cart.
-The MA also obtained some hand sanitizer from the Administrator's office and put it on top of the medication cart.

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D 371	Continued From page 21 Interview with the Resident Care Coordinator (RCC) on 06/05/24 at 12:28pm revealed: -The MAs were supposed to sanitize their hands between each resident and wash their hands after every 5 residents or if their hands were visibly soiled. -The MA should have changed gloves and sanitized her hands between each resident that morning, 06/05/24. Interview with the Administrator on 06/05/24 at 12:28pm revealed: -The MAs were supposed to sanitize their hands between each resident when administering medications. -Hand sanitizer was always available in the facility. -The MAs could also wash their hands with soap and water. -The MA should have changed gloves and sanitized her hands between each resident that morning, 06/05/24.	D 371		
D 452	10A NCAC 13F .1212(b)(c) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information: (1) resident's name; (2) name of staff who discovered the accident or incident; (3) name of the person preparing the report; (4) how, when and where the accident or incident	D 452		

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D 452	Continued From page 22 occurred; (5) nature of the injury; (6) what was done for the resident, including any follow-up care; (7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and (8) signature of the administrator or administrator-in-charge. (c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) within 48 hours of an incident resulting in an injury requiring emergency medical evaluation and treatment for 1 of 1 sampled resident (#1). The findings are: Review of Resident #1's current FL-2 dated 08/30/23 revealed diagnoses included dementia with other disease, Alzheimer's disease, overactive bladder, bronchitis, schizoaffective disorder, and osteoarthritis. Review of the undated Resident Register for	D 452		

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D 452	Continued From page 23 Resident #1 revealed the resident was admitted to the facility from another facility on 04/21/06. Review of Resident #1's current care plan assessment dated 08/28/23 revealed: -Resident #1 was ambulatory with the use of a wheelchair. -The resident was forgetful and needed reminders. -The resident required extensive assistance with transferring. Review of a staff progress note for Resident #1 dated 05/11/24 revealed: -The resident fell and hit her head on the ground. -Emergency medical services (EMS) was called and the resident was "sent out". -The staff documented she "wrote incident report and sent to DSS [Department of Social Service]". Review of the local hospital After Visit Summary dated 05/11/24 from the emergency department revealed Resident #1's reason for the hospital visit was documented as a fall. Review of a hospital Discharge Summary dated 05/20/24 for Resident #1 revealed: -The resident was admitted to the hospital on 05/11/24. -The admission diagnoses listed were fall and head injury. -The hospital emergency department workup x-ray was significant for an acute displaced fracture of the left hip. Review of an accident/incident report for Resident #1 dated 05/11/24 revealed: -A personal care aide (PCA) was getting Resident #1 up. -The resident grabbed the wheelchair.	D 452		

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-The resident turned the opposite way, fell and hit her head on the floor.
-EMS was called immediately and the resident was sent out.
-There was no documentation for notification to the local county DSS of Resident #1 being sent to the local hospital for evaluation and treatment for the injuries sustained.

Interview with a PCA on 06/04/24 at 2:19pm revealed:
-Resident #1 fell in May 2024.
-She did not remember the exact date of the fall.
-The resident was sent to the hospital.
-She was providing care for Resident #1 when the resident reached for the wheelchair and fell on the floor.

Interview with the staff completing the incident/accident report dated 05/11/24 and the progress note dated 05/11/24, on 06/05/24 at 7:56am revealed:
-She was working as the supervisor on the day Resident #1 fell.
-She completed the incident/accident report dated 05/11/24 regarding Resident #1's fall.
-She faxed the 05/11/24 incident/accident report for Resident #1 to the county DSS on 05/11/24.
-There was supposed to be a faxed confirmation attached to the incident/accident report.
-She forgot to put a faxed stamp on the incident/accident report.
-She always faxed every incident/accident report to the county DSS because the county DSS had to keep track of the incident/accidents.

Interview with the Resident Care Coordinator (RCC) on 06/04/24 at 4:55pm revealed:
-The supervisor that was working when the incident occurred was responsible to send the

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incident/accident report to the county DSS.
-She was not working when the incident/accident occurred and did not know if the incident/accident report was sent to the local county DSS.
-There was "usually" an attached fax confirmation to the incident/accident report kept at the facility.

Telephone interview with the Adult Home Specialist at the local county DSS on 06/05/24 at 8:25am revealed:
-She did not have confirmation the incident/accident report for Resident #1 dated 05/11/24 was sent to the county DSS.
-The last incident/accident report she had received regarding Resident #1 was dated 02/18/22.
-The last incident/accident report she had received from the facility was dated 03/17/24.

Interview with the RCC on 06/05/24 at 5:20pm revealed she had not yet faxed notification of the 05/11/24 incident/accident for Resident #1 to the local county DSS.

Interview with the Administrator on 06/05/24 at 5:30pm revealed:
-The medication aide (MA) or RCC were responsible for faxing notification to the local county DSS regarding incident/accidents.
-She expected the MA or RCC to fax the incident/accident report to the local county DSS.
-She had not notified the local county DSS of the 05/11/24 incident/accident for Resident #1.