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	HAL017054	A. BUILDING: _____ B. WING _____	R 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASWELL HOUSE	535 US HIGHWAY 158 WEST YANCEYVILLE, NC 27379

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/18/24 to 06/20/24.	D 000		
D 185	10A NCAC 13F .0604 Personal Care And Other Staff 10A NCAC 13F .0604 Personal Care And Other Staffing (a) Adult care homes shall staff to the licensed capacity of the home or to the resident census. When a home is staffing to resident census, a daily census log shall be maintained which lists current residents by name, room assignment and date of admission and must be available for review by the Division of Facility Services and the county departments of social services. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required aide hours were met to meet the needs of residents residing in the Assisted Living for 5 of 12 shifts sampled from 05/25/24 to 07/15/24. The finding are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was an Adult Care Home with a capacity of 100 residents, 58 residents reside in the Assisted Living. Review of the facility's census record for 05/25/24 to 05/26/24 revealed there was a census of 25 residents' residing in the Assisted Living which required 16 aide hours on first and second shifts, and 8 aide hours on third shift.	D 185		

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Review of staff timecard punches from 05/25/24 to 05/26/24 revealed:
-On 05/25/24, 11.25 aide hours were provided on first shift leaving a shortage of 4.75 aide hours.
-On 05/25/24, 7.50 aide hours were provided on second shift leaving a shortage of 8.5 aide hours.
-On 05/26/24, 5.00 aide hours were provided on second shift leaving a shortage of 11.00 aide hours.

Review of the facility's census record for 06/14/24 and 06/17/24 revealed there was a census of 23 residents' residing in the Assisted Living which required 16 aide hours on first and second shifts, and 8 aide hours on third shift.

Review of staff timecard punches from 06/13/24 through 06/15/24 revealed:
-On 06/14/24, 12.04 aide hours were provided on second shift leaving a shortage of 3.96 aide hours.
-On 07/15/24, 7.33 aide hours were provided on second shift leaving a shortage of 7.64 aide hours.

Interview with a personal care aid (PCA) on 06/20/24 at 11:15am revealed:
-She worked first shift and would stay over 4 hours on second shift when needed.
-There was not always enough staff on second shift.
-When she stayed over and worked second shift, she would give as many showers as she could because she did not know when there would be enough help to give showers again.
-No one came in to relieve her when she left at 7:00pm.
-The facility was short many days.

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Interview with a second PCA on 06/20/24 at 12:10pm revealed:
-She worked third shift.
-She had worked nights when there was one medication aide (MA) and one PCA.
-It was difficult to provide care to all residents when needed.
-Sometimes she was late getting to residents; but she always provided care that was needed.
-She was supposed to do laundry, but she rarely had time to do laundry on third shift.

Interview with the third and fourth PCAs on 06/18/24 at 8:57am revealed:
-The facility was always short staffed, and staff were constantly asked to work past their shift to cover the "holes" on the schedule.
-The facility had been short of staff on second shift for as long as they could recall.
-There was usually only two staff scheduled for the entire building on second shift.
-The facility did not have enough staff working the previous weekend, 06/15/24 to 06/17/24.
-The staff rotated from the SCU to the AL on the schedule.
-The staff stayed when they could and covered the staff shortages in the AL and the SCU.

Interview with a resident on 06/18/24 at 9:22am revealed:
-He resided on the Assisted Living (AL) side of the facility.
-There was not enough staff on the weekends on overnight.
-One night about three months ago he was sick to his stomach and he pulled his call bell for assistance and
staff never responded.
-There was only one or two staff on second and third shift most nights.

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D 185	Continued From page 3 Observation of the call bell system on 06/20/24 from 2:10pm to 2:24pm revealed: -At 2:10pm the surveyor pulled and activated the call bell in room 602 on the AL side of the facility. -There was a light above the door outside of the resident room; the light was turned on when the call bell cord was pulled and it stayed on. -No staff responded to the call bell for room 602. Interview with a MA on 06/20/24 at 10:55am revealed: -First shift was staff well most days during the week, but week-ends were mostly short. -Second shift was always short and staff was asked daily to work over and help out on second shift. -She stayed some days to help, but she could not stay every day. Interview with the Administrator on 06/20/24 at 2:14pm revealed: -She was aware that the facility was not meeting required staffing aide hours for April 2024 and May 2024. -She did not have any applications to review and hire from. -She was not accepting any new admissions at the time because of lack of staff. -The facility was offering the current staff time and a half plus bonuses to work extra hours. -The Administrator and the RCC had worked as MAs and PCAs to meet residents' needs.	D 185		
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	D 273		

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D 273	Continued From page 4	D 273		

of residents.

This Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure referral and follow-up were made for of 1 of 5 residents (#1) related to a referral for an appointment for eye dilation.

The findings are:

Review of Resident #1's current FL-2 dated 12/05/23 revealed diagnoses included diabetes mellitus, heavy chain disease, developmental disorder and intellectual disorder.

Review of a Resident #1's physician order dated 04/29/24 revealed there was a referral to have his eyes dilated was signed by Resident #1's endocrinologist.

Interview with Resident #1 on 06/20/24 at 10:07am revealed:
-He had not been to see the ophthalmologist since April 2024.
-He had not had his eyes dilated since April 2024.
-He did not know if he had trouble with his eyes, he did not have pain or problems with his vision.

Telephone interview with Resident 1's Primary Care Provider (PCP) on 06/20/24 at 10:35am revealed:
-Resident #2 had a diagnosis of diabetes and would typically be seen for two times a year to have his eyes dilated.
-His endocrinologist could have him monitored due to a concern for glaucoma.

Interview with a medication aide (MA) on 06/20/24 at 8:56am revealed:

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-She did not schedule appointments for the residents unless she was asked to by the Resident Care Coordinator (RCC).
-She had not been asked to schedule an appointment for eye dilation for Resident #1.

Interview with the RCC on 06/18/24 at 4:51pm revealed:
-She was responsible for making appointments for the residents.
-Sometimes the resident's PCP or specialist would schedule the appointment or make the referral at the specialist office.
-She would follow up with the referral to make sure the appointment was made.
-She did not recall scheduling any appointments with an ophthalmologist for Resident #1.
-The facility also had an ophthalmologist that visited the facility; the ophthalmologist had visited the facility in April 2024.
-The eye appointment for Resident #1 should have been made with in the next day of the referral.
-The eye appointment for Resident #1 was not made; the referral was missed.

Interview with the Administrator on 06/20/24 at 11:30am revealed:
-The RCC was responsible for scheduling physicians' appointments.
-The appointments should be made the same day the referral was received.
-The previous RCC should have made the eye appointment for Resident #1.
-It was overlooked.

Attempted telephone interview with Resident #1's endocrinologist on 06/20/24 at 8:43am was unsuccessful.

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D 296	Continued From page 6	D 296		
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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a therapeutic diet menu for 2 of 2 sampled residents (#6, #7) with a diet order for a pureed diet (#6) and an order for a mechanical soft (MS) diet (#7). The findings are: Observation of the kitchen on 06/18/24 at 8:27am revealed: -There was a regular weekly menu posted near the hot food line in the kitchen. -There was a resident diet list posted on the reach in cooler. -There was sheet of paper with an example of pureed food items and what a pureed consistency was. -A pureed consistency was described as required no chewing, was smooth and lump free, no hard pieces, thick and moist, held together well and was not runny, and a line drawn in the food would be slow to disappear. -The lunch meal listed for Tuesday, 06/18/24, was	D 296		

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D 296	Continued From page 7 North Carolina pork roast, mashed yams, collard greens, backed roll, assorted fruit and beverage of choice. 1. Review of Resident #6's current FL2 dated 08/30/23 revealed diagnoses included alzheimer's disease and coronary arteriosclerosis. Review of Resident #6's diet order sheet dated 02/13/24 revealed an order for a pureed diet and honey thickened liquids. Review of the facility's menus revealed there were no therapeutic diet menus available for a pureed diet. Review of the facility's weekly menu for the lunch meal service on 06/18/24 for regular diets revealed pork roast, mashed yams, collard greens, baked roll, assorted fruit, beverage choice, and milk to be served. Observation of the lunch meal service in the Special Care Unit (SCU) on 06/18/24 between 12:00pm and 12:30pm revealed: -Resident #6 was served a pureed white food item, a pureed brown food item, a pureed tan food item, a pureed green food item, honey thickened water, honey thickened juice, and honey thickened milk. -Resident #6 ate 100% of his meal. Review of the facility's daily menu for the breakfast meal service on 06/19/24 for regular diets revealed eggs of choice, hash brown patty, fresh fruit, 100% juices, whole grain toast, milk and water to be served. Observation of the breakfast meal service in the	D 296		

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D 296	Continued From page 8 SCU on 06/19/24 between 8:00am and 8:40am revealed: -Resident #6 was served a pureed yellow item, a second pureed yellow item, a pureed brown item, a pureed light brown item, honey thickened water, honey thickened juice, and honey thickened milk. -Resident #6 consumed 100% of his meal. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Refer to interview with the facility's primary care provider (PCP) on 06/20/24 at 10:55am. Refer to interview with the cook on 6/19/24 at 11:43am. Refer to interview with the Kitchen Manager (KM) on 06/18/24 at 10:58am. Refer to interview with the Administrator on 06/19/24 at 2:23pm. 2. Review of Resident #7's current FL2 dated 05/07/24 revealed diagnoses included alzheimer's disease and osteopenia. Review of Resident #7's diet order sheet dated 07/12/23 revealed an order for a mechanical chopped diet and nectar thickened liquids. Review of the facility's menus revealed there were no therapeutic diet menus available for a mechanical chopped diet. Review of the facility's weekly menu for the lunch meal service on 06/18/24 for regular diets revealed pork roast, mashed yams, collard greens, baked roll, assorted fruit, beverage	D 296		

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D 296	Continued From page 9 choice, and milk. Observation of the lunch meal service in the Special Care Unit (SCU) on 06/18/24 between 12:15pm and 12:45pm revealed Resident #7 was served a roll and milk for lunch. Review of the facility's daily menu for the breakfast meal service in the SCU on 06/19/24 for regular diets revealed eggs of choice, hash brown patty, fresh fruit, 100% juices, whole grain toast, milk and water. Observation of the breakfast meal service in the Special Care Unit SCU on 06/19/24 between 8:00am and 8:40am revealed: -Resident #7 was served eggs, chopped hash brown patty, fresh fruit, chopped toast, nectar thickened water, nectar thickened juice, and nectar thickened milk. -Resident #7 consumed 95% of her meal. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Refer to interview with the facility's primary care provider (PCP) on 06/20/24 at 10:55am. Refer to interview with the cook on 6/19/24 at 11:43am. Refer to interview with the Kitchen Manager (KM) on 06/18/24 at 10:58am. Refer to interview with the Administrator on 06/19/24 at 2:23pm. _____ Telephone interview with the facility's contracted	D 296		

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primary care provider (PCP) on 06/20/24 at 10:55am revealed if the facility staff were not following a therapeutic diet order not by preparing the residents' food correctly there could be a risk of aspiration or choking.

Interview with the cook on 06/19/24 at 11:43am revealed:
-She did not have a therapeutic diet menu to follow when she prepared the residents' meals.
-She served all the residents the food on the regular menu but excluded food items that were on the list for the mechanical soft (MS) and the pureed diets.
-She had a list of what not to serve to pureed diets, but the list fell off the region cooler and was gone.
-She was told not to puree bacon because it was too hard and would not puree well.
-She was trained by the administer on how to prepare food for the MS and pureed diets.

Interview with the Kitchen Manager (KM) on 06/18/24 at 10:58am revealed:
-The kitchen did not have a therapeutic diet menu to follow for MS or pureed diets.
-The residents were all served the same food items.
-The staff followed the regular weekly menu and either chopped or pureed the entire meal.
-The food for the MS therapeutic diet was cut up or blended in a blender until smooth and the puree foods were pureed to the consistency of baby food but wetter.

Interview with the Administrator on 06/19/24 at 2:23pm revealed:
-She trained the kitchen staff on how to prepare the food for the residents who were ordered the MS diets and the pureed diets.

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D 296	Continued From page 11 -She did not have a therapeutic diet menu for the kitchen staff to follow or use as guidance when preparing the therapeutic menus. -The residents who were ordered a therapeutic diet were served the same food as the residents who were on a regular diet. -She educated the staff on what food not to serve to the residents ordered a MS or pureed diet. -She told the staff not to serve bacon to the residents who were ordered a MS or pureed diet. -She had years of training in the kitchen; she was not a dietitian. -The food vender provided the regular menu. -She was not aware the kitchen staff needed a therapeutic diet menu signed by a dietitian for guidance while prepare the food for therapeutic diet orders.	D 296		
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, record reviews and interviews the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#1) including a medication by nebulizer treatment, a nasal spray and an antacid with calcium.	D 358		

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D 358	Continued From page 12 The findings are: Review of Resident #1's current FL-2 dated 12/05/23 revealed diagnoses included diabetes mellitus, heavy chain disease, developmental disorder and intellectual disorder. a. Review of Resident #1's FL-2 dated 12/05/23 revealed there was an order for ipratropium-albuterol (used to treat air flow blockage) 0.5mg-3mg inhale 3ml two times daily via nebulizer. Review of Resident #1's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for ipratropium-albuterol 0.5mg-3mg inhale 3ml via nebulizer twice daily scheduled at 8:00am and 8:00pm. -There was documentation ipratropium-albuterol was administered 60 of 60 opportunities from 04/01/24 to 04/30/24. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for ipratropium-albuterol 0.5mg-3mg inhale 3ml via nebulizer twice daily scheduled at 8:00am and 8:00pm. -There was documentation ipratropium-albuterol was administered 62 of 62 opportunities from 05/01/24 to 05/31/24. Review of Resident #1's June 2024 eMAR from 06/01/24 to 06/18/24 revealed: -There was an entry for ipratropium-albuterol 0.5mg-3mg inhale 3ml via nebulizer twice daily scheduled at 8:00am and 8:00pm. -There was documentation ipratropium-albuterol was administered 35 of 35 opportunities from 06/01/24 to 06/18/24.	D 358		

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D 358	Continued From page 13 Observation of Resident #1's medications on hand on 06/19/24 at 9:55am revealed: -There was a box of 60 vials of ipratropium-albuterol 0.5mg-3mg/3ml. -The box of ipratropium-albuterol was dispensed on 05/16/24. -There was an open date written on the box of 05/24/24. -There were 24 vials available for administration. -Based on the open date on the box there should have been only seven vials available for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 6/20/24 at 9:28am revealed: -Resident #1 had a current order for ipratropium-albuterol 0.5mg-3mg inhale 3ml via nebulizer twice daily. -Sixty vials of ipratropium-albuterol were dispensed on 02/06/24, 03/28/24 and 05/16/24; a thirty-day supply was dispensed each time. -The facility had to reorder ipratropium-albuterol because it was no on a cycle fill. -Ipratropium-albuterol was a breathing treatment used to help when a resident had difficulty breathing. Interview with Resident #1 on 06/20/24 at 10:07am revealed: -He did his nebulizer treatment every night before he went to bed. -The medication aide (MA) set it up for him and he did the treatments. -Sometimes he had a nebulizer treatment in the mornings but most of the time the MAs did not "get to him" so they skipped him. -He did not know why he was ordered the nebulizer treatment.	D 358		

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Telephone interview with Resident #1's Primary Care Provider (PCP) on 06/20/24 at 10:35am revealed:
-She had only been Resident #1's PCP for a few weeks.
-She was not sure why Resident #1 was ordered a nebulizer treatment twice a day.
-He could have had the order because he had heart issues or because he had pneumonia and had difficulty breathing after the pneumonia.
-It could be a concern if he was ordered the ipratropium-albuterol treatment twice a day and was not getting it because he could have difficulty breathing or shortness of breath.

Interview with a MA on 06/20/24 at 8:56am revealed:
-Resident #1 did not get a nebulizer treatment with ipratropium-albuterol in the morning.
-He was administered ipratropium-albuterol in the evening by the second shift MA.
-She had documented the morning administration of Resident #1's nebulizer treatment with ipratropium-albuterol on the eMAR because the third shift MA had set up the nebulizer with the medication in it and she checked on the resident to be sure he did the treatment.
-Ipratropium-albuterol vials were not on cycle fill and needed to be reordered by the MAs when the supply was getting low.
-If there were extra vials of the ipratropium-albuterol then staff were not administering the medication like it was supposed to be.

Interview with the Resident Care Coordinator (RCC) on 06/20/24 at 10:29am revealed:
-The MAs were responsible for reordering Resident #1's ipratropium-albuterol from the

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pharmacy.
-The MA on first shift should have been administering Resident #1's ipratropium albuterol.
-One shift should not be setting up medications for the next shift to administer.
-The MA should stay with the resident the entire time they are using the nebulizer machine.
-She could not explain why there were extra vials of Resident #1's ipratropium-albuterol.

Refer to the interview with the RCC on 06/20/24 at 10:29am.

Refer to the interview with the Administrator on 06/20/24 at 11:30am.

b. Review of Resident #1's FL-2 dated 12/05/23 revealed there was an order for fluticasone nasal spray (used to treat seasonal allergies) 50mcg two sprays in each nostril once daily.

Review of Resident #1's April 2024 eMAR revealed:
-There was an entry for fluticasone nasal spray 50mcg two sprays in each nostril once daily scheduled at 8:00am.
-There was documentation fluticasone 50mcg was administered 30 of 30 opportunities from 04/01/24 to 04/30/24.

Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for fluticasone nasal spray 50mcg two sprays in each nostril once daily scheduled at 8:00am.
-There was documentation fluticasone 50mcg was administered 31 of 31 opportunities from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 eMAR from

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06/01/24 to 06/18/24 revealed:
-There was an entry for fluticasone nasal spray 50mcg two sprays in each nostril once daily scheduled at 8:00am.
-There was documentation fluticasone 50mcg was administered 18 of 18 opportunities from 06/01/24 to 06/18/24.

Observation of Resident #1's medications on hand on 06/19/24 at 9:55am revealed:
-The was a box with a 16gm bottle of fluticasone nasal spray dispensed on 05/16/24; 120 metered sprays were in the bottle.
-There was an open date of 05/17/24 written on the box.
-The bottle was half full.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/20/24 at 9:28am revealed:
-Resident #1 had a current order for fluticasone nasal spray 50mcg two sprays in each nostril once daily.
-A thirty-day supply of fluticasone was dispensed on 01/09/24, 02/09/24, 05/16/24 and 06/18/24.
-The facility staff had to contact the pharmacy for a refill of fluticasone for Resident #1 because it was not on a cycle fill.
-Fluticasone nasal spray was a decongestant and provided relief from allergy symptoms.

Interview with Resident #1 on 06/20/24 at 10:07am revealed:
-He got [was administered] his nasal spray every morning.
-He got one spray in each nostril.
-The MA squeezed the bottle for him.

Telephone interview with Resident #1's PCP on 06/20/24 at 10:35am revealed:

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-Fluticasone was used to open the nasal passage and was usually ordered for seasonal allergies.
-If Resident #1 was not administered his fluticasone nasal spray as ordered he could have a runny nose, congestion and other symptoms of seasonal allergies.

Interview with a MA on 06/20/24 at 8:56am revealed:
-She administered Resident #1 his fluticasone nasal spray every morning.
-She inserted the applicator depressed the applicator nozzle one time for each nostril.
-She was not aware the order was for two sprays in each nostril.
-She followed the eMAR but missed the two sprays per nostril.

Interview with the RCC on 06/20/24 at 10:29am revealed:
-Resident #1's fluticasone nasal spray was not on cycle fill and had to be reordered by the MAs.
-The MA that administered Resident #1 one fluticasone nasal spray should have compared the order on the bottle to the order on the eMAR before administering.
-She was not aware Resident #1 was not administered the correct dose of fluticasone nasal spray.

Refer to the interview with the RCC on 06/20/24 at 10:29am.

Refer to the interview with the Administrator on 06/20/24 at 11:30am.

c. Review of Resident #1's physician's order dated 05/16/24 revealed an order for calcium carbonate (used to treat acid reflux) 500mg one chewable tablet once daily.

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Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for calcium carbonate 500mg one chewable tablet once daily scheduled at 8:00am.
-There was documentation calcium carbonate began being administered on 05/18/24.
-Calcium carbonate was documented as administered 14 of 14 opportunities from 05/01/24 to 05/31/24.

Review of Resident #1's June 2024 eMAR from 06/01/24 to 06/18/24 revealed:
-There was an entry for calcium carbonate 500mg one chewable tablet once daily scheduled at 8:00am.
-There was documentation calcium carbonate was administered 18 of 18 opportunities from 06/01/24 to 06/18/24.

Observation of Resident #1's medications on hand on 06/19/24 at 9:55am revealed:
-There was a bottle of one hundred and fifty chewable tablets of over the counter (OTC) calcium carbonate 500mg dispensed on 05/16/24.
-There was an open date of 05/18/24 written on the bottle.
-There were 135 tablets of calcium carbonate available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/20/24 at 9:28am revealed:
-Resident #1 had a current order for calcium carbonate 500mg one chewable tablet once daily.
-One hundred and fifty tablets of calcium carbonate were dispensed on 05/18/24; there was a 150-day supply of the calcium carbonate.

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-Calcium carbonate was used to prevent acid reflux.

Interview with Resident #1 on 06/20/24 at 10:07am revealed:
-The MA gave him a pill to chew just one time.
-Sometimes he got a burning sensation in his chest and when he told the MA they would give him a pill to chew.

Telephone interview with Resident #1's PCP on 06/20/24 at 10:35am revealed:
-Resident #1 was ordered the calcium carbonate because his calcium levels were 8.7 when his last laboratory results were done on 12/14/23.
-If he fell, he could break a bone if his calcium levels dropped any lower.
-She recommended all of Resident #1's medications be administered as ordered.

Interview with a MA on 06/20/24 at 8:56am revealed:
-She administered Resident #1 one OTC chewable tablet of calcium carbonate every morning.
-Resident #1 did not have any problems with chewing the tablet; he did not refuse his medications.
-She did not know why he had so many tablets available for administration; some of the other staff must not have administered them like they were supposed to.

Interview with the RCC on 06/20/24 at 10:29am revealed:
-Resident #1 should have been administered his calcium carbonate tablet every morning by the 1st shift MA.
-She was not sure why there were extra tablets of calcium carbonate available for administering to

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D 358	Continued From page 20 Resident #1. Refer to the interview with the RCC on 06/20/24 at 10:29am. Refer to the interview with the Administrator on 06/20/24 at 11:30am. _____ Interview with the RCC on 06/20/24 at 10:29am revealed: -She conducted medication cart audit couple of times a week. -The MAs were required to do daily chart audits and she followed up behind the MA audit to ensure it was done correctly. -The MAs were supposed to compare the eMAR to see what was ordered and then look at the medication being used. -The MA was supposed to look at the open date on the bottle and to ensure the medicine was on the medication cart. -The MAs were required to administer all medications including nebulizer treatments, nasal sprays and medications not in the medication cards as ordered by the PCP. Interview with the Administrator on 06/20/24 at 11:30am revealed: -The MAs were expected to check for the right resident, the right medication, the right dosage and the right time when administering medications. -The MAs were expected to document correctly on the eMAR when they administered medications. -If a resident had extra medication available for administration then it appeared that the MAs were not administering medications as ordered. -She expected the MA's to follow the physicians' orders.	D 358		

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D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required aide hours were met to meet the needs of residents residing in the Special Care Unit (SCU) for 14 of 25 shifts sampled from 05/24/24 to 06/16/24. The findings are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was an Adult Care Home with a capacity of 100 residents and licensed for 42 SCU beds. Review of the facility's census record for 05/24/24 to 05/26/24 revealed there was a census of 33 residents' residing in the SCU which required 33 aide hours on first and second shifts, and 26.4 aide hours on third shift. Review of staff timecard punches from 05/24/24 to 05/28/24 revealed: -On 05/24/24, 22.50 aide hours were provided on first shift in the SCU leaving a shortage of 9.5 hours.	D 465		

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-On 05/24/24, 18.00 aide hours were provided on second shift in the SCU leaving a shortage of 12.00 hours.
-On 05/25/24, 19.00 aide hours were provided on first shift in the SCU leaving a shortage of 13.00 aide hours.
-On 05/25/24, 12.00 aide hours were provided on second shift in the SCU leaving a shortage of 20.00 hours.
-On 05/26/24, 13.00 aide hours were provided on second shift in the SCU leaving a shortage of 19.00 aide hours.
-On 05/26/24, 15.00 aide hours were provided on third shift in the SCU leaving a shortage of 10.6 aide hours.

Review of the facility's census record on 06/13/24 through 06/15/24 revealed there was a census of 32 residents' residing in the SCU which required 32 aide hours on first and second shifts, and 25.6 aide hours on third shift.

Review of staff timecard punches from 06/13/24 through 06/15/24 revealed:
-On 06/13/24, 21.25 aide hours were provided on second shift in the SCU leaving a shortage of 10.75 aide hours.
-On 06/14/24, 16.85 aide hours were provided on second shift in the SCU leaving a shortage of 15.15 aide hours.
-On 06/15/24, 15.28 aide hours were provided on first shift in the SCU leaving a shortage of 16.72 aide hours.
-On 06/15/24, 12.04 aide hours were provided on second shift in the SCU leaving a shortage of 19.96 aide hours.
-On 06/15/24, 14.72 aide hours were provided on third shift in the SCU leaving a shortage of 10.88 aide hours.

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Review of the facility's census record on 06/16/24 revealed there was a census of 30 residents' residing in the SCU which required 30 aide hours on first and second shifts, and 24 aide hours on third shift.

Review of staff timecard punches on 06/16/24 revealed:
-On 06/16/24, 15.50 aide hours were provided on first shift in the SCU leaving a shortage of 14.50 aide hours.
-On 06/16/24, 23.15 aide hours were provided on second shift in the SCU leaving a shortage of 8.85 aide hours.
-On 06/16/24, 14.72 aide hours were provided on third shift in the SCU leaving a shortage of 10.88 aide hours.

Interview with a personal care aid (PCA) on 06/20/24 at 11:15am revealed:
-She worked first shift and would stay over 4 hours on second shift when needed.
-There was not always enough staff on second shift.
-When she stayed over and worked second shift, she would give as many showers as she could because she did not know when there would be enough help to give showers again.
-No one came in to relieve her when she left at 7:00pm.
-The facility was short many days.

Interview with a second PCA on 06/20/24 at 12:10pm revealed:
-She worked third shift.
-She had worked nights when there was one medication aide (MA) and one PCA.
-It was difficult to provide care to all residents when needed.
-Sometimes she was late getting to residents; but

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she always provided care that was needed.
-She was supposed to do laundry, but she rarely had time to do laundry on third shift.

Interview with a MA on 06/20/24 at 10:55am revealed:
-First shift was staff well most days during the week, but week-ends were mostly short.
-Second shift was always short and staff was asked daily to work over and help out on second shift.
-She stayed some days to help, but she could not stay every day.

Interview with the Administrator on 06/20/24 at 2:14pm revealed:
-She was aware that the facility was not meeting required staffing aide hours for April 2024 and May 2024.
-She did not have any applications to review and hire from.
-She was not accepting any new admissions at the time because of lack of staff.
-The facility was offering the current staff time and a half plus bonuses to work extra hours.
-The Administrator and the RCC had worked as MAs and PCAs to meet residents' needs.