STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: _____ B. WING _____	R 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 000	Initial Comments The Adult Care licensure Section and the Lenoir County Department of Social Services conducted a follow-up survey from June 26, 2024 to June 27, 2024.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#3 and #5) were tested for Tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: 1. Review of Resident #3's current FL-2 dated 06/21/24 revealed diagnoses included schizophrenia, hypertension, intellectual and developmental disabilities (IDD), Vitamin D deficiency and history of gastroesophageal reflux disease (GERD).	D 234		

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D 234	Continued From page 1	D 234		

Review of Resident #3's Resident Register revealed he was admitted to the facility on 10/18/23 from another facility.

Review of Resident #3's record revealed:
-There was no documentation that the 1st and 2nd step Tuberculosis (TB) tests were administered and read.
-There was no documentation of a chest X-ray.

Based on observations, interviews and record reviews it was determined that Resident #3 was not interviewable.

Review of a packing slip from the facility's contracted pharmacy dated 06/13/24 revealed Aplisol (used for administration as an aid in the diagnosis of tuberculosis) was received on 06/13/24.

Refer to interview with the Special Care Unit Coordinator (SCUC), who also supervised the assisted living (AL) staff, on 06/27/24 at 3:42pm.

Refer to interview with the Executive Director (ED) on 06/27/24 at 4:25pm.

2. Review of Resident #5's current FL-2 dated 01/09/24 revealed diagnoses included dementia, hypertension, dysphagia, chronic kidney disease and high cholesterol.

Review of Resident #5's Resident Register revealed he was admitted to the facility on 01/18/24 from home.

Review of Resident #5's record revealed there was only one TB test dated as administered on 01/15/24 and read on 01/17/24.

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D 234	Continued From page 2 Review of a packing slip from the facility's contracted pharmacy dated 06/13/24 revealed Aplisol (used for administration as an aid in the diagnosis of tuberculosis) was received on 06/13/24. Refer to interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 3:42pm. Refer to interview with the Executive Director (ED) on 06/27/24 at 4:25pm. _____ Interview with the Special Care Unit Coordinator (SCUC), who also supervised the assisted living (AL) staff, on 06/27/24 at 4:25pm revealed: -She became employed as the SCUC on 05/14/24. -She was responsible for ensuring residents had a 1st and 2nd step tuberculosis (TB) test. -She was not sure if anyone checked behind her to ensure the TB tests had been completed. -She went through all of the AL and special care unit (SCU) resident's charts at the beginning of June 2024. -She was aware Resident #3 had not had any TB tests and Resident #5 only had 1 step of the TB tests. -TB test serum and needles were ordered approximately 06/10/24 or 06/11/24 but the needles did not arrive. -She went to the facility's contracted pharmacy and purchased needles but was given the wrong needles. -She called the local health department to see if the residents could have been transported to the health department so the TB tests could be completed. -The health department advised the TB tests would be administered at the facility in July 2024. -She was unsure why the TB tests had not been	D 234		

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D 234	Continued From page 3	D 234		

administered to Resident #3 and #5.
-Resident #3 and Resident #5 were admitted to the facility prior to her hire date of 05/14/24.

Interview with the Executive Director on 06/27/24 at 4:25pm revealed:
-The SCUC was responsible for ensuring all residents' TB tests were completed upon admission and that the 2nd step TB test was completed.
-The ED was responsible for checking behind the SCUC to ensure that the TB tests had been completed.
-She knew the SCUC completed chart audits to see which residents needed TB tests.
-She was aware there were residents that needed TB tests but was not aware of specific resident names and what specific tests were needed.
-The Resident Care Coordinator (RCC) kept up with the TB tests.
-The RCC and SCUC are the same person.
-The facility's contracted pharmacy's nurse completed the TB tests.
-The nurse was scheduled to administer the TB tests on a day that would work out to where the primary care physician (PCP) could have read the test on her facility visit.
-The SCUC ordered the TB medication and syringes from the facility's contracted pharmacy.
-The TB medication arrived but the syringes did not arrive.
-The SCUC went to the facility's contracted pharmacy and picked up some syringes, but the nurse advised the syringes were not the correct syringes.
-She did not recall the order date for the TB medication and syringes.
-The TB tests were scheduled to be administered on 07/01/24 by the local health department.
-Resident #3 and Resident #5 were not admitted

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D 234	Continued From page 4 to the facility without TB tests. -She did not know where the TB tests documents were for Resident #3 and Resident #5. -She could not answer why the TB tests had not been completed for Resident #3 and Resident #5 because she was not employed at the facility at the time the residents were admitted.	D 234		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#2) for a resident who had three falls in a 21 day period with 3 emergency room visits. The findings are: Review of the facility's undated Fall policy on 06/27/24 revealed: -The fall policy provided guidance to residents and staff on fall prevention and education, which included steps to take when a fall occurred and actions for proper reporting of falls. -When a fall occurred an incident and accident report was completed -Procedures for what interventions to put into place after a resident had a fall was on a case by	D 270		

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D 270	Continued From page 5 case basis. Review of Resident #2's current FL-2 dated 05/31/24 revealed: -Diagnoses included dementia, seizure disorder, paranoid schizophrenia, and generalized anxiety disorder. -The resident was semi-ambulatory and intermittently disoriented. -The resident wandered. -The resident's level of care was Special Care Unit (SCU). Review an undated FL-2 for Resident #2 revealed: -Diagnoses included dementia, seizure disorder, paranoid schizophrenia, and generalized anxiety disorder. -The resident was semi-ambulatory and intermittently disoriented. -The resident wandered. -The resident's level of care was Assisted Living (AL). Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/06/23 to the facility. Review of Resident #2's care plan dated 06/15/24 revealed: -The resident required limited assistance with ambulation. -The resident required extensive assistance with toileting, bathing, dressing, grooming, and transfers. -The resident was sometimes disoriented and forgetful. -The resident used a wheelchair to ambulate and had a history of falls.	D 270		

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D 270	Continued From page 6 a. Review of Resident #2's accident/incident (A/I) report dated 05/28/24 revealed: -The incident occurred at 6:30am. -The resident was found on the floor in her room and had a skin tear on her forearm. -Staff administered first aid to the resident. -The primary care provider (PCP) was notified of the fall and ordered one hour checks on the resident for 6 hours to monitor for falls. Review of facility progress notes for Resident #2 revealed there were no progress notes related to the resident's fall on 05/28/24 at 6:30am. Request for increased supervision logs on 06/26/24 at 3:50pm and 06/27/24 at 8:25am were not provided. Refer to interview with a personal care aide (PCA) on 06/27/24 at 4:17pm. Refer to the interview with a medication aide (MA) on 06/27/24 at 4:07pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/27 at 4:47pm. Refer to interview with Resident #2's PCP on 06/27/24 at 2:36pm. Refer to interview with the Executive Director (ED) on 06/27/24 at 3:19pm. b. Review of Resident #2's emergency department (ED) after visit summary dated 05/28/24 revealed: -Resident #2 was seen in the ED on 05/28/24 at 11:49pm for a fall. -The resident reported that she lost her balance and fell forward off her wheelchair.	D 270		

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D 270	Continued From page 7 -Resident #2 was diagnosed with a fall, facial contusion, and left knee contusion (A contusion is a bruise). -Resident #2 was discharged back to the facility on 05/29/24. Review of a physician triage note dated 05/28/24 revealed: -Facility staff reported the resident had a fall and sustained a knot on her head. -Facility staff called the local emergency medical services (EMS). -There was an order for staff to increase supervision for Resident #2 every hour for 8 hours once the resident returned to the facility from the ED. Review of facility progress notes for Resident #2 revealed there were no progress notes related to the resident's second fall on 05/28/24. Request for increased supervision logs on 06/26/24 at 3:50pm and 06/27/24 at 8:25am were not provided. Refer to interview with a personal care aide (PCA) on 06/27/24 at 4:17pm. Refer to the interview with a medication aide (MA) on 06/27/24 at 4:07pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/27 at 4:47pm. Refer to interview with Resident #2's PCP on 06/27/24 at 2:36pm. Refer to interview with the Executive Director (ED) on 06/27/24 at 3:19pm.	D 270		

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D 270	Continued From page 8 c. Review of Resident #2's accident and incident (A/I) report dated 05/29/24 revealed: -The time of the incident was 9:00am. -The resident fell in the hallway and was helped off the floor into her wheelchair by staff. -Staff remained seated beside the resident until emergency medical services (EMS) arrived. -Resident #2's primary care provider (PCP) was notified, and staff were directed to increase supervision for the resident every hour for 12 hours once the resident returned from the local emergency department (ED). Review of Resident #2's ED after visit summary dated 05/29/24 revealed: -Resident #2 was seen at the ED on 05/29/24 at 10:15am. -The resident was seen for trauma due to a fall from her wheelchair. -The resident had multiple falls at the facility. -Resident #2 was diagnosed with an acute fall, nasal bridge abrasion, bilateral knee abrasions and contusions, and a head injury with scalp hematoma (Hematoma is bruise). -Resident #2 was discharged back to the facility on 05/29/24. Review of a physician triage note dated 05/29/24 revealed: -Staff called to report Resident #2 fell and had a bump and laceration over her right eye. -There was an addendum from the physician triage note dated 05/29/24 that upon return from the hospital, Resident #2 had another fall where she hit her head again. -The resident reported to staff that she wanted to return to the ED because they treated her well. -There was an order to increase supervision for Resident #2 to 1 hour for 12 hours and for staff to continue to monitor the resident closely.	D 270		

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D 270	Continued From page 9 Review of facility progress notes for Resident #2 revealed there were no progress notes related to the resident's fall on 05/29/24. Review of a one hour supervised checks form for Resident #2 dated 05/29/24 revealed: -There was a 24 hour period with times for first, second, and third shifts. -There was a blank space beside each time for staff to initial that they completed supervised checks. -There was one staff initial every hour from 10:00am to 6:00pm on 05/29/24. Review of a progress note from Resident #2's PCP dated 05/31/24 revealed: -Resident #2 was seen for a follow up visit due to her recent ED visits. -Staff reported to the PCP that Resident #2 fell two times on 05/28/24. -The resident was sent to the ED for a second fall on 05/28/24 that occurred at 11:49pm. -Resident #2 fell again on 05/29/24 and required treatment at the ED. -She completed a new FL-2 for Resident #2 on 05/31/24 to change her level of care from Assisted Living (AL) to Special Care Unit (SCU) to increase her supervision and care. -Resident #2 was diagnosed with recurrent falls. -The PCP ordered staff to provide increased supervision following her falls and to transition the resident to SCU. Review of a progress note from Resident #2's PCP dated 06/15/24 revealed: -Resident #2 was seen for a follow up visit due to a recent ED visit. -The resident was seen at the local ED for a rash and was doing better.	D 270		

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-The resident had been transitioned to the SCU to enhance her safety and decrease falls.
-Resident #2 had a history of multiple falls and multiple ED visits due to falls.
-The PCP documented under the plan for Resident #2 for staff to continue to monitor the resident closely to ensure the resident's safety.

Refer to interview with a personal care aide (PCA) on 06/27/24 at 4:17pm.

Refer to the interview with a medication aide (MA) on 06/27/24 at 4:07pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/27 at 4:47pm.

Refer to interview with Resident #2's PCP on 06/27/24 at 2:36pm.

Refer to interview with the Executive Director (ED) on 06/27/24 at 3:19pm.

d. Review of Resident #2's accident/incident (A/I) report dated 06/17/24 revealed:
-The time the incident occurred was 7:00am.
-The resident was found on the floor in her room and fell out of her wheelchair.
-Staff sent the resident to the local emergency department (ED) per primary care provider (PCP) order.

Review of Resident #2's emergency department (ED) after visit summary dated 06/17/24 revealed:
-Resident #2 was seen in the ED on 06/17/24 for a fall.
-Facility staff reported staff witnessed the resident fall out of her wheelchair.
-Resident #2 was diagnosed with an acute fall and closed head injury.

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D 270	Continued From page 11 Review of a physician triage note dated 06/17/24 revealed: -Facility staff reported the resident fell and hit her head. -Triage directed the facility to contact Emergency Medical Services (EMS) to have Resident #2 transported to the local ED for evaluation and treatment. -Staff were ordered to increase supervision to one time every 6 hours once the resident returned from the ED. Review of facility progress notes for Resident #2 revealed there were no progress notes related to the resident's fall on 06/17/24. Request for increased supervision logs on 06/26/24 at 3:50pm and 06/27/24 at 8:25am were not provided. Refer to interview with a personal care aide (PCA) on 06/27/24 at 4:17pm. Refer to the interview with a medication aide (MA) on 06/27/24 at 4:07pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/27 at 4:47pm. Refer to interview with Resident #2's PCP on 06/27/24 at 2:36pm. Refer to interview with the Executive Director (ED) on 06/27/24 at 3:19pm. _____ Interview with a personal care aide (PCA) on 06/27/24 at 4:17pm revealed: -Resideint #2 had a history of falls. -The resident would forget to ask for help and try	D 270		

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D 270	Continued From page 12	D 270		

to get out of her wheelchair which caused her to fall because the resident did not remember she was unable to walk.
-When a resident was placed on increased supervision one staff person each shift was responsible for completing a supervision checklist.
-The Special Care Unit Coordinator (SCUC) or medication aide (MA) would inform her at the beginning of her shift if a resident was on increased supervision.
-She had not seen an increased supervision checklist for Resident #2 since she had been moved to the SCU.

Interview with a MA on 06/27/24 at 4:07pm revealed:
-Resident #2 had frequent falls because the resident forgot that she was unable to walk.
-The resident would attempt to get out of her wheelchair and would fall.
-The MAs only implemented increased supervision if there was an order from the resident's primary care provider (PCP).
-The MA had the understanding that increased supervision was only implemented by a resident's PCP.

Interview with the SCUC on 06/27 at 4:47pm revealed:
-Resident #2 had been on increased supervision several times due to her frequency of falls.
-Resident #2 was moved from the Assisted Living part of the facility to the SCU to help decrease her falls.

Telephone interview with Resident #2's PCP on 06/27/24 at 2:36pm revealed:
-She recommended Resident #2 level of care be changed from Assisted Living to the Special Care

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D 270	Continued From page 13 Unit (SCU) due to the resident's cognitive decline and increased falls. -Resident #2's dementia had progressed, and the resident stayed in a wheelchair during the day because she was unable to walk. -Resident #2 would forget that she was unable to walk and fall when she attempted to get out of her wheelchair. -Resident #2 had several falls in May and had to be sent to the local emergency department (ED) due to injuries. -She had ordered increased supervision for Resident #2 after each fall to help prevent additional falls. -Facility staff did not have to wait for her or a triage physician to order increased supervision for Resident #2; it was important for staff to implement increased supervision immediately once it was needed to ensure the resident was not at risk of additional falls. Interview with the Executive Director (ED) on 06/27/24 at 3:19pm revealed: -Resident #2 had several falls on the Assisted Living side of the building and had been moved per her PCP's order to the SCU. -When a resident had a fall the MA on duty would complete an Accident and Incident form and notify the PCP. -The MAs and SCUC were only supposed to place a resident on increased supervision if the PCP ordered it. -Staff were instructed to implement increased supervision once a resident's PCP ordered it. -The facility did not automatically place any type of increased supervision in place when a resident had a fall with an injury that required treatment at a local emergency department (ED).	D 270		

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D 344	Continued From page 14	D 344		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure contact with a resident's primary care provider (PCP) for clarification of an incorrect order on an FL-2 for 1 of 5 residents (#2) for a medication used to treat anxiety. The findings are: Review of the facility's undated Medication Administration policy on 06/27/24 revealed: -Medications, prescriptions, non-prescription, and treatments should be administered in accordance with prescribing physicians' orders. -The medication administration record (MAR) should include the resident's name, name of medication, strength and dosage or quantity of medication, instructions for administering the medications, date and time of administration, name and initials of the person administering the medication, for medications when necessary, and	D 344		

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the reason for use and results of use to the resident.
-The MAR should be updated and changed when medication orders from the prescribing physician.

Review of Resident #2's current FL-2 dated 05/31/24 revealed:
-Diagnoses included dementia, seizure disorder, paranoid schizophrenia, and generalized anxiety disorder.
-The resident was semi-ambulatory and intermittently disoriented.
-The resident's level of care was Special Care Unit (SCU).
-There was an order for Lorazepam 0.5mg, take one tablet every 8 hours (Lorazepam is used to treat anxiety).

Review of Resident #2's June 2024 medication administration record (MAR) revealed:
-There was a printed entry for Lorazepam 0.5mg, take one tablet every 8 hours as needed.
-There was documentation that Lorazepam 0.5mg was administered on 06/01/24, with no time documented.
-There was documentation that Lorazepam 0.5mg was administered on 06/18/24, with no time documented.

Observation of medications on hand for Resident #2 on 06/27/24 revealed:
-There was a bubble card with a pharmacy label with a dispensing date of 08/15/23.
-There was a quantity of 30 tablets dispensed.
-Lorazepam 0.5mg tablet, take one tablet every 8 hours as needed for anxiety.
-There were 8 Lorazepam 0.5mg tablets on hand.

Interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 11:30am revealed:

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D 344	Continued From page 16 -She completed Resident #2's FL-2 that was signed by the primary care provider on 05/31/24. -She was not aware that Resident #2's FL-2 had an order for Lorazepam 0.5mg, take one tablet every 8 hours. -She had evidently typed the wrong dosage information for Lorazepam on the FL-2. -The order on the FL-2 should have been Lorazepam 0.5mg, take one tablet every 8 hours as needed. -She faxed the resident's updated FL-2 to the facility's contracted pharmacy, and the pharmacy prints the facility's MARs. -She should have caught her mistake and contacted Resident #2's primary care provider (PCP) to obtain a clarification order. Telephone interview with Resident #2's PCP on 06/27/24 at 2:36pm revealed: -She was not aware that Resident #2's FL-2 order for Lorazepam 0.5mg was scheduled to administer one tablet every 8 hours. -She would not schedule Lorazepam for Resident #2 because it would place the resident at an increased risk of falls. -Resident #2 had a history of falls and she ordered Resident #2 to have Lorazepam 0.5mg as needed for anxiety. -The SCUC or a medication aide (MA) should have contacted her for a clarification order of the FL-2 dated 05/31/24. Interview with the Executive Director (ED) on 06/27/24 at 4:56pm revealed: -The SCUC and MAs reviewed physician orders and MARS. -The SCUC or MA should have contacted Resident #2's PCP for a clarification order of Lorazepam 0.5mg.	D 344		

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D 358	Continued From page 17	D 358		
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 administer medications as ordered for 1 of 5 sampled residents (#1) including two medications to treat diabetes, and for 2 of 4 residents observed during the medication pass (#8, #9) including a medication to treat high blood pressure (Resident #8) and a topical medication to treat dry skin and a medicated mouth wash (Resident #9). The findings are: Review of the facility's undated medication policy revealed: -Medication, prescriptions and non-prescriptions, and treatments would be administered in accordance with the prescribing practitioner's orders. -Documentation would be provided for each dose of medication by the staff who prepared the medication for administration. -Documentation would be provided by staff who administered medications and performed treatment to the residents on the facility medication administration record (MAR).	D 358		

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D 358	Continued From page 18 -Staff shall provide documentation on the MAR after observing the resident taking the medications and before administration to another resident. -The MAR would include the following; the resident's name, name of the medication and/or treatment, strength and dosage or quantity of medication, instructions for administering the medication or performing the treatment, date and time of administration, or date when treatment was performed, name and initials of the person administering the medication or performing the treatment, for PRN medications and treatments, the reason for use and results of use to the resident, and omissions ad refusals of medications or treatments and the reason for omissions will be documented on the MAR. -In the event of medication errors and adverse reactions to medications, the facility staff would notify a physician or appropriate health professional, their immediate supervisor, would document any orders received by the physician or health professional and actions taken by the facility to comply with the order. -Charting would identify if documentation errors, unavailability of medications or resident's refusal of medication may have lead to the error. 1. The medication error rate was 9% as evidenced by 3 errors out of 31 opportunities during the 7: 00am and 9:00am medication pass on 06/27/24. a. Review of Resident #8's current FL-2 dated 06/20/24 revealed: -Diagnoses included hypertension and vascular dementia. -Her level of care was Special Care Unit (SCU). -Triamterene/hydrochlorothiazide 37.5-25mg (used to treat fluid retention or high blood	D 358		

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pressure), take one tablet daily, hold for systolic blood pressure (SBP) less than 100.

Review of Resident #8's signed physician order dated 05/02/24 revealed an order for triamterene/hydrochlorothiazide 37.5-25mg, take one tablet every morning, hold for SBP less than 100.

Review of Resident #8's June 2024 medication administration record (MAR) revealed:
-There was an entry for triamterene/hydrochlorothiazide 37.5/25mg, take one tablet every morning, hold for SBP less than 100, scheduled at 7:00am.
-Triamterene/hydrochlorothiazide was documented as administered at 7:00am from 06/01/24 to 06/27/24, with no documentation of the resident's blood pressure.

Observation of the 7:00am medication pass in the SCU on 06/27/24 revealed:
-The medication aide (MA) prepared 6 tablets in a medication cup that contained one triamterene/hydrochlorothiazide 37.5/25mg tablet at 7:43am.
-The MA administered the 6 medications to Resident #8 at 7:45am.
-The MA did not check Resident #8's blood pressure prior to administering the triamterene/hydrochlorothiazide 37.5/25mg.

Observation of Resident #8's medication on hand on 06/27/24 at 2:27pm revealed:
-There was a bubble package of triamterene/hydrochlorothiazide 37.5/25mg tablets, dispensed on 06/25/24 for a quantity of 28 tablets.
-There were 25 triamterene/hydrochlorothiazide 37.5/25mg tablets remaining in the bubble

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package.
-The bubble package was labeled triamterene/hydrochlorothiazide 37.5/25mg take one tablet by mouth every morning, hold for SBP less than 100.

Based on observations, interviews and record review it was determined that Resident #8 was a not interviewable.

Telephone interview with a representative from the facility's contracted pharmacy on 06/27/24 at 3:44pm revealed:
-Triamterene/hydrochlorothiazide 37.5/25mg was last dispensed for Resident #8 on 06/25/24 for a quantity of 28 for a 28-day supply to take 1 tablet every morning, hold for SBP less than 100.
-The facility used paper MARS and could document Resident #8's blood pressure on the paper MAR or the pharmacy could provide the facility with a different paper MAR with a specific place to document the resident's blood pressure.

Interview with the MA on 06/27/24 at 10:54am revealed:
-If a resident's medication included parameters, it was on the MAR and the medication label.
-She always compared the resident's medication label the MAR before she administered medications.
-She checked Resident #8's blood pressure each morning before she administered her medication but there was no place to record the daily vital signs, so they were not documented.
-She forgot to check Resident #8's blood pressure this morning before she administered her medications because she was nervous.
-She checked Resident #8's blood pressure at 11:01am and the resident's blood pressure was 108/62.

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D 358	Continued From page 21 Interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 11:13am revealed: -The MAs should always compare the medication to the MAR. -The MAs were expected to review the MAR for supplemental notes such as medication parameters. -If any medications had blood pressure parameters for administering, then the blood pressure should be checked each time before administration of the medication. -Resident #8's blood pressure should have been checked prior to administration of the triamterene/hydrochlorothiazide. Interview with the Executive Director (ED) on 06/27/24 at 11:29am revealed: -If a medication had special instructions or parameters for administration, the information was on the medication label and the MAR. -The MAs were expected to compare the residents' medication label to the MAR for any parameters or special instructions -She expected the MAs to follow any parameter instructions. Interview with Resident #8's primary care provider (PCP) on 06/27/24 at 1:50pm revealed: -She prescribed triamterene/hydrochlorothiazide for Resident #8 for hypertension. -Resident #8's blood pressure was stable, and she had been on this medication since November of 2022. -If Resident #8's blood pressure had been below the given parameter, administering the triamterene/hydrochlorothiazide could cause her blood pressure to drop too low, potentially causing weakness and dizziness.	D 358		

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b. Review of Resident #9's current FL2 dated 02/14/24 revealed:
-Diagnoses included type 1 diabetes, hypothyroidism (low thyroid), diabetic neuropathy (nerve damage due to diabetes) and bilateral tinea pedis (a fungal infection that usually begins between the toes).
-Ammonium lactate lotion 12% (used to soften dry skin) apply topically twice per day, may self-administer and keep at bedside.

Review of Resident #9's signed physicians order sheet dated 04/03/24 revealed there was an order for Ammonium Lactate lotion 12%, apply topically twice daily, may self-administer and keep at bedside.

Observation of the 9:00am medication pass on 06/27/24 at 8:01am revealed:
-The medication aide (MA) prepared and administered 6 tablets to Resident #9.
-There was no Ammonium Lactate lotion 12% available for application on the medication cart or in Resident #9's room.

Review of Resident #9's June 2024 Medication Administration Record (MAR) revealed:
-There was an entry for Ammonium Lactate lotion 12%, apply topically twice per day, may self-administer, may keep at bedside, scheduled at 9:00am and 9:00pm.
-Ammonium Lactate lotion 12% was documented as administered 06/01/24 through 06/20/24 at 9:00am with the exception of 06/16/24, the resident was documented as out of the facility. and 06/01/24 through 06/26/24 at 9:00pm with exception for 06/14/24 and 06/15/24, the resident was documented as out of the facility.
-There was documentation on 06/27/24 at 9:00am that Ammonium Lactate lotion 12% was

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D 358	Continued From page 23 not available in the facility. Interview with Resident #9 on 06/27/24 at 11:27am revealed: -He used the Ammonium Lactate lotion for his feet. -He thought he had been out of the Ammonium Lactate lotion for about a week. -He had not told the MA that he was out of the Ammonium Lactate lotion. Interview with the MA on 06/27/24 at 10:04am revealed: -The MAs were responsible for requesting refills for the residents. -Refills should be requested when the resident had a one-week supply of medication remaining. -Resident #9 usually notified the MAs when he was out of the Ammonium Lactate lotion. -The MAs were to observe Resident #9 apply the Ammonium Lactate lotion. -The MAs were to check with Resident #9 to make sure he had the Ammonium Lactate lotion. -An Ammonium Lactate lotion refill had not been requested for Resident #9. -Ammonium Lactate lotion was documented last administered on 06/20/24. -She was not sure why there was no documentation regarding the Ammonium Lactate lotion since 06/20/24. -She did not know why a refill for Resident #9's Ammonium Lactate lotion had not been requested. -She was not sure how long Resident #9 had been out of the Ammonium Lactate lotion. -She would request a refill for Resident #9's Ammonium Lactate lotion today and it should arrive this evening. Interview with a representative from the facility's	D 358		

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contracted pharmacy on 06/27/24 at 3:45pm revealed:
-Ammonium Lactate lotion 12%, apply topically twice daily had last been dispensed for Resident #9 on 05/11/24 for 396 grams.
-The pharmacy had not received a refill request from the facility for the Ammonium Lactate lotion for Resident #9.

Interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 11:13am revealed:
-The MAs were responsible for requesting refills for the residents.
-If a resident had a self-administration order, the MAs were to check with the resident to make sure they had the medication.
-She had started doing random medication cart audits every two weeks on 05/28/24 but had not done a medication cart audit on the assisted living side.
-Ammonium Lactate lotion should have been requested and available for Resident #9.

Interview with the Executive Director (ED) on 06/27/24 at 11:29am revealed:
-The MAs were responsible for requesting refills for the residents.
-Refills were requested when the resident had 5 days of medication remaining.
-She expected the MAs to order the residents' medication when they had 5 days remaining so they would not run out.

Interview with Resident #9's primary care provider on 06/27/24 at 2:11pm revealed:
-Ammonium Lactate lotion was prescribed for Resident #9 to treat dry skin.
-She expected the facility to have the residents' medication available as ordered.

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c. Review of Resident #9's current FL2 dated 02/14/24 revealed:
-Diagnoses included type 1 diabetes, hypothyroidism (low thyroid), diabetic neuropathy (nerve damage due to diabetes) and bilateral tinea pedis (a fungal infection that usually begins between the toes).
-Chlorhexidine Gluconate (used to treat gingivitis) solution 0.12% swish a half ounce for 30 seconds by mouth twice daily, may self-administer.

Review of Resident #9's signed physicians order sheet dated 04/03/24 revealed there was an order for Chlorhexidine Gluconate solution 0.12%, swish a half ounce for 30 seconds by mouth twice per day, may self-administer.

Observation of the 9:00am medication pass on 06/27/24 at 8:01am revealed:
-The medication aide (MA) prepared and administered 6 tablets to Resident #9.
-There was no Chlorhexidine Gluconate solution 0.12% available for administration on the medication cart or in Resident #9's room.

Review of Resident #9's June 2024 Medication Administration Record (MAR) revealed:
-There was an entry for Chlorhexidine Gluconate solution 0.12%, swish a half of an ounce for 30 seconds by mouth twice a day, may self-administer, scheduled at 9:00am and 9:00pm.
-Chlorhexidine Gluconate solution 0.12% was documented as administered at 9:00am 06/01/24 through 06/26/24 at 9:00am.
-Chlorhexidine Gluconate solution 0.12% was documented as administered at 9:00pm 06/01/24 and 06/02/24, 06/04/24 through 06/10/24, and 06/12/24 through 06/26/24.
-There was no documentation that Chlorhexidine

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D 358	Continued From page 26 Gluconate was administered at 9:00pm on 06/03/24 and 06/11/24. -There was documentation on 06/27/24 at 9:00am that Chlorhexidine Gluconate was not in the facility. Interview with Resident #9 on 06/27/24 at 11:27am revealed: -He thought he had been out of the Chlorhexidine mouthwash for about a week. -He had not told the MA that he was out of the Chlorhexidine mouthwash. Interview with a representative from the facility's contracted pharmacy on 06/27/24 at 3:45pm revealed: -Chlorhexidine Gluconate solution 0.12%, swish one-half ounce by mouth twice per day had last been dispensed for Resident #9 on 03/27/24 for a 473ml bottle. -The pharmacy had not received a refill request from the facility for the Chlorhexidine Gluconate for Resident #9. Interview with the MA on 06/27/24 at 10:04am revealed: -The MAs were responsible for requesting refills for the residents. -Refills should be requested when the resident had a one-week supply of medication remaining. -Resident #9 usually notified the MAs when he was out of the Chlorhexidine Gluconate mouthwash. -The MAs were to observe Resident #9 use the Chlorhexidine Gluconate mouthwash. -The MAs were to check with Resident #9 to make sure he had the Chlorhexidine Gluconate mouthwash. -A Chlorhexidine Gluconate refill had not been requested for Resident #9.	D 358		

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D 358	Continued From page 27 -Chlorhexidine Gluconate was documented last administered on 06/26/24 at 9:00pm. -She did not know why a refill for Resident #9's Chlorhexidine Gluconate had not been requested. -She would request a refill for Resident #9's Chlorhexidine Gluconate today and it should arrive this evening. Interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 11:13am revealed: -The MAs were responsible for requesting refills for the residents. -If a resident had a self-administration order, the MAs were to check with the resident to make sure they had the medication. -She had started doing random medication cart audits every two weeks on 05/28/24 but had not done a medication cart audit on the assisted living side. -Chlorhexidine Gluconate should have been requested and available for Resident #9. Interview with the Executive Director (ED) on 06/27/24 at 11:29am revealed: -The MAs were responsible for requesting refills for the residents. -Refills were requested when the resident had 5 days of medication remaining. -She expected the MAs to order the residents' medication when they had 5 days remaining so they would not run out. Interview with Resident #9's primary care provider on 06/27/24 at 2:11pm revealed: -Chlorhexidine Gluconate solution was prescribed for Resident #9 for poor dentation. -It was important for Resident #9 to receive the Chlorhexidine Gluconate mouthwash to prevent poor dental health. -She expected the facility to have the residents'	D 358		

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medication available as ordered.

2. Review of Resident #1's current FL-2 dated 06/21/24 revealed:
-Diagnoses included diabetes, chronic kidney disease and hypertension and coronary artery disease.
-Novolog Flexpen 100units/ml (Novolog is a rapid-acting insulin used to lower elevated blood sugar levels) three times daily per sliding scale (SSI) as follows, 0-149= 0 units, 150-200=1 unit, 201-250= 2 units, 251-300= 3 units, 301-350= 4 units, greater than 350=5 units and notify the primary care provider (PCP).

a. Review of Resident #1's signed physician's orders dated 04/05/24 revealed there was an order for Novolog sliding scale insulin (SSI) three times a day: 0-149= 0 units, 151-200= 1 units, 201-250= 2 units, 251-300=3 units, 300-350= 4 units, greater than 350= 5 units and notify the primary care provider.

Review of Resident #1's Medication Administration Record (MAR) for June 2024 revealed:
-There was an entry for Novolog Flexpen 100u/mL, three times per day, inject per SSI: 0-149= 0 units,151-200= 1 units, 201-250= 2 units, 251-300= 3 units, 301-350= 4 units, greater than 351= 5 units for administration at 9:00am, 11:30am, and 5:30pm.
-The entry for 9am,11:30am and 5:00pm was "Flowsheet".

Review of Resident #1's Diabetic Flow Sheet for June 2024 revealed:
-At the top of the flow sheet there was a typed heading that included the resident's name, an entry to check blood sugar three times a day

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before meals and to administer SSI: 150-200=2 units. 201-250= 2 units, 251-300= 3 units, 301-350= 4 units. If greater than 350= 5 units and notify the PCP.
-On 06/01/24 at 9:00am, there was handwritten documentation Resident #1's finger stick blood sugar (FSBS) was 180 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/02/24 at 11:30am, there was handwritten documentation Resident #1's FSBS was 193 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/04/24 at 11:30am, there was handwritten documentation Resident #1's FSBS was 200 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/06/24 at 9:00am, there was handwritten documentation Resident #1's FSBS was 154 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin and at 5:30pm, there was handwritten documentation Resident #1's FSBS was 185 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/07/24 at 9:00am, there was handwritten documentation Resident #1's FSBS was 184 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin, and at 11:30am, there was handwritten documentation Resident #1's FSBS was 164 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/08/24 at 9:00am, there was handwritten documentation Resident #1's FSBS was 185 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/11/24 at 9:00am, there was handwritten documentation Resident #1's FSBS was 167 and 2 units of insulin were administered; Resident #1

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should have been administered 1 unit of insulin.
-On 06/15/24 at 9:00am, there was handwritten documentation Resident #1's FSBS was 162 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/16/24 at 5:30pm, there was handwritten documentation Resident #1's FSBS was 171 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.
-On 06/23/24 at 5:30pm, there was handwritten documentation Resident #1's FSBS was 196 and 2 units of insulin were administered; Resident #1 should have been administered 1 unit of insulin.

Interview with a medication aide (MA) on 06/26/24 at 3:46pm revealed:
-She was not sure who created the diabetic flowsheets used for the residents with SSI.
-She thought that maybe the pharmacy provided diabetic flow sheets for residents on SSI.
-The order on the diabetic flow sheet was compared to the entry on the MAR at the first of the month when the new MARs for the month were received by the Special Care Unit Coordinator (SCUC), and the MA who placed the medication on the medication cart compared the diabetic flow sheet to the MAR and the MA the administered the SSI compared the diabetic flow sheet to the MAR.
-The MAs compared the diabetic flow sheet to the MAR.
-She worked primarily in the Special Care Unit (SCU) and was not familiar with Resident #1's SSI order.

Interview with a second MA on 06/26/24 at 4:10pm revealed:
-The SCUC created the diabetic flow sheets for the residents on SSI.
-The SCUC transcribed the orders for the

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residents that had SSI on to the diabetic flow sheet for each month.
-FSBSs and the number of insulin units were documented on the diabetic flow sheet instead of the MAR.
-The diabetic flow sheet was compared to the MAR by the SCUC and the MAs.
-She was certain that the SSI dose on Resident #1's diabetic flow sheet was correct because she thought Resident #1's SSI insulin order had changed.
-She worked the evening shift and said she was unable to verify Resident #1's SSI order because the residents' records were locked in the SCUC's office after the SCUC left for the day.
-She thought she had mentioned the difference in the SSI order to the SCUC.

Interview with the SCUC on 06/26/24 at 4:16pm revealed:
-She started at the facility on 05/14/24 as the SCUC.
-She created the diabetic flow sheet for Resident #1.
-She entered the SSI order on Resident #1's diabetic flow sheet.
-She realized today that she had entered SSI orders for Resident #1 incorrectly.
-When Resident #1's FSBS was 150-200 she should have received 1 unit of insulin instead of 2 units as noted on the June 2024 diabetic flow sheet.
-The MAs were to compare the residents' diabetic flow sheets with the MAR.
-None of the MAs had brought the error with Resident #1's SSI on the diabetic flow sheet to her attention.
-She would correct Resident #1's diabetic flow sheet to reflect the correct SSI order.
-She had started doing random medication cart

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audits every two weeks on 05/28/24 but had not done a medication cart audit on the assisted living (AL) side.

Interview with the Executive Director (ED) on 06/26/24 at 4:24pm revealed:
-The SCUC created the diabetic flow sheet for the residents with SSI.
-Resident #1's diabetic flow sheet should have had the correct SSI order entered.
-The SCUC should have reviewed and compared Resident #1's diabetic flow sheet to the MAR.
-The MAs should have compared Resident #1's diabetic flow sheet to the MAR each time SSI was administered.

Telephone interview with Resident #1's primary care provider (PCP) on 06/27/24 at 2:43pm revealed:
-Resident #1 has SSI orders for diabetes and elevated blood sugars.
-Administering more than or less than the ordered amounts of insulin per the sliding scale could result in hyperglycemia or hypoglycemia.
-Resident #1's blood sugar typically ran high so she was not too concerned about her receiving the additional unit of insulin.
-She was just notified by the facility of the SSI error yesterday afternoon.
-She expected the facility to administer Resident #1's SSI as ordered.

b. Review of Resident #1's current FL-2 dated 06/21/24 revealed Jardiance 10mg (Jardiance is used to lower blood sugar and may be used for benefits in treating cardiovascular disease), take 1 tablet daily.

Review of Resident #1's record revealed there was a signed physician order dated 05/10/24 for

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D 358	Continued From page 33 Jardiance 10mg, take one tablet every day. Observation of Resident #1's medications on hand on 06/27/24 at 10:30am revealed there was no Jardiance 10mg on the medication cart for Resident #1. Review of Resident #1's June 2024 Medication Administration Record on 06/27/24 at 10:49am revealed: -There was an entry for Jardiance 10mg, take one tablet daily, scheduled at 9:00am. -Jardiance 10mg was documented as administered at 9:00am 06/01/24 through 06/26/24 at 9:00am. -Jardiance 10mg was documented as not administered on 06/27/24 with no reason listed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/27/24 at 2:14pm revealed: -The pharmacy dispensed medications for residents on a 28-day cycle. -A physician's order for Jardiance 10mg, take one daily was received on 05/10/24 for Resident #1. -Jardiance 10mg was last dispensed for Resident #1 on 05/28/24 for a quantity of 28 tablets. -A refill request was received today (06/27/24) from the facility for a refill of Jardiance for Resident #1. Interview with Resident #1 on 06/27/24 at 3:31pm revealed as far as she knew she received all her medications as she should. Interview with the medication aide (MA) on 06/27/24 at 10:30am revealed: -The residents' medications were batch filled from the facility's contracted pharmacy every 28 days. -The MAs were responsible for requesting the	D 358		

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residents' medication refills.
-Medications were to be requested from the pharmacy when they reached the "blue portion" of the individual bubble package which indicated an eight-day supply of the medication remained.
-She did not know why a Jardiance refill had not been requested for Resident #1.
-She planned to request a Jardiance refill for Resident #1 today.
-A Jardiance refill should have been requested for Resident #1 when there was an 8-day supply remaining.

Interview with the Special Care Unit Coordinator (SCUC) on 06/27/24 at 11:13am revealed:
-Medications were batch filled from the pharmacy every 28 days.
-The MAs were responsible for requesting refills for the residents.
-Medications refills were requested when the resident had a 5-day supply remaining.
-Resident #1's Jardiance should have been requested by the MA when there was a 5-day supply remaining to ensure that she would not be without her medication.

Interview with the Executive Director (ED) on 06/27/24 at 11:29am revealed:
-The residents' medications were batch filled monthly by the facility's pharmacy.
-The MAs were responsible for requesting the residents' medication refills.
-Resident #1's Jardiance should have been re-ordered by the MA when there was a 5-day supply remaining.

Telephone interview with Resident #1's primary care provider (PCP) on 06/27/24 at 2:43pm revealed:
-She prescribed Jardiance for Resident #1 to help

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D 358	Continued From page 35 control diabetes. -Resident #1's blood sugar typically ran high. -Being without the Jardiance could cause Resident #1 to have elevated blood sugar levels. -Resident #1 received sliding scale insulin, which helped cover elevated blood sugar. -The long-term effects of elevated blood sugar included vision, kidney and artery problems and neuropathy. -She expected Resident #1's medications to be available for administration.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 63 beds including 37 beds for Assisted Living (AL) and 26 beds for the Special	D 466		

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Care Unit.

Review of the facility's resident census list provided on 06/26/24 revealed:
-9 residents resided on the 200 hall of the SCU.
-13 residents resided on the 300 hall of the SCU.
-25 residents resided on the AL unit.

Observation of the SCU on 06/26/24 at 8:55am revealed:
-There were 2 separate halls designated as SCU (200 hall and 300 hall) that were located at opposite ends of a hallway.
-Each SCU hall was secured, and a coded keypad was used by staff for secure entrance.
-The Special Care Unit Coordinator (SCUC) office was located just inside the locked door on the 200 hall.

Interview with a personal care aide (PCA) on 06/27/24 at 7:18am revealed:
-The facility did not have a Resident Care Coordinator (RCC).
-The Special Care Unit Coordinator (SCUC) covered both the AL and SCU.

Interview with a medication aide (MA) on 06/27/24 at 3:33pm revealed the SCUC covered both the AL and SCU.

Interview with a second MA on 06/27/24 at 3:38pm revealed:
-The SCUC covered both the AL and SCU.
-She thought one of the other supervising MAs helped the SCUC with the AL side when she could.

Interview with a third MA on 06/27/24 at 4:22pm revealed:
-She had been employed at the facility since

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2009.
-She identified herself as the supervisor in charge of the AL.
-Her duties included administering medications, staff scheduling, resident transportation and resident documentation.
-The SCUC oversaw the SCU and the AL.
-She was training to assist the SCUC with AL duties.

Interview with the SCUC on 06/27/24 at 4:49pm revealed:
-She was hired as the SCUC on 05/14/24.
-She worked 40 hours per week, sometimes more.
-Her title was the SCUC, but she also managed the AL unit as well.
-She had always covered both the SCU and the AL unit.
-There was no designated RCC for the AL unit.
-She and the medication aides (MAs) covered the AL unit.
-She could not say how many hours were spent coordinating care for AL versus SCU, but the majority of her hours were spent on the SCU.
-Her office was in the SCU, but she would bring charts from the AL unit and work on them in her office as well.

Interview with the Executive Director (ED) on 06/28/24 at 4:56pm revealed:
-The SCUC supervised both the SCU and the AL unit.
-The SCUC worked 40 hours per week, sometimes more.
-The MAs assisted the SCUC with AL unit duties.
-She could not say how many hours the SCUC dedicated to the SCU and to the AL unit but was sure 90 to 95 percent of her hours were dedicated to the SCU.

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D 466	Continued From page 38 -There was no RCC for the facility.	D 466		