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TERRABELLA HILLSBOROUGH	1911 ORANGE GROVE ROAD HILLSBOROUGH, NC 27278

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey with a complaint investigation from 06/25/24 to 06/27/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications independently had completed the medication aide clinical skills checklist prior to administering medications. Observation of Staff C on 06/25/24 from 9:15am to 2:15pm revealed she administered medications to residents on A and B hall. Observation of Staff C on 06/27/24 from 7:30am to 12:30pm revealed she administered medications to residents on A and B hall. Review of Staff C's personnel record revealed: -She was hired as a medication aide (MA) on 02/10/22.	D 125		

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D 125	Continued From page 1 -She passed the medication aide written examination on 12/04/17. -There was no documentation Staff C completed medication aide clinical skills competency validation checklist. Interview with Staff C on 06/27/24 at 2:25pm revealed: -She was hired on 02/10/22 as a MA. -She worked as a MA since December 2017, prior to being hired by this facility. -She recalled being checked off by a nurse at the facility, who no longer was employed by the facility. -She did not know where her medication aide clinical skills check off list was. Review of April 2024 electronic medication administration records (eMAR) revealed Staff C documented administration of medications on 04/03/24, 04/10/24, and 04/17/24. Review of June 2024 eMAR revealed Staff C documented administration of medications on first shift on 06/22/24, 06/23/24, and 06/25/24. Interview with the Administrator on 06/27/24 at 3:33pm revealed: -She thought Staff C's Medication Administration Competency Validation Clinical Skills checklist was completed when Staff C was hired. -The Business Office Manager (BOM) was responsible for ensuring medication aides (MA) completed the Medication Administration Competency Validation Clinical Skills checklist prior to administering medications.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137		

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D 137	Continued From page 2 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff D) had no substantiated findings on the North Carolina Health Care Personal Registry (HCPR) upon hire. The findings are: Review of Staff D's personnel record revealed: -Staff D was hired on 04/18/23 as a personal care aide (PCA). -There was no documentation that a HCPR review was completed upon hire. Interview with the Business Office Manager (BOM) on 06/27/24 at 2:15pm revealed: -She was responsible for checking the HCPR on all new hires. -She was not employed when Staff D was hired. -She audited personnel files but did not notice the HCPR was missing. Interview with the Administrator on 06/27/24 at 3:34pm revealed: -She expected Staff D's HCPR validation to be completed prior to hire. -She thought Staff D's HCPR validation was completed. -The Business Office Manager (BOM) was responsible to ensure HCPR validations were	D 137		

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D 137	Continued From page 3 completed for staff. Attempted telephone interview with Staff D on 06/27/24 at 3:10pm was unsuccessful.	D 137		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents (#5) related to daily application and removal of thrombo-embolic deterrent (TED) hose (#5). The findings are: Review of Resident #5's current FL-2 dated 05/07/24 revealed diagnoses included congestive heart failure, vascular dementia, transient ischemic attack and essential hypertension. -There was documentation Resident #5 was semi-ambulatory. Review of Resident #5's physician's order dated 06/18/24 revealed there was an order to start thrombo-embolic deterrent (TED) hose (used to prevent swelling and blood clots in the legs); apply to bilateral lower extremities daily at 9:00am	D 276		

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D 276	Continued From page 4 and to remove at 9:00pm. Review of Resident #5's June 2024 progress notes revealed: -On 06/03/24 at 1:21pm, there was documentation Resident #5 had swollen feet and small bumps on both feet in the morning. -Resident #5's primary care provider (PCP) was notified. -On 06/20/24 at 3:00pm, there was documentation Resident #5's preferred pharmacy was contacted to order compression stockings. -The pharmacy stated new orders were needed for the compression stockings. -The Resident Care Coordinator (RCC) contacted Resident #5's PCP for request new orders for the compression hose. Review of Resident #5's June 2024 electronic medication administration record (eMAR) from 06/18/24 to 06/25/24 revealed: -There was an entry for TED hose with the directions in the description box to apply every morning and remove every evening. -In the description box next to the order in parentheses was "need measurements". -There was a line for documentation of application of TED hose scheduled at 6:00am and a line for documentation of the removal of the TED hose scheduled at 6:00pm. -There was nothing documented from 06/18/24 to 06/20/24; the area wash shaded gray. -Resident #5's TED hose were documented as applied and removed on 06/20/24. -Resident #5's TED hose were documented as not applied on 06/21/24, 06/22/24 and 06/25/24 due to need size-waiting to be delivered from the pharmacy. -On 06/23/24, there was documentation no TED hose in his room.	D 276		

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-On 06/24/24, there was documentation orders were sent to [the] pharmacy.

Observation of Resident #5 on 06/25/24 at 2:00pm revealed he was sitting in a chair in his room and he did not have TED hose on and there were none in his room.

Observations of Resident #5 on 06/26/24 at various times from 10:00am and 4:06pm revealed:
-At 10:00am, Resident # was laying in his bed; he did not have on his TED hose.
-At 12:50pm, he was sitting up in his wheelchair eating lunch; he did not have on his TED hose.
-At 4:06pm, Resident #5 was asleep in his wheelchair; he did not have on his TED hose.

Observation of Resident #5 on 06/27/24 at 10:21am revealed he was sitting in his wheelchair and had on his TED hose.

Telephone interview with the pharmacist from Resident #5's preferred pharmacy on 06/27/24 at 9:55am revealed:
-Resident #5 had an order for TED hose dated 06/18/24; there was no request to fill the order and no measurements were provided.
-On 6/22/24, the facility requested the order be filled for the TED hose; the pharmacy requested the facility get measurements for the TED hose.
-The pharmacy requested the measurements for Resident #5's TED hose again on 06/24/24 and 06/25/24.
-The facility sent the measurements on 06/25/24; the pharmacy dispensed them the same day.
-TED hose were used to prevent edema; outcomes would include increased edema.

Telephone interview with Resident #5's PCP on

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06/27/24 at 8;39am revealed:
-She had just recently begun to see Resident #5.
-The first time she saw him was on 06/18/24 and his feet were swollen.
-She ordered the TED hose for him on 06/18/24 due to the swelling.
-She did not know if the TED hose were delivered to the facility or to Resident #5's power of attorney (POA).
-She did not know if Resident #5's TED hose were being applied as ordered; if they were not applied as ordered he could exprience swelling.

Interview with a personal care aide (PCA) on 06/26/24 at 3:49pm revealed:
-The PCAs removed and applied the residents' TED hose on second and third shift.
-She went to remove Resident #5 TED hose on Sunday 06/23/24, and she realized he did not have them on.
-She reported to a medication aide (MA) that Resident #5 did not have his TED hose on when she went to remove them.
-The PCAs report to the MA once they have applied and removed TED hose for residents.

Interview with a MA on 06/26/24 at 2:28pm revealed:
-Third shift applied TED hose before they left in the morning and remove them in the evening.
-She had checked the medication cart this morning 06/26/24, and Resident #5's TED hose were not on the medication cart.
-She went to the medication room and found Resident #5's TED hose this afternoon.
-Resident #5's TED hose must have come in the night before or sometime during the day today, 06/26/24.
-She placed them on the medication cart today 06/26/24, so they could be applied the next

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morning.

Interview with the RCC on 06/27/24 at 11:03am revealed:
-The MAs were responsible for measuring a resident for TED hose and sending the measurements to the pharmacy the day they get the order from the PCP.
-She did not know when Resident #5's measurements were sent to the pharmacy.
-If there had been a delay in getting Resident #5's TED hose from his preferred pharmacy then they should have been ordered from the facility's contracted pharmacy so there was not a delay in him getting them.
-TED hose should always me measured and ordered immediately without a delay.
-She realized Resident #5 did not have his TED hose when she pulled a report on 06/24/24.
-The MA had not reported to her that he did not have his TED hose.
-The MA should have been monitoring Resident #5 for edema during the time he did not have his TED hose; nothing had been reported to her or documented about edema during the time he did not have his TED hose.

Interview with the Administrator on 06/27/24 at 1:37pm revealed:
-She was not aware Resident #5 did not have TED hose until today, 06/27/24.
-The RCC told her she had run a report on 06/24/24, and realized resident #5 did not have the TED hose.
-The MA and the RCC were responsible for ensuring that Resident #5 had TED hose measured and ordered so they could be applied and removed.
-TED hose were something that could not be waited on and should have been ordered from the

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D 276	Continued From page 8 facility's contracted pharmacy so the resident would not go without them. Based on observations interviews and record reviews It was determined Resident #5 was not interviewed able.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to food being transported uncovered. The findings are: Observation of the lunch service meal in the Special Care Unit (SCU) on 06/25/24 at 11:48am	D 283		

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revealed:
-The kitchen staff delivered the lunch service meal to the SCU dining room.
-There were 16 bowls of tossed salad on a cart and the salads were uncovered.
-The bowls of salad remained on the cart from 11:48am until 12:10pm when the tossed salad was served to the residents.
-There were 16 individual slices of pie on dessert plates on a sheet pan placed on the bottom shelf of the warmer.
-The bottom shelf was 12 inches off the floor.
-The SCU coordinator began serving the hot food and asked the personal care assistance to move the dessert from the bottom shelf of the warmer because her skirt was "hitting" the pan of desserts.

Observation of the lunch service meal on 05/25/24 at 1:07pm revealed:
-The facility staff was pushing a food cart in the hallways delivering lunch to the residents who eat in their rooms.
-There were three desserts and four cups of tea uncovered on the food cart.

Interview with the SCU coordinator on 06/26/24 at 1:22pm revealed:
-She knew the food coming from the kitchen to the SCU dining room should be covered while being transported to the SCU dining room.
-It was the responsibility of the kitchen staff to ensure the food was covered before leaving the kitchen.
-On 06/25/24 and 06/26/24, the salads were uncovered for lunch both days.
-On 06/25/24, the dessert was on the bottom shelf of the meal warmer.
-She noticed her dress kept hitting the pan while she was serving lunch and she asked a personal

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D 283	Continued From page 10 care aide (PCA) to remove the pan from the bottom of the warmer. Interview with the kitchen manager (KM) on 6/26/24 at 2:31pm revealed: -Food for the SCU residents was sent down in bulk in a steam table. -Desserts and salads were pre plated in the kitchen so it was easier for the SCU staff to serve. -The bulk food in the steam table was covered but the pre plated desserts and salads were not covered. -She was not aware that the Pre plated salads and desserts needed to be covered while transported on an open cart through the hallways to the SCU unit. Interview with the Administrator on 06/27/24 at 1:18am revealed: -Any food being transported through the hallway should be covered or in an enclosed hot box. -Pre plated food including salads and desserts should also be covered when transported down the hallway. -She had not seen the food going down the hallway uncovered.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers.	D 286		

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D 286	Continued From page 11 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure mealtime table service in the Special Care Unit (SCU) included a place setting consisting of a knife, fork, and spoon. The findings are: Observation of the lunch meal service on 06/24/24 from 11:48am to 12:30pm revealed: -The meal consisted of a pulled pork sandwich, baked beans, potato salad, and a slice of peanut butter pie. -There were 15 place settings with a fork and a spoon; there were no knives on the tables. Observation of the breakfast meal service on 06/25/24 from 7:52am to 8:20am revealed: -The meal consisted of scrambled eggs, toast, bacon, sliced watermelon and assorted beverages. -There were 13 place settings with a fork and a spoon; there were no knives on the tables. Interview with a personal care aide (PCA) on 06/26/24 at 1:16pm revealed: -She assisted with the place setting and serving meals in the SCU. -She did not place knives on the table for the lunch service meal on 06/25/24. -The SCU did not receive any butter knives from the kitchen to place with the table setting. -She did not go to the kitchen to get butter knives for the lunch service meal. -She did not see any residents' needing a butter	D 286		

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D 286	Continued From page 12 knife during lunch on 06/25/24. Interview with the SCU coordinator on 06/26/24 at 1:22pm revealed: -She was aware each resident should be given a place setting including a knife, spoon, and fork. -The PCAs set the table with knives, spoons, and forks. -She had instructed the SCU multiple times to ensure there was a complete place setting at each meal for each resident. -Some of the staff think the residents cannot have a knife because the residents may injure themselves or others. -Sometimes the kitchen staff did not send knives to the SCU dining room. -There were no knives sent to the SCU dining room yesterday, 06/25/24 during lunch or today, 06/26/24, during breakfast. -The PCA should have gone to the kitchen and got knives for the tables. Interview with the kitchen manager (KM) on 6/26/24 at 2:31pm revealed: -The kitchen staff sent the same equipment to the SCU for every meal including a non-disposable knife, a fork and a spoon for each place setting. -There were enough forks knives and spoons in the kitchen for everyone in the facility to have a knife including the residents in the SCU. -She was not aware knives were not being sent down or used in the SCU. -She went through the SCU and saw forks, knives, and spoons on the place settings, and she was surprised there were no knives in the SCU. -The last time she had been to the SCU was Friday, 06/21/24 and there were knives at everyone's place setting.	D 286		

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D 286	Continued From page 13 Interview with the Administrator on 06/27/24 at 1:18am revealed: -She observed meals one to two times a week in the SCU and the AL; she looked to see that the tables were completely set. -The tables in the SCU were set just before the residence ate. -She did know there were no knives on the tables in the SCU on 06/25/24 and 06/26/24. -Typically, there was a full place setting on the tables including the knives and she saw the knives on the food delivery cart when it went down the hall. -The last meal observation she had done and the SCU was about a week and a half ago there were knives on the place settings. -She was aware of there needed to be a full place setting including a fork, knife, and a spoon at each place setting. -She did not know why there wasn't a full place setting at the table in the SCU.	D 286		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 1 of 3 residents with a diet order for finger foods (#8). The findings are:	D 310		

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Observation of the kitchen on 06/25/2024 at 11:32am revealed:
-There was a list of residents' names and diets posted in the kitchen; Resident #8 did not have a diet selected.
-The regular menu for lunch on 06/25/24 was soup or salad of the day, pulled pork sandwich, potato salad, baked beans, dessert of the day and beverages.
-The finger food menu for 06/25/24 was soup of the day in a mug, salad of the day, pulled pork on a bun, buttered green beans, French fries, and a finger dessert.
-The regular breakfast menu on 6/26/24 was Toast calmer cereal of choice, bacon, country fried potatoes, egg of choice, fruit juice, and fruit of choice.
-The finger food breakfast menu for 6/26/24 was oatmeal, grits or cold cereal in a mug, bacon, country fried potatoes hard scrambled eggs and toast with assorted beverages.

Review of Resident #8's FL 2 dated 02/01/24 revealed:
-Diagnoses included depression, macular degeneration and dementia.
-The was a checkmark next to diet but no diet was indicated.

Review of Resident #8's diet order dated 01/04/24 revealed an order for pre-cut meats and finger foods.

Observation of the morning snack on B-hall on 06/25/24 at 10:29am revealed:
-Resident #8 was served a bowl of yogurt with granola mix.
-The facility staff placed the bowl on the bedside table and assisted Resident #8 by placing a spoon in her right hand and cupping the bowl with

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her left hand while the bowl set on the bedside table.
-While feeding herself, Resident #8 dropped the yogurt with granola on a washcloth that was placed in her lap.
-Resident #8 attempted to search for the granola in her lap by "feeling" for the granola with her hand.
-Once Resident #8 "found" the granola lying on the washcloth in her lap, she placed the granola in her mouth.
-Resident #8 attempted to cup the bowl with her left hand and she placed her fingers in the yogurt with granola mixture.
-Resident #8 licked the yogurt from her fingers.

Observations of the lunch meal on 06/25/24 from 12:08pm to 12:50pm revealed:
-Resident #8 was served a salad with dressing, baked beans in a bowl, and a grilled cheese sandwich cut in half.
-The personal care aide (PCA) served Resident #8 her salad and gave her a fork; Resident #8 ate her salad with her fingers and did not use the fork.
-The PCA gave Resident #8 her baked beans and a spoon and instructed her on where her sandwich was on the plate.
-Resident #8 attempted to eat her baked beans with her spoon.
-Resident #8 was using her right hand to guide her spoon to her mouth and her left hand to hold the bowl of the spoon.
-Resident #8 spilled the baked beans out of the bowl onto the plate, the table and her lap several times while attempting to use her spoon.
-Resident #8 would feel around the edge of the plate with her fingers and pick up the beans that were on the plate and the table and place them into the bowl of the spoon one at a time and then

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place the spoon in her mouth.
-Resident #8 ate 100% of her backed beans, half of her salad and half of her grilled cheese sandwich.

Observation of the breakfast meal on 06/26/24 from 8:23am to 9:00am revealed:
-Resident #8 was served cold cereal in a bowl, scrambled eggs, bacon, watermelon slice and toast on a plate.
-A PCA served Resident #8 her cold cereal in a bowl and put the spoon in her hand.
-Resident #8 proceeded to eat the cold cereal with both hands; one on the bowl of the spoon and one on the arm of the spoon and guided it to her mouth.
-Resident #8 spilled milk down the front of her shirt and lap and on the table.
-Resident #8 ate her scrambled eggs, toast, watermelon and bacon with her fingers.
-She ate 90% of her cereal, less than half of her scrabbled eggs, half of her toast, all of her watermelon and one slice of her bacon.

Telephone interview with resident #8 primary care provider (PCP) on 06/27/24 at 9:14am revealed:
-She was not sure why Resident #8 was ordered a finger food diet.
-The facility may have thought it would be easier for her if she had eight finger food diet because she was blind.
-She had not had the opportunity to observe Resident #8 at meals.
-Resident #8 was ordered a finger food diet before she became the PCP for the facility.
-The facility had contacted her today 6/27/24 and requested Resident #8's diet be changed to a regular diet.

Interview with a PCA on 06/26/24 at 3:49pm

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revealed:
-She served food and the dining rooms.
-The kitchen staff had a diet list that they followed when they plated the residents' meals.
-There were residents in the Special Care Unit (SCU) with orders for finger foods, there were no residents with finger food orders in the Assisted Living (AL) dining room.
-She had to coax Resident #8 out of her room to come down to the dining room to eat.
-Resident #8 was blind and she said she was embarrassed to eat in the dining room because she was blind.
-Resident #8 ate better when she was in the dining room.
-She would use Resident #8's fingers to show her where the food was on her plate.
-Resident #8 she would feed herself using her fingers and her utensils.
-Sometimes she would drop food in her lap and down the front of her shirt, so she wore a clothing protector.

Interview with the kitchen manager (KM) on 6/26/24 at 2:31pm revealed:
-The diet list for the kitchen staff was updated based on the orders the Resident Care Coordinator (RCC) gave to her.
-She knew there were residents who had orders for finger foods in the SCU but there were no residents with an order for finger foods in the AL dining room.
-She was surprised to learn that Resident #8 had an order for finger foods because she ate everything that was on the menu without problems.
-She knew resident #8 was vision impaired and the staff would tell her where everything was on her plate.

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D 310	Continued From page 18 Interview with the RCC on 06/27/24 at 11:03am revealed: -She gave the diet orders to the KM and she created the diet list. -A new diet list would be created when there was even one diet order changed. -The KM was giving Resident #8 new diet order when she gave a stack of orders to her. -She could not recall what Resident #8's current diet it was. Interview with the Administrator on 06/26/24 at 9:00am revealed: -Resident #8 was blind but she did not have a need for finger foods because once she was set up, she was fine with eating her food. -She did not think Resident #8 needed to be on a finger food diet because she had been blind all her life and she managed eating just fine. -Resident #8 requested a lot of sandwiches so when the staff told the PCP she was eating sandwiches the PCP placed her on a finger food diet. Attempted interview with Resident #8 on 06/26/24 at 2:20pm was unsuccessful.	D 310		
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.	D 358		

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This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3 and #5) including a resident whose two blood pressure medications were not held according to ordered parameters (#3) and a resident who was not administered two blood pressure medications as ordered(#5).

The findings are:

1. Review of Resident #5's current FL-2 dated 05/07/24 revealed diagnoses included congestive heart failure, vascular dementia, transient ischemic attack and essential hypertension.

Review of Resident #5's Resident Register revealed he was admitted to the facility on 05/13/24.

a. Review of Resident #5's FL-2 dated 05/07/24 revealed there was an order for lisinopril (used to treat high blood pressure) 5mg one tablet once daily.

Review of Resident #5's May 2024 electronic medication administration record (eMAR) from 05/13/24 to 05/31/24 revealed:
-There was an entry for lisinopril 5mg one tablet once daily scheduled at 9:00am.
-There was documentation lisinopril was administered 18 of 19 opportunities from 05/13/24 to 05/31/24.
-There was no documentation Resident #5's lisinopril was administered on 05/31/24; the exceptions noted were "resident in the rest room".

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D 358	Continued From page 20 Review of Resident #5's June 2024 eMAR from 06/01/24 to 06/25/24 revealed: -There was an entry for lisinopril 5mg one tablet once daily scheduled at 9:00am. -There was documentation lisinopril was administered 9 of 25 opportunities from 06/01/24 to 06/25/24. -Resident #5's lisinopril was documented as administered once daily from 06/01/24 to 06/10/24. -There was documentation under exceptions on 06/11/24, "pending pharmacy delivery". -There was documentation under exceptions on 06/12/24, "called power of attorney (POA) and he said to call the Veterans Administration's (VA) physician for refills". -There was documentation under exceptions from 06/13/24 to 06/17/24, "pending pharmacy delivery". -There was documentation under exceptions for 06/17/24, "physician, pharmacy and VA were contacted about all medications, POA was supposed to bring that morning [06/17/24]". -There was documentation under exceptions on 06/18/24, "physician was coming in today [06/18/24] to write new orders". -There was documentation under exceptions from 06/19/24 to 06/23/24, "pending pharmacy delivery". -There was nothing documented under exceptions on 06/24/24. -There was documentation under exceptions on 06/25/24, "pending pharmacy delivery". -There was an entry to check blood pressure on Monday, Wednesday, and Friday; there were no parameters. -There was documentation on Wednesday, 06/19/24, Resident #5's blood pressure reading was, systolic 151 and diastolic 68.	D 358		

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D 358	Continued From page 21 -There was documentation on Friday, 06/19/24, Resident #5's blood pressure reading was, systolic 162 and diastolic 73. -There was documentation on Monday, 06/19/24, Resident #5's blood pressure reading was, systolic 167 and diastolic 72. Observation of Resident #5's medications on hand on 06/25/24 at 3:50pm revealed there was no lisinopril 5mg available for administration. Observation of Resident #5's medications on hand on 06/26/24 at 1:46pm revealed: -There were 30 tablets of lisinopril 5mg dispensed on 06/25/24. -There were 29 of the 30 tablets of lisinopril available for administration. Observation of Resident #5's blood pressure reading on 06/27/24 at 2:28pm revealed a blood pressure reading of systolic 143 and diastolic 61. Telephone interviews with a representative from the facility's contracted pharmacy on 06/27/24 at 9:55am and 3:35pm revealed: -The facility had attempted to reorder Resident #5's lisinopril through the eMAR on 06/09/24. -The pharmacy sent a reply to the facility informing them that Resident #5 did not get his orders filled through them. -The pharmacy could send a short supply of a few tablets until Resident #5's medication arrived from his preferred pharmacy, but the facility never requested a short supply for Resident #5's lisinopril. -Thirty tablets of lisinopril were dispensed on 06/25/24. -The request for the lisinopril order to be filled by the pharmacy was received via telephone on 06/25/24 at 1:10pm from the Resident Care	D 358		

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D 358	Continued From page 22 Coordinator (RCC) at the facility. -Lisinopril was ordered to treat hypertension and a complication of not administering the medication as ordered could be the resident's blood pressures would not be controlled and he would have high blood pressure readings. Telephone interview with Resident #5's primary care provider (PCP) on 06/27/24 at 8:39am revealed: -She saw Resident #5 on 06/18/24 for the first time. -He was ordered lisinopril because he had high blood pressure and heart issues. -She was not aware of how long Resident #5 had been without his lisinopril. -She had been told Resident #5 did not have his lisinopril on 06/18/24. -She was told he needed new orders for his medications on 06/18/24 because the POA had not brought Resident #5's medications and the facility's contracted pharmacy needed a new order, so she wrote new orders. -She expected Resident #5 to have his medication in the facility for administration. -If the resident's preferred pharmacy could not provide the medications in a timely manner and the POA did not bring the medications in then she expected the facility to have the means to get the medications from another pharmacy. -She was concerned Resident #5's blood pressure results were high during the time he was not administered his lisinopril. -If Resident #5's blood pressures continued to run high over a longer period he could be at risk of a stroke or heart attack. Attempted telephone interview with a representative from Resident #5's preferred pharmacy on 05/26/24 at 4:20pm was	D 358		

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unsuccessful.

Refer to the interview with Resident #5 on 06/25/24 at 10:22am.

Refer to the telephone interview with Resident #5's POA on 06/27/24 at 9:35am.

Refer to the interview with the medication aide (MA) on 06/26/24 at 1:17pm.

Refer to the interview with the RCC on 06/27/24 at 11:03pm.

Refer to the interview with the Administrator on 06/27/24 at 1:18pm.

b. Review of Resident #5's FL-2 dated 05/07/24 revealed there was an order for metoprolol (used to treat blood pressure) 12.5mg once daily.

Review of Resident #5's physician's order dated 06/18/24 revealed:
-There was an order to discontinue metoprolol 12.5 once daily.
-There was on order for metoprolol 25mg once daily.

Review of Resident #5's May 2024 electronic medication administration record (eMAR) from 05/13/24 to 05/31/24 revealed:
-There was an entry for metoprolol 12.5mg once daily scheduled at 9:00am.
-There was documentation metoprolol 12.5mg was administered 19 of 19 opportunities from 05/13/24 to 05/31/24.

Review of Resident #5's June 2024 eMAR from 06/01/24 to 06/25/24 revealed:
-There was an entry for metoprolol 12.5 mg once

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D 358	Continued From page 24 daily scheduled at 9:00am. -There was documentation metoprolol 12.5mg was administered 16 of 18 opportunities from 06/01/24 to 06/18/24. -There was documentation under exceptions on 06/17/24, "pending pharmacy delivery". -There was documentation under exceptions on 06/18/24, "physician was coming in today [06/18/24] to write new orders". -There was nothing documented for metoprolol 12.5mg or metoprolol 25mg from 06/19/24 to 06/21/24 and nothing documented in the exceptions. -There was a second entry for metoprolol 25mg once daily scheduled at 9:00am beginning 06/22/24 -There was documentation under exceptions from 06/22/24 to 06/25/24, "pending pharmacy delivery". -There was an entry to check blood pressure on Monday, Wednesday, and Friday; there were no parameters. -There was documentation on Wednesday, 06/19/24, Resident #5's blood pressure reading was, systolic 151 and diastolic 68. -There was documentation on Friday, 06/19/24, Resident #5's blood pressure reading was, systolic 162 and diastolic 73. -There was documentation on Monday, 06/19/24, Resident #5's blood pressure reading was, systolic 167 and diastolic 72. Observation of Resident #5's medications on hand on 06/25/24 at 3:50pm revealed there was no metoprolol 12.5mg or metoprolol 25mg available for administration. Observation of Resident #5's medications on hand on 06/26/24 at 1:46pm revealed: -There were 30 tablets of metoprolol 25mg	D 358		

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dispensed on 06/25/24.
-There were 29 of the 30 tablets of metoprolol 25mg available for administration.

Observation of Resident #5's blood pressure reading on 06/27/24 at 2:28pm revealed a blood pressure reading was, systolic 143 and diastolic 61.

Telephone interviews with a representative from the facility's contracted pharmacy on 06/27/24 at 9:55am and 3:35pm revealed:
-Resident #5 had an order for metoprolol 25mg once daily sent to the pharmacy on 06/25/24.
-The facility did not request the pharmacy fill the order for the metoprolol 25mg.
-The pharmacy could send a short supply of a few tablets until Resident #5's medication arrived from his preferred pharmacy, but the facility did not request a short supply for Resident #5's metoprolol.
-Thirty tablets of metoprolol were dispensed on 06/25/24.
-The request for the metoprolol order to be filled by the pharmacy was received via telephone on 06/25/24 at 1:10pm from the Resident Care Coordinator (RCC) at the facility.
-Metoprolol was used to treat hypertension and a complication of not administering the medication as ordered could be the resident's blood pressures would not be controlled and he would have high blood pressure readings.

Telephone interview with Resident #5's primary care provider (PCP) on 06/27/24 at 8:39am revealed:
-She saw Resident #5 on 06/18/24 for the first time.
-He was ordered metoprolol because he had high blood pressure and heart issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-She was not aware Resident #5 had been without his metoprolol after she changed the order from 12.5mg to 25mg on 06/18/24.
-She had been told Resident #5 did not have his metoprolol 12.5mg on 06/18/24.
-She was told he needed new orders for his medications on 06/18/24 because the POA had not brought Resident #5's medications and the facility's contracted pharmacy needed a new order, so she wrote new orders.
-She expected Resident #5 to have his medication in the facility for administration.
-If the resident's preferred pharmacy could not provide the medications in a timely manner and the POA did not bring the medications in then she expected the facility to have the means to get the medications from another pharmacy.
-She was concerned Resident #5's blood pressure results were high during the time he was not administered his lisinopril.
-If Resident #5's blood pressures continued to run high over a longer period he could be at risk of a stroke or heart attack.

Attempted telephone interview with a representative from Resident #5's preferred pharmacy on 05/26/24 at 4:20pm was unsuccessful.

Refer to the interview with Resident #5 on 06/25/24 at 10:22am.

Refer to the telephone interview with Resident #5's POA on 06/27/24 at 9:35am.

Refer to the interview with the medication aide (MA) on 06/26/24 at 1:17pm.

Refer to the interview with the RCC on 06/27/24 at 11:03pm.

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D 358	Continued From page 27 Refer to the interview with the Administrator on 06/27/24 at 1:18pm. ______________________________ Interview with Resident #5 on 06/25/24 at 10:22am revealed he did not know the name of the medications he was ordered but he knew he was ordered a medication for high blood pressure. Telephone interview with Resident #5's POA on 06/27/24 at 9:35am revealed: -Resident #5's medication was sent mail order to the POA's home prior to 6/14/24. -On 06/14/24 the POA had changed the mail order address to the facility's address. -He was not aware Resident #5 was waiting on any medications. -He had informed the facility the mail order medication would take three to five days to be shipped when Resident #5 was admitted. -He had not been contacted by the facility about Resident #5 needing a metoprolol refill or a change in the dosage. -The facility was handling Resident #5's medications and only reached out to him if necessary. Interview with a MA on 06/26/24 at 1:17pm revealed: -Resident #5's POA brought his medications to the facility. -She informed the RCC the same day Resident #5 ran out of medications; the RCC told her to contact the POA. -She had contacted the POA when Resident #5 ran out of his medications and he referred her to Resident #5's PCP. -The RCC was going to call the PCP.	D 358		

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D 358	Continued From page 28 -Resident #5's PCP came to the facility the previous week. -She asked the RCC daily about Resident #5's missing medications. -The RCC told her the facility's contracted pharmacy agreed to send Resident #5's medications. -Resident #5 still did not have all his medications; the facility's contracted pharmacy had not delivered them until today, 06/26/24. -She had administered Resident #5 his metoprolol 25mg today, 06/26/24. Interview with the RCC on 06/27/24 at 11:03am revealed: -When a resident used a pharmacy other than the facility's contracted pharmacy, the MAs contacted the preferred pharmacy or the POA for a refill prior to a medication running out. -The facility gave the POA or the resident's preferred pharmacy about three days to supply the medications. -The facility would notify the resident's POA they would have to order a supply of the medications from the facility's contracted pharmacy and the POA would be billed out of pocket for the medication. -The MA would order the medication once she gave approval for them to order it from the facility's contracted pharmacy. -She knew there was a lot of contact between the facility staff, herself and the POA about refilling Resident #5's medications including his metoprolol 25mg. -Resident #5's POA insisted his medication come from the resident's preferred pharmacy. -She realized now she should have gone ahead and ordered the medication from the facility's contracted pharmacy because Resident #5 needed his medications including his metoprolol.	D 358		

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-She realized Resident #5's metoprolol 25mg had not been administered since the order changed when she printed a report from the eMAR on 06/25/24.
-She ordered Resident #5's metoprolol 25mg from the facility's contracted pharmacy on 06/25/24.
-She should have been "on top" of Resident #5's medications and monitored them because she knew it took seven to 10 days for them to be delivered from his preferred pharmacy.

Interview with the Administrator on 06/27/24 at 1:18pm revealed:
-The facility allowed residents' POAs to provide their medication and/or for the resident to select a preferred pharmacy.
-Resident #5's medications were dispensed from his preferred pharmacy to his POA and the POA was bringing them to the facility.
-They MAs notified the resident's POA or the preferred pharmacy when the medication had only about seven days still available.
-The facility gave the POA or the resident's preferred pharmacy about 24 to 48 hours to supply the medication.
-The facility would then order a short supply of seven days' worth of medication from the facility's contracted pharmacy.
-The RCC made her aware Resident #5 did not have his metoprolol 25mg on 06/25/24.
-The facility ordered a supply of Resident #5's metoprolol on 06/25/24.
-She was concerned he did not receive his metoprolol as ordered because she was concerned about his blood pressure knowing there were various affects high blood pressure could have on him.

Attempted telephone interview with a

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representative from Resident #5's preferred pharmacy on 05/26/24 at 4:20pm was unsuccessful.

2. Review of Resident #3's current FL-2 dated 07/03/23 revealed diagnoses included hypertension and coronary artery disease.

a. Review of Resident #3's signed physician orders dated 07/03/23 revealed there was an order for Lisinopril 2.5mg (used to treat elevated blood pressure (BP) daily; hold for systolic BP reading less than 100 and/or diastolic BP reading less than 60.

Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for lisinopril 2.5mg daily with a scheduled administration time of 8:00am; hold medication for systolic BP reading less than 100 and/or diastolic BP reading less than 60.
-On 04/08/24, there was documentation lisinopril 2.5mg was administered for a BP reading of 138/59.
-On 04/20/24, there was documentation lisinopril 2.5mg was administered for a BP reading of 103/58.
-On 04/27/24, there was documentation lisinopril 2.5mg was administered for a BP reading of 136/58.
-On 04/29/24, there was documentation lisinopril 2.5mg was administered for a BP reading of 113/56.

Review of Resident #3's June 2024 eMAR from 06/01/24 to 06/24/24 revealed:
-There was an entry for lisinopril 2.5mg daily with a scheduled administration time of 8:00am; hold medication for systolic BP reading less than 100

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and/or diastolic BP reading less than 60.
-On 06/10/24, there was documentation lisinopril 2.5mg was administered for a BP reading of 82/51.

Observation of Resident #3's medication on hand on 06/25/24 at 3:32pm revealed there was a bubble pack of 22 of 28 lisinopril 2.5mg tablets available for administration with a dispensed date of 06/18/24.

Attempted interview with Resident #3 on 06/25/24 at 10:00am was unsuccessful.

b. Review of Resident #3's signed physician orders dated 07/03/23 revealed there was an order for metoprolol tartrate 50mg (used to treat elevated BP) twice daily; hold for systolic BP reading less than 100 and/or diastolic BP reading less than 60.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for metoprolol tartrate 50mg twice daily with a scheduled administration time of 7:30am and 7:30pm; hold for systolic reading less than 100 and/or diastolic less than 60.
-There were 11 of 60 occasions when metoprolol tartrate 50mg was given and should have been held.
-On 04/29/24 at 7:30am, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 96/76.
-On 04/10/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 96/78.
-On 04/22/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 105/52.
-On 04/29/24 at 7:30pm, there was

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documentation metoprolol tartrate 50mg was administered for a BP reading of 65/69.

Review of Resident #3's May 2024 eMAR revealed:
-There was an entry for metoprolol tartrate 50mg twice daily with a scheduled administration time of 7:30am and 7:30pm; hold for systolic reading less than 100 and/or diastolic less than 60.
-On 05/13/24 at 7:30am, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 96/71.
-On 05/15/24 at 7:30am, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 98/69.
-On 05/02/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 189/42.
-On 05/03/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 78/55.

Review of Resident #3's June 2024 eMAR from 06/01/24 to 06/24/24 revealed:
-There was an entry for metoprolol tartrate 50mg twice daily with a scheduled administration time of 7:30am and 7:30pm; hold for systolic reading less than 100 and/or diastolic less than 60.
-On 06/03/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 134/43.
-On 06/09/24 at 7:30pm, there was documentation metoprolol tartrate 50mg was administered for a BP reading of 99/81.

Observation of Resident #3's medication on hand on 06/25/24 at 3:31pm revealed there was a bubble pack of 18 of 28 metoprolol tartrate 50mg tablets available for administration with dispensed date of 06/18/24.

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D 358	Continued From page 33 Attempted interview with Resident #3 on 06/25/24 at 10:00am was unsuccessful. ___________________ Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 06/26/24 at 5:30pm revealed: -The facilty was on a cycle fill of every 28 days. -The pharmacy would send the medications 3 days before the medication was due to be placed on the medication cart. -The 3 days allowed for the facility staff to check all the medications to ensure accuracy. Interview with a medication aide (MA) on 06/27/24 at 11:40am revealed: -She administered medications to Resident #3. -She would check Resident #3's BP before administering the medications because Resident #3 had parameters for the BP readings. -She would hold the BP medications when Resident #3's systolic BP was less than 100 and diastolic BP was less than 60. -She did not realize she had administered Resident #3's BP medication when the BP medication should have been held. -She was busy and mistakenly administered the medication. -She needed to slow down and be careful when administering medications. Interview with a second MA on 02/27/24 at 3:30pm revealed: -She administered medications to Resident #3. -She checked Resident #3's BP before she administered the medications. -She held Resident #3's BP medication when the systolic BP was less than 100. -She did not hold Resident #3's BP medication when the diastolic BP was less than 60.	D 358		

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-She did not notice the second part of the order to hold Resident #3's BP for a diastolic BP less than 60.
-Resident #3's BP medications lower her BP, which could drop further when medications were administered when they should not have been.

Interview with Resident #3's Primary Care Provider (PCP) on 06/27/24 at 9:14am revealed:
-The MA should not administer the BP medication to Resident #3 when the BP reading was outside the ordered parameters.
-Resident #3 could experience increased hypotension and lead to increased risk of falls.

Interview with the RCC on 06/27/24 at 12:15pm revealed:
-The MAs should take Resident #3's BP and then administer the medication if the BP was within the ordered parameters.
-The MA should hold the BP when the BP was outside of the ordered parameters.
-The MA should document on the eMAR why the medication was held.
-The documentation on the eMAR read as if the MA administered the BP medication when it should have been held.
-Resident #3's BP could drop even further.
-She expected the MAs to administer medication as ordered and to follow the PCP's orders when there were parameters and hold the medication.

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Interview with the RCC on 04/27/24 at 12:15pm revealed:
-She provided direct supervision to the MAs.
-She ensured the MAs administered the correct medications.
-The MAs audited the medications for two residents on each medication cart every Monday, Tuesday, and Wednesday on all shifts.

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-The MAs ensure the medication was on the medication cart to be administered and removed any discontinued or expired medications from the medication cart.
-The facility was on cycle fill.
-The pharmacy sent a 28 day supply of medications in bubble packs each month.
-When there was a medication order change during the 28 day cycle, the pharmacy will send enough medication to last the remainder of the current cycle.

Interview with the Administrator on 06/27/24 at 11:09am revealed:
-The RCC managed the MAs.
-The RCC conducted meetings and inservices every other month for training.
-The MA should read the order and administer the medications as ordered.
-She expected the MAs to administer medications as ordered.

____

The facility failed to ensure medications were administered as ordered for a resident (#3) who was administered two blood pressure medications when the blood pressure readings were outside the ordered parameter and the medications should have been held due to the increased risk of hypotension and falls, and a resident (#5), who was ordered two blood pressure medications and was not administered the medications as ordered due to the medications not being in the facility. This failure of the facility to administer medication as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/27/24 for this violation.

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D 358	Continued From page 36 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2024.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents take their medications for 3 of 3 residents (#9, #11, and #12) as evidenced by medication observed in the residents' rooms. The findings are: 1. Review of Resident #9's current FL-2 dated 12/08/23 revealed: -Diagnoses included depression, chronic obstructive pulmonary disease (COPD), vitamin D deficiency, macular degeneration, and insomnia. -There was an order for multivitamin daily. Review of Resident #9's physicians' order dated 12/14/23 revealed there was an order for probiotics daily.	D 366		

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Review of Resident #9's physicians' order dated 03/25/24 revealed there was an order for omeprazole 20mg daily.

Observation of Resident #9's room on 06/25/24 at 10:29am revealed:
-Resident #9 was lying in her bed, which was against the wall.
-There was a souffle cup of pills across the room on a table.
-The cup of pills was out of reach of Resident #9.
-There was no medication aide (MA) in Resident #9's room.

Review of Resident #9's June 2023 electronic medication administration record (eMAR) on 06/25/24 revealed:
-Multivitamin was documented as administered.
-Probiotic was documented as administered.
-Omeprazole was documented as administered.

Interview with Resident #9 on 06/25/24 at 10:39am revealed the MA would place her medications on the table and she would take them when she got out of bed.

Interview with a MA on 06/27/24 at 11:30am revealed:
-She prepared Resident #9's medication the morning of 06/25/24.
-She placed Resident #9's medication on the table to take when Resident #9 gets out of bed.
-Resident #9 does not like to take her pills before she gets out of bed.
-There had never been a problem where another residents took Resident #9's medications.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/24 at 11:29am.

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D 366	Continued From page 38 Refer to the interview with the Administrator on 06/27/24 at 2:39pm. 2. Review of Resident #11's current FL2 dated 03/20/24 revealed: -Diagnoses included hypothyroidism, insomnia and dementia. -There was an order for Vitamin D (a supplement) 5000IU two tablets once daily. -There was an order for escitalopram (used to treat anxiety) 10mg once daily. -There was an order for fish oil (used to help with liver function) 1000mg once daily. -There was an order for lamotrigine (used to treat seizures) 25mg two tablets twice daily. -There was an order for levothyroxine (used to treat hypothyroidism) once daily. -There was an order for Vitamin B12 (used to for healthy blood cells) 100mcg once daily. -There was an order for Vitamin C (used to help the immune system) 250mg once daily. Review of Resident #11's June 2024 electronic medication administration record (eMAR) from 06/01/ 24 to 06/25/24 revealed: -There was an entry for Vitamin D 5000IU two tablets once daily scheduled at 10:00am. -There was an entry for escitalopram 10mg once daily scheduled at 10:00am. -There was an entry for fish oil 1000mg once daily scheduled at 10:00am. -There was an entry for lamotrigine 25mg two tablets twice daily scheduled at 9:30am and 9:30pm. -There was an entry for levothyroxine once daily scheduled at 6:00am -There was an entry for Vitamin B12 100mcg once daily scheduled at 10:00am. -There was an entry for Vitamin C 250mg once	D 366		

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daily scheduled at 10:00am.

Observation of Resident #11 on 06/25/24 at 9:00am revealed:
-She was seated in a rocking chair on the front porch of the facility with another resident.
-She had two small plastic medication cups and a small cup of water on the arm of the rocker.
-One cup contained a large pink tablet and the second cup contained 13 tablets including a large white capsule, a large peach color tablet, two orange gel capsules, a small pink tablet, one small oval tablet, a large oval tablet and multiple round tablets.
-There were no staff on the porch with the residents.

Interview with Resident #11 on 06/25/24 at 9:00am revealed:
-She came out to the porch with her medication after she had eaten breakfast.
-She brought her medication in the cups with her to take them.
-The medication aid (MA) knew she had the cups with her medicine in them.
-The MA did not stay with her while she took her medications; she thought it was because she had so many to take.
-She would eventually take all her medications it just took her a while because there were so many.
-The MA would not ask her later if she took all her medications because the MA knew she would take them.
-She knew she had a calcium pill and a fish oil capsule; she was not sure what other medication she took.

Interview with a MA on 06/27/24 at 11:30am revealed:

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-She did not know where Resident #11 got a cup of pills from on the morning of 06/25/24.
-Resident #11 resided on A-hall, and she had just popped medications for the 1st resident on A-hall when the surveyors walked through the door.
-She had not administered Resident #11 her morning medications when the surveyors entered the morning of 06/25/24.
-Resident #11 likes to pocket her medications.
-It is possible, the medications were her night medications the night before.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/24 at 11:29am.

Refer to the interview with the Administrator on 06/27/24 at 2:39pm.
3. Review of Resident #12's current FL2 dated 06/06/24 revealed:
-Diagnoses included hypertension, hypothyroidism, generalized anxiety, type two diabetes mellitus and depression.
-There was an order for Vitamin D3 (used to treat Vitamin D3 deficiency) 25mcg once daily.
-There was an order for gabapentin (used to treat seizures) 100mg once daily.
-There was an order for amlodipine (used to treat high blood pressures) 7.5mg once daily.
-There was an order for aspirin (used to treat high blood pressures) 81mg once daily.
-There was an order for bupropion (used to treat depression) 150mg once daily.
-There was an order for docusate (used to treat constipation) 100mg once daily.
-There was an order for donepezil (used to treat Alzheimer's disease) 10mg once daily.
-There was an order for levothyroxine (used to treat hypothyroidism) 125mcg once daily.
-There was an order for lorazepam (used to treat seizures) 100mcg once daily.

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D 366	Continued From page 41 -There was an order for metformin (used to treat diabetes) 500 once daily. -There was an order for mirtazapine (used to treat depression) 30mg once daily. -There was an order for omeprazole (used to treat heartburn) 20mg once daily. -There was an order for oxybutynin (used to treat overactive bladder) 5mg once daily. -There was an order for sertraline (used to treat depression) 100mg once daily. Review of Resident #12's June 2024 electronic medication administration record (eMAR) from 06/01/ 24 to 06/25/24 revealed: -There was an entry for Vitamin D3 25mcg once daily scheduled at 9:30am. -There was an entry for gabapentin 100mg once daily scheduled at 9:30am. -There was an entry for amlodipine 7.5mg once daily scheduled at 9:30am. -There was an entry for aspirin 81mg once daily scheduled at 9:30am. -There was an entry for bupropion 150mg once daily scheduled at 9:30am. -There was an entry for docusate 100mg once daily scheduled at 9:30am. -There was an entry for donepezil 10mg once daily scheduled at 9:30am. -There was an entry for levothyroxine 125mcg once daily scheduled at 6:00am. -There was an entry for lorazepam 100mcg once daily scheduled at 9:30am. -There was an entry for metformin 500 once daily scheduled at 9:30am. -There was an entry for mirtazapine 30mg once daily scheduled at 9:30am. -There was an entry for omeprazole 20mg once daily scheduled at 9:30am. -There was an entry for oxybutynin 5mg once daily scheduled at 9:30am.	D 366		

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-There was an entry for sertraline 100mg once daily scheduled at 9:30am.

Observation of Resident #12 on 06/25/24 at 10:12am revealed:
-She was seated in a chair in her room with her foot soaking in a bath.
-She had two small plastic medication cups and a cup of water on her nightstand.
-There were multiple tablets and capsules in each cup.
-There were no staff in the room with Resident #12.

Interview with Resident #12 on 06/25/24 at 10:12am revealed:
-The medication aid (MA) left her medication on her nightstand for her to take.
-The MA left her medication for her to take between her eye drop doses; she had to wait between doses.
-She was soaking her foot and the MA would come back to take care of her foot and apply her second dose of eye drops.
-It took her a while to take her medications because there were so many of them.
-The MA would come back later and check the cups to be sure she took them all.

Interview with a MA on 06/27/24 at 11:30am revealed:
-She administered Resident #12 her morning medications on 06/25/24.
-Resident #12 was administered 3 eye drops in addition to her pills.
-Resident #12 also has a wound to her toe that has to be soaked.
-She takes the cup of pills and an eye drop to Resident #12's room.
-She places the cup of pills down at Resident

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#12's bedside.
-She administered one eyedrop, then would leave the room to get the second eye drop because she had to wait 3 to 5 minutes between eye drops.
-She would also set up for Resident #12 to soak her toe.
-She did leave the cup of pills in Resident #12's room, while she was in and out of the room, preparing the soak and waiting 3 to 5 minutes between 3 eye drops.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/27/24 at 11:29am.

Refer to the interview with the Administrator on 06/27/24 at 2:39pm.

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Interview with the Resident Care Coordinator (RCC) on 06/27/24 at 11:29am revealed:
-The MAs were supposed to watch the residents take their medications and then document on the eMAR after the resident had taken the medication.
-The MAs were no allowed to leave medications in the residents' rooms or with the residents for the residents to take on their own.
-The MA should not go on to the next resident until they are sure the current resident had taken all their medication.

Interview with the Administrator on 06/27/24 at 2:39pm revealed:
-The MAs were supposed to verify the resident took their medications by staying with the resident until they have taken their medication or refused it.
-If the resident refused to take their medications at the time the MA attempted to administer it then the MA should take the medication away from the resident and document the refusal on the eMAR.

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D 366	Continued From page 44 -The MA could not document the administration of a medication on the eMAR until the entire process was complete. -Medications should never be left with the resident because the MA is responsible for making sure the resident took their medications.	D 366		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an	D 482		

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effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure there was a written order from a physician for a mechanical device adjacent to a resident's body for 1 of 1 sampled residents (#2) with bedrails.

The findings are:

Review of the facility's restraints policy dated January 2022 revealed:
-The Community's philosophy was to foster a restraint-free environment.
-Restraints may not be used for any reason.
-A physical restraint was a device which physically limited, restricted, or deprived an individual of movement or mobility, including, but not limited to, a half-bed rail.

1. Review of Resident #2's current FL2 dated 04/22/24 revealed:
-Diagnoses included cerebral infarction,

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D 482	Continued From page 46 depression and hyperlipidemia. -Resident #2 was intermittently disoriented. -She was non-ambulatory and wheelchair bound. Review of Resident #2's care plan dated 04/30/24 revealed: -Resident #2 needed extensive assistance with toileting, ambulation, bathing, and transferring. -She needed moderate assistance with dressing and grooming. -She was non-ambulatory and used a wheelchair. Review of Resident #2's signed physician's orders dated 05/02/24 revealed there was no order for bedrails nor documentation related to bedrails. Review of Resident #2's signed physician order dated 05/16/24 revealed there was an order for a HALO (a safety ring placed on institutional beds as a mobility device) device to better assist with moving in bed and transferring from bed to wheelchair. Observation of Resident #2 on 06/25/24 at 9:55am on the initial tour revealed: -Resident #2 was lying in her bed and both bedrails were in the up position. -The bed was in the middle of the room and the bedrails extended from the top of the bed to about one-third of the length of the bed. Interview with Resident #2 on 06/25/24 at 9:56am revealed: -She used the bedrails to help herself turn in the bed. -She needed staff assistance to turn in the bed. -She would need help to free herself from the bedrails if she were to become entrapped in them.	D 482		

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Second observation of Resident #2 on 06/26/24 at 3:33pm revealed:
-Resident #2 was lying in bed and the bedrails were in the up position.
-The bedrails extended from the top of the bed to about one-third of the length down the bed.

Second interview with Resident #2 on 06/26/24 at 3:32pm revealed:
-She thought the rails had been attached to both sides of her bed for about two weeks.
-There was only one bedrail before, and the second bedrail was added about two weeks ago.

Interview with a medication aide (MA) on 06/25/24 at 4:30pm revealed:
-Resident #2 was wheelchair dependent and needed staff assistance for transfers.
-Resident #2 wore a call bell pendant and was able to call for help if she needed it.

Interview with Resident #2's primary care provider (PCP) on 06/27/24 at 9:25am revealed:
-Resident #2 had a paralyzing stroke and she was bed-bound.
-She knew that Resident #2 had bedrails attached to her bed and the bedrails had come with the bed when Resident #2 was admitted to the facility.
-Resident #2 needed assistance to move in the bed and she needed something to help herself turn in the bed.
-She and the facility had been trying to figure out a way to remove the bedrails from the bed.
-The facility was aware of Resident #2's bedrails.
-She did not ever recommend bedrails and Resident #2 did not have a current order for bedrails.
-She wanted Resident #2 to have a HALO device.

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-Resident #2 needed staff assistance to turn or move at all in the bed.
-She did not think the bedrails were a safety hazard.
-Resident #2 should not have bedrails, but she thought that was the only way to completely keep Resident #2 from falling.

Telephone interview with Resident #2's occupational therapist (OT) on 06/27/24 at 10:50am revealed:
-Resident #2 was able to move herself in bed, could sit herself up on the edge of the bed, roll herself in bed, and turn herself and roll from side to side.
-Resident #2 used her bedrails to help herself turn and move in her bed, and sometimes to help herself roll in the bed.
-Resident #2 sometimes used the bedrails for stability when she was sitting up to the edge of the bed.
-Resident #2's bed used to be against the wall in her room and she thought Resident #2 used to only have one bedrail.
-She thought Resident #2's bed was moved to the middle of her room during the week of 06/27/24.
-Resident #2 was oriented and she did not think Resident #2 would get caught or entrapped in the bedrails.
Resident #2 wore a pendant necklace that she used for a call bell.

Interview with Resident #2's physical therapist (PT) on 06/27/24 at 11:40am revealed:
-She started working with Resident #2 on 05/06/24.
-Resident #2's bed was against the wall, and she had two bedrails attached to each side of her bed on 05/06/24.
-Resident #2 was able to move herself in her bed

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by using her bedrails, and she used the bedrails primarily for mobility.
-Resident #2 used her bedrails to roll from side to side and to get herself from her side to a sitting a position, and to scoot herself forward in her bed.
-Resident #2 needed staff assistance for stand and pivot transfer from her bed to her chair and from her chair to her bed.
-Resident #2 needed the bedrails to maintain bed mobility independence.
-Resident #2 was oriented and she thought Resident #2 would be able to free herself if she were to become entrapped in her bedrails.

Interview with a second MA on 06/27/24 at 1:50pm revealed:
-She was not sure if Resident #2 had bedrails.
-She did not know if Resident #2 had a physician's order for bedrails.
-The RCC normally completed assessments of residents.
-She had never documented anything about Resident #2 having bedrails.

Interview with the Resident Care Coordinator (RCC) on 06/27/24 at 1:30pm revealed:
-Resident #2 was admitted to the facility with the bedrails at the beginning of May 2024.
-Resident #2 did not have a current physician's order for the bedrails, and only had an order for a HALO device.
-Resident #2's family member refused to allow Resident #2's bedrails to be removed and refused the HALO device that was ordered.
-She had not seen Resident #2 move in her bed and she did not know Resident #2's mobility level.
-She could not recall there being any assessments completed regarding Resident #2's bedrails.

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Interview with the second RCC on 06/27/24 at 1:35pm revealed:
-Resident #2 was admitted to the facility with her bedrails in place.
-Resident #2's family member said staff could not touch Resident #2's bedrails because they were under warranty, and the company would have to remove the bedrails.
-She explained to Resident #2's family member that bedrails were considered a restraint.
-Resident #2 had an order for a HALO device but did not have an order for bedrails.
-Staff helped Resident #2 turn herself in the bed, but she had not personally seen Resident #2 use the bedrails for mobility.
-There was no documentation or assessment completed for Resident #2's bedrails.

Interview with the Administrator on 06/27/24 at 2:35pm revealed:
-The facility allowed certain bedrails for mobility only but did not typically allow bedrails.
-If a bedrail was used to keep a resident in bed, it was considered a restraint.
-Resident #2 was admitted to the facility with bedrails.
-Resident #2's bed was rented and "under warranty" from a rental company.
-She did not know if Resident #2 had an order for bedrails.
-Resident #2 used her bedrails when she was getting out of bed or for stability when transferring to her wheelchair.
-She had not seen Resident #2 use her bedrails to move in her bed.
-Staff had not completed any documentation about Resident #2's bedrails.
-She did not know if an assessment was completed regarding Resident #2's bedrails.