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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 06/25/24 to 06/26/24.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the walls, ceiling and floors were kept in good repair related to a toilet in the common bathroom, holes in the walls and doors, closet doors, wall air conditioning units, electrical outlets with burn marks, and peeling flooring with gaps in the floors in residents' rooms and bathrooms on the North Hall and South Hall. The findings are: Review of the Facility Maintenance Log with a start date of 05/16/24 revealed: -There were 55 total entries of maintenance repairs identified from 5/16/24 through 06/18/24. -There were 22 entries of maintenance repairs identified from 05/16/24 with no completion date. -The items listed to be repaired or replaced on	D 074		

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the North and South Hall included floors, doorknobs, toilets, shower heads, holes in the walls, the ceiling leak, and air conditioners.
-There were 10 entries of maintenance repairs identified from 06/03/24 with no completion date.
-The items listed to be repaired or replaced on the North Hall included floors, doorknobs, toilets, and a sink.
-There were 18 entries of maintenance repairs identified from 06/11/24 with no completion date.
-The items listed to be repaired or replaced on the North and South Hall included toilets, sinks, hallway bathrooms, a hole in the ceiling, and leaking showers.
-There were 5 entries of maintenance repairs identified from 06/18/24 with no completion date.
-The items listed to be repaired or replaced on the North and South Hall included floors, toilets, doorknobs, sinks, and a hole in the ceiling.

Review of the Facility Maintenance Room Audit Log with a start date of 05/17/24 revealed:
-There were 20 total entries of weekly audits for maintenance repairs identified from 05/17/24 through 06/10/24.
-There were 4 entries of maintenance repairs identified from 05/17/24 with no completion date.
-The items listed to be repaired or replaced on the North Hall included floors, walls, and bathrooms.
-There were 4 entries of maintenance repairs identified from 05/20/24 with no completion date.
-The items listed to be repaired or replaced included toilets, air conditioners, and carpets.
-There were 4 entries of maintenance repairs identified from 05/27/24 with no completion date.
-The items listed to be repaired or replaced on the North and South Hall included floors, doorknobs, walls, and bathrooms.
-There were 4 entries of maintenance repairs

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identified from 06/03/24 with no completion date.
-The items listed to be repaired or replaced on the North and South Hall included doors, carpets, and painting.
-There were 4 entries of maintenance repairs identified from 06/10/24 with no completion date.
-The items listed to be repaired or replaced on the North and South Hall included floors, air conditioners, and a bathroom sink.

Interview with the facility's contracted maintenance staff on 06/25/24 at 4:20pm revealed:
-He brought all needed repairs to the Owner's attention after he and the Administrator had reviewed the concerns in the middle of May 2024.
-The Owner had not paid the contracted maintenance staff for completed repair projects and the Owner informed the contracted maintenance staff that funding was unavailable for the pending repair projects.
-The contracted maintenance staff was never supplied the funding or materials for the facility repair projects by the Owner.

Observation of the North Hall of the facility on 06/26/24 at 9:00am revealed:
-The toilet in the North Hall common bathroom was not secured to the floor; the front of the toilet swiveled from side to side and there was a dark brown substance on the floor underneath the toilet.
-The wall air conditioning unit on the left side of the hallway was not in use and the electrical outlet for the air conditioning unit had obvious burn marks.

Observation of resident room #1 on 06/24/24 at 9:10am revealed:
-There was a one-inch gap between the wall

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where the air conditioning unit was placed in the wall.
-Resident room #1 did not have a closet door.
-There was a fire alarm hanging by electrical cords from the ceiling in resident room #1.

Observation of resident room #2 on 06/24/24 at 9:15am revealed:
-The floor covering was peeled from the flooring material in the center of the room and there were gaps between the ends of the flooring material.
-There was a one and half-inch crack in the ceiling above the door entering the room.
-The wall trimming at the right corner floor area was loose and stuck out from the wall.

Observation of resident room #3 on 06/24/24 at 9:20am revealed:
-Resident room #3 had a wall air conditioning unit that was not in use with the front cover removed.
-The electrical outlet for the air conditioning unit had burn marks.

Based on observation and interview, it was determined the resident in room #3 was not interviewable.

Observation of resident room #6 and #7 on 06/24/24 at 9:23am revealed:
-Resident room #6 did not have a closet door.
-In resident room #7, the floor covering was peeled from the flooring material at the entryway to the room and the flooring stuck up with rough edges presenting a trip hazard when the resident door was fully opened.
-Resident room #7 did not have a doorknob.

Observations of resident room #4 on 06/26/24 at 9:28am revealed:
-There was a hole in the ceiling the size of a golf

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ball outside resident room #4.
-There were brownish stains and cracks in the ceiling around the hole.
-There was no closet door.
-The front cover of the air conditioning unit was removed and the air conditioner was running.

Interview with the resident who resided in room #4 on 06/26/24 at 9:35am revealed:
-The holes were in the room when he moved in the room and he had never had a closet door.
-The hole in the ceiling outside his door had been there for several weeks.
-Facility staff had told the resident that the holes in the bathroom door would be fixed, but no staff came to look at the door or to replace the doorknob.
-He had told the staff about the hole in the ceiling because it was outside of his room, but he had not seen any staff attempt to fix the hole in the hallway ceiling.
-The air conditioner cover was removed by the maintenance staff within the last week and never reattached by the maintenance staff or the facility staff.

Observation of resident room #5 on 06/26/24 at 9:40am revealed:
-There was 1 hole in the wall the size of a baseball and 1 hole on each side of the bathroom door with rough, jagged edges in the door.
-The bathroom door had multiple holes of various shapes and sizes on the lower half of the door with rough, jagged edges of wood.
-The door trim of the bathroom door had missing pieces of wood framing with jagged edges.
-There was no closet door and there was no doorknob on the resident room door.
-The shared bathroom between resident rooms #5 and #4 had a hole on the inside of the

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bathroom door, the size of a volleyball.

Interview with the resident who resided in room #5 on 06/26/24 at 9:45am revealed:
-The holes were in the room when he moved in the room and he had never had a closet door.
-Facility staff had told the resident that the holes in the bathroom door would be fixed, but no one came to look at the door.
-The hallway ceiling leaked in the hallway on occasion, but the hole in the ceiling had been there for several weeks.
-The resident had not seen any staff attempting to fix the hole in the hallway ceiling, but he had not told staff about the hole in the ceiling.

Observations of resident room #12 on 06/24/24 at 9:50am revealed:
-The floor covering was peeled from the flooring material and there were gaps between the pieces of the flooring material.
-There was no transition strip between the laminate flooring in the room and tile flooring in the bathroom which posed a trip hazard.
-There was a one-inch gap between the flooring of the resident room and bathroom.
-There was a half-inch height difference between the flooring of the room and bathroom which posed a trip hazard.
-There was an incontinence pad covering the gap between the flooring of the room and bathroom.

Interview with the resident who resided in room #12 on 06/24/24 at 9:55am revealed:
-The gap in the flooring between her room and the bathroom made it hard to maneuver her wheelchair between the two rooms.
-She had tripped on the gap in the flooring when she ambulated to the bathroom.
-She used the common bathroom in the hallway

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for toileting and bathing to avoid tripping on the gap in the flooring.
-The gap in the flooring in the room and in the flooring between her room and the bathroom had been there since she moved into the room within the last year.
-She had not noticed any facility staff addressing the issue recently, but was told by the staff that the gaps would be fixed eventually when she told staff about her concerns.

Interview with the Resident Care Supervisor (RCS) on 06/26/24 at 10:05am revealed:
-She was not aware of the burnt electrical outlets in resident room #3 and in the North Hall hallway.
-She was not aware the front covers were removed from the air conditioning units in resident room #3 and in resident room #4.
-She was aware of the hole in the ceiling, but the Administrator, the Owner, and the contracted maintenance staff were responsible for repairs.
-She was aware of the North Hall bathroom toilet was not fastened and was unsteady.
-The personal care aides (PCA), medication aides (MA), or housekeeping staff had not informed her of issues related to burnt electrical outlets or uncovered wall air conditioning units.

Observations of resident room #18 on the South Hall on 06/26/24 at 10:10am revealed:
-The bathroom door had 3 holes of various shapes and sizes with jagged edges in the drywall on the outside of the bathroom.
-The bathroom door was locked and the resident did not have a roommate.

Interview with the resident who resided in room #18 on 06/26/24 at 10:15am revealed:
-The holes had been in the walls in his room for over a year.

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-He had not noticed any facility staff addressing the issue recently.
-He had complained to the staff about wanting to use his own bathroom.
-The facility staff told the resident to use the hallway restroom for bathing and toileting until the bathroom was fixed.

Second interview with the RCS on 06/26/24 at 10:25am revealed:
-She was aware the bathroom in resident room #18 was locked and the resident had been told to use the hallway bathroom for bathing and toileting.
-The bathroom in resident room #18 was closed and locked until repairs were completed on the inside of the bathroom, but she was not aware of what repairs were needed for the bathroom.
-She was not aware of when the repairs were to be completed for the bathroom in resident room #18.

Interview with a housekeeper on 06/26/24 at 10:35am revealed:
-He was a housekeeper for the South Hall.
-He was aware of the holes in the bathroom door for resident room #18 and was aware the bathroom was closed for repairs.
-The Administrator and the contracted maintenance staff had discussed the repairs for the bathroom.
-The housekeeper thought the issue had been fixed.
-He and the housekeeping staff were responsible for conducting weekly room audits for maintenance concerns.
-The weekly room audit process was started by the Administrator in the middle of May 2024, and he submitted completed audit sheets to the Administrator every week.

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-The Administrator was responsible for providing the results of the weekly room audit logs to the Owner for maintenance repairs.
-He was not aware of burnt electrical outlets from the North Hall or any residents rooms.
-The other housekeeping staff had not told him about issues with burnt electrical outlets.

Interview with a second housekeeper on 06/26/24 at 10:45am revealed:
-She was a housekeeper for the North Hall.
-She was aware of the holes in the resident rooms and bathrooms.
-She was aware of the toilet in the North Hall bathroom not being fastened to the floor.
-She was aware of resident rooms missing doorknobs, closet doors, and covers for the wall air conditioning units.
-The contracted maintenance staff removed the front covers on the air conditioning units to examine them.
-She was unsure why the covers were still off of the air conditioner units.
-She was aware of the burnt electrical outlets in the North Hall and the residents room.
-The staff found the burnt electrical outlets after the air conditioner power cords was unplugged because of a burn smell.
-She was not aware of any plans to fix the repairs on the North Hall.
-The issues had continued for the last couple months.
-She and the housekeeping staff were responsible for conducting weekly room audits for maintenance concerns.
-The weekly room audit process was started by the Administrator in the middle of May 2024.
-She submitted completed audit logs to the Administrator every week.
-The Administrator was responsible for providing

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the results of the weekly room audit logs to the Owner for maintenance repairs.

Interview with the Office Manager (OM) on 06/26/24 at 10:55am revealed:
-She was aware the same maintenance repair issues existed for the last two months and had not been corrected.
-All staff were responsible for notifying either the previous Resident Care Director (RCD)or the OM when maintenance repair issues were identified before the Administrator started on 05/14/24.
-The previous RCD or the OM were responsible for notifying the Owner of the identified maintenance issues.
-The Owner arranged for the contracted maintenance staff to complete the repairs.
-She knew a weekly room audit process was started by the Administrator in the middle of May 2024 that involved the housekeeping staff, but she was not involved in the new process.
-The new Administrator was responsible for notifying the Owner of maintenance repair issues after 05/14/24 and the Owner arranged for the contracted maintenance staff to complete the repairs.
-The OM noticed different contracted maintenance staff came in and addressed certain maintenance repair issues, but she was unaware if any repair projects were completed within the last two months.
-She became aware only yesterday (06/25/24) the current contracted maintenance staff had not been paid by the Owner for repairs completed and purchased parts related to repairs.
-She could not recall if the maintenance repair issues identified within the last 2 months were completed by any contracted maintenance staff.
-She was not aware of burnt electrical outlets in the resident rooms or on the North Hall.

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D 074	Continued From page 10 Interview with the Administrator on 06/26/24 at 11:15am revealed: -She was aware of the previous maintenance issues before her start date of 05/14/24 because the she was responsible to initiate audit processes upon her arrival. -She was unaware if any repair projects were completed before her start date of 05/14/24 and she had no documentation for estimates or completed maintenance work. -She recognized maintenance repair issues upon her start date on 05/14/24 and started a weekly room audit process and a facility maintenance log. -The housekeeping staff were responsible for conducting weekly room audits for maintenance concerns and she was responsible for reviewing the weekly room audits along with additional concerns possibly missed by the housekeeping staff. -She was responsible for providing the results of the weekly room audit logs to the Owner for maintenance repairs throughout the facility maintenance log which reflected all the facility's needed repairs. -The Owner was responsible for arranging for the contracted maintenance staff to complete repairs and the Owner contacted her the day the contracted maintenance staff was scheduled to arrive at the facility. -The contracted maintenance staff had performed work at night and she was unaware of the status of completed projects upon his departure the next morning. -She had notified the Owner repair projects were not completed by the contracted maintenance staff after the contracted maintenance staff told the Owner the repair projects were finished. -The contracted maintenance staff had been to	D 074		

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the facility 3 times from her start date of 05/14/24 and had never completed a review of the facility's maintenance repair issues with her.
-She was aware completion dates were not documented for the facility maintenance log and the weekly room audits because she was not sure what projects were completed currently.
-She was not aware the Owner had not paid the current contracted maintenance staff for completed repair projects and the Owner informed the current contracted maintenance staff funding was unavailable for the pending repair projects.
-She was aware of the hole in the ceiling in the North Hall but thought the hole in the ceiling had been fixed by the contracted maintenance staff.
-She was aware resident room #5 and resident room #7 were missing doorknobs but thought the doorknobs had been replaced by the contracted maintenance staff.
-She was not aware of the missing front covers from the air conditioning units in resident room #3 and resident room #4.
-She was not aware of the burnt electrical outlets in resident room # 3 and in the North Hall hallway.
-She expected the maintenance repair projects to be completed in a prompt manner when maintenance issues were addressed from her communication.
-She expected a chain of communication from both the Owner and the contracted maintenance staff on the progress of maintenance repair projects.

Telephone interview with the Owner on 06/26/24 at 1:40pm revealed:
-He was aware of the hole in the ceiling in the North Hall hallway and the peeling and gapping of floors in residents' rooms.
-He was not aware the toilet on the North Hall hall

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common bathroom was loose and thought it had been fixed by the contracted maintenance staff.
-He was aware of the facility maintenance log and the facility weekly room audits initiated upon the Administrator's start date of 05/14/24.
-The Administrator submitted the facility maintenance log to the Owner.
-The Owner was responsible to contact the contracted maintenance staff upon his completed review of the facility maintenance log.
-The Owner had requested for the maintenance log to be sent to him because he had not received the facility maintenance log weekly from the Administrator in a timely manner within the previous weeks.
-Previous maintenance projects were not completed satisfactorily due to the former contracted maintenance staff being unreliable.
-The Owner and the contracted maintenance staff had communicated on a constant basis and the Owner had provided updates to the Administrator.
-When asked about concerns with funding available for needed repairs and supplies the Owner responded, there were no issues that should have delayed the completion of the maintenance repair projects.
-He visited the facility last week and had not identified any issues.
-He expected the Administrator to report maintenance concerns in a timely manner and for the contracted maintenance staff to complete repair projects in a timely manner.

_____

The facility failed to ensure walls, ceiling and floors were kept clean and in good repair related to the floor in resident room #12 having a gap, missing a transition strip, and an unleveled floor between the resident room and bathroom causing a trip hazard resulting in the resident residing in resident room #12 to trip on the floor and was

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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
D 074	Continued From page 13 unable to propel her wheelchair across the gap resulting in the resident having to use the common bathroom in the hallway; a resident residing in resident room #18 was unable to use the bathroom in his room due to the bathroom door was locked resulting in the resident having to use the common hall bathroom; and 2 electrical outlets with obvious burn marks located at air conditioner units on the North Hall and resident room # 3 which posed a fire hazard. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 07/01/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 10, 2024.	D 074		
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.	D 234		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 3 of 5 sampled residents (#1, #2, and #4) had completed tuberculosis (TB) testing upon admission.

The findings are:

1. Review of Resident #1's current FL2 dated 08/08/23 revealed diagnoses included Alzheimer's disease, dementia, atrial fibrillation, dysphagia, and hypertension.

Review of the Resident Register for Resident #1 revealed Resident #1 was admitted to the facility on 07/28/22 and was admitted to the facility directly from a hospital.

Review of Resident #1's immunization records revealed there was no documentation a first or a second TB skin tests were completed.

Interview with Resident #1 on 06/26/24 at 2:45pm revealed the resident could not recall if he had received a TB skin test upon admission to the facility.

Interview with the Resident Care Supervisor (RCS) on 06/26/24 at 2:40pm revealed:
-She did not know Resident #1 did not have either a first or a second TB skin test completed.
-She did not know if anyone audited Resident #1's record to see if his TB skin tests were completed.

Interview with the Administrator on 06/26/24 at 3:20pm revealed:
-She was aware Resident #1's first and second step TB skin tests were not completed upon the

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resident's admission by review of the weekly audit checklist tool.
-She had instructed TB skins tests be administered to all residents this week in order to correct Resident #1's missing TB skin tests.

Refer to interview with the RCS on 06/26/24 at 11:05am.

Refer to interview with the Administrator on 06/26/24 at 3:20pm.
2. Review of Resident #2's current FL2 dated 01/08/2024 revealed diagnoses included atrial fibrillation, anemia, benign essential hypertension, diabetes mellitus, hypertrophy of the prostate with urinary obstruction, major depression, hyperlipidemia, obesity, end of stage renal failure on dialysis and amputation above the knee.

Review of the Resident Register for Resident #2 revealed Resident #2 was admitted to the facility on 10/19/21 from the hospital.

Review of Resident #2's immunization records revealed:
-There was documentation a TB skin test was administered on 09/27/21 with documentation of a negative TB skin test result dated 09/28/21.
-There was no documentation that a second TB skin test was completed.

Interview with the Resident Care Supervisor (RCS) on 06/26/24 at 2:40pm revealed:
-She was not aware Resident #2 did not have a second TB skin test completed.
-She was not sure if Resident # 2's record had been audited in the previous couple of months to check for completion of TB skin tests.

Interview with the Administrator on 06/26/24 at

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D 234	Continued From page 16 3:18pm revealed: -She was not aware Resident # 2 did not have a second TB skin test completed prior to admission. -Resident # 2's record was listed as audited and checked off with two completed TB skin test. -She reviewed Resident # 2's record and located the first TB skin test with an admission date of 09/27/19 with documentation of a negative TB skin test result dated 09/28/21. -She could not locate documentation a second TB skin test was administered. Refer to interview with the RCS on 06/26/24 at 11:05am. Refer to interview with the Administrator on 06/26/24 at 3:20pm. 3. Review of Resident #4's current FL2 dated 12/28/23 revealed diagnoses included catatonic schizophrenia, acute kidney failure, and bipolar disorder. Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 01/09/23. Review of Resident #4's immunization record revealed: -Resident #4 received a TB skin test applied on 01/03/23 and was read as negative on 01/05/23. -There was no documentation a second TB skin test for Resident #4 was completed. Interview with Resident #4 on 06/26/24 at 1:00pm revealed: -He remembered receiving one TB skin test but could not remember if it was completed prior to his admission to the facility.	D 234		

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D 234	Continued From page 17 -He could not remember if he had completed a second TB skin test. Interview with the Resident Care Supervisor (RCS) on 06/26/24 at 2:40pm revealed: -She did not know that Resident #4 was missing a second TB skin test. -She and the medication aides (MAs) had been auditing resident records during the previous month and TB skin tests were one of the items on the audit checklist. -She could not remember if Resident #4's record had been audited yet. Interview with the Administrator on 06/26/24 at 3:20pm revealed: -She was not aware that Resident #4 was missing a second TB skin test. -Upon review of the weekly record audit checklist tool that the MAs and the RCS had been working on, there was documentation that Resident #4's record had been audited on 06/21/24. -They only found documentation of one TB skin test. Refer to interview with the RCS on 06/26/24 at 11:05am. Refer to interview with the Administrator on 06/26/24 at 3:20pm. _____ Interview with the RCS on 06/26/24 at 11:05am revealed: -She knew that TB skin tests were supposed to be completed upon a resident's admission to the facility. -She was responsible to ensure TB skin tests were completed upon a resident's admission to the facility. -The current Administrator had started a resident	D 234		

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D 234	Continued From page 18 record audit process in the middle of May 2024 which was delegated to the MAs and the RCS. -There had been no system in place to audit resident records for TB skin tests prior to the new Administrator starting in mid-May 2024. -The MAs and the RCS were responsible to audit 5 resident records per week with an audit checklist tool provided by the Administrator. -The Administrator was responsible to verify the information documented on the checklist after the MAs and the RCS completed their weekly audits. Interview with the Administrator on 06/26/24 at 3:20pm revealed: -She knew that TB skin tests were supposed to be completed upon each resident's admission to the facility. -The RCS was responsible to ensure that residents had TB skin tests completed upon admission to the facility. -She started a resident record audit process in the middle of May 2024 which was delegated to the MAs and the RCS. -She expected that all TB skin tests be completed upon each residents' admission. -She preferred that all residents have both TB skin tests completed before admission.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and	D 273		

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interviews, the facility failed to ensure health care referral and follow-up was completed for 1 of 5 sampled residents (#3) related to follow up with the primary care provider (PCP) after missed appointments for laboratory work for medication monitoring.

The findings are:

Review of Resident #3's current FL2 dated 09/12/23 revealed diagnoses included atrial fibrillation, diabetes type 2, and hypertension.

Review of Resident #3's physician's orders dated 12/21/23 revealed there was an order for warfarin 3mg tablet once a day.

Review of Resident #3's physician's orders dated 05/31/24 revealed there was an order to continue the current warfarin dose and to recheck INR in 1 to 2 weeks.

Review of Resident #3's record revealed:
-There was an INR result on 05/29/24 which was 1.64 with a normal reference range of 2-3 from the contracted laboratory agency.
-There was no documentation Resident #3 had an INR check completed between 05/30/24 and 06/25/24.

Telephone interview with a representative from the contracted laboratory agency on 06/25/24 at 2:42pm revealed:
-There was a result on 05/29/24 for an INR of 1.64 for Resident #3 on record.
-There was no order for Resident #3's INR in 1 to 2 weeks on 05/31/24.

Interview with Resident #3 on 06/25/24 at 3:00pm revealed:

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D 273	Continued From page 20 -She took warfarin to thin her blood and the laboratory staff came to the facility to collect her blood when her primary care provider (PCP) ordered blood work. -She had her blood drawn once a week, but now it was usually about every 2 weeks. -She did not have her blood drawn at all in the month of June 2024. -She did not know when her INR was due or what dose of warfarin she was ordered. Interview with a medication aide (MA) on 06/25/24 at 3:15pm revealed: -Resident #3 was ordered warfarin 3mg every evening and had blood drawn often for it. -The contracted laboratory agency sent staff to the facility to collect blood from residents that had laboratory orders. -She did not know the contracted laboratory agency's schedule or the process by which they received the PCP's orders. -She did not know the last time Resident #3 had her blood drawn by the laboratory staff. -Resident #3 had no bleeding concerns in the past 2-3 weeks that she was aware of. Interview with a second MA on 06/25/24 at 3:45pm revealed: -She administered Resident #3 warfarin 3mg every evening. -The contracted laboratory agency sent staff to the facility to collect blood from residents that had laboratory orders. -She did not know if the contracted laboratory agency had a set schedule and did not know who sent laboratory test orders to the laboratory for Resident #3's INRs. -She had not noted any bleeding issues with Resident #3 in the past month.	D 273		

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D 273	Continued From page 21 Interview with the Resident Care Supervisor (RCS) on 06/25/24 at 2:15pm revealed: -Resident #3 had her INR checked by the contracted laboratory agency. -The PCP sent the orders for INR laboratory tests directly to the facilty's contracted laboratory agency. -The representative at the laboratory told her today that Resident #3's order to recheck her INR in 1-2 weeks was missed by the contracted laboratory agency. -She and the Administrator were responsible for reviewing residents' visit summaries for new orders and appointments. -Resident #3's blood draw ordered for 1-2 weeks from 05/31/24 was missed. -She did not realize that Resident #1 had not had her INR checked since 05/29/24. -There was no staff assigned to track residents' INR and warfarin dosing. Telephone interview with a representative from Resident #3's PCP's office on 06/26/24 at 2:15pm revealed: -Resident #3 was receiving warfarin anticoagulant therapy to prevent blood clots associated with atrial fibrillation; the INR goal was to be maintained between 2-3. -They did not know that Resident #3 had not had an INR check from 05/29/24 to 06/25/24. -There was no documentation the facility staff reported Resident #3's INR had not been checked since 05/29/24. -When there were orders for laboratory tests, the PCP relied on the facility to monitor when the test was due and to ensure that the ordered tests were completed as ordered. Interview with the Administrator on 06/26/24 at 3:18pm revealed:	D 273		

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D 273	Continued From page 22 -The RCS and the MAs were responsible to review after visit summaries and orders for resident follow up appointments and orders. -Resident #3's INR test for 1-2 weeks after 05/31/24 was missed by facility staff. -She did not realize Resident #3 did not have an INR check since 05/29/24. -There was no process in place to track INR checks and warfarin doses for residents. -She and the RCS had not had a chance to audit Resident #3's record. -She expected the staff to review after-visit summaries and to make sure follow up appointments were attended as scheduled and orders were carried out. _____ The facility failed to ensure healthcare referral and follow-up for a resident (#3) who was administered warfarin daily and did not have INR checks completed as ordered which placed the resident at risk of developing blood clots or increased risk of bleeding (#3). This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on June 26, 2024. THE CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED AUGUST 10, 2024.	D 273		
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	D 344		

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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 the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments for 1 of 5 sampled residents (#2).

The findings are:

Review of Resident #2's current FL2 dated 01/08/2024 revealed diagnoses included bacterium due to methicillin resistant staphylococcus epidermidis, cellulitis of abdominal wall, atrial fibrillation, anemia, benign essential hypertension, diabetes mellitus, hypertrophy of the prostate with urinary obstruction, major depression, non-dependent alcohol abuse in remission, unspecified hyperlipidemia, obesity end of stage renal failure on dialysis and amputation above the knee.

Review of Resident #2's signed physician's orders dated 12/01/22 revealed:
-There was an order for gabapentin 300mg (used to treat moderate pain) once at bedtime.
-There was an order for mirtazapine 15mg (used to treat mood disorders) once a day.

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D 344	Continued From page 24 Review of Resident #2's hospital discharge summary dated 01/08/24 revealed: -Resident #2 was hospitalized from 12/21/24 through 01/08/24 for a medical intervention for a severe life-threatening condition. -There was an order to discontinue gabapentin 300mg a day. -There was an order to discontinue mirtazapine 15mg once a day. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was no entry for gabapentin 300mg on the eMAR. -There was no entry for mirtazapine 15mg on the eMAR. Review of Resident #2's June 2024 eMAR revealed: -There was no entry for gabapentin 300mg on the eMAR. -There was no entry for mirtazapine 15mg on the eMAR. Observation of medications on hand for Resident #2 on 06/25/24 at 2:15pm revealed: -Gabapentin 300mg with a dispensed date of 02/27/24 was on the medication cart with 67 of 90 doses remaining. -Mirtazapine 15mg with a dispensed date of 05/29/24 was on the medication cart with 30 out of 30 doses remaining. Interview with a medication aide (MA) on 06/25/24 at 2:30pm revealed: -She was not aware gabapentin and mirtazapine were discontinued. -She would not have administered the medication	D 344		

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because it was not on the eMAR.
-The MA should write discontinued on the medication bottle, remove it from the medication cart and dispose of it or return it to the pharmacy.
-When a MA received a new medication order, they would notify the pharmacy and the pharmacy would make the correction on the eMAR to reflect the medication change.
-Resident #2 was a veteran and received his medications from the Veteran's Administration (VA) pharmacy.

Interview with Resident #2 on 06/26/24 at 9:05am revealed:
-He received all his medications from the VA.
-He was not aware gabapentin and mirtazapine were discontinued.
-He was not sure why he was prescribed the medications.
-Someone from the facility picked up medications from the VA or the medications came in the mail.

Telephone interview with Resident #2's primary care provider (PCP) at the VA on 06/26/23 at 9:30am revealed:
-She was not aware gabapentin 300mg or mirtazapine 15mg were discontinued on 01/08/24.
-She had not been contacted by the facility about the medication change when the resident was discharged from the hospital on 01/08/24.
-The facility should have notified her, and she would have notified the VA pharmacy.
-She would have expected to be notified to clarify or approve the medication change.
-The resident should still be taking gabapentin and mirtazapine.
-She confirmed 90 doses of gabapentin 300mg were last dispensed from the VA pharmacy 02/27/24.

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D 344	Continued From page 26 -She confirmed 30 doses of mirtazapine 15mg were last dispensed from the VA pharmacy on 05/29/24. -Gabapentin was prescribed to decrease pain associated with diabetic neuropathy; without it the resident could experience increased pain. -Mirtazapine was prescribed for depression and insomnia; without it the resident could experience increased depression and lack of sleep. Interview with the Resident Care Supervisor (RCS) on 06/26/24 at 2:30pm revealed: -She was not aware gabapentin and mirtazapine were discontinued. -The MA was responsible for removing all discontinued medications from the medication cart. -The MA should contact the pharmacy so they could change the eMAR to reflect the medication change and notify the PCP. -The MA was responsible for clarifying medication orders and that medication entries on the eMAR matched the medications on hand. Interview with the Administrator on 06/26/24 at 3:20pm revealed: -The protocol for discontinued medication should be to notify the pharmacy of the new order so they could change the eMAR, remove the medication from the medication cart and notify the PCP. -The MA should have contacted the contracted pharmacy about the new order. -The MAs were responsible for clarifying medication orders.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 27 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6 and #7) observed during the medication pass including errors with a vitamin supplement and a proton pump inhibitor (#6), and an iron supplement, a vitamin supplement and an antipsychotic medication (#7). The findings are: The medication error rate was 14% as evidenced by 5 errors out of 35 opportunities during the 8:00am morning medication pass on 06/26/24. 1. Review of Resident #7's current FL2 dated 02/21/24 revealed diagnoses included vitamin D deficiency, schizophrenic disorder, and anemia. a. Review of Resident #7's current FL2 dated 02/21/24 revealed there was an order for ferrous sulfate 325mg (used to treat iron deficiency and anemia) one tablet every other day. Observation of the morning medication pass on 06/26/24 at 7:40am revealed: -The morning medication aide (MA) prepared 11 oral medications for administration to Resident #7.	D 358		

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-The MA administered 11 oral medications and documented administration on the electronic medication administration record (eMAR) after watching the resident take the medications.
-Ferrous sulfate 325mg was not administered.

Review of Resident #7's eMAR from 06/01/24 to 06/26/24 revealed:
-There was an entry for ferrous sulfate 325mg every other day at 8:00am, due on 06/26/24.
-There was documentation ferrous sulfate 325mg was administered on 06/26/24.

Observation of medication on hand for Resident #7 on 06/26/24 at 10:50am revealed there was no ferrous sulfate 325mg on the medication cart available for administration.

Interview with the MA on 06/26/24 at 10:21am revealed:
-She thought she gave Resident #7 her iron but was not sure why it was not on the medication cart.
-She must have ran out and would have been in the facility's cycle fill that was delivered on 06/25/24.
-The MAs reordered medications by faxing a request to or calling the facility's contracted pharmacy for enough doses to last until the cycle fill medications were delivered.
-She did not reorder Resident #7's ferrous sulfate from the pharmacy.

Observation of a medication storage room on 06/26/24 at 10:30am revealed:
-The facility's monthly cycle fill medications were delivered and available for administration.
-The MA did not audit the delivery for Resident #7's ferrous sulfate.

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D 358	Continued From page 29 Telephone interview with a pharmacist from the contracted pharmacy on 06/26/24 at 10:45am revealed: -Resident #7 had a current physician's order dated 02/27/24 for ferrous sulfate 325mg every other day. -Resident #7's ferrous sulfate was only profiled with the pharmacy, meaning the pharmacy kept resident's current order on file but did not dispense the medication. -Resident #7's ferrous sulfate was last dispensed on 03/01/24 and 03/20/24 for 14 tablets each time at the facility's request. -There was no documentation the facility had requested the pharmacy to dispense Resident #7's ferrous sulfate. -If the facility staff had requested the pharmacy refill Resident #7's ferrous sulfate, the pharmacy would have informed staff that it was only profiled. -The pharmacy would have dispensed the medication if the resident or family member wanted the pharmacy to start sending the medication with the facility's cycle fill. Interview with Resident #7 on 06/26/24 at 11:30am revealed: -She did not pay attention to the medications the MA gave her and was not sure of all the medications she took. -She was not sure if she took ferrous sulfate during the morning medication pass. -She had never asked for the facility's contracted pharmacy to not send her ferrous sulfate. Second interview with the MA on 06/26/24 at 11:35am revealed: -She did not know that the facility's contracted pharmacy only profiled Resident #7's ferrous sulfate and did not dispense it in the facility's monthly cycle fill.	D 358		

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-She did not know if Resident #7 or her family brought her iron tablets in or got it from an outside pharmacy.

Telephone interview with Resident #7's family member on 06/26/24 at 11:44am revealed:
-She was Resident #7's power of attorney.
-She was unaware that the facility's contracted pharmacy did not dispense Resident #7's ferrous sulfate.
-She had never asked for the facility's pharmacy to not send her ferrous sulfate and would have liked them to send all of Resident #7's medications.
-If she had known that Resident #7 did not have her ferrous sulfate, she would have had it delivered from a local store since it could be purchased over the counter.

Telephone interview with a representative from the Resident #7's primary care provider's (PCP) office on 06/26/24 at 2:15pm revealed:
-Resident #7 was ordered ferrous sulfate 325mg every other day to treat iron deficiency anemia.
-It was expected that staff at the facility administered all of Resident #7's medications as ordered.

Refer to interview with the Resident Care Supervisor (RCS) on 06/26/24 at 10:30am.

Refer to interview with the Administrator on 06/26/24 at 3:18pm.

b. Review of Resident #7's current FL2 dated 02/21/24 revealed there was an order for vitamin D3 25mcg (used to treat vitamin D3 deficiency) one tablet every day.

Observation of the morning medication pass on

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D 358	Continued From page 31 06/26/24 at 7:40am revealed: -The morning MA prepared 11 oral medications for administration to Resident #7. -The MA administered 11 oral medications and documented administration on the eMAR after watching the resident take the medications. -Vitamin D3 25mcg was not administered. Review of Resident #7's eMAR from 06/01/24 to 06/26/24 revealed: -There was an entry for vitamin D3 25mcg every day at 8:00am. -There was documentation vitamin D3 25mcg was administered on 06/26/24. Observation of medication on hand for Resident #7 on 06/26/24 at 10:50am revealed there was no vitamin D3 25mcg on the medication cart available for administration. Interview with the MA on 06/26/24 at 10:21am revealed: -She thought she gave Resident #7 her vitamin D3, but was not sure why it was not on the medication cart. -She must have ran out and it would have been in the facility's cycle fill that was delivered on 06/25/24. -The MAs reordered medications by faxing a request to or calling the facility's contracted pharmacy for enough doses to last until the cycle fill medications were delivered. -She did not reorder Resident #7's vitamin D3 from the pharmacy. Observation of a medication storage room on 06/26/24 at 10:30am revealed: -The facility's monthly cycle fill medications were delivered and available for administration. -The MA did not audit the delivery for Resident	D 358		

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D 358	Continued From page 32 #7's vitamin D3.. Telephone interview with a pharmacist from the contracted pharmacy on 06/26/24 at 10:45am revealed: -Resident #7 had a current physician's order dated 02/27/24 for vitamin D3 25mcg one time a day. -Resident #7's vitamin D3 was only profiled with the pharmacy, meaning the pharmacy kept resident's current order on file since 01/18/24 but did not dispense the medication. -Family members or residents sometimes purchased over the counter medications at local stores instead of having the medications sent by the facility's contracted pharmacy. -There was no documentation the facility had requested the pharmacy to dispense Resident #7's vitamin D3. -If the facility staff had requested the pharmacy refill Resident #7's vitamin D3, the pharmacy would have informed staff that it was only profiled but would dispense the medication if the resident or family member wanted the pharmacy to start sending the medication with the facility's cycle fill. Interview with Resident #7 on 06/26/24 at 11:30am revealed: -She did not pay attention to the medications the MA gave her and was not sure of all the medications she took. -She was not sure if she took vitamin D3 during the morning medication pass. -She had never asked for the facility's contracted pharmacy to not send her vitamin D3. Interview with the MA on 06/26/24 at 11:35am revealed: -She did not know the facility's contracted pharmacy only profiled Resident #7's vitamin D3	D 358		

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and did not dispense it in the facility's monthly cycle fill.
-She did not know if Resident #7 or her family brought her vitamin D3 in or got it from an outside pharmacy.

Telephone interview with Resident #7's family member on 06/26/24 at 11:44am revealed:
-She was Resident #7's power of attorney.
-She was unaware that the facility's contracted pharmacy did not dispense Resident #7's vitamin D3.
-She had never asked for the facility's pharmacy to not send her vitamin D3 and would have liked for the pharmacy to send all of Resident #7's medications.
-If she had known that Resident #7 did not have her vitamin D3 25mcg, she would have had it delivered from a local store since it could be purchased over the counter.

Telephone interview with a representative from Resident #7's PCP's office on 06/26/24 at 2:15pm revealed:
-Resident #7 was ordered vitamin D3 25mcg every day to treat vitamin D deficiency.
-It was expected that staff at the facility administered all of Resident #7's medications as ordered.

Refer to interview with the Resident Care Supervisor (RCS) on 06/26/24 at 10:30am.

Refer to interview with the Administrator on 06/26/24 at 3:18pm.

c. Review of Resident #7's current FL2 dated 02/21/24 revealed there was an order for olanzapine 5mg (used to treat schizophrenia) one tablet once a day and 2 tablets at bedtime.

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D 358	Continued From page 34 Observation of the morning medication pass on 06/26/24 at 7:40am revealed: -The morning medication aide (MA) prepared 11 oral medications for administration to Resident #7. -The MA administered 11 oral medications and documented administration on the eMAR after watching the resident take the medications. -Olanzapine 5mg was not administered. Review of Resident #7's eMAR from 06/01/24 to 06/26/24 revealed: -There was an entry for olanzapine 5mg every day at 8:00am. -There was documentation olanzapine 5mg was administered on 06/26/24. Observation of medication on hand for Resident #7 on 06/26/24 at 10:50am revealed there was no olanzapine 5mg on the medication cart available for administration. Interview with the MA on 06/26/24 at 10:21am revealed: -Resident #7 did not have olanzapine 5mg on the medication cart because she ran out before the contracted pharmacy delivered the facility's monthly delivery (cycle fill) for the residents. -She did not reorder Resident #7's olanzapine 5mg from the pharmacy. -The facility's cycle fill medications were delivered 06/25/24, but no one had exchanged the new medications that were delivered for the used medication cards. -The MAs were responsible to exchange new medications with used cards in the medications cart when they had time. -Resident #7's olanzapine 5mg was delivered in the cycle fill on 06/25/24, but MAs were not to use	D 358		

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those medications until someone refilled the medication cart after cycle fill delivery.
-Resident #7 had not displayed any change in behavior.

Observation of a medication storage room on 06/26/24 at 10:30am revealed:
-The facility's monthly cycle fill medications were delivered and available for administration.
-The MA did not audit the delivery for Resident #7's olanzapine.

Telephone interview with a pharmacist from the contracted pharmacy on 06/26/24 at 10:45am revealed:
-Resident #7 had a current physician's order dated 02/27/24 for olanzapine 5mg one time a day and 2 tablets at bedtime.
-Resident #7's olanzapine 5mg was sent in the facility's monthly cycle fill on 06/25/24.
-There was no documentation the facility had requested the pharmacy to dispense Resident #7's olanzapine 5mg before the monthly cycle fill.
-If the facility staff had requested the pharmacy refill Resident #7's olanzapine 5mg, the pharmacy would have sent enough tablets to last until the monthly cycle fill was sent.
-There was no documentation that staff at the facility requested extra tablets of olanzapine 5mg for Resident #7.

Interview with Resident #7 on 06/26/24 at 11:30am revealed:
-She did not pay attention to the medications the MA gave her and was not sure of all the medications she took.
-She was not sure if she took olanzapine 5mg during the morning medication pass.
-She was not feeling any agitation or depression symptoms.

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D 358	Continued From page 36 Telephone interview with a representative from the Resident #7's PCP's office on 06/26/24 at 2:15pm revealed: -Resident #7 was ordered olanzapine 5mg once a day and 2 tablets at bedtime to treat obsessive compulsive disorder. -The olanzapine 5mg was originally ordered by the psychiatric provider but the PCP did sign a physician's order for the medication on 02/21/24. -It was expected that staff at the facility administered all of Resident #7's medications as ordered. Attempted telephone interview with Resident #7's psychiatric provider on 06/26/24 at 1:00pm was unsuccessful. Refer to interview with the RCS on 06/26/24 at 10:30am. Refer to interview with the Administrator on 06/26/24 at 3:18pm. 2. Review of Resident #6's FL2 dated 08/08/23 revealed diagnoses included gastroesophageal reflux disease, anemia and malnutrition. a. Review of Resident #6's current FL2 dated 08/08/23 revealed there was an order for folic acid 1mg (used to treat folate deficiency) one tablet every morning. Observation of the morning medication pass on 06/26/24 at 7:30am revealed: -The morning medication aide (MA) prepared 9 oral medications for administration to Resident #6. -The MA administered 9 oral medications and documented administration on the electronic	D 358		

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medication administration record (eMAR) after watching the resident take the medications.
-Folic acid 1mg was not administered.

Review of Resident #6's eMAR from 06/01/24 to 06/26/24 revealed:
-There was an entry for folic acid 1mg one tablet every morning at 8:00am.
-There was documentation folic acid 1mg was administered on 06/26/24.

Observation of medication on hand for Resident #6 on 06/26/24 at 10:50am revealed there was no folic acid 1mg on the medication cart available for administration.

Interview with the MA on 06/26/24 at 10:21am revealed:
-Resident #6 did not have folic acid 1mg on the medication cart because she ran out before the contracted pharmacy delivered the facility's monthly delivery (cycle fill) for the residents.
-The MAs reordered medications by faxing a request to or calling the facility's contracted pharmacy for enough doses to last until the cycle fill medications were delivered.
-She thought she had reordered the medication when she used the last tablet on 06/25/24.
-The facility's cycle fill medications were delivered 06/25/24, but no one had exchanged the new medications that were delivered for the used medication cards.
-The MAs were responsible to exchange new medications with used cards in the medications cart when they had time.
-Resident #6's folic acid 1mg was delivered in the cycle fill on 06/25/24 but MAs were not to use those medications until someone refilled the medication cart after cycle fill delivery.

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D 358	Continued From page 38 Observation of a medication storage room on 06/26/24 at 10:30am revealed: -The facility's monthly cycle fill medications were delivered and available for administration. -The MA did not audit the delivery for Resident #6's folic acid. Telephone interview with a pharmacist from the contracted pharmacy on 06/26/24 at 10:45am revealed: -Resident #6 had a current physician's order dated 02/27/24 for the current order for folic acid 1mg one time a day. -The facility was on automatic monthly refills (cycle fill) for medications. -The facility was expected to reorder medications 2-3 days prior to the resident running out of medication. -Resident #6's folic acid 1mg was sent in the facility's cycle fill on 06/25/24 for 28 tablets (one month supply) and on 05/24/24, 04/26/24, 03/29/24 and 03/01/24 all included 28 tablets. -There was no documentation the facility had requested a refill or extra tablets before the cycle fill was delivered on 06/25/24. -If the facility staff had notified the pharmacy before Resident #6's folic acid ran out, the pharmacy could have sent the needed number of folic acid 1mg tablets needed to last until the cycle fill arrived. Telephone interview with a representative from the Resident #6's primary care provider's (PCP) office on 06/26/24 at 2:15pm revealed: -Resident #6 was ordered folic acid 1mg every day to treat vitamin B12 deficiency. -It was expected that staff at the facility administered all of Resident #6's medications as ordered.	D 358		

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D 358	Continued From page 39 Interview with Resident #6 on 06/26/24 at 10:20am revealed: -She did not know all of the medications that she took and just took what the MAs gave her. -She did not know if she took her folic acid during the morning medications pass. Refer to interview with the Resident Care Supervisor (RCS) on 06/26/24 at 10:30am. Refer to interview with the Administrator on 06/26/24 at 3:18pm. b. Review of Resident #6's current FL2 dated 08/08/23 revealed there was an order for omeprazole 20mg (used to treat gastroesophageal reflux disease) one tablet every morning. Observation of the morning medication pass on 06/26/24 at 7:30am revealed: -The morning medication aide (MA) prepared 9 oral medications for administration to Resident #6. -The MA administered 9 oral medications and documented administration on the eMAR after watching the resident take the medications. -Omeprazole 20mg was not administered. Review of Resident #6's eMAR from 06/01/24 to 06/26/24 revealed: -There was an entry for omeprazole 20mg one tablet every morning at 8:00am. -There was documentation omeprazole 20mg was administered on 06/26/24. Observation of medication on hand for Resident #6 on 06/26/24 at 10:50am revealed there was no omeprazole 20mg on the medication cart available for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	R 06/26/2024

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D 358	Continued From page 40 Interview with the MA on 06/26/24 at 10:21am revealed: -Resident #6 did not have omeprazole 20mg on the medication cart because she ran out before the contracted pharmacy delivered the facility's monthly delivery (cycle fill) for the residents. -The MAs reordered medications by faxing a request to or calling the facility's contracted pharmacy for enough doses to last until the cycle fill medications were delivered. -She thought she had reordered the medication on 06/25/24 when she used the last tablet. -The facility's cycle fill medications were delivered 06/25/24 but no one had exchanged the new medications that were delivered for the used medication cards. -The MAs were responsible to exchange new medications with used cards in the medications cart when they had time. -Resident #6's omeprazole 20mg was delivered in the cycle fill 06/25/24 but MAs were not to use those medications until someone refilled the medication cart after cycle fill delivery. Observation of a medication storage room on 06/26/24 at 10:30am revealed: -The facility's monthly cycle fill medications were delivered and available for administration. -The MA did not audit the delivery for Resident #6's omeprazole. Telephone interview with a pharmacist from the contracted pharmacy on 06/26/24 at 10:45am revealed: -Resident #6 had a current physician's order dated 02/27/24 for the current order for omeprazole 20mg one time a day. -The facility was on automatic monthly refills (cycle fill) for medications.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 41 -The facility was expected to reorder medications 2-3 days prior to the resident running out of medication. -Resident #6's omeprazole 20mg was sent in the facility's cycle fill on 06/25/24 for 28 tablets (one month supply) and on 05/24/24, 04/26/24, 03/29/24 and 03/01/24 all included 28 tablets. -There was no documentation the facility had requested a refill or extra tablets before the cycle fill was delivered on 06/25/24. -If the facility staff had notified the pharmacy before Resident #6's omeprazole ran out, the pharmacy could have sent the needed number of folic acid 1mg tablets needed to last until the cycle fill arrived. Telephone interview with a representative from the Resident #6's PCP's office on 06/26/24 at 2:15pm revealed: -Resident #6 was ordered omeprazole 20mg every day to treat gastroesophageal reflux disease. -It was expected that staff at the facility administer all of Resident #7's medications as ordered. Interview with Resident #6 on 06/26/24 at 10:20am revealed: -She did not know all of the medications that she took and just took what the MAs gave her. -She did not know if she took her omeprazole during the morning medications pass. Refer to interview with the RCS on 06/26/24 at 10:30am m. Refer to interview with the Administrator on 06/26/24 at 3:18pm. Interview with the Resident Care Supervisor	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 42 (RCS) on 06/26/24 at 10:30am revealed: -Medication aides (MA) were to continually audit the medication cart for low or missing medications during their shift. -MAs should reorder extra doses of any medication that was below 8 doses remaining when they saw that the medication will not last until the facility's monthly cycle fill from the facility's contracted pharmacy. -When the cycle fill was delivered, any MA could refill the medication carts and retrieve the delivered medication to administer to residents. -If a medication was not in the monthly cycle fill, the MA should inform her so that she could check to see why the medication was not delivered. -She expected MAs to administer all medications as ordered. Interview with the Administrator on 06/26/24 at 3:18pm revealed: -MAs should reorder medications for the needed number of doses to last until the monthly cycle fill was delivered or order the needed medications from the local back -up pharmacy. -MAs should retrieve needed medications from the monthly cycle fill even if the medications had not been restocked in the medication carts. -She had not initiated a medication cart audit routine since she took the Administrator position last month. -She expected MAs to administer all residents' medications as ordered by the PCP.	D 358		