STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CENTRAL CARE	139 APEX LANE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation on July 31, 2024 and August 1, 2024.	D 000		
D 083	10A NCAC 13F .0306(a)(9) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care home shall: (9) have curtains, draperies or blinds at windows in resident use areas to provide for resident privacy; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based observations and interviews, the facility failed to provide window blinds that were not damaged in 3 of 10 sampled resident rooms (A1, A2, and A3). The findings are: Observation of resident room A1 on 08/01//24 at 7:30am revealed: -Two residents resided in the room. -The room had one large window that faced the back of the building that included the facility's parking lot. -The window had vertical blinds that covered part of the window. -There were 9 slats missing from the vertical blinds. Interview with one of the residents who resided in room A1 on 08/01/24 at 7:32am revealed:	D 083		

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D 083	Continued From page 1 -The window blinds had missing slats since she moved into the facility in March 2024. -She did not like that there were missing slats in the blinds. -She wanted the blinds to close completely for privacy. -Anyone outside at night could see into her room if she had the light on and that bothered her. Observation of resident room A2 on 08/01/24 at 7:35am revealed: -Two residents resided in the room. -The room had one large window that faced the back of the building that included the facility's parking lot. -The window had vertical blinds that covered part of the window. -There were 8 slats missing from the vertical blinds. -There was a blanket that hung over part of the window. Observation of resident room A3 on 08/01/24 at 7:40am revealed: -Two residents resided in the room. -The room had one large window that faced the back of the building that included the facility's parking lot. -The window had vertical blinds that covered part of the window. -There were 3 slats missing from the vertical blinds. Interview with one of the residents that resided in room A3 on 08/01/024 at 7:45am revealed: -She did not like that the blinds did not cover the entire window. -She thought people might be able to see in the window at night if the light was on. -When the sun came up, it was awfully bright in	D 083		

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D 083	Continued From page 2 the room and she liked to keep the blinds closed but could not. Interview with a maintenance worker on 08/01/24 revealed: -He was aware that some rooms had blinds that were broken and did not cover the entire window. -He has talked with the Administrator and the Business Office Manager (BOM) about replacing the blinds. -The Administrator did instruct him to order more blinds. -The company the facility was using to order blinds was too expensive, so he was looking for another company to order the blinds from. Interview with the Administrator on 08/01/24 at 3:45pm revealed: -The blinds were replaced after the last survey. -She did not know what happened to the blinds; they were breaking, or the residents were pulling them down. -She was responsible for making sure the resident rooms had blinds in good condition.	D 083		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed	D 087		

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D 087	Continued From page 3 shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a clean top and bottom sheet for 1 of 4 sampled residents (#8) with bed changed as often as necessary, but at least once a week. The findings are: Review of Resident #8's current FL2 dated 12/17/23 revealed: -Diagnoses included diabetes, hard of hearing, hypertension, paranoid schizophrenia, unspecified non-psychotic mental disorder, and bipolar. -He was ambulatory. -He was continent of bowel and bladder. -He required prompting for bathing and dressing. Review of Resident #8's care plan dated 07/01/24 revealed he required supervision for eating and grooming and personal hygiene. Observation of Resident #8's room on 07/31/24 at 9:20am revealed: -Resident #3 was not in his room. -The bed covers were thrown back against the edge of the mattress and along the wall. -Resident #3's bottom fitted sheet was soiled with	D 087		

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D 087	Continued From page 4	D 087		

brown stains at the foot of the bed.

A second observation of Resident #8's room on 08/01/24 at 7:45am revealed:
-Resident #8 was asleep in his bed.
-Resident #8's sheets had not been changed and there were no clean sheets present in his room.

A third observation of Resident #8's room on 08/01/24 at 2:50pm revealed:
-Resident #8 was not in his room.
-Resident #8's sheets had not been changed and there were no clean sheets present in his room.

Review of residents' personal care records on 08/01/24 revealed:
-The facility documented bathing and bed linen changes for residents who required assistance with bathing.
-The facility did not document bathing and bed linen changes for residents who did not require assistance with bathing.
-There was no documentation of bed linen changes for Resident #8.

Interview with Resident #8 on 08/01/2024 at 1:25pm revealed:
-He had resided at the facility since February 2024.
-His bed linens were changed last week.
-His bed linens had been changed 3 times since he came to the facility.
-The stains on his bed linens were chocolate.
-He had told the housekeeper that his bed linens needed to be changed on some days.

Interview with a medication aide (MA) on 08/01/2024 at 1:25pm revealed:
-The facility did not keep logs of bed linen changes for residents who bathed themselves.

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D 087	Continued From page 5 -She usually checked residents' room 3 times a week to see if the bed linens need to be changed. Interview with a personal care aide (PCA) on 08/01/2024 at 1:45pm revealed: -The staff changed bed linens every time they assisted a resident with their shower. -When staff observed a resident getting towels and going in to bathe themselves, staff changed their bed linens while the resident showered -If residents asked for bed linens to be changed, staff changed their bed linens. -Bed linens were supposed to be changed on A hall on Thursday. -Bed linens were supposed to be changed on B hall on Friday. Interview with a MA on 08/01/2024 at 2:20pm revealed: -Resident #8 would not leave sheets on his bed. -He removed his sheets as soon as his bed was changed. Interview with the housekeeper on 08/01/2024 at 2:35pm revealed: -She cleaned Resident #8's room. -She had wiped his bed off because he has left cookie crumbs on his bed linens. -She had not changed Resident #8's bed linens. Interview with the Administrator on 08/01/2024 at 3:00pm revealed: -The PCAs and MAs were supposed to change bed linens at least one time a week. -The PCAs and MAs were supposed to change bed linens, if the bed linens were soiled. -The PCAs and MAs were supposed to check the beds to make sure bed linens were clean. -Staff should have checked Resident #8's bed and changed his bed linens.	D 087		

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D 087	Continued From page 6 Interview with second MA on 08/01/2024 at 3:10 pm revealed she had not checked Resident #8's bed and bed linens today on 08/01/24.	D 087		
D 091	10A NCAC 13F .0306(b)(5)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a comfortable chair for each resident in 5 of 10 resident rooms (A1, A3, B13, B16, and B22) on the A and B halls. The findings are: Observation of resident room A1 on 08/01/24 at 7:30am revealed: -Two residents resided in the room. -There was a brown leather chair in the room. -The chair was located at the end of the resident's bed that was by the door. -There was no chair for the second resident who resided in room A1. Interview with one of the residents who resided in	D 091		

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D 091	Continued From page 7	D 091		

room A1 on 08/01/24 at 7:35am revealed:
-There was only one chair in the room, and it belonged to the other resident that resided in the room with her.
-There had never been a chair in her room.
-She did not have a chair to sit in.
-When she was in her room, she either sat on the bed or laid down on the bed.
-If he had visitors, they would have to stand up or sit on the bed.

Observation of resident room A3 on 08/01/24 at 7:40am revealed:
-Two residents resided in room A3.
-Both residents had wheelchairs.
-There were no other chairs in the room.

Interview with a resident that resided in room A3 on 08/01/24 at 7:42am revealed:
-She sat in her wheelchair all day.
-She did not have another chair in her room to sit in.

Observation of resident room B13 on 08/01/24 at 7:50am revealed:
-Two residents resided in room B13.
-There were no chairs in the room.

Interview with one of the residents who resided in room B13 on 08/01/24 at 7:52am revealed:
-There was not a chair in her room for her to sit in.
-She spent all of her time on her bed.
-She would like a chair to sit in.

Based on observations and staff interviews, the other resident who resided in room B13 was not interviewable.

Observation of resident room B16 on 08/01/24 at

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D 091	Continued From page 8 7:55am revealed: -Two residents resided in room B16. -There were no chairs in the room. -Both residents were observed in their room sitting on their walker seats watching television. Interview with one of the residents who resided in room B16 on 08/01/24 at 7:56am revealed: -He had been in the facility since May 2024 and had not had a chair to sit in. -He used his walker seat to sit on or he laid on the bed. -He would like a comfortable chair to sit in. Interview with the second resident who resided in room B16 on 08/01/24 at 7:58am revealed: -He did not have a chair to sit in. -He either sat on his walker seat or laid on the bed. -He would like a chair to sit in. Observation of resident room B22 on 08/01/24 at 8:00am revealed: -Two residents resided in room B16. -There were no chairs in the room. -Both residents were observed lying on their beds. Interview with a resident who resided in room B22 on 08/01/25 at 8:02am revealed: -There had never been a chair in the room for him or his roommate to sit in. -He did not know he was supposed to have a chair. -He would like to have a chair to sit in so he was not in bed all day. Interview with a maintenance worker on 08/01/24 revealed: -He has had a discussion with the Administrator	D 091		

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D 091	Continued From page 9 about replacing chairs in resident rooms. -He is aware that there are several rooms without chairs. -He had a list of resident rooms that needed chairs but did not know where it was. -After the last survey, the Administrator instructed him to order more chairs for the resident rooms. -He did not order the chairs because the supply company's prices were too high, and he was looking for another company to order the chairs from. Interview with the Administrator on 08/01/24 at 3:45pm revealed: -All department heads were responsible for making sure resident rooms had what they needed and to let her know if they did not. -She did not know why some of the resident rooms did not have chairs. -She replaced chairs in all of the rooms, but they must have been removed. -All residents should have a chair in their room.	D 091		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40	D 201		

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residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure aide hours met the minimum requirements for the Assisted Living (AL) facility for 7 of 42 sampled shifts from 07/14/24 to 07/27/24.

The findings are:

Review of the facility's current license effective 01/01/24 revealed the assisted living facility was licensed for a capacity of 53 beds.

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Review of the Daily Census Report for 0719/24 revealed the AL had a census of 28 residents which required 16 aide hours on second shift.

Review of staff timecards dated 07/19/24 revealed there was a total of 14.75 aide hours provided on second shift leaving a shortage of 1.25 hours.

Review of the Daily Census Report dated 07/20/24 revealed the AL had a census of 28 which required 16 aide hours on first shift.

Review of staff timecards dated 07/20/24 revealed there was a total of 13.5 aide hours provided on second shift leaving a shortage of 1.5 hours.

Review of the Daily Census Report dated 07/24/24 revealed the AL had a census of 28, which required 16 aide hours on second shift.

Review of staff timecards dated 07/24/24 revealed there was a total of 14.0 aide hours provided on second shift leaving a shortage of 2.0 hours.

Review of the Daily Census Report dated 07/25/24 revealed the AL had a census of 29, which required 16 aide hours on second shift.

Review of staff timecards dated 07/25/24 revealed there was a total of 14.75 aide hours provided on second shift leaving a shortage of 1.25 hours.

Review of the Daily Census Report dated 07/26/24 revealed the AL had a census of 28, which required 16 aide hours on second shift.

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Review of staff timecards dated 07/26/24 revealed there was a total of 14.5 aide hours provided on second shift leaving a shortage of 1.5 hours.

Review of the Daily Census Report dated 07/27/24 revealed the AL had a census of 28, which required 16 aide hours on first and second shifts.

Review of staff timecards dated 07/27/24 revealed:
-There was a total of 14.75 aide hours provided on first shift leaving a shortage of 1.25 hours.
-There was a total of 14.75 aide hours provided on second shift leaving a shortage of 1.25 hours.

Interview with a medication aide/personal care aide (MA/PCA) on 08/01/24 at 8:00am revealed:
-The facility was short on aide hours sometimes when he worked.
-He sometimes punched out to avoid logging too many hours for his restricted income constraints.
-He did not leave the facility with just one staff person on duty during second shifts he worked but punched out early.
-He was not a full-time employee of the facility.

Interview with a MA on 08/18/22 at 10:20am revealed:
-The schedule was completed by the Administrator or the Resident Care Coordinator (RCC).
-She resided in a designated room on one end of the facility.
-She worked a few second shift hours with 1.00 to 1.5 hours not covered by an additional second shift aide.
-The RCC was within 500 feet of the facility and available to assist in the event she had an

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emergency.
-She was not aware of an occasion when a resident required additional assistance or was sent out for an emergency on a shift when she was working alone for a short time.

Interview with the Administrator on 08/01/24 at 1:50pm revealed:
-The RCC was responsible for completing the staff schedule.
-The facility used 3 shifts, 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:pm to 7:00am, for aide shifts.
-She thought the facility did not have to have 2 aides on duty after 9:00pm on second shift.
-She did not know who had informed her that after 9:00pm on second she only had to have one aide like on the third shift.
-She reviewed the staff schedule but did not ensure there were 16 hours of aide coverage from 3:00pm to 11:00pm (second shift).

Interview with the RCC on 08/18/22 at 2:30pm revealed:
-She was responsible for generating the staff schedule.
-The Administrator had informed her she did not have to have a second employee on the second shift after 9:00pm.
-Most second shifts were staffed by regular full-time aides, but some of the shift had call outs or coverage by a part-time staff.
-The second shifts were sometime short of aide hours because she did not know she had to have 16 hours with 2 aides until 11:00pm.
-The Administrator routinely reviewed the staff schedule for completeness.

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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, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 3 sampled residents (#1 and #2) related to not notifying the primary care provider about weight increases as ordered and a dermatology referral (#2) and an order for laboratory testing (#1).

The findings are:

1. Review of Resident #2's current FL2 dated 04/25/24 revealed diagnoses included hypertension, congestive heart failure, and chronic renal failure.

a. Review of Resident #2's current FL2 dated 04/25/24 revealed there was an order to check and record weight daily and notify the provider of a 2 to 3 pound weight gain in 1 day or a 3 to 5 pound weight gain in 3 days.

Review of Resident #2's physician's orders dated 06/18/24 revealed there was an order for Bumex 2mg (a diuretic used to treat edema) 2 tablet in the morning and 1mg 1 tablet in the evening. Call provider (cardiologist) with weight gain of 2 pounds in a day or 5 pounds in a week, edema, or shortness of breath.

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D 273	Continued From page 15 Review of Resident #2's electronic medication administration record (eMAR) for May 2024 revealed: -There was an entry to check and record weight daily. Notify provider of 2 to 3 pound weight gain in 1 day or a 3 to 5 pounds weight gain in 3 days. -There was documentation of a 2 to 3 pound weight gain in 1 day for 5 times on 05/04/24, 05/06/24, 05/20/24, 05/25/24, and 05/28/24; weight increases ranged from 2 to 7 pounds. -There was documentation of a 3 to 5 pound weight gain in 3 days for 3 times on 05/04/24, 05/06/24, and 05/20/24; weight increases ranged from 3 to 4 pounds. -There was no documentation that the cardiologist was notified of any of the 2 to 3 pound weight gains or the 3 to 5 pound weight gains. -Resident #2's daily weights ranged from 268 to 278 pounds between 05/01/24 and 05/31/24. Review of Resident #2's eMAR for June 2024 revealed: -There was an entry to check and record weight daily. Notify provider of 2 to 3 pound weight gain in 1 day or a 3 to 5 pounds weight gain in 3 days. -There was documentation of a 2 to 3 pound weight gain in 1 day for 3 times between 06/01/24 and 06/18/24 on 06/12/24, 06/15/24, and on 06/17/24; weight increases ranged from 2 to 6 pounds. -There was documentation of a 3 to 5 pound weight gain in 3 days for 4 times between 06/01/24 and 06/18/24 on 06/04/24, 06/13/24, 06/16/24 and on 06/17/24; weight increases ranged from 2 to 7 pounds. -There was an entry dated 06/19/24 to check and record weight daily. Notify provider of 2 pound weight gain in 1 day or 5 pound weight gain in 1 week, edema, shortness of breath.	D 273		

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D 273	Continued From page 16 -There was documentation of a 2 pound weight gain in 1 day for 3 times between 06/19/24 and 06/30/24 on 06/23/24, 06/26/24, and on 06/29/24; weight increases ranged from 3 to 5 pounds. -There was documentation of a 5 pound weight gain in 1 week between 06/19/24 and 06/30/24 for 1 time on 06/23/24; weight increase was 5 pounds. -There was no documentation that the cardiologist was notified of any 2 to 3 pound weight gains in 1 day; 3 to 5 pound weight gains in 3 days between 06/01/24 and 06/19/24 or of any 2 pound weight gains in 1 day; 5 pound weight gains in 1 week. between 06/20/24 and 06/30/24. -Resident #2's daily weights ranged from 264 to 272 pounds. Review of Resident #2's eMAR for July 2024 revealed: -There was an entry to check and record weight daily. Notify provider of 2 pound weight gain in 1 day or 5 pound weight gain in 1 week, edema, shortness of breath. -There was documentation of a 2 pound weight gain in 1 day for 8 times on 07/03/24, 07/06/24, 07/07/24, 07/13/24, 07/20/24, 07/23/24, 07/25/24, and on 07/30/24. -There was documentation of 1 5 pound weight gain in 1 week for 3 times on 07/0/24, 07/13/24, and 07/25/24. -There was no documentation that the cardiologist was notified of any 2 pound weight gains in 1 day or 5 pound weight gains in 1 week. -Resident #2's weights ranged from 262 to 270. Review of Resident #2's progress notes revealed there was no documentation Resident #2's cardiologist had been notified of any weight gains in May, June, or July 2024.	D 273		

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Review of Resident #2's hospital records dated 06/04/24 revealed:
-Resident #2 had a history of stage IV systolic congestive heart failure.
-Resident #2 went to his cardiologist for evaluation for chest pain, volume overload.
-Resident #2 had increased chest tightness, dyspnea, and volume overload of bilateral lower extremities over the last week.
-Resident #2 had pulmonary edema and chronic kidney disease stage IV with admission.

Review of Resident #2's discharge summary dated 06/09/24 revealed:
-Resident #2 was hospitalized from 06/04/24 through 06/09/24.
-His diagnoses included congestive heart failure and acute systolic heart failure.

Interview with Resident #2 on 07/31/24 at 3:49pm revealed:
-His cardiologist wanted him to be weighed every day.
-Staff were supposed to weigh him, but they did not always weigh him every day.
-He usually stepped on the scale and told the MA on the medication cart what his weight was.
-Staff did not tell him if he had weight gain, but they were supposed to keep up with it.

Interview with Resident #2 on 08/01/24 at 6:40am revealed:
-He had a heart condition that caused fluid to gather around his heart.
-He saw a cardiology doctor as well as the facility's primary care provider (PCP).
-He was scheduled for an appointment with a kidney (nephrology) clinic today on 08/01/24.
-He had been to the hospital at least 2 times this

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year for the fluid gathering around his heart which made it hard for him to breathe.
-He took a medication to help with the fluid build-up and thought that was why he was weighed each day.
-He usually weighed about the same amount each day.

Observation of the facility's scale on 07/31/24 at 3:51pm revealed there was a digital scale on the floor in front of the medication aide (MA) desk.

Interview with a MA on 08/01/24 at 7:48am revealed:
-Resident #2 had an order for daily weights.
-Resident #2 weighed himself; he stepped on the scale and the MA went to look at the weight.
-He did not know there were physician's orders to notify the provider with a weight gain of 2 pounds in 1 day or 5 pounds in a week.
-The orders to notify the provider did not show up when he entered the weight on the eMAR.
-He would not have known which provider to contact if he did know about the order to notify the provider for weight gain.

Interview with a second MA on 08/01/24 at 7:58am revealed:
-Resident #2 had orders for daily weights and to notify the provider if he had a 2 pound weight gain in 1 day or a 5 pound weight gain in a week.
-Sometimes Resident #2 gave her his weights to enter and sometimes she looked at his weights before entering them onto the eMAR.
-Resident #2's weights stayed around the same number, and she had not noticed weight gains that she needed to report.
-She had not notified Resident #2's cardiologist or PCP regarding any increased weights in May, June, or July 2024.

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D 273	Continued From page 19 Interview with the Resident Care Coordinator (RCC) ON 08/01/24 at 1:45pm revealed: -She and the Administrator were responsible for reviewing resident eMARs every other month. -She thought the MAs were not really weighing Resident #2 because there were multiple occurrences of the same number throughout the month. -She saw what was documented as Resident #2's weight for the morning of 08/01/24; she reweighed him and his weight was a few pounds different from what was documented. -The MAs should have had Resident #2 stand on the scale, looked at his weight, and documented his weight. -MAs were able to see Resident #2's previously documented weights and should have reported weight increases, according to his order, to his cardiologist. -If there were increased weights, according to Resident #2's order, the MAs should have told her or the Administrator and contacted Resident #2's cardiologist to report the increased weight. -She sent Resident #2 out to the hospital on 06/04/24 because his oxygen saturations were low and he was having trouble breathing. Telephone interview with a nurse from Resident #2's cardiologist's office on 07/31/24 at 4:37pm revealed: -Resident #2 had an order for daily weights and to call the cardiologist with a weight gain of 2 pounds in a day or 5 pounds in a week, edema, or shortness of breath. -The subsequent order for daily weights was written after Resident #2's hospitalization in June 2024 due to congestive heart failure. -Resident #2's cardiologist expected him to be weighed daily and weights reported to determine	D 273		

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if his current medications were working, to know if his weight was under control, and to help prevent hospitalization.
-If Resident #2's cardiologist had known of his weight gain, he may have possibly made medication adjustments.
-Not monitoring Resident #2's weight gains as ordered could lead to fluid overload with congestive heart failure and Resident #2 could be required to be hospitalized to remove the fluid.

Interview with Resident #2's PCP on 08/01/24 at 10:31am revealed:
-Resident #2's cardiologist managed his weights.
-He expected the facility staff to contact Resident #2's cardiologist regarding increases in weights.
-Facility staff had not notified him of any increases in weights.

Interview with the Administrator on 08/01/24 at 3:37pm revealed:
-She did not know about Resident #2's physician's order to contact his cardiologist for weight increases.
-The MAs should have reviewed Resident #2's weight daily and notified the RCC of any weight increases that needed to be reported to Resident #2's cardiologist.
-The RCC was responsible to contact Resident #2's cardiologist regarding weight increases.

b. Review of Resident #2's physician's order dated 05/23/24 revealed an order for a dermatology evaluation for an abnormal lesion on his right hand.

Review of Resident #2's PCP's after visit summary dated 05/24/24 revealed:
-There was documentation Resident #2 had scaly, dry, keratotic lesion with surrounding

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erythema noted to his right hand consistent with possible squamous cell carcinoma.
-The PCP recommended a dermatology referral for evaluation of the area to the right hand.

Review of Resident #2's record revealed no documentation he was seen by a dermatologist.

Interview with the RCC on 07/31/21 at 12:21pm revealed:
-She reviewed the physician's order dated 05/23/24 and thought Resident #2's PCP made a mistake with the order because she did not remember Resident #2 having a lesion on his right hand.
-She knew he had a wound to his abdomen, but it was treated and healed; she thought that the order was supposed to refer to Resident #2's abdomen rather than his hand.
-She did not know Resident #2's PCP's after visit summary dated 05/25/24 referred to his abdomen as well as the lesion on his right hand.
-The facility usually referred all their residents who needed dermatology services to the same dermatologist.

Telephone interview with a scheduling representative at the dermatologist's office on 07/31/24 at 3:37pm revealed Resident #2 had not been seen in the office and there were no scheduled appointments for him.

Interview with Resident #2 on 07/31/24 at 3:49pm revealed:
-He first noticed a raised, scabby bump on his right hand a few months ago.
-The place looked a lot better and there was not currently a scab.
-His PCP wanted him to see a dermatologist to get it checked out because it could be cancerous.

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-The facility staff never said anything to him about an appointment for a dermatologist and he did not ask.
-He had another raised bump on his right hand that he noticed about a month ago, but he had not shown it to his PCP yet.
-The raised bumps did not itch or hurt.
-He had a cancerous spot on the right side of his nose that was removed about a year ago.

Interview with a MA on 08/01/24 at 7:48am revealed the RCC was responsible for reviewing and following up with new orders from the facility's PCP after he visited the facility including referrals to outside providers.

Interview with the RCC on 08/01/24 at 1:45pm revealed:
-She reviewed orders from the facility's PCP after he visited the facility and followed through with the orders.
-She was not working on the day the PCP wrote the order for him to have a dermatology evaluation.
-She did not look to see if the order had been followed up on when she returned to work.

Interview with Resident #2's PCP on 08/01/24 at 10:31am revealed:
-He wrote an order for Resident #2 to be seen by a dermatologist due to him having a scaly, raised lesion on his right hand.
-He expected the facility to follow up with the order for Resident #2 to be seen by a dermatologist because he wanted to make sure that the lesion was not cancerous.
-He did not know Resident #2 had not been seen by a dermatologist as ordered.

Interview with the Administrator on 08/01/24 at

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D 273	Continued From page 23 3:37pm revealed: -She did not know about Resident #2's physician's order for a dermatology referral due to an abnormal lesion on his right hand. -She and the RCC were responsible for following up with orders for referrals and for making appointments with outside providers. -She did not know why Resident #2 was not referred to a dermatologist. 2. Review of Resident #3's current FL2 dated 07/18/2024 revealed diagnoses included bacteria extended spectrum beta-lactamase (ESBL), kidney failure, bipolar, hypertension, anxiety, excision of skin cancer, right below knee amputation and prostatectomy. Review of Resident #3's physician's order dated 07/01/2024 revealed an order to check Resident #3's complete blood count (CBC), comprehensive metabolic panel (CMP) and lipid panel. Review of Resident #3's record revealed there were no laboratory test results in the month of July 2024 available for review. Interview with the Resident #3's primary care provider (PCP) on 08/01/2024 at 10:35am revealed: -The facility was responsible to send the request for laboratory test to the contracted laboratory. -He expected the facility to ensure ordered laboratory test were completed. -He ordered CBC, CMP and lipid panel laboratory test for routine monitoring of residents' overall health condition. -The facility provided him with the laboratory test results for review at his next visit to the facility after the test were ordered. -He was not aware Resident #3's ordered	D 273		

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laboratory test had not been completed.

Telephone interview with a representative from the facility's contracted laboratory on 08/01/24 at 3:16pm revealed:
-The laboratory sent a laboratory staff member to the facility weekly for obtaining laboratory tests.
-The physician order for laboratory check for Resident #3's CMP, CBC, and lipid panel dated 07/01/24 was received by the laboratory.
-Resident #3's laboratory order for checking CMP, CBC, and lipid panel was assigned to a former laboratory staff member for completion and documented as completed by the staff member.
-They had no documentation for the laboratory test results or that Resident #3's CMP, CBC and lipid panel orders were completed by the laboratory.
-They would complete the labs next Tuesday on their next facility visit.

Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 4:09pm revealed:
-She was unable to locate documentation Resident #3's laboratory test for CMP, CBC, and lipid panel dated 07/01/24 had been completed.
-She thought she had faxed the laboratory test request to the contracted laboratory.
-She was not aware there were no laboratory test results in Resident #3's record.

Interview with the RCC on 08/01/2024 at 3:45pm revealed:
-It was her responsibility to ensure laboratory test results were completed for residents.
-She was responsible to notify the doctor if they were not completed.

Interview with the Administrator on 08/01/2024 at

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D 273	Continued From page 25 3:55pm revealed: -It was both the RCC and her responsibility to ensure laboratory test were completed for residents. -The Administrator or the RCC should notify the PCP if laboratory tests were not completed as ordered. -She did not know Resident #3's CMP, CBC and lipid panel laboratory test ordered 07/01/24 had not been completed. _____ The facility failed to ensure healthcare referral and follow-up for a resident who had a diagnosis of congestive heart failure and a hospitalization due to congestive heart failure with physician's orders for daily weights with directions to notify the provider of specified weight gains and there was no notification of weight gains to the provider which placed the resident at risk for fluid overload and hospitalization to remove the fluid (#3); and a resident not referred to a dermatologist as ordered to rule out a cancerous skin lesion (#3). This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on August 1, 2024. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 15, 2024.	D 273		
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:	D 276		

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D 276	Continued From page 26 (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 interviews and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents (#3) who had an order to check and record blood pressures and vital signs monthly. The findings are: Review of Resident #3's current FL2 dated 07/18/2024 revealed diagnoses included bacteria extended spectrum beta-lactamase (ESBL), kidney failure, urinary tract infection, bipolar, hypertension, anxiety, excision of skin cancer, foot surgery, tonsillectomy, right below knee amputation and prostatectomy. Review of Resident's signed physician orders dated 05/30/2024 revealed there was an entry to take and record vital signs monthly. Review of the facility vitals logbook revealed: -Resident #3's name was not listed in the logbook. -There was no documentation blood pressure or vital signs had been taken for Resident #3. Review of Resident #3's May, June and July 2024 electronic Medication Administration Records (eMARs) revealed: -There was an entry to take and record blood pressures and vital signs monthly. -There was no documentation of blood pressure	D 276		

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D 276	Continued From page 27 readings or vital signs. Interview with a medication aide (MA) on 08/01/2024 at 10:10 am revealed: -She did not realize Resident #3's name was not listed in the vitals logbook. -She did not realize blood pressure and vitals had not been documented for Resident #3. Interview with the Resident Care Coordinator (RCC) on 08/01/2024 at 11:00am revealed: -She did not know Resident #3's name was not listed in the vitals logbook. -She did not know his vitals were not being taken and recorded on the eMARs. Interview with the Administrator on 08/01/2024 at 11:15am revealed: -She did not know Resident #3's name was not listed in the vitals logbook. -She did not know his vitals were not being taken and recorded on the eMARs. Second interview with the RCC on 08/01/2024 at 3:45pm revealed: -She did not record the names in the vitals logbook and did not know who did. -She was responsible for making sure residents vitals were being taken and documented on the eMARs. Second interview with the Administrator on 08/01/2024 at 3:55pm revealed: -She did not record the names in the vitals logbook and did not know who did. -She and RCC were responsible for making sure residents vitals were being taken and documented on the eMARs.	D 276		

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D 296	Continued From page 28	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there were matching therapeutic diet menus for food service guidance for 4 of 5 sampled residents (#4, #5, #6, and #7) with physicians' orders for an 1800 calorie American Diabetes Association (ADA) diet (#4), a mechanical soft (MS) ground and chopped diet (#5), a no concentrated sweets (NCS) chopped diet (#6) and a NCS/no added salt (NAS) diet (#7). The findings are: Observation of the kitchen on 07/31/24 at 9:38am revealed: -There was a binder which contained the regular menus and therapeutic diet menus. -There was not a therapeutic menu for an 1800 calorie ADA diet, a MS ground and chopped diet, a NCS chopped diet, or a NCS/NAS diet. Review of the regular menu for the lunch meal service on 07/31/24 revealed baked chicken, garlic mashed cauliflower, breaded tomatoes,	D 296		

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cornbread, margarine, assorted ice cream, and milk were to be served.

Review of the regular menu for the breakfast meal service on 08/01/24 revealed oatmeal, fresh whole apples, sausage patty, pancakes, margarine, syrup, milk, coffee, and apple juice were to be served.

1. Review of Resident #4's current FL2 dated 07/29/24 revealed:
-Diagnoses included prediabetes, stage 3a chronic kidney disease, chronic obstructive pulmonary disease, and hypertension.
-There was an order for an 1800 calorie ADA diet.

Review of the therapeutic diet list dated 04/24/24 posted in the kitchen on 07/31/24 revealed Resident #4 was not listed.

Observation of the lunch meal service on 07/31/24 between 11:30am and 12:30pm revealed Resident #4 was prepared a plate with a chicken drumstick, cornbread, mashed cauliflower, stewed tomatoes, and stewed apples, but she declined to eat lunch.

Observation of the breakfast meal service on 08/01/24 between 6:54am and 7:15am revealed Resident #4 was served pancakes with sugar free syrup, oatmeal, stewed apples, coffee, and milk.

It could not be determined if Resident #4 was served the appropriate diet because there was no 1800 calorie ADA therapeutic diet menu available for staff guidance.

Interview with Resident #4 on 07/31/24 at 4:28pm revealed she thought she was supposed to be on a salt free diet.

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D 296	Continued From page 30 Interview with the Dietary Manager (DM) on 08/01/24 at 8:09am revealed: -When Resident #4 was admitted to the facility a few days ago, she asked her what she liked to eat. -She did not know Resident #4 had an order for an 1800 calorie ADA diet, so she served her from the regular menu. -There was not an 1800 calorie ADA diet therapeutic menu available. Refer to the interview with the DM on 08/01/24 at 8:09am. Refer to the interview Resident Care Coordinator (RCC) ON 08/01/24 at 1:45pm. Refer to the interview with Resident #2's primary care provider (PCP) on 08/01/24 at 10:31am. Refer to the interview with the Administrator on 08/01/24 at 3:37pm. 2. Review of Resident #5's current FL2 dated 05/23/24 revealed: -Diagnoses included hypertension, hyperglycemia, acute congestive heart failure, and peripheral vascular disease. -There was an order for a MS ground and chopped diet. Review of the therapeutic diet list dated 04/24/24 posted in the kitchen on 07/31/24 revealed Resident #5 was listed to be served a MS ground diet. Observation of the lunch meal service on 07/31/24 between 11:30am and 12:30pm revealed Resident #5 was served mashed sweet	D 296		

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D 296	Continued From page 31 potatoes and ground turkey, and vanilla ice cream. Observation of the breakfast meal service on 08/01/24 between 6:54am and 7:15am revealed Resident #5 was served oatmeal, 3 boiled eggs, and grits. It could not be determined if Resident #4 was served the appropriate diet because there was no MS ground and chopped therapeutic diet menu available for staff guidance. Interview with Resident #5 on 08/01/24 at 7:31am revealed: -He requested to eat the same meal daily. -He preferred grits and hard boiled eggs for breakfast and mashed sweet potatoes and ground turkey for lunch and dinner. -Sometimes the dietary staff served him ground chicken instead of ground turkey, but he preferred the turkey; he did not eat meat from any animal that had 4 legs. -He wanted his meals served with his meats ground and sweet potatoes mashed because he did not have teeth and could not chew well. Interview with the Dietary Manager (DM) on 08/01/24 at 8:09am revealed: -Resident #5 was to be served a MS ground diet. -She did not know there was also an order for a chopped diet in addition to MS ground -Resident #5 only ate certain food items and preferred for all his foods to be ground or soft. -There was not a MS ground or chopped diet therapeutic menu available. Refer to the interview with the DM on 08/01/24 at 8:09am.	D 296		

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D 296	Continued From page 32 Refer to the interview Resident Care Coordinator (RCC) ON 08/01/24 at 1:45pm. Refer to the interview with Resident #2's primary care provider (PCP) on 08/01/24 at 10:31am. Refer to the interview with the Administrator on 08/01/24 at 3:37pm. 3. Review of Resident #6's current FL2 dated 05/23/24 revealed: -Diagnoses included hypertension, diabetes mellitus, and chronic lymphocytic leukemia. -There was an order for a NCS chopped diet. Review of the therapeutic diet list dated 04/24/24 posted in the kitchen on 07/31/24 revealed Resident #6 was listed to be served a regular chopped diet. Observation of the lunch meal service on 07/31/24 between 11:30am and 12:30pm revealed Resident #6 was served a chicken drumstick, mashed cauliflower, stewed tomatoes, corn bread, and ice cream. Observation of the breakfast meal service on 08/01/24 between 6:54am and 7:15am revealed Resident #6 was served a pancake, sugar free syrup, sausage, oatmeal, and stewed apples. It could not be determined if Resident #4 was served the appropriate diet because there was no NCS chopped therapeutic diet menu available for staff guidance. Interview with Resident #6 on 08/01/24 at 7:31am revealed: -She was not on a special diet. -She ate what the staff gave her.	D 296		

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D 296	Continued From page 33 Interview with Dietary Manager (DM) on 08/01/24 at 8:09am revealed: -She did not know Resident #6 was supposed to be served a NCS chopped diet. -She thought that Resident #6 was just supposed to have her meats chopped, but she overlooked chopping them for the lunch meal on 07/31/24 and the breakfast meal on 08/01/24. -There was not a NCS chopped diet therapeutic menu available. Refer to the interview with the DM on 08/01/24 at 8:09am. Refer to the interview Resident Care Coordinator (RCC) ON 08/01/24 at 1:45pm. Refer to the interview with Resident #2's primary care provider (PCP) on 08/01/24 at 10:31am. Refer to the interview with the Administrator on 08/01/24 at 3:37pm. 4. Review of Resident #7's current FL2 dated 05/30/24 revealed: -Diagnoses included type 2 diabetes mellitus, and chronic right heart failure. -There was an order for a NCS/NAS chopped diet. Review of the therapeutic diet list dated 04/24/24 posted in the kitchen on 07/31/24 revealed Resident #7 was listed to be served a NCS diet. Observation of the lunch meal service on 07/31/24 between 11:30am and 12:30pm revealed Resident #7 was served a chicken drumstick, mashed cauliflower, stewed tomatoes, corn bread, and ice cream.	D 296		

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D 296	Continued From page 34 Observation of the breakfast meal service on 08/01/24 between 6:54am and 7:15am revealed Resident #7 did not eat breakfast. It could not be determined if Resident #4 was served the appropriate diet because there was no NCS/NAS therapeutic diet menu available for staff guidance. Interview with Resident #7 on 08/01/24 at 7:31am revealed: -He was not on a special diet. -He was served the same meal as the other residents at his table. Interview with Dietary Manager (DM) on 08/01/24 at 8:09am revealed: -She knew Resident #7 was on a NCS diet, but she did not know his complete diet order was NCS/NAS. -Resident #7 did not eat a lot of sweets and did not even care for fruit. -She did not add salt to his food items. -There was not a NCS/NAS therapeutic menu available. Refer to the interview with the DM on 08/01/24 at 8:09am. Refer to the interview Resident Care Coordinator (RCC) ON 08/01/24 at 1:45pm. Refer to the interview with Resident #2's primary care provider (PCP) on 08/01/24 at 10:31am. Refer to the interview with the Administrator on 08/01/24 at 3:37pm. _____ Interview with the DM on 08/01/24 at 8:09am	D 296		

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revealed:
-There were no therapeutic menus available at the facility when she started working 2 months ago.
-She requested therapeutic menus and they were provided by the DM at a sister facility.
-She noticed that the therapeutic menus did not match the diet orders on the therapeutic diet list, but she did not request additional menus.
-She thought the Administrator was responsible for ensuring menus were available for guidance in preparing meals for residents.

Interview with the RCC on 08/01/24 at 1:45pm revealed:
-She was responsible for making sure therapeutic menus were in place for guidance in preparing residents' meals.
-She did not know the kitchen did not have matching therapeutic menus for residents who had therapeutic diet orders.

Interview with the facility's PCP on 08/01/24 at 10:31am revealed:
-He did not know the residents with therapeutic diets were not being served according to a therapeutic diet menu.
-He expected for residents to be served according to a therapeutic diet menu that matched their diet order.

Interview with the Administrator on 08/01/24 at 3:37pm revealed:
-The DM for the sister facility brought menus from the sister facility and made a menu binder for this facility.
-She was aware that matching menus were needed for each therapeutic diet.
-She did not know the menus brought to the facility by the sister facility did not match the

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D 296	Continued From page 36 residents' therapeutic diets.	D 296		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by:	D 316		

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Based on observations and interviews, the facility failed to prepare a monthly activity calendar of planned group activities posted in an accessible location by the first day of the month.

The findings are:

Observation of the facility on 07/31/24 at 9:00am revealed there was not an activities calendar posted within the facility for July 2024.

Observation of the dining room on 07/31/24 at 9:30am revealed:
-There was a bulletin board covered with paper on the wall.
-There was no activities calendar posted on the wall for July 2024.

Observation of the activity area on 07/31/24 at 9:45am revealed:
-There was no activities calendar posted on the wall for July 2024.

Interview with a resident on 08/01/24 at 8:30am revealed:
-She did not have an activity calendar for July 2024.
-She had not seen an activity calendar posted in the facility.
-She never knew what activities were going to be done.
-She would like an activities calendar, so she knew how to plan her day.
-They did not do activities every day.

Interview with a second resident on 08/01/24 at 8:47am revealed:
-She did not have an activity calendar for July 2024.
-She had not seen an activity calendar posted in

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D 316	Continued From page 38 the facility. Interview with the Administrator on 08/01/24 at 2:45pm revealed: -She was responsible for completing the monthly activity calendar. -She had not completed an activity calendar for July 2024. -She had too much going on and just did not get to it. -An activity calendar was to be posted each month. -Activities were being done but not according to a schedule.	D 316		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to follow-up on pharmacy medication review recommendations for 1 of 3 sampled residents (#1) who had recommendations for medication changes. The findings are: Review of Resident #1's current FL-2 dated 10/30/23 revealed: -Diagnoses included gastroesophageal reflux	D 406		

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disease (GERD).
-There was an order for omeprazole (used to treat GERD) 40mg daily.

Review of a pharmacy review for Resident #1 dated 05/07/24 revealed:
-Recommendation to decrease omeprazole for Resident #1 from 40mg to 20mg daily to decrease risk of associated hypomagnesemia, vitamin B-12 deficiency and increased incidence of C.difficile infections and pneumonia.
-Resident #1's primary care provider (PCP) agreed with the pharmacist's recommendation and signed the recommendation on 05/09/24.
-There was a "faxed" stamp dated 05/09/24 at 11:45am.

Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for omeprazole 40mg daily.
-Omeprazole 40mg daily was documented as administered from 05/01/24 to 05/31/24.
-There was no entry to decrease the omeprazole dose from 40mg to 20mg daily.

Review of Resident #1's June 2024 eMAR revealed:
-There was an entry for omeprazole 40mg daily.
-Omeprazole 40mg daily was documented as administered from 06/01/24 to 06/30/24.
-There was no entry to decrease the omeprazole dose from 40mg to 20mg daily.

Review of Resident #1's July 2024 eMAR revealed:
-There was an entry for omeprazole 40mg daily.
-Omeprazole 40mg daily was documented as administered from 07/01/24 to 07/31/24.
-There was no entry to decrease the omeprazole

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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 406	Continued From page 40	D 406		

dose from 40mg to 20mg daily.

Observation of Resident #1's medications on hand on 07/31/24 at 2:45pm revealed:
-There was one card of 30 capsules of omeprazole 40mg that was dispensed by the pharmacy on 07/03/24.
-There were 3 capsules of omeprazole 40mg left in the card.
-There was not a card for omeprazole 20mg available for administration.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/31/24 at 3:00pm revealed:
-The pharmacy received the pharmacy recommendation from the facility with the PCP's signature on 05/09/24.
-The pharmacy would then process the order by entering it into the quick MAR system and the eMAR would reflect the change.
-The omeprazole 4mg daily order would have been discontinued.
-There would be a new order for omeprazole 20mg daily.
-She did not see any notes in the system to indicate why the order to change the omeprazole from 40mg daily to 20mg daily did not get processed.
-She did not know how the order got missed.

Interview with Resident #1's previous PCP on 08/01/24 at 10:35am revealed:
-He reviewed and agreed with the pharmacist's recommendation to decrease omeprazole from 40mg daily to 20mg daily.
-Taking omeprazole at a higher dose could cause changes to Resident #1's esophagus.
-He was not aware the order to decrease Resident #1's omeprazole from 40mg daily to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086001	A. BUILDING: _____ B. WING _____	R-C 08/01/2024

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D 406	Continued From page 41 20mg daily did not get implemented. Interview with a medication aide (MA) on 07/31/24 at 3:30pm revealed: -She did not have anything to do with the pharmacy recommendations. -She was not aware there was an order to change Resident #1's omeprazole from 40mg daily to 20mg daily. Interview with the Resident Care Coordinator (RCC) on 08/01/24 at 1:40pm revealed: -After the pharmacist completed the reviews, any recommendations got sent to her email. -If the recommendation required the PCP to address it, it got put into the PCP's folder for the next visit. -After the PCP reviewed the pharmacist's recommendation, the form got faxed to the pharmacy, got confirmation the pharmacy received the fax and then filed in the resident's record. -She did not complete a check of Resident #1's eMAR to ensure the order to change the omeprazole from 40mg to 20mg got implemented by the pharmacy. Interview with the Administrator on 08/01/24 at 3:45pm revealed: -Pharmacy recommendations were faxed to the pharmacy after the PCP addressed them. -The pharmacy entered the orders into the quick MAR system so they showed up on the eMAR. -The RCC was responsible for making sure the orders were implemented. -She did not know why the order for Resident #1's omeprazole did not get changed.	D 406		

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D 613	Continued From page 42	D 613		
D 613	10A NCAC 13F .1801 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the mandatory annual state approved infection control training was completed for 1 of 3 sampled staff (Staff C). The findings are: Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 03/21/19. -There was documentation of state approved infection control training on 05/28/19 and 11/08/21, but no documentation of the training in 2022, 2023, or 2024. Interview with Staff C on 08/01/24 at 2:22pm revealed: -He took infection control training at another job that he worked in home health in 2023. -He had not taken the Infection Control Training	D 613		

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D 613	Continued From page 43 Course at the current facility in 2023 or 2024. -He was having issues with his eyes in May 2023 when he was enrolled for the Infection Control Course and was not able to take it. -He had not been scheduled for any further Infection Control Training Courses. -He worked as a MA and took residents' fingerstick blood sugars (FSBS), administered insulin, and assisted with cleanup of body fluids. Interview with the Administrator on 08/02/24 at 2:15pm revealed: -Staff C was enrolled in an online Infection Control Training Course on 05/01/23. -Staff C was responsible for completing the course independently by 05/18/23. -Once the course was completed, Staff C had to pass the course before he could print a certificate. -After Staff C passed the course, he was to be checked off by a nurse who then signed the certificate. -Staff C never completed the online Infection Control Training Course. -She was responsible for ensuring Staff C completed the Infection Control Training annually, but it probably got overlooked. -The most recent Infection Control Training certificate that she had for Staff C was from 2021.	D 613		