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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-survey from 08/13/24 to 08/14/24. | D 000 | | |
| D 049 | 10A NCAC 13F .0305 (d) Physical Environment<br><br>10A NCAC 13F .0305Physical Environment<br><br>(d) The requirements for the bedroom are:<br>(1) The number of resident beds set up shall not exceed the licensed capacity of the facility;<br>(2) There shall be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, any live-in staff and other persons living in the home. Residents shall not share bedrooms with staff or other live-in non-residents;<br>(3) Only rooms authorized as bedrooms shall be used for residents' bedrooms;<br>(4) Bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved for a resident's bedroom;<br>(5) There shall be a minimum area of 100 square feet excluding vestibule, closet or wardrobe space in rooms occupied by one person and a minimum area of 80 square feet per bed, excluding vestibule, closet or wardrobe space, in rooms occupied by two people;<br>(6) The total number of residents assigned to a bedroom shall not exceed the number authorized for that particular bedroom;<br>(7) A bedroom may not be occupied by more than two residents.<br>(8) Resident bedrooms shall be designed to accommodate all required furnishings;<br>(9) Each resident bedroom shall be ventilated with one or more windows which are maintained operable and well lighted. The window area shall be equivalent to at least eight percent of the floor | D 049 | | |

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space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and
(10) Bedroom closets or wardrobes shall be large enough to provide each resident with a minimum of 48 cubic feet of clothing storage space (approximately two feet deep by three feet wide by eight feet high) of which at least one-half shall be for hanging clothes with an adjustable height hanging bar.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure the window openings in the Special Care Unit (SCU) residents' bedrooms were restricted to 6 inches or had a workable sounding device in place to notify staff when a resident's window was opened to prevent elopement.

The findings are:

Observation of the windows in the SCU on 08/13/24 at various times between 8:48am-2:52pm revealed:
-There were 14 resident rooms with 1 window in each room.
-All the windows had an alarm attached to the windowsill with an on and off switch; the alarms were in the on position.
-When the window was raised an audible alarm sounded.
-The alarm could be stopped by turning the switch to the off position or closing the window.
-Nine of the windows had a safety latch in place to limit the distance the window could be opened; there was one component of the safety latch that

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could be removed to allow the window to open fully.
-Three of the windows with the missing safety latch opened 24 inches.
-Three of the windows with the missing safety latch opened 13 inches; there was a screw in the window preventing the window from opening any further.

Observation of the window in room #204 on 08/13/24 at 10:52am-11:03am revealed:
-The alarm sounded when the window was opened.
-After 42 seconds, the alarm stopped even though the window remained open.
-The window was closed and reopened; the alarm sounded a second time.
-No staff responded to either of the alarms.
-There were 3 staff seen in the hallway when exiting the room at 11:03am.

Observation of the window in room #209 on 08/13/24 at 11:12am revealed:
-The alarm was in the on position.
-When the window was opened the alarm did not sound.
-The window opened 24 inches.

Observation of the window in room #203 on 08/13/24 at 2:52pm revealed:
-The alarm sounded when the window was opened.
-After 43 seconds, the alarm stopped even though the window remained open.
-The window was closed and reopened; the alarm sounded a second time.
-No staff responded to either of the alarms.
-The window opened 24 inches.

Observation of the outside area of the SCU on

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| D 049 | Continued From page 3<br><br>08/14/24 between 7:38am-7:40am revealed:<br>-The area outside of the SCU windows was not enclosed.<br>-The area opened to a parking lot in one direction and to a wooded area in the opposite direction.<br>-One of the windows that opened to the back of the facility did not have a screen attached to the window; it was on the ground leaning against the facility.<br>-A second window that opened to a parking lot did not have a screen on the window; the screen was behind a bush on the ground.<br><br>Interview with a personal care aide (PCA) on 08/14/24 at 9:29am revealed:<br>-All the windows had alarms.<br>-Staff were supposed to make sure the windows were closed, and the alarms were in the on position.<br>-She could hear an alarm if it sounded.<br>-She did not hear an alarm on 08/13/24.<br><br>Interview with a second PCA on 08/14/24 at 9:43am revealed:<br>-Maintenance staff was responsible for checking the resident windows.<br>-She thought the Maintenance Director checked the windows every other day.<br>-She did not know what the Maintenance Director checked on the windows.<br>-She had not heard the window alarms going off.<br><br>Interview with a third PCA on 08/14/24 at 9:51am revealed:<br>-The Maintenance Director checked the alarms on the windows in the SCU.<br>-She had not heard an alarm going off in a resident's room.<br>-If she heard an alarm, she would go into the resident's room to see why the alarm was on. | D 049 | | |

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| D 049 | Continued From page 4<br><br>Interview with a medication aide (MA) on 08/14/24 at 10:00am revealed:<br>-Maintenance staff checked the residents' windows.<br>-She was told if she saw a resident's window open, to close it.<br>-She had not seen any windows open in a resident's room.<br>-She had not heard an alarm from a resident's window being opened.<br><br>Interview with the SCU Coordinator 08/14/24 at 10:17am revealed:<br>-The PCAs should make sure residents' windows were closed.<br>-If a window alarm was sounded, staff should respond.<br>-She did not know why staff did not respond on 08/13/24, when the alarms sounded.<br>-Staff may have been in another resident's room.<br>-She was not sure how far the windows in the SCU could open up.<br><br>Telephone interview with the Maintenance Director on 08/14/24 at 2:25pm revealed:<br>-Staff should respond to a resident's room if the alarm was sounded.<br>-Alarms could be turned on and off by anyone.<br>-He did not know the alarm stopped sounding after a limited amount of time.<br>-It may be the alarm stopped sounding to save the battery.<br>-He did not know windows could have a 6-inch limited opening.<br>-He thought windows had to open "all the way" for fire safety.<br>-The alarm was the only thing in place to prevent elopement at this time. | D 049 | | |

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| D 049 | Continued From page 5<br><br>Telephone interview with the facility's contracted primary care provider (PCP) on 08/14/24 at 12:18pm revealed she would expect windows in the SCU to have a safety feature in place to prevent elopement.<br><br>Interview with the Business Office Manager on 08/14/24 at 3:23pm revealed:<br>-She expected staff to respond immediately if a window alarm sounded to see why the alarm was going off.<br>-The concern if the staff did not respond would be someone could get in the window or someone could get out. | D 049 | | |
| D 056 | 10A NCAC 13F .0305(f)(4) Physical Environment<br><br>10A NCAC 13F .0305 Physical Environment<br>(f) The requirements for storage rooms and closets are:<br>(4) Housekeeping storage requirements are:<br>(A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and<br>(B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use;<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure that cleaning agents and other substances that may be hazardous if ingested were kept in a separate locked area and not accessible to residents in the Special Care Unit (SCU). | D 056 | | |

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| D 056 | Continued From page 6<br><br>The findings are:<br><br>Observation of a resident's room on 08/13/24 at 8:57am revealed:<br>-There was a bottle of powder sitting on the resident's bedside table.<br>-The warnings on the bottle of powder included external use only. Do not use it in the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away.<br>-There was a second bottle of powder sitting on another table in the resident's room.<br>-The warnings on the bottle of powder included avoiding contact with eyes. For external use only. Do not use it on broken skin. Keep away from the face to avoid inhalation, which could cause breathing problems. Close tightly and keep out of reach of children.<br><br>Second observation of this resident's room on 08/14/24 at 8:17am revealed two bottles of powders and a lotion remained in open view in the resident's room.<br><br>Observation of a shower room in the SCU on 08/13/24 at various times from 9:20am-4:00pm revealed:<br>-The room was not locked.<br>-In the bathroom, sitting on a half wall by the spa tub, there were various bottles of lotions, shampoos, and an empty spray bottle labeled as bleach water.<br>-The warning label on two of the bottles of shampoo included for external use only. Avoid contact with us. The contact occurs, rinse thoroughly with water. Keep out of reach of children. If swallowed, get medical help or contact the Poison Control Center right away. | D 056 | | |

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| D 056 | Continued From page 7<br><br>Observation of the linen room in the SCU on 08/13/24 at various times between 9:22am-2:50pm revealed:<br>-The room was not locked.<br>-Signage on the door was to please keep the door locked at all times. No exceptions.<br>-Inside the room was a bottle of versatile cleaner.<br>-The warnings on the cleaner bottle label included keeping out of the reach of children. Wash thoroughly after handling.<br>-Two bottles of foam shaving cream were sitting on a tabletop.<br>-The warnings on the bottle of shaving cream included to keep out of reach of children.<br><br>Observation of a second shower room on 08/13/24 at 9:23am revealed:<br>-The shower room was unlocked.<br>-A bottle of foam shaving cream, a cream deodorant, and an empty spray bottle labeled as a sanitizer were in an unlocked cabinet.<br>-The warnings on the bottle of shaving cream included keeping out of reach of children, and deliberately inhaling the contents could be harmful or fatal.<br>-The warning labels on the bottles of deodorant included for external use only. Do not use it on broken skin. Keep out of reach of children. If swallowed, get medical help or contact the Poison Control Center right away.<br><br>Second observation of this shower room on 08/14/24 at 7:28am revealed:<br>-The room was unlocked.<br>-The shaving cream, a cream deodorant, and an empty spray bottle labeled as sanitizer were in the unlocked cabinet.<br><br>Observation of a second resident's room on 08/13/24 at 11:17am revealed: | D 056 | | |

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| D 056 | Continued From page 8<br>-There was a large bottle of shaving cream in the resident's bathroom, in an unlocked cabinet.<br>-The warnings on the bottle of shaving cream included keeping out of reach of children, and deliberately inhaling the contents could be harmful or fatal.<br><br>Observation of a third resident's room on 08/14/24 at 8:16am reveled:<br>-There was a large bottle of shaving cream on the resident's bedside table.<br>-The warnings on the bottle of shaving cream included keeping out of reach of children, and deliberately inhaling the contents could be harmful or fatal.<br><br>Observation of the storage closet in one of the shower rooms on 08/14/24 at 9:48am revealed:<br>-There were multiple bottles of lotions, mouthwash, deodorants, toothpaste, petroleum jelly, zinc oxide, and shampoo on an open shelf.<br>-There were multiple plastic containers labeled with individual resident names on the shelves; each box contained personal care items including lotions, deodorants, and shampoos.<br>-The warnings on the container of petroleum jelly included for external use only, do not get into the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away.<br>-The warnings on the container of zinc oxide included for external use only. Avoid contact with the eye. Keep out of reach of children. If swallowed, get medical help or contact the Poison Control Center right away.<br>-The warnings on the container of mouthwash included keeping out of reach of children. If accidentally swallowed, get medical help or contact a poison Control Center right away.<br>-The warnings on the tube of toothpaste included | D 056 | | |

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keeping out of reach of children. If accidentally swallowed, get medical help or contact a poison Control Center right away.

Observation of the SCU on 08/13/24 at various times from 8:00am-4:00pm revealed:
-The linen room and both shower rooms were all located on the main hallway where residents were observed walking up and down the hallway daily.
-There were no staff members seen in the hallway in sight of the linen room, and shower rooms multiple times when residents were seen walking by these rooms.

Observation of the SCU on 08/14/24 at 7:29am revealed one of two shower rooms was unlocked.

Observation of the SCU on 08/14/24 at 8:18am revealed.
-The linen room was unlocked.
-The two bottles of shaving cream remained on the tabletop.

Interview with a personal care aide (PCA) on 08/14/24 at 9:29am revealed:
-There were residents who went in and out of other resident rooms.
-There were 2 [named] residents who wandered within the SCU.
-Residents were not supposed to have shaving cream in their rooms.
-The residents might think the shaving cream was whipped cream and try to eat it.
-Shaving cream was supposed to be locked in the shower room.
-Staff should take the shaving cream out to use it and then lock it back up.
-She thought the residents could have lotion in their rooms.
-Shower rooms were supposed to be always

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locked.

Interview with a second PCA on 08/14/24 at 9:43am revealed:
-There were 4 [named] residents who wandered within the SCU.
-Residents were not supposed to have shaving cream in their rooms.
-staff can get the shaving cream out for the resident to use but then it needs to be put back up.
-residents can have lotion in their room.
-She did not think residents were supposed to have the powder in their rooms.
-The linen closet should be locked.
-The shower rooms were not locked but the items in the room were locked.

Interview with a third PCA on 08/14/24 at 9:51am revealed:
-There were 2 [named] residents who wandered within the SCU.
-Things like shaving cream, deodorants, and razors were locked up.
-She thought lotions and powders were fine.
-There was a [named] resident who might put something in her mouth.
-Shower rooms were usually locked.

Interview with a medication aide (MA) on 08/14/24 at 10:00am revealed:
-There were 4 [named] residents who wandered within the SCU.
-There was a [named] resident who might put something in her mouth.
-Shaving creams should not be in a resident's room.
-She knew one resident had lotion in her room.
-Shampoos were kept in the shower room locked.
-Anything a resident might put in their mouth that

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would not be safe should be locked up.
-All chemicals were supposed to be locked up.
-Cleaning supplies were kept locked by housekeeping outside of the SCU.
-If a PCA saw something in a resident's room, the item should be removed, and then tell the MA.
-Staff should be looking every day to ensure nothing is left in a resident room.
-Shower rooms should be kept locked to keep residents from going in unattended.
-The closet in the shower room should be locked because the closet contained razors, shampoos, and lotions.

Interview with the SCU Coordinator 08/14/24 at 10:17am revealed:
-Shaving cream should be locked when not in use.
-Shaving cream should not be left in a resident's room.
-There were "wanderers" in the SCU.
-She had seen a [named] resident start to put a crayon in her mouth, so the staff had to be careful what the resident had access to.
-Shower rooms should be locked for the safety of the residents.
-If a staff member saw shaving cream in a resident's room, the staff should remove the shaving cream.
-If a resident had lotion in their room, it should be kept in the resident's locked closet where other residents could not get to it.
-The linen room door should be locked at all times.
-Chemicals should be locked by the housekeeper.
-Anything that could be dangerous to the resident should be locked up because a resident could spray the item and have it turned wrong and accidentally spray it in their mouth, nose, or eyes.

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| D 056 | Continued From page 12<br><br>Interview with a housekeeper on 08/14/24 at 10:55am revealed:<br>-She did not leave any chemicals in the SCU.<br>-All the chemicals she used stayed on her cart and her cart always stayed within her sight.<br>-She did not know how a chemical got into the linen room.<br>-She was told by the Maintenance Director to never leave any chemicals out because a resident "might see it and drink it."<br><br>Telephone interview with the Maintenance Director on 08/14/24 at 2:25pm revealed:<br>-Chemicals should be kept locked by the housekeeper.<br>-He knew the door to the linen closet was supposed to be locked at all times.<br><br>Telephone interview with the facility's contracted primary care provider (PCP) on 08/14/24 at 12:18pm revealed:<br>-Chemicals should be in a locked area because residents could potentially harm themselves by ingesting or getting it into their eyes.<br>-Even personal care items should be locked.<br><br>Interview with the Business Office Manager on 08/14/24 at 3:23pm revealed:<br>-Chemicals should be kept locked.<br>-Anything that was ingestible should be kept locked. | D 056 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. | D 273 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|
| PIEDMONT CHRISTIAN HOME | 1510 DEEP RIVER ROAD HIGH POINT, NC 27265 |

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| D 273 | Continued From page 13<br><br>This Rule is not met as evidenced by:<br>Based on interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#1 and #2) related to a primary care provider (PCP) not being notified of elevated finger stick blood sugar (FSBS) values (1 and #2) and refusing FSBS and sliding-scale insulin (#2) .<br><br>The findings are:<br><br>1. Review of Resident #2's current FL-2 dated 03/07/24 revealed:<br>-Diagnoses included Alzheimer's Dementia, Diabetes Mellitus Type II, and hypertension.<br>-There was documentation that the resident was intermittently confused.<br><br>a. Review of Resident #2's physician's orders dated 08/01/24 revealed an order to check FSBS 4 times daily and to notify the PCP of FSBS greater than 400.<br><br>Review of Resident #2's August 2024 electronic medication administration record (eMAR) from 08/01/24 to 08/13/24 revealed:<br>-There was an entry for a blood sugar checks before meals and at bedtime and notify the PCP for FSBS greater than 400 scheduled for 7:30am, 11:30am, 4:30pm, and 8:00pm.<br>-On 08/03/24, Resident #2's FSBS was documented as 527 at 4:30pm.<br>-On 08/08/24, Resident #2's FSBS was documented as 427 at 8:00pm.<br>-On 08/11/24, Resident #2's FSBS was documented as 411 at 4:30pm.<br>-On 08/13/24, Resident #2's FSBS was documented as 433 at 4:30pm. | D 273 | | |

| 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 273 | Continued From page 14<br><br>Review of Resident #2's medication administration administration exceptions for August 2024 revealed no documentation that the PCP was notified of FSBS greater than 400.<br><br>Review of the facility's abnormal value reporting sheets for Resident #2's revealed there was no documentation the PCP was notified of FSBS greater than 400.<br><br>Interview with a medication aide (MA) on 08/14/24 at 10:20am revealed:<br>-If Resident #2's FSBS was too high she called the PCP.<br>-FSBS outside of the parameters were documented on the eMAR in the exceptions.<br>-Resident #2's FSBS parameter order was to notify the provider for a FSBS over 400.<br>-When showed the FSBS reading of 443 on 08/13/24 at 4:30pm, she stated she called the on-call provider at Resident #2's PCP office.<br>-She did not know where to document she had contacted the PCP regarding FSBS greater than 400 in the eMAR system.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/14/24 at 11:27am revealed:<br>-She did not recall being notified Resident #2's FSBS was elevated.<br>-If a resident had an abnormal FSBS, the MA would document the abnormal value and a PCP call on the abnormal value sheet.<br>-She had not seen any abnormal value sheets for Resident #2.<br><br>Telephone interview with Resident #2's PCP on 08/14/24 at 12:18pm revealed:<br>-The PCP's could be reached daily on Monday through Friday 8:00am to 5:00pm by phone, text, or fax. | D 273 | | |

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| D 273 | Continued From page 15<br>-The PCP's office had on-call staff available after hours and on weekends.<br>-She expected to be notified if residents' FSBS was outside the ordered parameters.<br>-She did not see any documentation for notifications in August 2024 for the dates of 08/03,24, 08/08/24, 08/11/24, or 08/13/24.<br>-Resident #2's FSBS parameter was set at 400 because she routinely wanted to be notified for FSBS values greater than 400.<br>-She would not be able to treat a resident with abnormal FSBS if she was not notified.<br>-Diabetic residents could have complications (damage to eyes, and kidneys) if their FSBS was too high.<br><br>Interview with the Special Care Unit Coordinator (SCUC) on 08/14/24 at 2:55pm revealed:<br>-If Resident #2's FSBS was outside of the ordered parameters, the PCP should be notified, and the abnormal value sheet completed immediately.<br>-Resident #2 had new medication treatment orders for FSBS before meals and at bedtime with parameters to notify the PCP for FSBS greater than 400.<br>-She was out of work the week of 08/04/24, so the RCC should have been notified.<br>-She had not been told Resident #2 had an elevated FSBS in the past two weeks.<br><br>Interview with the Business Office Manager (BOM) on 08/14/24 at 3:23pm revealed:<br>-The MA should contact the PCP immediately for FSBS outside of the ordered parameters set by the PCP.<br>-The MA should document the FSBS on the abnormal value sheet and document the PCP was notified. | D 273 | | |

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| D 273 | Continued From page 16 | D 273 | | |

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

b. Review of Resident #2's physician's orders dated 08/01/24 revealed an order to check FSBS 4 times daily and start Humalog (a rapid acting insulin) per sliding scale insulin (SSI) parameters as follows: 70-140= 0 units, 141-180= 2 units, 181-220= 4 units, 221-260= 6 units, 261-300= 8 units, 301-350= 10 units, 351-400= 12 units, greater than 400 call PCP.

Review of Resident #2's August 2024 eMAR from 08/02/24 to 08/13/24 revealed:
-There was an entry for check FSBS 4 times daily and inject Humalog insulin per SSI: parameters 70-140= 0 units, 141-180= 2 units, 181-220= 4 units, 221-260= 6 units, 261-300= 8 units, 301-350= 10 units, 351-400= 12 units scheduled for 7:30am, 11:30am, 4:30pm, and 9:00pm.
-FSBS were refused and SSI Humalog SSI not administered due to refused FSBS on 7 of 39 opportunities from 08/03/24 to 08/13/24 as follows:
-On 08/03/24, Resident #2's FSBS was documented as refused at 11:30am and at 8:00pm .
-On 08/04/24, Resident #2's FSBS was documented for refused at 8:00pm.
-On 08/08/24, Resident #2's FSBS was documented for refused at 11:30am.
-On 08/09/24, Resident #2's FSBS was documented for refused at 11:30am.
-On 08/11/24, Resident #2's FSBS was documented for refused at 11:30am and 8:00pm.

Review of Resident #2's medication administration administration exceptions for August 2024 revealed no documentation that the

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| D 273 | Continued From page 17 | D 273 | | |

PCP was notified for Resident #2's refusing Humalog insulin injections.

Review of the facility's abnormal value reporting sheets revealed Resident #2's revealed there was no documentation of the PCP being notified for Resident #2's refusing Humalog insulin injections.

Interview with a medication aide (MA) on 08/14/24 at 10:10am revealed:
-She documented FSBS refusals on the eMAR exceptions.
-She did not report refusals of FSBS to the Special Unit Care Coordinator (SCUC) because she had been trained to document refusal of treatments or medications on the eMAR.
-She did not know where to document if she had contacted the PCP regarding FSBS refusals.

Telephone interview with Resident #2's PCP on 08/14/24 at 12:18pm revealed:
-Resident #2 had new medication/treatment orders for FSBS before meals at bedtime with Humalog SSI ordered 08/01/24 due to elevated laboratory values for blood glucose.
-The PCP's could be reached daily on Monday through Friday 8:00am to 5:00pm by phone, text, or fax.
-The PCP's office had on-call staff available after hours and on weekends.
-She expected to be notified if residents refused FSBS and/or insulin.
-She had not seen Resident #2 for a follow-up since she ordered the FSBS checks and Humalog SSI but was scheduled to see her on her Thursday facility visit this week (08/15/24).
-She did not see documentation for refusals for Resident #2 in August 2024.
-She would not be able to treat a resident for refusing FSBS unless she was notified.

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| D 273 | Continued From page 18<br><br>Interview with the Resident Care Coordinator (RCC) on 08/14/24 at 2:30pm revealed:<br>-She did not recall being notified Resident #2 was refusing FSBS checks.<br>-The MA should document refused FSBS on the eMAR exception sheet.<br>-If a resident refused FSBS checks, the MA should document the refused FSBS check on the abnormal value sheet and place the sheet for the SCUC and RCC to review.<br>-She had not seen any abnormal value sheets for Resident #2.<br>-The RCC and SCUC were responsible to review eMAR exceptions for missed or refused medications.<br>-The RCC and SCUC reviewed residents' eMARs randomly.<br><br>Interview with the SCUC on 08/14/24 at 2:55pm revealed:<br>-If Resident #2's refused FSBS, the PCP should be notified, and the abnormal value sheet (used by the facility to report missed medications) completed immediately.<br>-She was out of work the week of 08/04/24 so the RCC should have been notified.<br>-She had not been told Resident #2 had refused FSBS in the past two weeks.<br><br>Interview with the Business Office Manager (BOM) on 08/14/24 at 3:20pm revealed:<br>-The MA should report refusals to the RCC or SCUC after each refusal.<br>-The MA should document the refused FSBS on the eMAR and on the abnormal value sheet.<br>-The PCP should be notified after 3 refused medications or treatments.<br>-The PCP reviewed the residents' eMAR, including the exceptions page, when she saw the | D 273 | | |

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| D 273 | Continued From page 19<br>resident on the next scheduled PCP appointment.<br><br>Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.<br><br>2. Review of Resident #1's current FL2 dated 07/18/24 revealed:<br>-Diagnoses included dementia, diabetes, hypertension, and diabetic neuropathy.<br>-There was an order for finger stick blood sugar (FSBS) three times daily and to notify the Primary Care Provider (PCP) of FSBS greater than 250.<br><br>Review of Resident #1's previous signed physician's orders dated 11/20/23 revealed an order to check FSBS three times daily and to notify the PCP of FSBS greater than 250.<br><br>Review of Resident #1's July 2024 electronic medication administration record (eMAR) revealed:<br>-There was an entry for a blood sugar check three times daily scheduled for 6:00am, 11:00am, and 4:00pm.<br>-On 07/05/24, Resident #1's FSBS was documented as 300 at 11:00am and 327 at 4:00pm.<br>-On 07/09/24, Resident #1's FSBS was documented as 307 at 4:00pm.<br>-On 07/11/24, Resident #1's FSBS was documented as 277 at 11:00am.<br>-On 07/13/24, Resident #1's FSBS was documented as 277 at 11:00am.<br>-On 07/15/24, Resident #1's FSBS was documented as 326 at 4:00pm.<br>-On 07/16/24, Resident #1's FSBS was documented as 269 at 4:00pm.<br>-On 07/24/24, Resident #1's FSBS was | D 273 | | |

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documented as 253 at 6:00am.
-On 07/27/24, Resident #1's FSBS was documented as 255 at 4:00pm.

Review of Resident #1's exceptions for July 2024 revealed no documentation that the PCP was notified of FSBS greater than 250.

Review of Resident #1's August 2024 eMAR revealed:
-There was an entry for a blood sugar check three times daily scheduled for 6:00am, 11:00am, and 4:00pm.
-On 08/03/24, Resident #1's FSBS was documented as 300 at 4:00pm.
-On 08/11/24, Resident #1's FSBS was documented as 411 at 4:00pm.
-On 08/12/24, Resident #1's FSBS was documented as 269 at 11:00am.
-On 08/13/24, Resident #1's FSBS was documented as 263 at 6:00am.

Review of Resident #1's exceptions for August 2024 revealed no documentation that the PCP was notified of FSBS greater than 250.

Review of Resident #1's abnormal value reporting sheets revealed the PCP was notified of the FSBS of 269 on 07/16/24; there was no other documentation of the PCP being notified of FSBS greater than 250.

Interview with a medication aide (MA) on 08/14/24 at 11:10am revealed:
-If a resident had an abnormal FSBS the MA would notify the PCP and document on the abnormal value sheet.
-Resident #1 had FSBS parameters.
-She had not filled out an abnormal value sheet for Resident #1.

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-She thought Resident #1's FSBS parameter to notify the PCP was a FSBS greater than 400; she did not know the parameter was 250.

Interview with a second MA on 08/14/24 at 11:33am revealed:
-If Resident #1's FSBS was too high she called the PCP.
-FSBS outside of the parameters were documented on the eMAR in the exceptions.
-Resident #1's FSBS parameter was a FSBS over 400.
-She did not recall any elevated FSBS for Resident #1 in July 2024 or August 2024.
-She did not know Resident #1's FSBS parameter was 250.
-When showed the FSBS reading of 411 on 08/11/24 at 4:00pm, she stated she thought she tried the PCP twice and did not get an answer, so she notified the Special Care Unit Coordinator (SCUC).

Interview with the SCUC on 08/14/24 at 11:14am revealed:
-If Resident #1's FSBS was outside the parameter, the PCP should be notified, and the abnormal value sheet completed immediately.
-She had not been told Resident #1 had an elevated FSBS in the past two weeks.
-She was on vacation on 08/11/24 so the Resident Care Coordinator (RCC) may have been notified.

Interview with the RCC on 08/14/24 at 11:47am revealed:
-She did not recall being notified Resident #1's FSBS was elevated.
-If a resident had an abnormal FSBS, the MA would document the abnormal value and PCP call on the abnormal value sheet.

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| D 273 | Continued From page 22<br>-She did not see any abnormal value sheet for Resident #1 for 08/11/24.<br><br>Telephone interview with Resident #1's PCP on 08/13/24 at 12:18pm revealed:<br>-She expected to be notified if Resident #1's FSBS was outside the parameters set.<br>-She did not see any documentation she was notified of abnormal FSBS in July 2024 or August 2024 for the dates discussed.<br>-Resident #1's FSBS parameter was set at 250 because she was trying to establish a baseline for the resident.<br>-She would not be able to treat a resident with abnormal FSBS if she was not notified.<br>-Diabetic residents could have complications if their FSBS was too low or too high.<br><br>Interview with the Business Office Manager (BOM) on 08/14/24 at 3:23pm revealed:<br>-The MA should contact the PCP immediately for FSBS outside the parameter set by the PCP.<br>-The MA should document the FSBS on the abnormal value sheet and the PCP was notified. | D 273 | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of | D 375 | | |

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prescription medications are printed on the medication label.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to assure 1 of 1 sampled resident (#2) who resided in the Special Care Unit (SCU) had physicians' orders to self-administer medications for a topical pain reliever lotion and cream, and 2 vitamin supplements.

The findings are:

Review of Resident #2's current FL-2 dated 03/07/24 revealed:
-Diagnoses included Alzheimer's Dementia, Diabetes Mellitus Type II, and hypertension.
-There was documentation that the resident was intermittently confused.

Observation of Resident #2's room on 08/13/24 at 3:04pm revealed:
-There was a full manufacturer's container of an over-the-counter (OTC) topical arthritis pain reliever lotion.
-There was a partial manufacturer's container of an OTC topical pain reliving cream.
-There was an opened, almost full, manufacturer's container of an OTC vitamin B12 (a vitamin supplement) gummy vitamins.
-There was a partial manufacturer's container of an OTC women's complete multivitamin supplement packaged for 80 chewable tablets with 20 tablets remaining.

Review of Resident #2's record revealed there

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| D 375 | Continued From page 24 | D 375 | | |

was no documentation of a self-administration assessment, order, or documentation to keep medication in her room.

Interview with the Special Care Unit Coordinator (SCUC) on 08/13/24 at 4:10pm revealed:
-She had not previously observed medications in Resident #2's room before today.
-Residents in the SCU were not supposed to have medications in their rooms for self-administration.
-She occasionally checked residents' rooms for cleanliness and inappropriate items.
-No staff members had told her Resident #2 had OTC medications in her room.

-Interview with a medication aide (MA) on 08/13/24 at 4:15pm revealed:
-She had not seen medications in Resident #2's room before 08/13/24.
-Residents in the SCU were not supposed to have medications in their rooms for self-administration.
-She would be concerned residents could come into Resident #2's room and consume the medication without knowing what the medications were used to treat.

Observation on 08/13/24 at 4:20pm revealed over-the-counter (OTC) topical arthritis pain reliever lotion, OTC topical pain reliving cream, OTC vitamin B12 gummy vitamins, and OTC women's complete multivitamin supplement were no longer in Resident #2's room.

Interview with the same MA on 08/14/24 at 10:15am revealed if staff found OTC medications in a resident's room in the SCU, the procedure would to be to remove the medications and give it to the SCUC.

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| D 375 | Continued From page 25<br><br>Interview with a personal care aide (PCA) on 08/14/24 at 10:20am revealed:<br>-She had not seen OTC medications in residents' rooms before.<br>--She would report to the MA on duty if she observed OTC medications in a resident's room.<br><br>Interview with Resident #2's mental health provider (MHP) on 08/14/24 at 11:30am revealed:<br>-Residents in the SCU would not be able to self-administer medications.<br>-She would not expect residents residing in the SCU to have medications in their rooms for self-administration.<br>-Other residents residing in the SCU could have access to medications and consume them without a need for the medication.<br><br>Telephone interview with Resident #2's primary care provider (PCP) on 08/14/24 at 12:30pm revealed:<br>-Residents in the SCU would not have orders for OTC medications to be self-administered due to impaired mental judgement.<br>-She would expect all medications to have orders and be located on the medication carts.<br><br>-Telephone interview with the Administrator on 08/14/24 at 12:13pm revealed:<br>-She was not on site due to unexpected circumstances.<br>-The Business Office Manager (BOM), SCUC and the RCC were responsible to ensure facility policy or procedures were enforced when she was not present.<br>-She was in close contact by phone and computer during her brief absence.<br>-The BOM should be able to answer questions and address concerns. | D 375 | | |

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| D 375 | Continued From page 26<br><br>Interview with the BOM on 08/14/24 at 3:30pm revealed:<br>-She knew medications in residents' rooms should only be present if the resident had and order to self-administer the medication, and assessment for the ability to self-administer.<br>-She was not aware of residents having medications in their room in the SCU.<br>-No resident in the SCU had orders to self-administer medications.<br>-Medications found in residents' rooms in the SCU should be reported to the MA, SCUC or RCC and removed from the room.<br><br>Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. | D 375 | | |
| D 392 | 10A NCAC 13F .1008 (a) Controlled Substances<br><br>10A NCAC 13F .1008 Controlled Substances<br>(a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances for 1 of 3 sampled residents (Resident #1) related to a controlled substance for anxiety. | D 392 | | |

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| D 392 | Continued From page 27<br>The findings are:<br><br>Review of Resident #1's current FL2 dated 07/18/24 revealed:<br>-Diagnoses included dementia, diabetes, hypertension, and diabetic neuropathy.<br>-There was an order for Lorazepam (used to treat anxiety) 0.5mg twice daily.<br>-There was an order for Lorazepam 0.5mg twice daily as needed (PRN) for anxiety.<br><br>Review of Resident #1's signed physician's order dated 05/16/24/24 revealed an order for Lorazepam (used to treat anxiety) 0.5mg twice daily as needed for anxiety.<br><br>Review of Resident #1's signed physician's order dated 06/06/24 revealed an order for Lorazepam 0.5mg twice daily.<br><br>Telephone interview with a Pharmacist from the facility's contracted pharmacy on 08/13/24 at 3:04pm revealed:<br>-Resident #1 was dispensed 2 tablets of Lorazepam 0.5mg on 06/06/24, 06/09/24, 06/11/24, 07/12/24, 07/22/24, and 08/09/24.<br>-Resident #1 was dispensed 30 tablets of Lorazepam 0.5mg on 05/16/24, 06/13/24, 06/26/24, and 07/22/24.<br>-The pharmacy provided a Controlled Substance Count Sheet (CSCS) for each quantity dispensed to document administration of controlled medications.<br>-The purpose of the CSCS was to keep track of the doses administered to deter theft of controlled medications.<br><br>Review of Resident #1's June 2024 electronic medication administration record (eMAR) revealed: | D 392 | | |

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| D 392 | Continued From page 28<br>-There was an entry for Lorazepam 0.5mg twice daily with a scheduled administration time of 9:00am and 9:00pm.<br>-Lorazepam 0.5mg was documented as administered on 06/13/24 at 9:00am and 9:00pm.<br>-Lorazepam 0.5mg was documented as administered on 06/18/24 at 9:00am and 9:00pm.<br><br>Review of Resident #1's CSCS for Lorazepam 0.5mg tablets revealed:<br>-On 05/16/24, 30 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 06/13/24 or 06/18/24.<br>-On 06/06/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 06/13/24 or 06/18/24.<br>-On 06/09/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 06/13/24 or 06/18/24.<br>-On 06/11/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was documentation Lorazepam 0.5mg was administered at 7:00pm on 06/13/24.<br>-On 06/13/24, 30 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 06/13/24.<br>-There was documentation for the Lorazepam 0.5mg documented as administered on 06/18/24 at 8:00am.<br>-There was no documentation for the Lorazepam 0.5mg documented as administered on 06/13/24 at 9:00am.<br>-There was no documentation for the Lorazepam 0.5mg documented as administered on 06/18/24 at 9:00pm.<br><br>Review of Resident #1's July 2024 eMAR revealed:<br>-There was an entry for Lorazepam 0.5mg twice daily with a scheduled administration time of 9:00am and 9:00pm. | D 392 | | |

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-There was a second entry for Lorazepam 0.5mg twice daily as needed (PRN) for anxiety.
-Lorazepam 0.5mg was documented as refused on 07/03/24 and 07/12/24 at 9:00pm.
-Lorazepam 0.5mg was documented as refused on 07/09/24 at 9:00am.
-Lorazepam 0.5mg was documented as administered on 07/16/24 at 9:00am and 9:00pm.
-Lorazepam 0.5mg was documented as administered on 07/19/24 at 9:00am.
-Lorazepam 0.5mg was documented on the PRN entry on 07/20/24.

Review of Resident #1's CSCS for Lorazepam 0.5mg tablets revealed:
-On 05/16/24, 30 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-There was documentation that Lorazepam 0.5mg was administered on 07/16/24 at 8:00pm.
-On 06/06/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-On 06/09/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-On 06/11/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-On 06/13/24, 30 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
On 06/26/24, 30 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-There was documentation that Lorazepam 0.5mg was administered on 07/03/24 and

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07/12/24 at 8:00pm.
-There was documentation that Lorazepam 0.5mg was administered on 07/09/24 at 9:00am.
-There was documentation that Lorazepam 0.5mg was administered on 07/16/24 at 8:00am and 9:00am
-On 07/17/24, 2 tablets of Lorazepam 0.5mg were dispensed; there was no documentation dated 07/19/24 at 9:00am or 07/20/24 for the prn dose.
-There was no documentation for the PRN dose of Lorazepam 0.5mg administered on 07/20/24.

Observation of Resident #1's medication on hand 08/13/24 at 2:38pm revealed 30 tablets of Lorazepam 0.5mg tablets were dispensed on 05/16/24; 9 tablets were remaining.

Interview with a medication aide (MA) on 08/14/24 at 10:00am revealed:
-When administering a controlled substance, she would reference the eMAR to prepare the medication.
-She would then pull the medication, read the eMAR again, sign the CSCS, administer the medication, and then click off on the eMAR once the medication was administered.
-She was not sure why she documented she administered Resident #1's Lorazepam on 07/16/24 at 8:00am and 9:00am; she would not administer Resident #1's Lorazepam "back-to-back."
-She did not know why she missed documenting Lorazepam 0.5mg on 07/19/24.
-She did not know why she missed documenting the PRN dose of Lorazepam 0.5mg on 07/20/24.

Interview with the Special Care Unit (SCU) Coordinator on 08/14/24 at 11:14am revealed:
-When the MA administered controlled medications, she expected the MA to take the

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| D 392 | Continued From page 31<br>medication out of the drawer, match the medication to the MAR, administer the medication, click off on the eMAR, and document on the CSCS.<br>-She had audited the eMARs last month.<br>-She could not recall if the CSCS had been audited with the eMAR.<br>-She was not aware there were doses of Lorazepam documented as refused on the eMAR and documented as administered on the CSCS.<br>-She was not aware there were doses of Lorazepam documented as administered on the eMAR and not documented on the CSCS.<br><br>Interview with the Business Office Manager (BOM) on 08/14/24 at 3:23pm revealed:<br>-The MAs should document the administration of controlled medication on the eMAR and the CSCS.<br>-If the medication was not documented correctly, it would be hard to track diversion. | D 392 | | |