Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL014014	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROCKFORD INN	56 N HIGHLAND AVENUE GRANITE FALLS, NC 28630

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D 000	Initial Comments The Adult Care Licensure Section and the Caldwell county Department of Social Services conducted an annual survey and complaint investigation on 07/24/24 through 08/01/24.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; 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 ensure the environment was free of hazards related to roaches in Assisted Living (AL) resident rooms. The findings are: Observation in resident room # 212 on 07/29/24 at 9:25am revealed there was a small roach visible on the wall under the window frame adjacent to the end of a residents bed. Interview with a personal care aide (PCA) on 07/26/24 at 3:00pm revealed: -There were roaches in resident room #212 and in other resident rooms on the 200 hall. -She was told the facility had a contracted pest control company. Interview with a housekeeper on 07/29/24 at 9:07am revealed:	D 079	D079 NCAC 13.F .0306 Housekeeping and Furnishings On 7-30-24 rooms 211 and 212 were deep cleaned of clutter. Pest ControlCompany was Contacted for additional Treatment with a focus on rooms 211-212. Pest Control company completed tentment of these rooms 7-30-24. 7/30/24 A housekeeping employee will be designated to mop the resident rooms and halways, beginning 8-22-24 (added position) Housekeeping staff given a declutter room schedule which includes cleaning rooms of clutter ensuring all rooms are deep cleaned on a quarterly basis. Maintenance Director to monitor compliance. 8/22/24	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-4-24

AS Reviewed and Acknowledged 09/10/24

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D 079	Continued From page 1 -She had seen a few roaches on the 200 hall hallway. -She had not seen any roaches in resident rooms. -Anytime she saw a roach, she reported it to the Maintenance Director. -The Maintenance Director would contact the pest control company and the next day the pest control company would come in and spray. Interview with one resident on 07/29/24 at 9:08am revealed: -She saw roaches in her room. -She had been seeing roaches in her room for "quite some time." -"Last week" one of the cleaning ladies had pulled the bedside table out and eight or ten roaches came out. -The cleaning lady stomped and killed the roaches. -Pest control had sprayed not long before the bedside table incident, but it had not killed all the roaches. Interview with a second resident on 07/29/24 at 9:12am revealed: -The pest control company had sprayed her room, but the spray was weak because she did not smell anything afterward. -The roaches hid in the room and came out at night. -At night, she could see the roaches climbing on the walls, and she was scared to get up. -There were roaches in the bathroom at night. -The roaches walked down the wall beside her bed. -The roaches got into her bed. -She kept a book beside her bed to hit the roaches and kill them. -She put facial tissue in her ears at night, so the	D 079	D079 Continued from page 1 On 8/27/24 Resident Council meeting was held to inform Community members how to report insects seen in the building to Administration while encouraging them to keep all food in rooms in sealed containers. 8/27/24 Beginning 8/27/24 the administration team during routine rounds of the facility will check the rooms and interview residents for any insects seen in facility 8/27/24 On 8/29/24 The Pest Control Company treated the entire building including all resident rooms. Pest Control aggreement in place for two treatments monthly and as often as needed until insect issue is resolved. Aggreement will be reviewed Annualy 8/29/24	

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D 079	Continued From page 2 roaches did not get in her ears as she slept. -She told the staff how bad the roaches were, but they "just ignore us." -"We have to live here in this mess..." -The staff would say they would get someone to take care of the roaches, but it did not happen. Interview with another PCA on 07/29/24 at 10:05am revealed: -There were roaches in resident rooms #211 and #212. -"A few" residents had reported seeing roaches to her. -She knew there had been problem with roaches in the building for as long as she had worked there for over a year. -Pest control came in and sprayed the baseboards in the resident rooms. Interview with the Maintenance Director on 07/29/24 at 10:10am revealed: -The facility had a contract with a pest control company. -The pest control company sprayed the facility once a month. -The pest control company was also available to come and spray as needed whenever he called them. -The roaches were a problem in resident rooms, because administration allowed residents to have food in their rooms. -The pest control staff had never said anything to him about there being a large number of roaches in the building. -He had personally seen two roaches come out of a room and into the hallway. Interview with a third resident on 07/29/24 at 10:15am revealed: -She had problems with roaches in her room.	D 079	D079 Continued from page 2 On 8/30/24 inservice conducted for all staff on procedures for reporting insect sightings. New hires will be trained on reporting procedures during orientation. Reporting procedures will be included in all staff inservices every six months. Administrator responsible.	9/30/24

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D 079	Continued From page 3	D 079		

-The roaches were "too fast."
-She had told some of the medication aides about the roaches in her room "about a month ago."
-Somebody had come in and sprayed but it did not help.
-She still saw bugs after her room was sprayed.
-The roaches got in the bed with her sometimes.
-The other morning a roach ran across her bed.
-She had observed "baby roaches" in her room.

Interview with the Business Office Manager (BOM) on 07/29/24 at 10:37am revealed:
-The facility did not have a contract with a pest control company.
-The pest control company would just send someone out wherever they needed them to come out to spray.

Review of pest control service invoices dated 05/06/24-07/11/24 revealed:
-On 05/06/24, the office areas, kitchen areas, storage rooms, and janitors area were treated for general pests and roaches as a main target.
-On 05/23/24, the interior hallways and entryways, kitchen, and other entry points were treated for spiders.
-On 06/13/24, the resident rooms, SCU area restrooms, common areas, entryways, and kitchen area and storage were treated for general pests and roaches.
-On 06/28/24, treated the interior of the building for crawling insects including all laundry areas, kitchen areas, storage areas, and all entry points and exit points.
-On 07/11/24, full interior treatment for roaches, including kitchen, janitor closet, hallways, laundry room, SCU kitchen, also several rooms on different hallways.
-On 07/19/24, interior treatment of all rooms with roach activity on right hall and unit laundry room,

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D 079	Continued From page 4	D 079		

restrooms, office area, kitchen area, storage, janitor's closet, day room, as well as using glue boards and add beyond roach bait.

Interview with the Resident Care Coordinator (RCC) on 07/30/24 at 12:16pm revealed:
-None of the residents had ever said anything to her about roaches being in their rooms.
-They encouraged residents not to bring food into their rooms.

Interview with a representative from the pest control company on 07/30/24 at 4:02pm revealed:
-He was there to place roach baits in two AL resident rooms where roaches had reportedly been seen.
-The facility staff contacted him that morning (07/30/24) to request he come out to treat for roaches in two AL resident rooms.
-The pest control company routinely sent out someone to spray the facility two times a month as a preventative measure.
-Staff had not recently reported seeing any roaches in resident rooms until today (07/30/24).

Interview with the Administrative Assistant on 07/31/24 at 3:41pm revealed none of the residents had ever mentioned having roaches in their rooms to him.

Interview with the Administrator on 08/01/24 at 1:15pm revealed:
-Anytime a problem with roaches was reported to the administrative staff "we take care of it."
-The pest control company they used would generally come out and treat the same day they notified them.

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D 137	Continued From page 5	D 137		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and Staff C) had no substantiated findings on the North Carolina Healthcare Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff B's, personal care aide (PCA), personnel record revealed: -There was a hire date of 07/16/24. -There was no documentation a HCPR check was completed upon hire. -There was documentation that a HCPR check was completed on 07/23/24. Refer to the interview with the Resident Care Coordinator (RCC) on 07/31/24 at 4:32pm. Refer to the interview with the Administrative Assistant (AA) on 08/01/24 at 2:07pm. Refer to the interview with the Administrator on 08/01/24 at 1:13pm. 2. Review of Staff C's, medication aide (MA), personnel record revealed: -There was a hire date of 06/28/24.	D 137	D137 10A NCAC 13F .0407(a)(5) Other staff Qualifications The current employees personnel records were audited to determine they contained North Carolina Health Care Personnel Registry Checks A Health Care Personnel Registry Check will be Completed prior to working of any prospective employee. The Special Care Supervisor will be responsible for completion All New hire documentation will be reviewed during Monday thru Friday Management Meetings to ensure Compliance. Special Care Supervisor will will maintain the Audit log with copy of the Health Care Personnel Registry Check Attached.	8/1/24 8/1/24 8/1/24

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D 137	Continued From page 6 -There was no documentation a HCPR check was completed upon hire. -There was documentation that a HCPR check was completed on 07/12/24. Refer to the interview with the RCC on 07/31/24 at 4:32pm. Refer to the interview with the Administrative Assistant (AA) on 08/01/24 at 2:07pm. Refer to the interview with the Administrator on 08/01/24 at 1:13pm. --- Interview with the Resident Care Coordinator (RCC) on 07/31/24 revealed: -She was responsible for completing the HCPR check on newly hired employees since 07/22/24. -The staffing coordinator would have been responsible to complete HCPR checks prior to 07/19/24. -The staffing coordinator resigned on 07/19/24. Interview with the Administrative Assistant (AA) on 08/01/24 at 2:07pm revealed: -He did not realize HCPR checks did not get completed upon hire for Staff B and Staff C. -The staffing coordinator would have been responsible to complete HCPR checks prior to 07/19/24. Interview with the Administrator on 08/01/24 at 1:13pm revealed: -He expected HCPR checks to be completed upon hire on all employees. -The staffing coordinator would have been responsible to complete HCPR checks prior to 07/19/24. -The staffing coordinator resigned on 07/19/24.	D 137		

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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 was a matching therapeutic diet menu for residents who had physician orders for therapeutic diets. The findings are: Observation of the kitchen on 07/24/24 at 10:30am revealed: -There were no therapeutic diet menus available for staff reference for meal preparation. -A list of resident therapeutic diets was posted for staff reference. -Therapeutic diets on the diet list included chopped meats, puree, and diabetic. Interview with the dietary manager (DM) on 07/24/24 at 3:04pm revealed: -They did not have therapeutic menus available or any instructions on how to make foods such as pureed, chopped meats, etc. -They had cards on each individual tray specifying what diets the individuals were on. -They had no instructions for the cooks on how to	D 296	D296 10A NCAC 13F.0904 (c)(7) Nutrition And Food Service. The daily instructional menu format was revised to include specific instructions and substitutions for therapeutic diets An inservice was conducted by the dietary manager with the Registered dietician approval on detailed instructions for the preparation and techniques to utilize for the therapeutic diets. The inservice training will be repeated every six months. Dietary Manger responsible.	8/9/24 7/29/24

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D 296	Continued From page 8 prepare the foods or what foods to prepare for those who were on therapeutic diets. -The cooks trained the new cooks on how to prepare the foods. -She was not sure how the cooks knew how to prepare the foods other than training from the prior cook. -It was her responsibility to ensure therapeutic diet menus were available for staff to follow. Interview the cook on 07/24/24 at 10:45am and on 07/31/24 at 10:58am revealed: -Each resident had a card on their meal trays that specified what their diet was. -There were no therapeutic diet menus available. -There were no directions available on how to prepare therapeutic foods such as chopped meats and pureed foods or any instructions on what to serve residents who were on a diabetic diet. -He had no training prior to 07/29/24 on how to prepare therapeutic diets. -He asked the DM on how to prepare foods if he ever had questions. -He knew chopped meats needed to be chopped small, but he was not sure how small. Interview with the Administrator on 08/01/24 at 1:13pm revealed: -He was unsure why they did not have a therapeutic menu available. -He did not realize they did not have therapeutic menus for the cooks. -It was the DM's responsibility to ensure therapeutic menus were available to the kitchen staff.	D 296	D296 Continued from page 8 The dietary manual was revised to include the DHHS Food Service Orientation Manual. All dietary employees were given a copy to study and instructed to return a signed completed post test to be filed in the employee record. All new dietary employees will be given a copy to study and post tested during new hire orientation. All dietary personnel were instructed on the location and availability of the dietary manual. Dietary Manager will ensure compliance	8/31/24
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358	D358 10A NCAC 13F .1004(a) Medication Administration	

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D 358	Continued From page 9 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#10 and #11) observed during the medication pass including errors with medications used to treat anxiety (#10), used to treat coronary artery disease (#10 and #11), a medication used to treat high cholesterol (#11) and 2 of 8 sampled residents (#12 and #5) related to a medication used to treat chronic obstructive pulmonary disease (#12) and a medication used to treat dementia (#5). The findings are: 1. Review of Resident #12's current FL2 dated 03/01/24 revealed diagnoses included mild multi-infarct dementia without behavioral disturbance and encephalopathy. Review of Resident #12's physician order dated 06/27/24 revealed Duoneb, three times a day for diagnosis of chronic obstructive pulmonary disease. Review of a subsequent order for Resident #12 dated 07/23/24 revealed an order for Duoneb, four times a day.	D 358	D 358 Continued from page 9 The procedure for administering inhaled nebulizer medications was revised to include shift count sheets for each inhaled nebulized medication. The nebulized medications are to be counted and documented at the end of each shift to ensure the medication administration complies with the physician order. All nebulizer medication records will be audited by the Director of Nursing Services. 2 times weekly times 1 month. Will be monitored ongoing 1 time a month during monthly Audits by the Director of Nursing Services.	9/24/24

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D 358	Continued From page 10 Review of Resident #12's June 2024 medication administration record (MAR) revealed: -There was an entry for Duoneb, inhale one vial via nebulizer, three times a day scheduled at 6:00am, 12:00pm, and 6:00pm. -There was documentation Duoneb was administered three times a day from 06/27/24 through 06/30/24, 6:00am, 12:00pm, and 6:00pm for a total of 10 vials documented used. Review of Resident #12's July 2024 MAR revealed: -There was an entry for Duoneb, inhale one vial via nebulizer, three times a day scheduled at 6:00am, 12:00pm and 6:00pm. -There was documentation Duoneb was administered three times a day from 07/01/24 through 07/23/24, 6:00am, 12:00pm, and 6:00pm with a total of 63 vials documented used. -There was an entry dated 07/23/24 for Duoneb, inhale one vial via nebulizer four times a day, 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation Duoneb was administered at 8pm on 07/23/24. -There was documentation Duoneb was administered four times a day from 07/24/24 through 07/31/24, 8:00am, 12:00, 4:00pm, and 8:00pm with a total of 33 vials documented used. Review of Resident #12's August 2024 MAR revealed: -There was an entry for Duoneb 0.5 mg. 3ml, inhale one vial (3ml) via nebulizer four times a day scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm. -There was documentation Duoneb was administered on 08/01/24 at 8:00am with a total of one vial documented used.	D 358	D358 Continued from page 10 Personal Over the counter medications. and or prescribed bottled Medictions will be clearly labeled on the lid with residents identifying information on a label. Compliance will be monitored monthly during medication Cart audits. Secure Unit Supervisor responsible. 8/30/24 One Medication Technician removed from position and demoted to lesser position not administering Medications 7/26/24 Consultant Pharmacist Conducted education/training on Medication Administration and reordering medications. Evaluated Skills between 7/26/24 and 8/1/24 8/1/24	

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D 358	Continued From page 11 Observation of Resident #12's medications on hand on 08/01/24 at 9:10am revealed: -There were 11 unopened packs (one pack equals 15ml) of Duoneb with a dispense date of 06/27/24. -There was one open pack of Duoneb with 9ml available with a dispense date of 06/27/24. -There was a total of 174ml (58 doses) of Duoneb available. Telephone interview with the facility's contracted pharmacy on 08/01/24 at 9:57am revealed: -On 06/27/24, they received an order for Resident #12 for Duoneb 0.5-3 (2.5mg) one vial three times a day. -The pharmacy dispensed 270ml (90 doses) of Duoneb on 06/27/24 which was a 30-day supply. -On 07/23/24, they received an order for Resident #12 for Duoneb 0.5-3 (2.5mg) one vial four times a day. -The pharmacy did not dispense any Duoneb for the change order received on 07/23/24. -The Duoneb dispensed on 06/27/24 was the last time the pharmacy had dispensed the medication for Resident #12. Interview with a personal care aide (PCA) on 08/01/24 at 8:45am revealed: -She last worked with Resident #12 on 07/05/24. -She observed medication aides (MA's) take Resident #12's Duoneb out of the medication cart, document as given, then put back in medication cart without giving it. -She reported this happened daily. Interview with a medication aide (MA) on 08/01/24 at 10:08am revealed: -He thought Resident #12 was ordered breathing treatments once a day "now." -Last month he thought the Duoneb was given	D 358	D358 Continued from page 11 Pharmacy Consultant Completed Audit of of all Medication Carts and Medication Administration Record.	7/26/24
			Medication Carts and Medication Administration Record beginning 7/26/24 Audited daily times 14 days then weekly times 1 month and monthly thereafter. Director of Nursing Services responsible	9/6/24

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three times a day.
-He did not think Resident #12 always got his breathing treatments, depending on who was working.
-He was not aware Resident #12 was supposed to have the nebulizer treatments four times a day.

Telephone interview with the hospice registered nurse (RN) on 08/01/24 at 11:05am revealed:
-He began seeing Resident #12 on 07/23/24.
-Resident #12 has had a decline in condition since May 2024.
-Resident #12 had a diagnosis of chronic obstructive pulmonary disease (COPD) and chronic bronchitis and received nebulizer breathing treatments four times a day.

Telephone interview with hospice Nurse Practitioner (NP) on 08/01/24 at 12:54pm revealed:
-If Resident #12 did not receive his nebulizer breathing treatments as prescribed, he could have increased exacerbation of COPD and could increase his need for oxygen.
-She would expect Resident #12 to get all medications as prescribed.

Telephone interview with Resident #12's Power of Attorney (POA) on 07/31/24 at 2:11pm revealed:
-A friend who checked on Resident #12 was visiting about a week ago and when she arrived he was having trouble breathing.
-Often when visiting, he appeared to have labored breathing, and the visitors had to ask for his nebulizer treatments.
-She did not feel he was getting his breathing treatments regularly.

Interview with the Resident Care Coordinator (RCC) on 07/31/24 at 4:32pm revealed:

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D 358	Continued From page 13 -Resident #12 had "always" had issues with coughing and breathing. -She felt breathing treatments were given as scheduled. -When she worked, he always received his breathing treatments. -She was not aware he was not receiving breathing treatments as prescribed. -It was her responsibility to ensure medications were given as prescribed. Interview with the Administrator on 08/01/24 at 1:13pm revealed: -He did not know anything about Resident #12's condition. -He did not know why he would not be getting his breathing treatments as prescribed. -The RCC would be responsible for making sure medications were given as prescribed. Based on observations, interviews, and record reviews it was determined Resident #12 was not interviewable. 2. The medication error rate was 13% as evidenced by 4 errors out of 31 opportunities during the 10:00am medication pass on 07/26/24. a. Review of Resident #10's current FL2 dated 03/06/24 revealed: -Diagnoses included dementia and altered mental status. -There was an order for Zyprexa (used to treat anxiety) 2.5mg one tablet twice daily. Review of Resident #10's mental health provider (MHP) order dated 06/20/24 revealed Zyprexa 5mg one tablet twice daily. Review of Resident #10's MHP order dated	D 358		

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D 358	Continued From page 14 06/27/24 revealed Zyprexa 10mg one tablet twice daily. Review of Resident #10's MHP order dated 07/19/24 revealed Zyprexa Zydis (orally disintegrating tablets) 10mg one tablet dissolved in liquid twice daily. Interview with the MA who prepared Resident #10's medications on 07/26/24 at 11:05am revealed he was not able to locate Resident #10's Zyprexa Zydis in the drawer where the resident's medications were stored or in the overstock drawer. Observation of the 10:00am medication pass on 07/26/24 revealed: -The medication aide (MA) prepared eight oral medications for administration to Resident #10. -Zyprexa Zydis was not prepared for Resident #10 or administration observed. -The MA administered the eight oral medications to Resident #10 at 11:06am. Review of Resident #10's July 2024 medication administration record (MAR) revealed: -There was a handwritten entry for Zyprexa Zydis 10mg one tablet twice daily dissolve in liquid scheduled for administration at 10:00am and 6:00pm. -Zyprexa Zydis 10mg one tablet twice daily was documented as administered as ordered starting 07/20/24 at 10:00am to 07/25/24 at 6:00pm. -On 07/26/24 at 10:00am, the Zyprexa Zydis was documented as not administered due to being on order from the pharmacy. Interview with the Resident Care Coordinator (RCC) on 07/26/24 at 2:15pm revealed: -She found Resident #10's Zyprexa Zydis in the	D 358		

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medication cart.
-The MA overlooked the Zyprexa Zydis that morning during the 10:00am medication pass.

Telephone interview with a representative from the facility's contracted pharmacy on 07/30/24 at 11:07am revealed:
-The pharmacy received an order for Resident #10 on 07/19/24 for Zyprexa Zydis 10mg twice daily.
-The pharmacy dispensed Zyprexa Zydis 30 tablets on 07/19/24 which was a 15-day supply.

Telephone interview with Resident #10's primary care provider (PCP) on 08/01/24 at 9:26am revealed:
-Resident #10's Zyprexa was changed to Zyprexa Zydis on 07/19/24 due to Resident #10 refusing his medications.
-The Zyprexa Zydis was easily dissolved in liquid making it easier to administer.
-Resident #10 missing the 10:00am dose of Zyprexa Zydis could have resulted in increased anxiety or have no effect on the resident.

b. Review of Resident #10's current FL2 dated 03/06/24 revealed there was an order for aspirin (used to treat coronary artery disease) 81mg one tablet daily.

Interview with the MA who prepared Resident #10's medications on 07/26/24 at 11:01am revealed he was not able to locate an over-the-counter bottle of aspirin with Resident #10's name on it in the medication cart.

Observation of the 10:00am medication pass on 07/26/24 revealed:
-The medication aide (MA) prepared eight oral medications for administration to Resident #10.

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D 358	Continued From page 16 -Aspirin was not prepared for Resident #10 or administration observed. -The MA administered the eight oral medications to Resident #10 at 11:06am. Review of Resident #10's July 2024 medication administration record (MAR) revealed: -There was an entry for aspirin 81mg one tablet daily scheduled for administration at 10:00am. -The aspirin was documented as administered as ordered from 07/01/24-07/25/24. -On 07/26/24, the aspirin was documented as not administered due to being on order from the pharmacy. Interview with the Resident Care Coordinator (RCC) on 07/26/24 at 2:15pm revealed: -She found Resident #10's aspirin in the medication cart. -The MA had overlooked the aspirin due to poor labeling of the over-the-counter bottle with Resident #10's initials. c. Review of Resident #11's current FL2 dated 05/20/24 revealed: -Diagnoses included unspecified dementia, muscle wasting and atrophy, and anxiety. -There was an order for aspirin 81mg one tablet daily. Observation of the 10:00am medication pass on 07/26/24 revealed: -The medication aide (MA) prepared six oral medications and one inhalation medication for administration to Resident #11. -Aspirin was not prepared for Resident #11 or administration observed. -The MA administered the six oral medications to Resident #11 at 11:12am. -The MA administered one inhalation medication	D 358		

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D 358	Continued From page 17 to Resident #11 at 11:13am. Review of Resident #11's July 2024 medication administration record (MAR) revealed: -There was an entry for aspirin 81mg one tablet daily scheduled at 10:00am. -The aspirin was documented as administered as ordered from 07/01/24-07/26/24. Interview with the Resident Care Coordinator (RCC) on 07/26/24 at 2:15pm revealed she found Resident #11's aspirin in the medication cart. d. Review of Resident #11's current FL2 dated 05/20/24 revealed: -Diagnoses included unspecified dementia, muscle wasting and atrophy, and anxiety. -There was an order for simvastatin (used to treat high cholesterol) 40mg one tablet daily at bedtime. Observation of the 10:00am medication pass on 07/26/24 revealed: -The medication aide (MA) prepared six oral medications and one inhalation medication for administration to Resident #11. -The MA prepared six oral medications including the simvastatin and administered the oral medications to Resident #11 at 11:12am. Review of Resident #11's July 2024 medication administration record (MAR) revealed: -There was an entry for simvastatin 40mg one tablet daily at bedtime scheduled at 10:00am. -There was a hand drawn line through bedtime with daily in the morning handwritten beside the entry. -The simvastatin was documented as administered from 07/01/24-07/26/24.	D 358		

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D 358	Continued From page 18 Interview with the Resident Care Coordinator (RCC) on 07/30/24 at 12:16pm revealed: -Resident #11's simvastatin was ordered to be administered at bedtime. -She called the pharmacy to find out why it was on the MAR scheduled at 10:00am when the order was for bedtime. 3. Review of Resident #5's current FL2 dated 05/29/24 revealed: -Diagnoses included alcoholic induced dementia, diabetes mellitus type 2, and hypertension. -There was an order for Namenda (used to treat moderate to severe dementia) 10mg one tablet twice daily. Review of Resident #5's June 2024 medication administration record (MAR) revealed: -There was an entry for Namenda 10 mg one tablet two times a day scheduled at 8:00am and 8:00pm. -The Namenda was documented as administered as ordered from 06/01/24-06/30/24. Review of Resident #5's July 2024 MAR revealed: -There was an entry for Namenda 10mg one tablet two times a day scheduled at 8:00am and 8:00pm. -The Namenda was documented as administered as ordered from 07/01/24 to 07/26/24. -On 07/27/24 at 8:00am, on 07/29/24 at 8:00am, and on 07/29/24 at 8:30am, the Namenda was documented as not administered due to the medication being on order or unavailable. Observation of Resident #5's medications on hand on 07/29/24 at 11:54am revealed there was no Namenda available. Telephone interview with a representative from	D 358		

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D 358	Continued From page 19 the facility's contracted pharmacy on 07/29/24 at 2:13pm revealed: -Resident #5's current Namenda order was 10mg two times a day. -On 05/20/24 and 06/20/24, they dispensed 60 tablets of Namenda 10mg for Resident #5. -They had received a request for refill of the Namenda on 07/27/24. -Resident #5's Namenda would arrive at the facility on 07/29/24 at 11:30pm. Interview with a medication aide (MA) on 07/29/24 at 2:37pm revealed: -She worked the 7:00am to 3:00pm shift on 07/27/24. -She discovered there was no supply of Namenda on the medication cart for Resident #5. -She checked the overstock supply and there was no Namenda for Resident #5. -The reorder sticker had already been removed from Resident #5's bubble pack of Namenda, so she assumed the refill request had already been sent to the pharmacy. -The MAs were responsible for reordering medications when they were at the top of the blue colored section on the bubble pack. -To reorder a medication, the MAs pulled the reorder sticker from the bubble pack and faxed it to the pharmacy. -Reordering in this way gave the pharmacy time to refill the medication and deliver it to the facility before the resident ran out of the medication. -If the medication did not arrive when expected, she would call the pharmacy to follow up and find out why the medication had not arrived. -She did not call the pharmacy on 07/27/24 to check on the Namenda as it had been reordered and her dose as far as she knew was the first dose missed. -The MAs on the next shift should also call the	D 358		

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pharmacy to check on the status of missing medications and their reorder status and expected delivery.

Interview with Resident #5 on 07/29/24 at 3:08pm revealed:
-She did not know what medications she was ordered and received from the MAs on a daily basis.
-She could not identify her medications.

Interview with the Resident Care Coordinator (RCC) on 07/30/24 at 12:16pm revealed:
-There was no way to tell how long Resident #5 had been without the Namenda.
-The MAs documented the Namenda on the MAR as if they administered it until the 07/27/24 8:00am dose.
-The MA who needed to request medication refills was supposed to pull the reorder bubble pack sticker off three to four days prior to the medication supply running out.
-The reorder sticker was then faxed to the pharmacy and typically if faxed before 6:00pm or 7:00pm the medication would be delivered to the facility that night at 10:30pm-11:30pm delivery.
-If an order was needed to refill a medication, the pharmacy faxed over and requested a new order, and she contacted the primary care provider (PCP) to get an order.
-The pharmacy was responsible for monthly medication cart audits.

Interview with the Administrator on 08/01/24 at 1:15pm revealed the RCC was responsible to ensure medications were in the building and available for administration.

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D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR) related to an allegation of Staff B, Personal Care Aide (PCA), twisting Resident #2's finger while providing incontinence care. The findings are: Review of Resident #2's current FL2 dated 7/12/24 revealed diagnoses included benign essential hypertension, unspecified schizophrenia, senile dementia uncomplicated and chronic airway obstruction. Review of Resident #2's Care Plan dated 10/22/23 revealed Resident #2 required assistance with incontinence care. Interview with Resident #2 on 07/26/24 at 11:22am revealed: -She required assistance with incontinent care. -She reported Staff B assisted her with incontinence care while she was still in bed. -She felt like she was going to fall off the bed. -Staff B grabbed her hand too hard. -She reported to staff but could not remember who she reported it to.	D 438	D438 10A NCAC 13F .1205 Health Care Personnel Registry An inservice for all staff was held on Resident Rights Administrative Team was inserviced on the procedure to submit the required 24hr and 5 day reports to the Health Care Personnel Registry. All staff inserviced on the necessity of reporting allegations of abuse to administration	8/2/24 7/29/24 7/26/24

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D 438	Continued From page 22 Interview with a medication aide (MA) on 07/30/24 at 3:30pm revealed: - She worked night shift on 07/22/24. -She saw Resident #2 had a red finger. -Around 6:00am, she observed Resident #2's finger was bruised. -Resident #2 told her Staff B pulled on it. -She notified the resident care coordinator (RCC). Interview with the Resident Care Coordinator (RCC) on 7/26/24 at 3:26pm and on 7/31/24 at 4:27pm revealed: -She administered evening medications on 07/22/24. -Between 7:00pm and 8:00pm, she heard Resident #2 upset and crying in her room. -Resident #2 was upset about snacks. -About one hour later, she went back to her room and observed Resident #2 had a red finger. -She went in to look at the finger on 07/23/24 and was told by Resident #2 that Staff B smashed her finger. -She informed the Administrative Assistant (AA) and the Administrator. -Before this incident occurred, she did not know what a 24-hour report was. -She assumed the Administrator or AA would be responsible for submitting them at the time the incident occurred. Interview with Administrative Assistant (AA) on 7/26/24 at 11:40am and 7/31/24 at 4:45pm am revealed: -He became aware on 7/23/24 that there was an allegation of physical abuse by Staff B. -He printed the 24 Hour HCPR but did not complete it. -He did not report Staff B to HCPR. -He and the Administrator were responsible to report to the HCPR when incidents occurred.	D 438	D438 continued from page 22 An investigation of any alleged abuse will be initiated immediately. A 24 hour report will be completed and faxed to the health care registry within the required 24 hour time period. Any employee Alleged or suspected of abuse will be suspended from duty during the investigation process. The five day report with documentation of the investigation will be faxed to the Healthcare Personnel Registry within the 5 day time period. Administrar to ensure compliance. Inservice held for all Staff on types of elder abuse. Reporting of elder Abuse. How to prevent elder abuse	7/26/24 8/30/24

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D 438	Continued From page 23 Interview with the Administrator on 7/26/24 at 12:00pm and 7/31/24 at 4:47pm revealed: -He became aware on 7/23/24 that there was an allegation of physical abuse by Staff B. -He did not complete the HCPR. -He was not sure he should complete the HCPR because Resident #2 had cognitive issues and often was an unreliable historian. -He thought the AA would complete the HCPR. -The Administrator was responsible to make sure reports to the HCPR were completed on time.	D 438		