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D 000	Initial Comments The Adult Care Licensure Section and the Stokes County Department of Social Services conducted an annual survey on 08/20/24.	D 000		
D 034	10A NCAC 13F .0302 (f) Design And Construction 10A NCAC 13F .0302 Design And Construction (f) The facility shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a current building sanitation report. The findings are: Review of the facility's current building sanitation report revealed: -The most recent report was dated 06/14/23. -There was a demerit score of 3. -Demerits received were in the following areas: walls and ceilings and soiled wastes. Telephone interview with the local county environmental health representative on 08/20/24 at 3:40pm revealed: -The building sanitation inspection was past due for the facility. -The last inspection was on 06/14/23. -There had not been any calls received from facility staff to come out to complete a sanitation inspection.	D 034		

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D 034	Continued From page 1 -If the facility had called for a sanitation inspection, he would have tried to make the inspection a priority on his list. Interview with the Manager on 08/20/24 at 4:58pm revealed: -She was responsible for ensuring the facility had a current sanitation inspection. -She had not reached out to the health department to have a sanitation inspection completed because the last time she called (She did not remember when.) she was told that the inspectors were backed up. -She thought the sanitation inspectors would just come out to conduct the sanitation inspections when they were able to. Attempted telephone interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful.	D 034		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health	D 161		

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D 161	Continued From page 2 professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensue a licensed health professional support (LHPS) competency validation had been completed for tasks including clean dressing changes. The findings are: 1. Review of Staff A's, Manager/medication aide (MA), personnel record revealed: -She was hired on 02/10/14. -There was no documentation that an LHPS competency validation had been completed. Interview with Staff A on 08/20/24 at 4:58pm revealed: -She worked as the facility Manager and as a MA. -She had been employed at the facility since 2014. -She had never been LHPS validated that she could recall and no one every told her she needed to be competency validated for LHPS tasks. -She was responsible for ensuring LHPS validations were completed for staff and covered all tasks completed for residents. -She assisted with dressing changes when she worked as a MA.	D 161		

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D 161	Continued From page 3 Attempted interview with the facility's LHPS nurse on 08/20/24 at 1:22pm was unsuccessful. Attempted interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful. 2. Review of Staff B's, personal care aide (PCA)/medication aide (MA), record revealed: -She was hired on 10/12/23. -There was an LHPS competency validation completed on 11/07/23, but there was no documentation Staff B had been competency validated to perform clean dressing changes. Attempted interview with the facility's LHPS nurse on 08/20/24 at 1:22pm was unsuccessful. Attempted interview with Staff B on 08/20/24 at 6:13pm was unsuccessful. Attempted interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful.	D 161		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the	D 280		

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resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 1 of 3 sampled residents (#1) to include the identified task of clean dressing changes.

The findings are:

Review of Resident #1's current FL2 dated 08/09/24 revealed:
-Diagnoses included cellulitis, impaired functional mobility, balance, gate, and endurance, and acute kidney injury.
-Resident #1 was ambulatory and constantly disoriented.

Review of Resident #1's FL2 dated 12/20/23 revealed:
-Diagnoses included mental retardation, history of seizures, and dyslipidemia.
-Resident #1 was ambulatory and there was no information on his orientation.

Review of Resident #1's physician's orders dated 06/27/24 revealed an order for dressing changes once daily; use betadine to area then place gauze

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and wrap in kerlin.

Review of Resident #1's physician's orders dated 07/23/24 revealed an order for dressing changes 5-7 days per week; dress with betadine to wound and apply gauze.

Review of Resident #1's physician's orders dated 08/19/24 revealed an order to continue betadine and dry dressing.

Review of Resident #1's care plan dated 12/20/23 revealed:
-Resident #1 was independent with ambulation and transferring.
-He needed limited assistance with bathing, dressing, grooming, and supervision with eating.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 09/12/23 revealed Resident #1 did not have any LHPS tasks.

Observation of Resident #1 on 08/20/24 at 9:05am revealed:
-Resident #1 was seated in a chair in his room.
-Resident #1 had on socks and shoes, and a dressing was observed extending above the top of the sock on his right leg.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

Interview with the LHPS Nurse on 08/20/24 at 12:54pm revealed:
-Resident #1 last had an LHPS review completed on 09/12/23 and he did not have any LHPS tasks.
-She completed yearly evaluations for residents who did not have any LHPS tasks.
-Staff had not made her aware Resident #1 had

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D 280	Continued From page 6 an LHPS task of dressing changes. -She was scheduled to see Resident #1 in September 2024 for his yearly evaluations. Interview with the Resident Care Coordinator (RCC) on 08/20/24 at 4:09pm revealed: -The Manager was responsible for ensuring follow up with the LHPS nurse when residents acquired new tasks that had not been assessed and documented in the resident's most recent LHPS review. -She did not know Resident #1's LHPS review did not include clean dressing changes as a marked task. Interview with the Manager/MA on 08/20/24 at 4:58pm revealed: -She completed dressing changes for Resident #1 when she worked as a MA. -She was responsible for ensuring LHPS reviews were completed for residents and for following up with the LHPS nurse for residents with any new tasks. -She did not contact the LHPS nurse to let her know that staff were doing dressing changes for Resident #1. -She did not know she needed to contact the LHPS nurse to notify her of the new task since his last review. Attempted interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful.	D 280		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	D 344		

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medications and treatments:
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure contact with the resident's primary care provider (PCP) for verification or clarification of orders for medications for 1 of 3 sampled residents (#1) who had a pharmacy request for clarification of two medications for acid reflux.

The findings are:

Review of Resident #1's current FL2 dated 08/09/24 revealed:
-Diagnoses included cellulitis, impaired functional mobility, balance, gate, and endurance, and acute kidney injury.
-There was an order for omeprazole 20mg (used to treat acid reflux) 1 capsule daily.

Review of Resident #1's FL2 dated 12/20/23 revealed:
-Diagnoses included gastroesophageal reflux disease (GERD).
-There was an order for rabeprazole 20mg 1 tablet daily at bedtime.

Review of a pharmacy medication change request dated 03/04/24 revealed:

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-Resident #1 had an order for rabeprazole sodium (used to treat GERD) 20mg tablets.
-Rabeprazole sodium was not covered by insurance and Resident #1 would be responsible for $14.21 in out of pocket expenses.
-The pharmacy would not be able to dispense rabeprazole sodium 20mg to the facility due to high cost of the medication and the inability to send a partial amount.
-Resident #1's insurance would cover omeprazole and esomeprazole magnesium (used to treat acid reflux) and a physician would need to determine if the medications were appropriate.
-There was a physician's order for omeprazole 20 mg 1 tablet daily in the physician's response section of the form.

Review of a new prescription summary from the pharmacy dated 04/03/24 revealed:
-There was a prescription for esomeprazole magnesium 40mg delayed release (DR) 1 capsule every morning before breakfast.
-There was a note from the pharmacy: Patient has order on file for omeprazole. Which order is to continue? Should not be on both.

Review of Resident #1's medication administration records (MARs) for June 2024 revealed:
-There was an entry for esomeprazole 40mg 1 capsule before breakfast scheduled for administration at 8:00am.
-There was documentation esomeprazole was administered for 30 of 30 opportunities.
-There was an entry for omeprazole 20mg 1 capsule daily scheduled for administration at 8:00am.
-There was documentation omeprazole had been discontinued, but there was no documentation of the date when it was discontinued.

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-There was no documentation omeprazole was administered in June 2024.

Review of Resident #1's MAR for July 2024 revealed:
-There was an entry for esomeprazole 40mg 1 capsule before breakfast scheduled for administration at 8:00am.
-There was documentation esomeprazole was administered for 31 of 31 opportunities.
-There was an entry for omeprazole 20mg 1 capsule daily scheduled for administration at 8:00am.
-There was documentation omeprazole was administered for 30 of 31 opportunities.

Review of Resident #1's August 2024 MAR from 08/01/24 through 08/20/24 revealed:
-There was an entry for esomeprazole 40mg 1 capsule before breakfast scheduled for administration at 8:00am.
-There was documentation esomeprazole was administered for 16 of 20 opportunities between 08/01/24 and 08/20/24.
-There was an entry for omeprazole 20mg 1 capsule daily scheduled for administration at 8:00am.
-There was documentation omeprazole was administered for 16 of 20 opportunities.

Observation of medications available for Resident #1 on 08/20/24 revealed:
-Esomeprazole 40mg 1 capsule before breakfast was available on the medication cart.
-Esomeprazole was dispensed to the facility on 07/24/24 with a quantity of 28 capsules and 4 capsules were remaining.
-Omeprazole 20mg 1 capsule daily was available on the medication cart.
-Omeprazole was dispensed on 07/24/24 with a

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quantity of 28 capsules and 4 capsules were remaining.

Based on record reviews and interviews, it was determined Resident #1 was not interviewable.

Interview with a pharmacist from the facility's contracted pharmacy on 08/20/24 at 2:55pm revealed:
-There was documentation of a note from the pharmacy regarding whether Resident #1 should be administered omeprazole or esomeprazole, but she did not see the provider' response.
-There was documentation omeprazole was stopped on 06/14/24, but it became active again on 06/14/24.
-Both the omeprazole and esomeprazole were showing as active.
-Omeprazole and Esomeprazole were dispensed to the facility on 06/19/24, 07/17/24, and on 08/14/24 with a quantity of 28 tablets each time.

Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 08/20/24 at 4:09pm revealed:
-She or the Manager/MA were responsible for following up with Resident #1's primary care provider (PCP) regarding the omeprazole and esomeprazole.
-She spoke with Resident #1's PCP about administration of his omeprazole and esomeprazole, but she did not remember when.
-There had not been any orders received to clarify if Resident #1 was to be administered omeprazole or esomeprazole.
-She did not know why omeprazole stopped in June 2024 and then restarted.

Interview with the Manager/MA on 08/20/24 at 4:58pm revealed:

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D 344	Continued From page 11 -When the pharmacy sent over a request to clarify medications, she or the RCC/MA were responsible for reaching out to the PCP for clarification. -Once the medications were clarified the RCC/MA or the Manager/MA sent the clarification order back to the pharmacy. -She questioned a nurse at Resident #1's PCP's office during one of his visits (She did not remember when.) and was told Resident #1 may have been provided both omeprazole and esomeprazole because he had bad acid reflux. -The nurse was supposed to call back to the facility to clarify, but she did not. -She did not follow up with the PCP to clarify which medication Resident #1 should have been administered as the pharmacy documented he should not have been on both omeprazole and esomeprazole. Attempted telephone interview with Resident #1's PCP on 08/20/24 at 2:39pm was unsuccessful. Attempted telephone interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) related to an anti-epileptic medication and a supplement.

The findings are:

Review of Resident #2's current FL2 dated 03/08/24 revealed diagnoses included depression, hypothyroidism, hiatal hernia, borderline mental retardation, sleep apnea, tracheostomy in place 2002, hypertension and chronic venous insufficiency.

a. Review of Resident #2's current FL2 dated 03/08/24 revealed an order for topiramate 100mg (used to treat seizures) 1 tablet at bedtime.

Review of Resident #2's hospital discharge summary dated 07/26/24 revealed an order to discontinue topiramate 100mg.

Review of Resident #2's medication administration record (MAR) for 08/01/24 through 08/19/24 revealed:
-There was an entry for topiramate 100mg 1 tablet at bedtime scheduled for 8:00pm.
-There was documentation topiramate was administered for 19 of 19 opportunities.

Observation of medications available for Resident #2 on 08/20/24 at 2:05pm revealed:
-There was a bubble pack of topiramate 100mg 1 tablet at bedtime.
-Fifteen tablets were dispensed from the pharmacy on 08/16/24 and there were 14 tablets remaining.

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Interview with a representative from the facility's contracted pharmacy on 08/20/24 at 2:55pm revealed:
-Resident #2 had an order for topiramate 100mg 1 tablet at bedtime.
-Topiramate was dispensed to the facility on 06/19/24 with a quantity of 28 tablets and on 07/31/24, and 08/16/24 with a quantity of 15 tablets each time.

Interview with the Resident Care Coordinator (RCC)/medication aide (MA) on 08/20/24 at 4:09pm revealed:
-She and the Manager/MA were responsible for reviewing hospital discharge summaries.
-She did not remember seeing the Resident #2's hospital discharge summary dated 07/26/24 where there was an order to discontinue his topiramate.
-She did not know Resident #2's topiramate should have been stopped and had not reach out to his primary care provider (PCP).

Interview with the Manager/MA on 08/20/24 at 4:58pm revealed:
-She and the RCC/MA were responsible for reviewing hospital discharge reports.
-Once the hospital reports were received at the facility, they should have been sent to the pharmacy so that orders could be added or discontinued.
-She did not know there was an order to discontinue Resident #2's topiramate.

Attempted telephone interview with Resident #1's PCP on 08/20/24 at 2:39pm was unsuccessful.

Attempted telephone interview with the Administrator on 08/20/24 at 5:56pm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 358	Continued From page 14 unsuccessful. b. Review of Resident #2's physician's orders dated 06/23/24 revealed an order for Vitamin D3 2000 (used to treat Vitamin D defiencies) units 1 capsule daily. Review of Resident #2's discharge summary dated 07/26/24 revealed an order to discontinue Vitamin D3 2,000 units. Review of Resident #2's medication administration record (MAR) for 08/01/24 through 08/20/24 revealed: -There was an entry for Vitamin D3 2000 units 1 capsule daily scheduled for 8:00am. -There was documentation topiramate was administered for 19 of 19 opportunities. Observation of medications available for Resident #2 on 08/20/24 at 2:05pm revealed there was an over the counter bottle of vitamin D3 available and it could not be determined how many tablets were remaining. Interview with a representative from the facility's contracted pharmacy on 08/20/24 at 2:55pm revealed: -Resident #2 had an order for Vitamin D3 2,000 units 1 capsule daily. -There was a note in the pharmacy's system that Resident #2's family provided the Vitamin D3. Interview with the RCC/MA on 08/20/24 at 4:09pm revealed: -She and the Manager/MA were responsible for reviewing hospital discharge summaries. -She did not remember seeing the Resident #2's hospital discharge summary dated 07/26 where there was an order to discontinue his Vitamin D3.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL085013	A. BUILDING: _____ B. WING _____	08/20/2024

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GRACELAND LIVING CENTER II	1290 DENNY ROAD KING, NC 27021

(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 358	Continued From page 15 -She did not know Resident #2's Vitamin D3 should have been stopped and had not reach out to his PCP. Interview with the Manager/MA on 08/20/24 at 4:58pm revealed: -She and the RCC/MA were responsible for reviewing hospital discharge reports. -Once the hospital reports were received at the facility, they should have been sent to the pharmacy so that orders could be added or discontinued. -She did not know there was an order to discontinue Resident #2's Vitamin D3. Attempted telephone interview with Resident #1's PCP on 08/20/24 at 2:39pm was unsuccessful. Attempted telephone interview with the Administrator on 08/20/24 at 5:56pm was unsuccessful.	D 358		