Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Wilson House Assisted Living — County: Wilson
Address: 1800 Martin Luther King, Jr. Pkwy, Wilson, NC — License Number: HAL 098-023
II. Date(s) of Visit(s): 11/29/22, 12/09/22, 12/15/22, 01/27/23 — Purpose of Visit(s): CI
Instructions to the Provider ***(please read carefully)*****:** — Exit/Report Date: 01/27/23

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation,** this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation,** this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004(a)/Medication Administration The facility shall assure the administration of medications by staff in accordance with orders by a licensed prescribing practitioner.	☑ POC Accepted BG *DSS Initials*	—
Level of Non-Compliance: TYPE A2 VIOLATION	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth. In the statement of deficiencies; the plan of correction is prepared solely as a matter of compliance with State Law.	
Findings: Based on observations, interviews and record reviews, the facility failed to administer medication as ordered for 4 of 5 (#1, #2, #4, #5) residents sampled in the Assisted Living Unit on 11/07/22 and failed to ensure medications were available for administration to 3 of 5 (#1, #2, #5) residents sampled including medications used to treat diabetes (#1), high cholesterol (#1), eye surgery/pain or pressure (#1) and mood stabilization (#2, #5). The findings are: Review of the facility's policy for Preparation and General Guidelines dated November 2018 revealed medications are to be administered without unnecessary interruptions. 1. Telephone interview with the Executive Director (ED) on 12/13/22 at 1:50 pm revealed:	10A NCAC 13F .1004 (a) The Care Managers will conduct weekly cart audits against the EMAR to the medication cart to ensure accuracy. Ongoing. The Area Clinical Director, RN will conduct random Med Tech Observation med passes during on site visits. Community ED and Care Managers will review Matrix Care Medication Reporting daily in aland up to ensure that all medications and treatments are being administered per physician orders. Ongoing. Community Area Clinical Director and Regional Director of Operations will review medication cart audits and pull Medication Administration Report from Matrix Reporting during on site visits. All Med Tech's were in serviced on Medication Errors and High Alert Medications by ED and Care Managers.	2/26/2023 2/26/2023 2/26/2023 2/26/2023 1/05/2023 Completed

-The morning of 11/08/22, the lead MA-Supervisor informed her a medication aide (MA) refused to administer night time medications to any of the residents in the Assisted Living Unit (AL).
-On 11/08/22, two residents also informed her they had not received their night time medication on 11/07/22.
-The primary care provider was informed the residents in the AL unit had not received their night time medication.

Telephone interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:25 pm revealed:
-On 11/07/22, there was one medication aide (MA) on duty for the entire facility.
-The MA on duty on 11/07/22 was assigned to the special care unit and did not administer the assisted living (AL) unit resident's night time or bedtime medication.
-She assumed or was under the impression the MA was going to work both medication carts on 11/07/22.
-The MA said she "just refused to do it" when asked why she did not administer the nighttime or bed time medications to any of the 25 residents in the AL unit on 11/07/22.

Interview with Resident #4 on 11/29/22 at 1:00 pm revealed:
-No medication aide (MA) worked the night (11/07/22) and no residents in the assisted living unit received their medication for that night.
-The morning of 11/08/22, she told the MA who normally worked in the special care unit (SCU) what to do because she didn't know what she was supposed to do for the residents up front in the assisted living unit.
-Resident #4 was administered her medication the morning of 11/08/22 by a MA who normally worked in the SCU.
-The last time she received her medication on 11/07/22 was at 2:00 pm.
-A lot of times the facility only had one aide working both halls in the front and that was too much for one person to handle.
-On 11/08/22, she spoke with the Administrator about not receiving her nighttime medication on 11/07/22.
-Resident #4 stated that was the first time that had ever happened, and it needed to be the last time because she was taking medication for a reason.

a. Review of Resident #1's current FL-2 dated 11/21/22 revealed diagnoses included moderate recurrent major depression, type 2 diabetes mellitus (DM II), chronic obstructive pulmonary disease (COPD), lymphoma, hyperlipidemia, bipolar disorder, schizoaffective disorder,

anxiety disorder, vitamin B-12 deficiency, partial intestinal obstruction. Review of Resident #1's Physician Order Report for November 2022 signed on 11/21/22 revealed: -An order for Jardiance 10 mg tablet, take 1 tablet by mouth once a day, every day; 9:00 am. (Jardiance is a medication used to treat diabetes.) -An order for Levemir FlexTouch U-100 Insulin pen, 100 unit/mL (3 mL), inject 19 units subcutaneous at bedtime; 9:00 pm. (Levemir is a medication used to treat diabetes.) -An order for divalproex tablet (Depakote), 500 mg tablet, 1 tablet by mouth twice a day, 9:00 am and 9:00 pm. (Depakote is a medication used to treat bipolar disorder.) -An order for gabapentin (Neurontin) 100 mg capsule, take 1 capsule by mouth at bedtime, 9:00 pm. (Neurontin is a medication used to treat nerve pain.) -An order for Lorazepam Schedule IV 0.5 mg tablet, take 1 tablet by mouth at bedtime, 9:00 pm. (Lorazepam is a medication used to treat anxiety.) -An order for olanzapine 7.5 mg tablet (Zyprexa), take 1 tablet by mouth at bedtime, 9:00 pm. (Zyprexa is a medication used to treat schizophrenia.) Review of Resident #1's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Jardiance 10 mg tablet with instructions to take 1 tablet by mouth once a day scheduled for administration at 9:00 pm. -Jardiance was documented as not administered: missed administration on 11/07/22 at 9:00 pm -There was an entry for Levemir FlexTouch U-100 Insulin pen with instructions to inject 19 units subcutaneously at bedtime at 9:00 pm. -Levemir U-100 was documented as not administered: missed administration on 11/07/22, at 9:00 pm. -There was an entry for divalproex tablet (Depakote), 500 mg tablet with instructions to take 1 tablet by mouth twice a day, 9:00 am and 9:00 pm. -Depakote 500 mg tablet was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for gabapentin (Neurontin) 100 mg capsule with instructions to take 1 capsule by mouth at bedtime, 9:00 pm. -Neurontin 100 mg capsule was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for Lorazepam Schedule IV 0.5 mg tablet with instructions to take 1 tablet by mouth at bedtime, 9:00 pm.		

-Lorazepam 0.5 mg tablet was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for olanzapine 7.5 mg tablet (Zyprexa) with instructions to take 1 tablet by mouth at bedtime, 9:00 pm. -Zyprexa 7.5 mg tablet was documented as not administered: missed administration on 11/07/22 at 9:00 pm.		
Interview with Resident #1 on 11/29/22 at 11:15 am revealed: -"One night nobody received their bedtime meds." -"We all had to wait until the next day to get our meds." -She did not receive her medication to help her sleep at night and had trouble sleeping. -She did not receive her anti-depressant and she had not received her insulin. -"My sugar was out the roof the next day." Telephone interview with the facility's Primary Care Provider (PCP) on 12/21/22 at 3:40 pm revealed: -She was aware of residents not receiving their medication on 11/07/22 because the medication aide did not administer medication to residents in the assisted living unit. -Missing one or two doses of some medications would not be detrimental, but she did expect resident medications to be administered as ordered. -Insulin should be administered as ordered because the blood sugar could be elevated the next day. b. Review of Resident #2's current FL-2 dated 06/20/22 revealed diagnoses of seizure disorder, blind, hypertension, irritable bowel syndrome, schizophrenia, anxiety, glaucoma and elevated prostate specific antigen. Review of Resident #2's Physician Order Report for November 2022 revealed: -An order for artificial tears drops 1-0.2 – 0.2%, instill 1 drop in each eye twice a day, 8:00 am and 8:00 pm. (Artificial tears are drops used to relieve dryness and irritation of the eye._ -An order for brimonidine-timolol (Combigan) 0.2-0.5% drops, instill 1 drop in right eye twice a day, 8:00 am and 8:00 pm. (Combigan is a medication used to treat high pressure inside the eye due to glaucoma or other eye diseases.) -An order for divalproex (Depakote) tablet, 500 mgs, take 1 tablet by mouth twice a day, 8:00 am and 8:00 pm. (Depakote is a medication used to treat bipolar disorder.) -An order for olanzapine (Zyprexa) tablet, 20 mgs, take 1 tablet by mouth at bedtime, 8:00 pm. (Zyprexa is a medication used to treat schizophrenia.)		

-An order for Trazodone tablet, 50 mgs, take ½ tablet (25 mg) by mouth at bed time, 8:00 pm. (Trazodone is an anti-depressant medication used to treat to treat anxiety disorders.) Review of Resident #2's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for artificial tear drops 1-0.2 – 0.2%, with instructions to instill 1 drop in each eye twice a day, 8:00 am, 8:00 pm. -Artificial tear drops was documented as not administered: missed administration on 11/07/22 at 8:00 pm. -There was an entry for brimonidine-timolol (Combigan) 0.2-0.5% drops, with instructions to instill 1 drop in right eye twice a day, 8:00 am, 8:00 pm. -Brimonidine-timolol (Combigan) 0.2-0.5% drops was documented as not administered: missed administration on 11/07/22 at 8:00 pm. -There was an entry for divalproex (Depakote) tablet, 500 mgs, with instructions to take 1 tablet by mouth twice a day, 8:00 am, 8:00 pm. -Divalproex (Depakote) 500 mgs was documented as not administered: missed administration on 11/07/22 at 8:00 pm. -There was an entry for olanzapine (Zyprexa) tablet, 20 mgs, with instructions to take 1 tablet by mouth at bedtime, 8:00 pm. -Olanzapine (Zyprexa) 20 mgs was documented as not administered: missed administration on 11/07/22 at 8:00 pm. -There was an entry for Trazodone tablet, 50 mgs, with instructions to take ½ tablet (25 mg) by mouth at bed time, 8:00 pm. -Trazodone 50 mg was documented as not administered: missed administration on 11/07/22 at 8:00 pm. Refer to telephone interview with the facility's Primary Care Provider on 12/21/22 at 3:40 pm. c. Review of Resident #4's FL-2 dated 10/24/22 revealed diagnoses of hemiplegia following cerebral infarction left side, hypertension heart disease without heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, hyperlipidemia, irritability and anger, nocturia, history of right breast cancer and history of COVID-19. Review of Resident #4's Physician Order Report for November 2022 revealed: -An order for atorvastatin (Lipitor) 40 mg tablet, take 1 tablet by mouth at bedtime, 9:00 pm. (Atorvastatin/Lipitor is a medication used to improve cholesterol levels and decrease the risk for heart attack and stroke.)		

-An order for baclofen 10 mg tablet, take 1 tablet by mouth three times a day, 9:00 am, 2:00 pm and 9:00 pm. (Baclofen is a medication used to treat muscle pain, spasms and stiffness.) -An order for desmopressin 0.2 mg tablet, take 1 tablet by mouth at bedtime, 9:00 pm. (Desmopressin is a medication used to control bed-wetting.) -An order for nortriptyline 25 mg capsule, take 1 capsule by mouth at bedtime, 9:00 pm. (Nortriptyline is a medication used to treat mental/mood problems.) Review of Resident #4's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for atorvastatin 40 mg tablet, with instructions to take 1 tablet by mouth at bedtime, 9:00 pm. -Atorvastatin 40 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for baclofen 10 mg tablet, with instructions to take 1 tablet by mouth three times a day, 9:00 am, 2:00 pm, 9:00 pm. -Baclofen 10 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for desmopressin 0.2 mg tablet, with instructions to take 1 tablet by mouth at bedtime, 9:00 pm. -Desmopressin 0.2 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for nortriptyline 25 mg capsule, with instructions to take 1 capsule by mouth at bedtime, 9:00 pm. -Nortriptyline 25 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. Refer to telephone interview with the facility's Primary Care Provider on 12/21/22 at 3:40 pm. d. Review of Resident #5's FL-2 dated 09/12/22 revealed diagnoses of mild cognitive impairment, vitamin-D deficiency, chronic obstructive pulmonary disease (COPD) with acute exacerbation, hyperlipidemia, essential hypertension, anxiety disorder, primary insomnia, osteoarthritis, gastroesophageal reflux disease (GERD) and mild depression. Review of Resident #5's Physician Order Report for November 2022 revealed: -An order for carbamazepine 100 mg tablet, take 1 tablet by mouth twice a day, 9:00 am and 9:00 pm. (Carbamazepine is a medication used to bipolar mania and depression.) -An order for diclofenac sodium gel 1%, apply 2 grams topically to right shoulder and bilateral knees twice a day for		

arthritis, 9:00 am and 9:00 pm. (Diclofenac sodium gel is a medication used to relieve joint pain from arthritis.) -An order for donepezil 5 mg tablet, take 1 tablet by mouth at bedtime for cognitive impairment, 9:00 pm. (Donepezil is a medication used to treat dementia associated with Alzheimer's disease.) -An order doxepin 6 mg tablet, take 1 tablet by mouth at bedtime, 9:00 pm. (Doxepin is a medication used to treat insomnia.) -An order for gabapentin 300 mg tablet, take 1 capsule by mouth twice a day, 9:00 am and 9:00 pm. (Gabapentin is a medication used to treat nerve pain.) -An order for lactulose solution 10 mg/15 mL, take 30 ML (20 gms) by mouth twice a day for constipation, 9:00 am, 9:00 pm. (Lactulose is a medication used to treat constipation.) -An order for stimulant laxative 8.6-50 mg tablet, take 2 tablets by mouth at bedtime, 9:00 pm. (A stimulant laxative is a medication used to treat constipation.) -An order for ipratropium-albuterol 0.5 mg – 3 mg (2.5 mg base)/3 ml, inhale 1 vial (3 ml) per nebulizer at bedtime *may self-administer*, 9:00 pm. (Ipratropium-albuterol is a medication used to relieve runny nose.) Review of Resident #5's November 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry for carbamazepine 100 mg tablet, with instructions to take 1 tablet by mouth twice a day, 9:00 am, 9:00 pm. -Carbamazepine 100 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for diclofenac sodium gel 1%, with instructions to apply 2 grams topically to right shoulder and bilateral knees twice a day for arthritis, 9:00 am and 9:00 pm. -Diclofenac sodium gel 1 % was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for donepezil 5 mg tablet, with instructions to take 1 tablet by mouth at bedtime for cognitive impairment, 9:00 pm. -Donepezil 5 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for doxepin 6 mg tablet, with instructions to take 1 tablet by mouth at bedtime, 9:00 pm. -Doxepin 6 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for gabapentin 300 mg tablet, with instructions to take 1 capsule by mouth twice a day, 9:00 am, 9:00 pm.		

-Gabapentin 300 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for lactulose solution 10 mg/15 mL, with instructions to take 30 ML (20 gms) by mouth twice a day for constipation, 9:00 am, 9:00 pm. -Lactulose 10 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for stimulant laxative 8.6-50 mg tablet, with instructions to take 2 tablets by mouth at bedtime, 9:00 pm. -Stimulant laxative 8.6-50 mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. -There was an entry for ipratropium-albuterol 0.5 mg – 3 mg (2.5 mg base)/3 ml, with instructions to inhale 1 vial (3 ml) per nebulizer at bedtime *may self-administer*, 9:00 pm. -Ipratropium-albuterol 0.5 mg – 3mg was documented as not administered: missed administration on 11/07/22 at 9:00 pm. Telephone interview with the facility's Primary Care Provider (PCP) at 3:40 pm on 12/21/22 revealed: -She was aware of residents not receiving their medication on 11/07/22 because the medication aide did not administer medication to residents in the assisted living unit. -Continually missing albuterol doses could lead to breathing issues for Resident #5. 2. Review of Resident #1's current FL-2 dated 11/21/22 revealed diagnoses included moderate recurrent major depression, type 2 diabetes mellitus (DM II), chronic obstructive pulmonary disease (COPD), lymphoma, hyperlipidemia, bipolar disorder, schizoaffective disorder, anxiety disorder, vitamin B-12 deficiency, partial intestinal obstruction. a. Review of Resident #1's Physician Order Report for September 2022 revealed an order for Jardiance 10 mg tablet, take 1 tablet by mouth once a day, every day; 9:00 am; Start date 08/06/22 End date 09/12/22 (order on hold from 08/31/22 to 09/01/22). (Jardiance is a medication used to treat diabetes.) Review of Resident #1's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Jardiance 10 mg tablet with instructions to take 1 tablet by mouth once a day. -On 09/08/22, Jardiance 10 mg tablet was documented as not administered because the med ordered on delivery.		

Review of Resident #1's September 2022 Resident Progress Notes revealed a medication cart audit was conducted on 09/06/22, 09/13/22 and 09/20/22. Telephone interview with a representative from the facility's previous contracted pharmacy on 01/18/23 at 3:00 pm revealed: -Scheduled medications went out on a rotating refill cycle. -On the 4th or 5th day before the new refill cycle begins, the facility should either receive the medication so it can be started on the 7th or 8th day. -When the new cycle started, the facility would have received a 7-day or multi-dose pack for the next week. -On 09/02/22, they received an updated Physician's Order Form but there was no cover sheet indicating that the resident was actually in the building or what medication was needed or if there were any allergy changes. -She did not know why the pharmacy needed to send six tablets when Resident #1 was on a regular rotating schedule. -If a resident was a new admit or readmit, it was possible for the facility to request enough medication to get a resident through until the next cycle would start. -There was an order to hold Resident #1's medication from 5:30 pm on 08/31/22 to 10:29 am on 09/01/22. -If the resident was out due to a hospital visit, depending on how long the resident was in the hospital, the resident should still have medication in the facility during the time of the hospital stay. -Whenever they received notification paperwork from the facility of a new admission or a readmission, they would call the facility to clarify if the resident is in the facility, there are any new allergies or the same allergies and if the resident needed any medication. -On 09/02/22, a pharmacy representative attempted to contact the facility multiple times after they had received Resident #1's Physician Order Form. -If they were unable to reach anyone at the facility, leave a voice mail if possible, email or fax the facility. -They were unable to dispense medications, if they are unable to make contact with someone at the facility to get resident information needed to update the resident's profile. -On 09/05/22, another pharmacy representative attempted to call facility again and no return call or message was received from the facility. -On 09/06/22, another pharmacy representative left a message for the facility attempting to confirm if Resident #1 was in the facility.		

-On 09/07/22, another pharmacy representative attempted and was able to speak with the Resident Care Coordinator who stated she would call back and confirm what medications were needed for Resident #1. -On 09/08/22, the pharmacy was informed by the facility that Jardiance 10 mg tablets were needed for Resident #1. -Once they received all requested information on a resident, the pharmacy had at least 24 hours to dispense medications for a resident. -On 09/08/22, a quantity of six (6) Jardiance 10 mg tablets were dispensed to the facility during the 12:30 pm run, so the facility should have received them on the same day that they were dispensed by the pharmacy.		
Telephone interview with the Resident Care Coordinator (RCC) at 2:25 pm on 12/02/22 revealed: -On 09/01/22, Resident #1's Jardiance was on hold because she had just been discharged from the psychiatric hospital and the RCC had to get clarification from the primary care provider (PCP) and mental health (MH) doctors. Interview with the facility's Primary Care Provider on 12/21/22 at 3:40 pm revealed: -Resident #1 was on Jardiance as secondary protection because she had diabetes, and it could help lower her cardiac risk factors. b. Review of Resident #1's Physician Order Report for October 2022 revealed an order for Humalog U-100 Insulin, 100 unit/ml, inject 3 units three times daily with meals *hold if blood sugar is less than 100 or if resident not eating; 8:00 am, 12:00 pm, 6:00 pm; amount to administer: per sliding scale: -If blood sugar (BS) is less than 60, call doctor. -If BS is 60 – 100, give 0 units. -If BS is greater than 100, give 3 units. -If BS is greater than 400, call doctor. (Humalog is a medication used to treat diabetes.) Review of Resident #1's October 2022 eMAR revealed: -There was an entry for Humalog U-100 Insulin with instructions to inject 3 units three times daily with meals; *hold if blood sugar is less than 100 or if resident is not eating. -On 10/03/22, 3 units of insulin was documented as not administered at 8:00 am with reason due to missed. -On 10/03/22, BS sugar documented as 252 at 5:00 pm. -On 10/03/22, 3 units was not documented as administered at 6:00 pm with no reason why documented.		

Telephone interview with the Resident Care Coordinator (RCC) at 2:25 pm on 12/02/22 revealed: -On 10/03/22, she was on the medication cart because a MA called out. -She did not know why Resident #1 did not receive 3 units of insulin on 10/03/22 at 7:30 am other than it was "just missed." -She did not know why Resident #1 did not receive 3 units of insulin when her blood sugar reading on 10/03/22 at 5:00 pm was 252. c. Review of Resident #1's Physician Order Report for October 2022 revealed an order for blood sugar (BS) check three times a day before meals; if BS is less than 60 or greater than 400, call doctor; Three times a day; 7:30 am, 11:30 am and 5:00 pm. Review of Resident #1's October 2022 eMAR revealed: -There was an entry for blood sugar check with instructions to check blood sugar three times a day before meals; if BS is less than 60 or greater than 400, call the doctor. -On 10/03/22, BS was documented as not administered: missed administration at 7:30 am. Telephone interview with the Resident Care Coordinator (RCC) at 2:25 pm on 12/02/22 revealed: -When the facility transitioned to a new pharmacy provider on 10/03/22, there was no order change for Resident #1's Lipitor prescription other than a change from 9:00 pm to 5:00 pm. -When Resident #1 did not receive medication administration of Lipitor 10 mg at 5:00 pm on 10/03/22, 10/04/22 and 10/05/22, it was most likely on the medication cart because of the previous 9:00 pm dose. -The MAs might not have administered Lipitor 10 mg to Resident #1 on 10/03/22, 10/04/22 and 10/05/22 because the medication was in a multi-dose pack. -The RCC did not know why Resident #1 Lipitor 10 mg was not administered and documented "pill not in packet" on 10/27/22. d. Review of Resident #1's Physician Order Report for October 2022 revealed an order for atorvastatin (Lipitor) 10 mg tablet, take 1 tablet by mouth daily; 5:00 pm. (Lipitor is a medication used to improve cholesterol levels and decrease the risk for heart attack and stroke.) Review of Resident #1's October 2022 eMAR revealed:		

-There was an entry for atorvastatin (Lipitor) 10 mg tablet with instructions to take 1 tab by mouth at 5:00 pm; start date 10/03/22 – end date 10/06/22. -On 10/03/22, a Lipitor 10 mg tablet was documented as not administered at 5:00 pm with reason due to new order -On 10/04/22, a Lipitor 10 mg tablet was documented as not administered at 5:00 pm with reason due to new order -On 10/05/22, a Lipitor 10 mg tablet was documented as not administered at 5:00 pm with reason due to new order. -There was an entry for atorvastatin (Lipitor) 10 mg tablet with instructions to take 1 tab by mouth at 5:00 pm; start date 10/19/22 – end date 10/27/22. -On 10/27/22, a Lipitor 10 mg tablet was documented as not administered at 5:00 pm with reason due to pill not in packet. Telephone interview with a representative from the facility's current contracted pharmacy on 01/18/23 at 5:00 pm revealed: -The facility was expected to request refills three (3) to five (5) days before the medication was finished. -If they received a refill request no later than noon, the prescription could be filled the same day and would arrive the following day. -If the facility requested an emergency refill, the pharmacy would contact the local back-up pharmacy and the facility would receive the medication within a few hours. Review of Resident #1's Pharmacy Medication History Report dated for 10/01/22 – 11/30/22 revealed: -On 10/01/22, six (6) tablets of Lipitor 10 mg were dispensed to the facility. -On 10/07/22, seven (7) tablets of Lipitor 10 mg were dispensed to the facility. -On 10/14/22, seven (7) tablets of Lipitor 10 mg were dispensed to the facility. -On 10/21/22, seven (7) tablets of Lipitor 10 mg were dispensed to the facility. -On 10/28/22, four (4) tablets of Lipitor 10 mg were dispensed to the facility. e. Review of Resident #1's Physician Order Report for October 2022 revealed an order for prednisolone acetate drops 1%, instill 1 drop in right eye three times a day for 7 days; start date 10/18/22 and end date of 10/24/22, 8:00 am, 2:00 pm, 8:00 pm. (Prednisolone drops are a medication used to treat certain eye conditions due to inflammation or injury.) Review of Resident #1's October 2022 eMAR revealed:		

-There was an entry for prednisolone acetate drops 1% with instructions to instill 1 drop in right eye three times a day for 7 days; start date 10/18/22 and end date of 10/24/22, 8:00 am, 2:00 pm and 8:00 pm. -On 10/18/22, there was no documentation of medication administration of Resident #1's prednisolone drops at 8:00 am and 2:00 pm, but was documented as administered at 8:00 pm. -On 10/24/22, a prednisolone drop was documented as administered at 8:00 am and 2:00 pm but was not administered at 8:00 pm. Review of Resident #1's October 2022 Resident Progress Notes revealed a medication cart audit was conducted on 10/11/22, 10/18/22 and 10/31/22.		
Telephone interview with the Resident Care Coordinator (RCC) at 2:25 pm on 12/02/22 revealed: -On 10/18/22, Resident #1 received her first administration of prednisolone drops 1% at 8:00 pm because it was a new order and it was not in the facility for the 8:00 am and 2:00 pm administration. -The RCC did not know why Resident #1's prednisolone drop was not administered at 8:00 pm on 10/24/22. -The pharmacy puts in medication orders based on the day the order was received from the facility. Interview with the facility's Primary Care Provider on 12/21/22 at 3:40 pm revealed: #1 was using prednisolone drops as an anti-inflammatory because she had cataract surgery sometime within the last six (6) to eight (8) months. -Not receiving the eye drops could have resulted in pain, discomfort and the risk of infection after her eye surgery. Refer to Medication Ordering and Receiving from Pharmacy dated November 2018. Refer to Cart Audit/Medications on Hand Review dated September 2021. Refer to interview with the Resident Care Coordinator on 12/02/22 at 2:25 pm. Refer to interview with the facility's Area Clinical Director on 12/15/22 at 3:30 pm. 2. Review of Resident #2's current FL-2 dated 06/20/22 revealed diagnoses of seizure disorder, blind, hypertension,		

irritable bowel syndrome, schizophrenia, anxiety, glaucoma and elevated prostate specific antigen.

a. Review of Resident #2's Physician Order Report for September 2022 revealed an order for Trazodone 50 mg tablet, take ½ tab (25 mg) tablet by mouth at bedtime, 8:00 pm; start date 08/11/22 end date 09/20/22. (Trazodone is an anti-depressant medication used to treat to treat anxiety disorders.)

Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Trazodone 50 mg tablets with instructions to take ½ tablet (25 mg) by mouth at bedtime; 8:00 pm, start date 08/11/22 and end date 09/20/22.
-On 09/15/22, ½ tablet of Trazodone 50 mgs was not administered due to awaiting refills from PCP.
-On 09/16/22, a ½ tablet of Trazodone 50 mgs was not administered due to awaiting refills from PCP.
-On 09/17/22, a ½ tablet of Trazodone 50 mgs was not administered due to awaiting refills from PCP.

Review of Resident #2's pharmacy Prescription History dated 09/01/22 through 10/31/22 revealed:
-On 09/15/22, one (1) Trazodone 50 mg tablet was dispensed to the facility for 0.5 tablet (25 mg) by mouth at bedtime.
-On 09/19/22, fifteen (15) Trazodone 50 mg tablets were dispensed to the facility for 0.5 tablet (25 mg) by mouth at bedtime.

Review of Resident #2's September 2022 Resident Progress Notes revealed a medication cart audit was conducted on 09/18/22.

Refer to interview with the Resident Care Coordinator on 12/02/22 at 2:25 pm.

Refer to interview with the facility's Area Clinical Director on 12/15/22 at 3:30 pm.

3. Review of Resident #5's FL-2 dated 09/12/22 revealed diagnoses of mild cognitive impairment, vitamin-D deficiency, chronic obstructive pulmonary disease (COPD) with acute exacerbation, hyperlipidemia, essential hypertension, anxiety disorder, primary insomnia, osteoarthritis, gastroesophageal reflux disease (GERD) and mild depression.

Review of Resident #5's Physician Order Report for September 2022 signed on 09/12/22 revealed an order for

carbamazepine (Tegretol) 100 mg. tablet, take one tablet by mouth twice a day; 9:00 am, 9:00 pm; start date 09/20/22 end date 09/26/22. (Tegretol is a medication used to treat bipolar mania.) Review of Resident #5's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for carbamazepine (Tegretol) 100 mg. tablet with instructions to take one tablet by mouth twice a day; 9:00 am, 9:00 pm; start date 09/20/22 end date 09/26/22. -On 09/20/22, there was no documentation Tegretol 100 mg had been administered at 9:00 am, but was documented as administered at 9:00 pm. -On 09/24/22, Tegretol 100 mg was not administered at 9:00 pm due to awaiting pharmacy. -On 09/25/22, Tegretol 100 mg was not administered 9:00 am and 9:00 pm due to awaiting pharmacy. -On 09/26/22, Tegretol 100 mg was not administered at 9:00 am due to awaiting pharmacy. -There was an entry for carbamazepine 100 mg. tablet with instructions to take one tablet by mouth twice a day; 9:00 am, 9:00 pm; (Please reorder three (3) business days ahead) start date 09/26/22 end date 10/25/22. -On 09/26/22, Tegretol 100 mg was not administered at 9:00 pm due to awaiting pharmacy. Review of Resident #5's pharmacy Prescription History dated 09/01/22 through 10/31/22 revealed: -On 09/24/22, (60) tablets of Tegretol 100 mg was dispensed to the facility for one tablet by mouth twice daily. Telephone interview with the facility's Primary Care Provider (PCP) on 12/21/22 at 3:40 pm revealed: -Resident #5 was taking Tegretol as a mood stabilizer and missing a dose here or there would not make much of difference. -If missing doses happened on a continual basis, it could result in more mood issues and agitation. Review of Resident #5's September 2022 Resident Progress Notes revealed a medication cart audit was conducted on 09/06/22, 09/13/22 and 09/18/22. Refer to Medication Ordering and Receiving from Pharmacy dated November 2018.		

Refer to Cart Audit/Medications on Hand Review dated September 2021.

Review of the facility's policy for Medication Ordering and Receiving from Pharmacy dated November 2018 revealed:
-If a medication is not automatically refilled by the pharmacy, repeat medications (refills) are ordered as follows:
-Reordering of medication is done in accordance with the order and delivery schedule developed by the pharmacy provider(s).
-Quantities of medications sent from the pharmacy may vary in accordance with payer status, insurance plan or law.
-Reorder medication several days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand.
-The medication administration personnel who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors.

Review of the facility's policy for Cart Audit/Medications on Hand Review dated September 2021 revealed:
-Facility will develop a schedule so that all resident medication orders are checked on a weekly basis by completing a cart audit.
-Staff will check to see that all medications are available using a copy of the Physicians Orders.
-Staff will reorder as needed and the reorder will be placed in the Order Processing System for follow-up.
-Staff will check expiration dates on medications; remove any expired medications, reorder as needed and place in the Order Processing System for follow-up.
-Staff will date/sign the physician orders once the cart audit is complete and leave for review by the Lead Supervisor-in-Charge (LSIC), Care Coordinator

Interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:25 pm revealed:
-Medication Aides (MAs) were responsible for reordering medications.
-All MAs had received training from the Corporate Area Clinical Director regarding the timeline for reordering medication, which was seven (7) days before the last dose was to be administered.
-MAs were responsible for conducting weekly medication cart audits and she conducted follow-up audits.
-To ensure medication was available for administration, the facility's policy was that medication be ordered seven (7) days in advance, not when there were seven (7) pills left in a pack.

Interview with the facility's Area Clinical Director on 12/15/22 at 3:30 pm revealed:
-At one point, medication aides would reorder medication three (3) days before the last dose.
-On 11/03/22, all medication aides had received in-service on the changes for when medication should be ordered.
-After the in-service, medication was required to be reordered seven (7) days before the last dose was administered.

The facility failed to administer prescribed medications to 4 of 5 sampled residents (#1, #2, #4, #5) because a medication aide refused to administer medications to residents in the assisted living unit and failed to administer medication as prescribed for unknown reasons resulting Resident #1 missing 2 doses of insulin in the same day. Residents #1, #2 and #5 missed doses of multiple medications due to medications being unavailable due to awaiting refills from the pharmacy or primary care provider, including anti-inflammatory eye drops needed after eye surgery to prevent pain, discomfort and possible infection (#1). The facility's failure resulted in the residents not receiving the medications necessary to maintain their physical and mental health which resulted in serious substantial risk for harm constitutes a Type A2 Violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED February 26, 2023.

Rule/Statute Number:
10A NCAC 13F .0901(b)/Personal Care and Supervision
The facility shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

☑ POC Accepted
BG
DSS Initials

Level of Non-Compliance:
TYPE B VIOLATION

Findings:

Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (Resident #2) with diagnoses of blindness and glaucoma who was escorted by other residents to and from the facility's smoking area and smoked without staff suspension.

The findings are:

10A NCAC 13F .0901 (b)
The Wilson House shall provide care to residents based on their care plans, and attend to any other personal care needs residents may be unable to attend to for themselves. — 2/26/2023

Care Managers will complete smoking assessments following the Community schedule, and will review the results of the assessments with care staff. This will allow staff to be sure to develop a plan to meet the Resident's needs. — 2/26/2023

Care Managers will make unit rounds no less than twice daily to ensure Residents are receiving appropriate care based on their care plan, and no voiced needs or concerns. ED will make facility rounds no less than twice daily to ensure Residents needs are met; and no voiced needs or concerns are voiced. — 2/26/2023

Review of the facility's smoking policy dated September 2021 revealed: -Each resident at admission was assessed for ability to smoke safely by means of an interview with the resident, responsible party and through staff observations. -Assessments were repeated at least on admission, readmission from hospital visit, quarterly or as needed to assure safe practices. -Staff was in-serviced to provide ongoing assessment of resident smoking habits and to report to their supervisor any change in ability to smoke safely. -Residents assessed to need supervision will be placed on the smoking schedule and will be supervised while smoking by staff; smoking materials will be secured by community staff who will supervise materials during use. -Residents who smoked safely outside the building, may be allowed access to smoking materials during the time(s) they were in the designated smoking area outside the building. Review of Resident #2's FL-2 dated 06/20/22 revealed: -Diagnoses included seizure disorder, blind, hypertension, irritable bowel syndrome, schizophrenia, anxiety, glaucoma and elevated prostate specific antigen. -There was no documentation of orientation status. Review of Resident #2's Resident Register dated 06/10/22 revealed an admission date of 06/10/22. Review of Resident #2's Care Plan dated 06/30/22 revealed: -Resident #2 required extensive assistance with ambulation and transferring. -Resident #2 was ambulatory with aide or device – staff. -Device(s) needed by Resident #2 were a cane (walking cane for the blind) and other: Staff. -Resident #2 was identified with very limited vision (Blind). Review of Resident #2's Licensed Health Professional Support (LHPS) dated 07/08/22 and 10/27/22: -The type of assistive device required was a walking cane. -The type of help required with the use of assistive device was one (1) person assist. -The frequency of staff assistance required was "at all times." Review of Resident #2's Rapid Geriatric Assessment dated 06/30/22 revealed for assistance in walking, the amount of difficulty the resident would have walking across a room was identified as "a lot, use aids or unable."	continue from page 17 Care Managers will make unit rounds no less than twice daily to ensure Residents are receiving appropiate care based on their individualized care plans, and there are no voiced needs or concerns. ED will make facility rounds no less than twice daily to ensure Residents needs are met, and no voiced needs or concerns are voiced. Care Managers will monitor the 24 hour shift reports to ensure all staff is aware of any new interventions that have been updated on resident care plans. Along with following up with daily stand up per shift to ensure information is being passed to appropiate staff. Ongoing.	2/26/2023 2/26/2023 2/26/2023

Review of Resident #2's Psychiatry Progress Note dated 09/30/22 revealed: -Resident #2 continued to smoke and it appeared that attributed to his anxiety, as well as exacerbated it as he was often seen having difficulty waiting on staff to assist him to the patio. -Resident #2 required assistance due to his blindness.		
Review of Resident #2's Progress Notes dated 11/26/22 revealed: -A medication aide (MA) documented that at 2:30 pm, Resident #2 was yelling for staff and other residents to take him outside. -He was told staff could not always stop what they were doing with another resident to take him outside. -He was told he may have to get on a 2-hour smoking schedule if it continued to be an issue. Observation of the facility on 11/29/22 at 11:15 am revealed: -A resident assisted Resident #2 out of the facility, to a chair in the smoking area and helped him sit down in the chair outside. -Another resident in the smoking area lit Resident #2's cigarette for him. -A total of five (5) residents were sitting in the smoking area and no staff were present. -One staff later came outside to the smoking area, announced it was time for lunch and then went back inside. -The resident who assisted Resident #2 out of the facility, also assisted Resident #2 back inside the facility. Telephone interview with the Resident Care Coordinator (RCC) on 12/15/22 at 12:15 pm revealed smoking assessments were completed quarterly for all residents who were identified as smokers. Review of Resident #2's quarterly Smoking Risk Assessment Results dated 06/16/22 revealed: -Resident #2 was a new admit to the facility. -Resident #2's frequency of use was every few hours. -Resident #2 had a moderate problem with mobility and needed assistance getting to the designated smoking area. -Resident #2's smoking risk score was 4 which fell into the level of 0-9 which was identified as a safe smoker-follow facility policy. -The assessment's clinical judgment identified Resident #2 as capable of supervised smoking and smoking would not result in danger to self or others. -Plan of Care action indicated Resident #2 was a safe smoker who could hold his own material.		

Review of Resident #2's quarterly Smoking Risk Assessment Results dated 10/12/22 revealed: -Resident #2's frequency of use was every few hours. -Resident #2 had no problem with mobility, but needed assistance getting to designated smoking area. -Resident #2's smoking risk score was 3 which fell into the level of 0-9 which was identified as a safe smoker-follow facility policy. -The assessment's clinical judgment identified Resident #2 as capable of supervised smoking and smoking would not result in danger to self or others. -Plan of Care action indicated Resident #2 was a safe smoker who could hold his own material.		
Interview with the facility's Area Clinical Director on 12/15/22 at 3:30 pm revealed: -Resident #2's care plan, which required extensive assistance with ambulation and transfers, did not match the recommendations made in his smoking assessment. -Based on Resident #2's current state of being blind, he did not need to be in the smoking area without staff supervision. -It was the responsibility of staff, not other residents, to assist Resident #2 with ambulation to and from the smoking area. Telephone interview with the facility's Primary Care Provider (PCP) on 12/21/22 at 3:40 pm revealed: -Resident #2 was blind or had limited vision and had very advanced glaucoma. -Her biggest concern for Resident #2 was in regards to other residents assisting Resident #2 with his ambulation. -Staff should be the ones assisting Resident #2 with his ambulation. -It was not the other residents' responsibility to assist Resident #2 with moving around the facility and going back and forth to the smoking area. -Resident #2 sitting in the smoking area without staff supervision could definitely be a fire hazard and he could get burned because of his limited vision. Interview with the Executive Director on 12/15/22 at 3:30 pm revealed Resident #2 smoked a lot. Interview with the Executive Director on 01/27/23 at 1:40 pm revealed: -She was aware of residents assisting Resident #2 outside to the smoking area off and on. -Staff had tried to stop the residents from assisting Resident #2.		

-A lot of times he would not say anything and just start walking down the hall and a resident would come up beside him and guide him to the smoking area. -Resident #2 was blind, but could see light and that was how he would attempt to walk to the smoking area without assistance. Interview with the Executive Director on 01/27/23 at 1:40 pm revealed prior to November 2022, Resident #2 was dependent upon whoever got beside him and helped him move around the facility. The facility failed to provide supervision for 1 of 5 residents sampled (Resident #2) who was blind and assessed as needing assistance getting to the facility's designated smoking area and was being assisted by residents and not staff. The facility's failure was detrimental to the resident's health, safety and welfare which constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/15/22 for this violation. THE CORRECTION DATE FOR THE TYPE VIOLATION SHALL NOT EXCEED February 26, 2023.		
Rule/Statute Number: 10A NCAC 13F .0902(b)/Health Care The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	☑ POC Accepted BG *DSS Initials*	___
Level of Non-Compliance: STANDARD DEFICIENCY		
Findings: Findings: Based on record reviews and interviews, the facility failed to ensure physician notification for 1 of 5 sampled residents (Resident #2) according to facility policy to notify the prescribing provider of missed/refused medications after three (3) consecutive medication refusals. The findings are: Review of the facility's policy for Missed or Refused Medication dated September 2021 revealed: -Missed/refused medications are documented in the resident's medication administration record (MAR) and the provider, responsible party/guardian is notified and documented.	10A NCAC 13F .0902 (b) The Wilson House shall ensure referral and follow-up to meet the routine and acute health care needs of Residents. — 2/26/2023 The ED and Care Managers will review Matrix Care Reports daily to review and follow up with making sure the Physicians have been notified appropriately of missed or refused medications. Ongoing. — 2/26/2023 Care Managers will review Facility documentation daily with ED to ensure documentation is in place, as well as to follow up on any noted areas of concern. Ongoing. — 2/26/2023	

-The Medication Aide (MA) and/or Resident Care Coordinator (RCC) notifies the prescribing provider of missed/refused medications immediately using the Medication Notification form after three (3) consecutive refusals unless the medication is related to Diabetic, Coumadin, Seizure Disorders. Review of Resident #2's FL-2 dated 11/20/22 revealed a diagnoses included seizure disorder, blind, hypertension, irritable bowel syndrome, schizophrenia, anxiety, glaucoma and elevated prostate specific antigen. Review of Resident #2's Physician Order Report for October 2022 revealed an order for brimonidine-timolol (Combigan) drop in the right eye twice a day; 8:00 am and 8:00 pm. (Combigan is a medication used to treat high pressure inside the eye due to glaucoma. Review of Resident #2's October 2022 eMAR revealed: -There was an entry to instill one (1) brimonidine-timolol (Combigan) drop in the right eye twice a day; 8:00 am, 8:00 pm. -On 10/02/22, it was documented Resident #2 refused administration at 8:00 pm. -On 10/03/22, it was documented Resident #2 refused administration at 8:00 am. -On 10/05/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/06/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/07/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/11/22, it was documented, Resident #2 refused administration at 8:00 am. -On 10/25/22, it was documented, Resident #2 refused administration at 8:00 am. Review of Resident #2's Physician Order Report for October 2022 revealed an order for artificial tears (OTC) drops; instill one (1) drop into both eyes twice daily; 8:00 am and 8:00 pm. (Artificial tear drops is medication used to relieve dry, irritated eyes.) Review of Resident #2's October 2022 electronic Medication Administration Record (eMAR) revealed: -There was an entry to instill one (1) drop of artificial tears in each eye twice a day; 8:00 am, 8:00 pm. -On 10/02/22, it was documented Resident #2 refused administration at 8:00 pm.		

-On 10/03/22, it was documented Resident #2 refused administration at 8:00 am. -On 10/05/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/06/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/07/22, it was documented Resident #2 refused administration at 8:00 am and 8:00 pm. -On 10/11/22, it was documented, Resident #2 refused administration at 8:00 am. -On 10/25/22, it was documented Resident #2 refused administration at 8:00 am.		
Review of Resident #2's Physician Order Report for October 2022 revealed an order for dorzolamide drops 2%; instill one (1) drop in right eye daily; 8:00 am. (Dorzolamide is a medication used to treat glaucoma.) Review of Resident #2's October 2022 eMAR revealed: -There was an entry to instill one (1) dorzolamide drop in the right eye daily at 8:00 am. -On 10/05/22, it was documented Resident #2 refused administration -On 10/06/22, it was documented Resident #2 refused administration. -On 10/07/22, it was documented Resident #2 refused administration -On 10/11/22, it was documented, Resident #2 refused administration. -On 10/25/22, it was documented Resident #2 refused administration. Review of Resident #2's October Progress Notes revealed: -On 10/02/22, the provider was notified Resident #2 refused one time dose of the artificial eye drop and brimonidine-timolol. -On 10/05/22, the provider was notified Resident #2 refused one time dose of the artificial eye drop and brimonidine-timolol. Telephone interview with the Resident Care Coordinator (RCC) on 12/02/22 at 2:25 pm revealed: -Resident #2 could be very non-complaint with his medications. -The facility's policy was to notify the doctor if a resident had refused to receive their medication for three consecutive days. -She did not know why the doctor was not notified Resident 2 refused to receive his eye drops three days in a row.		

Facility Name:

Telephone interview with the facility's Primary Care Provider (PCP) on 12/21/22 at 3:40 pm revealed: -Resident #2 was very non-compliant with the administration and could not be forced to receive his eye medication. -The risk to him would be pain and worsening of his vision and ocular pressure. -Although Resident #2 was very non-compliant with his medication administration, she still expected to be notified when multiple administrations were missed. -She was notified when Resident #2 refused a one-time dose on 10/02/22 and 10/05/22. -She was not notified when Resident #2 refused medication administration on 10/06/22, 10/07/22, 10/11/22 and 10/25/22.		

IV. Delivered Via:	Hand-delivery	Date: 02/08/2023
DSS Signature:	Benita Grant	Return to DSS By: 02/28/23

V. CAR Received by:	Administrator/Designee (print name): Donna Dawson	
	Signature: Donna Dawson	Date: 2/8/23
	Title: administrator	

VI. Plan of Correction Submitted by:	Administrator (print name): Donna Dawson	
	Signature: Donna Dawson	Date: 2/27/23

VII. Agency's Review of Facility's Plan of Correction (POC)

☑ *POC Not Accepted* | By: Benita Grant | Date: 03/01/23

Comments: The POC submitted for the Type B Violation cannot be accepted at this time. The POC does not provide the interventions placed on the care plan and does not clearly address the supervision needed by the resident. On 02/08/23, the resident involved in the Type B violation, was observed in the smoking area with no supervision. Please revise and resubmit. Thank you.

☑ *POC Accepted* | By: Benita Grant | Date: 03/13/23

Comments:

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

Facility Name: