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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 10/29/24 and 10/30/24.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#2) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #2's current FL2 dated 05/16/24 revealed diagnoses included schizophrenia and acute respiratory failure with hypoxia. Review of the Resident Register for Resident #2 revealed an admission date of 05/21/24 from a hospital.	D 234		

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Review of Resident #2's immunization records revealed:
-There was no documentation of a negative TB skin test.
-There was no documentation of a positive TB skin test.
-There was documentation of a negative chest x-ray to rule out TB dated 05/21/24.

Interview with Resident #2 on 10/30/24 at 11:10am revealed he last had a TB skin test completed "a long time ago."

Interview with the Resident Care Director (RCD) on 10/30/24 at 1:30pm revealed:
-Resident #2 did not have a completed TB skin test on file.
-Resident #2 only had a negative chest x-ray completed to rule out TB.
-She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test.
-She did not know a negative TB skin test or blood test must be completed instead of a chest x-ray upon a resident's admission to the facility.
-She or the Manager was responsible to ensure a TB testing was completed upon a resident's admission to the facility.

Interview with the Manager on 10/30/24 at 2:17pm revealed:
-She did not know Resident #2 did not have a TB skin test completed upon admission to the facility.
-She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test.
-She did not know a negative TB skin test or blood test must be completed instead of a chest x-ray upon a resident's admission to the facility.
-She and the RCD were responsible to ensure TB

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D 234	Continued From page 2 testing was completed upon a resident's admission to the facility. Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure physician follow up was completed for 2 of 3 sampled residents (#2 and #3) who had refusals of two different eyedrops (#2) and a resident who had refusals of a corticosteroid inhaler (#3). The findings are: 1. Review of Resident #1's FL-2 dated 05/16/24 revealed diagnoses included schizophrenia and acute respiratory failure with hypoxia. a. Review of Resident #2's FL-2 dated 05/16/24 revealed there was an order for brimonidine 0.2%/brinzolamide 1% suspension, 1 drop in each eye every 8 hours. Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration	D 273		

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at 7:00am, 3:00pm, and 11:00pm.
-There were 23 refusals documented of 93 opportunities for administration from 08/01/24 to 08/31/24.
-There were seven consecutive refusals of the 11:00pm dose of simbrinza from 08/02/24 to 08/08/24 and from 08/17/24 to 08/23/24.

Review of Resident #2's September 2024 eMAR revealed:
-There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration at 7:00am, 3:00pm, and 11:00pm.
-There were 19 refusals documented of 90 opportunities for administration from 09/01/24 to 09/30/24.
-There were five consecutive refusals of the 11:00pm dose of simbrinza from 09/26/24 to 09/30/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration at 7:00am, 3:00pm, and 11:00pm.
-There were 21 refusals documented of 85 opportunities for administration from 10/01/24 to 10/29/24.
-There were twelve consecutive refusals of the 11:00pm dose of simbrinza from 10/13/24 to 10/24/24.

Review of Resident #2's progress notes revealed there was no documentation Resident #2's primary care provider (PCP) was notified of the simbrinza refusals.

Interview with Resident #2 on 10/30/24 at

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11:10am revealed:
-He sometimes refused his simbrinza eyedrops, mainly at night.
-He did not know if his PCP knew Resident #2 refused his eyedrops.
-His vision had not worsened over the last few months.

Attempted telephone interview with Resident #2's PCP on 10/30/24 at 11:04am unsuccessful.

Interview with the medication aide (MA) on 10/29/24 at 3:38pm revealed:
-Resident #2 had told her not to wake him up for eyedrops.
-Resident #2 refused his 11:00pm simbrinza eyedrops most of the time.
-She informed the Resident Care Director (RCD) about Resident #2's eyedrops refusals.
-She did not know if Resident #2's PCP knew about Resident #2's eyedrops refusals.

Telephone interview with a second MA on 10/30/24 at 10:10am revealed:
-She documented five refusals of simbrinza in September 2024 and seven refusals of simbrinza in October 2024.
-She offered Resident #2 his simbrinza eyedrops every night she worked, and he always refused the eyedrops.
-The RCD was responsible for contacting the PCP about medication refusals.
-She let the RCD know if a resident refused a medication after 3 consecutive days.

Interview with the RCD on 10/30/24 at 2:00pm revealed:
-She administered medications to Resident #2, mostly during the day.
-The other MAs had not let her know Resident #2

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was refusing eyedrops the last few months.
-She expected the MAs to let her know if a resident refused medications for one week to ten days, or for ten days out of the month.
-She had not notified Resident #2's PCP of the simbrinza refusals in the last three months.

Interview with the Manager on 10/30/24 at 2:17pm revealed:
-She did not know about Resident #2's simbrinza refusals.
-She would expect the PCP to be notified of medication refusals after four consecutive refusals.
-The RCD was responsible to notify the PCP about medication refusals.

Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful.

b. Review of Resident #2's FL-2 dated 05/16/24 revealed there was an order for latanoprost 0.005%/netarsudil 0.02% suspension, 1 drop in each eye at bedtime.

Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for latanoprost 0.005% ophthalmic suspension instill one drop in both eyes at bedtime scheduled for administration at 8:00pm.
-There were 3 refusals documented of 30 opportunities for administration on 09/22/24, 09/28/24 and 09/29/24.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for latanoprost 0.005%

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ophthalmic suspension instill one drop in both eyes at bedtime scheduled for administration at 8:00pm.
-There were 16 refusals documented of 28 opportunities for administration from 10/01/24 to 10/29/24, including nine consecutive refusals from 10/15/24 to 10/23/24.

Review of Resident #2's progress notes revealed there was no documentation Resident #2's primary care provider (PCP) was notified of the latanoprost refusals.

Interview with Resident #2 on 10/30/24 at 11:10am revealed:
-He sometimes refused his latanoprost eyedrops.
-He did not know if his PCP knew Resident #2 refused his eyedrops.
-His vision had not worsened over the last few months.

Attempted telephone interview with Resident #2's PCP on 10/30/24 at 11:04am unsuccessful.

Interview with the medication aide (MA) on 10/29/24 at 3:38pm revealed:
-Resident #2 had told her not to wake him up for eyedrops.
-Resident #2 refused his nightly eyedrops most of the time.
-She informed the Resident Care Director (RCD) about Resident #2's eyedrop refusals.
-She did not know if Resident #2's PCP knew about Resident #2's eyedrop refusals.

Telephone interview with a second MA on 10/30/24 at 10:10am revealed:
-She documented five refusals of latanoprost in September 2024 and eight refusals of latanoprost in October 2024.

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D 273	Continued From page 7 -She offered Resident #2 his latanoprost eyedrops every night she worked, and he always refused the eyedrops. -The RCD was responsible for contacting the PCP about medication refusals. -She let the RCD know if a resident refused a medication after 3 consecutive days. Interview with the RCD on 10/30/24 at 2:00pm revealed: -She administered medications to Resident #2, mostly during the day. -The other MAs had not let her know Resident #2 was refusing eyedrops the last few months. -She expected the MAs to let her know if a resident refused medications for one week to ten days, or for ten days out of the month. -She had not notified Resident #2's PCP of the latanoprost refusals in the last three months. Interview with the Manager on 10/30/24 at 2:17pm revealed: -She did not know about Resident #2's latanoprost refusals. -She would expect the PCP to be notified of medication refusals after four consecutive refusals. -The RCD was responsible to notify the PCP about medication refusals. Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful. 2. Review of Resident #3's FL2 dated 04/11/2024 revealed diagnosis included dementia, Chronic Obstructive Pulmonary Disease (COPD), diabetes, atrial fibrillation, hypothyroidism and schizophrenia.	D 273		

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D 273	Continued From page 8 Review of Resident # 2's signed physician's order dated 8/14/24 revealed an order for fluticasone 50MCG/ACT two sprays in each nostril once daily for allergic rhinitis. Review of Resident #3's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50MCG/ACT two sprays in each nostril once a day scheduled for administration at 8:00am. -There were 18 refusals documented out of 31 opportunities for administration from 8/01/24 to 8/31/24. -There were 3 consecutive refusals from 8/5/24 to 8/07/24. -There were 4 consecutive refusals from 8/19/24 to 8/22/24. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for fluticasone 50MCG/ACT two sprays in each nostril once a day scheduled for administration at 8:00am. -There were 10 refusals documented out of 30 opportunities for administration from 9/01/24 to 9/30/24. -There was no documentation for three consecutive refusals. Review of Resident #3's October 2024 eMAR revealed: -There was an entry for fluticasone 50MCG/ACT two sprays in each nostril once a day scheduled for administration at 8:00am. -There were 20 refusals documented out of 29 opportunities for administration from 10/01/24 to 10/29/24. -There were 3 consecutive refusals from 10/01/24	D 273		

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to 10/03/24.
-There were 3 consecutive refusals from 10/05/24 to 10/07/24.
-There were 3 consecutive refusals from 10/09/24 to 10/11/24.
-There were 6 consecutive refusals from 10/16/24 to 10/21/24.

Review of Resident #3's progress notes revealed there was no documentation Resident #3's primary care provider (PCP) was notified of fluticasone refusals.

Interview with Resident #3 on 10/30/24 at 8:30am revealed:
-She had refused the nasal spray sometimes when it was offered.
-She currently had a stuffy nose and was congested.
-She did not know if the facility notified her PCP about the refusals.

Interview with the Resident Care Director (RCD) on 10/30/24 at 9:30am.
-She worked as a medication aide (MA) on the first shift on weekdays.
-She administered medication to Resident # 3 on first shift.
-She was aware of the refusals.
-It was her responsibility to notify the PCP of refusals.
-She did not notify the PCP because a new provider started in July 2024.
-She did not remember notifying the new provider.

Interview with Resident #3's PCP at 9:30am on 10/30/24 revealed:
-She was not aware of the resident refusals.
-The medication was prescribed to help reduce

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D 273	Continued From page 10 nasal congestion. -Her expectation would be for the facility to notify her if the resident had three consecutive refusals or more than 10 refusals a month. -The resident may not be getting the expected nasal congestion relief without the medication. -If the facility had made her aware, she would have spoken to the resident about the refusals and possibly offered the medication at a different time or discontinued the medication. Telephone interview (MA) on 10/30/24 at 10:20am revealed: -She was aware of the refusals for the nasal spray. -She always documented resident refusals. -The protocol was to notify the Resident Care Director (RCD) if the resident refused medication for more than 3 consecutive days. -She notified the RCD who the resident had 3 consecutive refusals. -It was the RCD's responsibility to notify the PCP. Interview with the Manager on 10/30/24 at 2:15pm revealed: -She was not aware of the fluticasone refusals. -She expected the MAs to inform the RCD if the resident refused medication for 4 consecutive days. -She was not aware the RCD did not notify the PCP about the refusals. Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 11 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 interviews and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) including a resident with orders for two eyedrops. The findings are: Review of Resident #2's FL-2 dated 05/16/24 revealed diagnoses included schizophrenia and acute respiratory failure with hypoxia. a. Review of Resident #2's FL-2 dated 05/16/24 revealed there was an order for latanoprost 0.005%/netarsudil 0.02% (an eyedrop used to decrease eye pressure), one eyedrop in each eye at bedtime. Review of Resident #2's September 2024 medication administration record (MAR) revealed: -There was an entry for latanoprost 0.005% ophthalmic suspension instill one drop in both eyes at bedtime scheduled for administration at 8:00pm. -There was documentation latanoprost was "withheld per doctor orders" 12 times out of 30 opportunities for medication administration on 09/13/24, 09/14/24, 09/15/24, 09/16/24, 09/18/24, 09/19/24, 09/20/24 09/23/24, 09/24/24, 09/25/24, 09/26/24 and 09/27/24.	D 358		

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D 358	Continued From page 12 Review of Resident #2's October 2024 MAR revealed: -There was an entry for latanoprost 0.005% ophthalmic suspension instill one drop in both eyes at bedtime scheduled for administration at 8:00pm. -There was documentation latanoprost was "withheld per doctor orders" 3 times out of 28 opportunities for medication administration on 10/03/24, 10/07/24 and 10/08/24. Observation of Resident #2's medications on hand on 10/29/24 at 2:26pm revealed there was a mostly full opened bottle of latanoprost dispensed on 10/07/24 available for administration. Attempted telephone interview with Resident #2's pharmacy on 10/30/24 at 10:48am unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/30/24 at 11:04am unsuccessful. Interview with Resident #2 on 10/30/24 at 5:01pm revealed: -Staff offered his eyedrops for medication administration every day. -He sometimes did not want to be administered the eyedrops. Interview with a medication aide (MA) on 10/29/24 at 3:38pm revealed: -Resident #2 ran out of his latanoprost eyedrops for about a week in September 2024. -She documented on the eMAR "withheld per doctor orders" in September 2024 because the latanoprost was not available to administer. -She documented "withheld per doctor orders" for latanoprost on the eMAR in October 2024	D 358		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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because the medication was not available to administer to Resident #2.
-There was not an option on the eMAR to document "medication not available to administer."

Interview with the Resident Care Director (RCD) on 10/30/24 at 2:00pm revealed:
-There were times in the last couple of months when the MAs were waiting on the latanoprost to arrive from the pharmacy.
-She expected MAs to let her know a medication needed to be reordered three or four doses before it ran out.
-MAs were responsible to administer medications as ordered.

Interview with the Manager on 10/30/24 at 2:17pm revealed:
-She did not know Resident #2's latanoprost was not available to be administered for 12 days in September 2024.
-She audited the medication carts and the eMARs of four random residents per month, or two residents every two weeks.
-Her audits included ensuring medication was available to be administered on the medication cart and the medication on the medication cart matched the provider orders.
-MAs were responsible to administer and document medications as ordered.

Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful.

b. Review of Resident #2's FL-2 dated 05/16/24 revealed there was an order for brimonidine 0.2%/brinzolamide 1% suspension, 1 drop in each eye every 8 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080027	A. BUILDING: _____ B. WING _____	R 10/30/2024

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D 358	Continued From page 14 Review of Resident #2's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration at 7:00am, 3:00pm, and 11:00pm. -There were blank spaces and no documentation of simbrinza administration for 25 of 93 opportunities from 08/01/24 to 08/31/24. -There were blank spaces and no documentation of simbrinza administration from 08/02/24 to 08/09/24, 08/12/24, from 08/14/24 to 08/16/24, 08/19/24, 08/20/24, 08/22/24, 08/23/24 and from 08/26/24 to 08/30/24 at the 3:00pm administration time. -There were blank spaces and no documentation of simbrinza administration on 08/11/24 and 08/16/24 at the 11:00pm administration time. Review of Resident #2's September 2024 eMAR revealed: -There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration at 7:00am, 3:00pm, and 11:00pm. -There were blank spaces and no documentation of simbrinza administration for 22 of 90 opportunities. -There were blank spaces and no documentation of simbrinza administration from 09/02/24 to 09/10/24, 09/12/24, 09/13/24, 09/16/24, 09/17/24, 09/21/24 and from 08/23/24 to 08/30/24 at the 3:00pm administration time. -There were blank spaces and no documentation of simbrinza administration on 09/11/24 and 09/19/24 at the 11:00pm administration time. -There was documentation simbrinza was "withheld per doctor orders" for 3 of 90	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 15 opportunities on 09/14/24, 09/16/24 and 09/17/24. Review of Resident #2's October 2024 eMAR revealed: -There was an entry for simbrinza 1%/0.2% ophthalmic suspension instill one drop in both eyes every 8 hours scheduled for administration at 7:00am, 3:00pm, and 11:00pm. -There were blank spaces and no documentation of simbrinza administration for 25 of 85 opportunities for administration from 10/01/24 to 10/29/24. -There were blank spaces and no documentation of simbrinza administration from 10/01/24 to 10/07/24, from 10/10/24 to 10/18/24, from 10/21/24 to 10/23/24, and on 10/28/24 at the 3:00pm administration time. -There were blank spaces and no documentation of simbrinza administration on 10/01/24, 10/02/24, 10/09/24, 10/12/24 and 10/25/24 at the 11:00pm administration time. Observation of Resident #2's medications on hand on 10/30/24 at 2:08pm revealed: -There was a mostly full bottle of simbrinza dispensed on 07/15/24 available for administration. -There was an unopened bottle of simbrinza dispensed on 10/03/24 available for administration. Attempted telephone interview with Resident #2's pharmacy on 10/30/24 at 10:48am unsuccessful. Telephone interview with a representative from the facility's contracted pharmacy on 10/30/24 at 10:27am revealed: -There was an active order on file for simbrinza 1%/0.2%, one drop in each eye every 8 hours. -The indication for simbrinza was to try to keep	D 358		

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eye pressure down.
-Simbrinza was last dispensed on 07/15/24 for a quantity of one 8 milliliter bottle, which would have lasted approximately 27 days if administered as ordered.
-According to Resident #2's profile, it appeared that some of Resident #2's medications were dispensed from a different pharmacy.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 10/30/24 at 11:04am unsuccessful.

Interview with Resident #2 on 10/30/24 at 5:01pm revealed:
-Staff offered his eyedrops for medication administration every day.
-He sometimes did not want to be administered the eyedrops.

Interview with a medication aide (MA) on 10/29/24 at 3:38pm revealed she did not know why there were so many blank spaces on the eMARs for Resident #2's simbrinza.

Interview with the Resident Care Director (RCD) on 10/30/24 at 2:00pm revealed:
-She administered medications to Resident #2.
-She had issues with the facility's eMAR documentation for simbrinza the last few months.
-She had emailed the facility's contracted pharmacy's information technology (IT) department about the eMAR documentation issues.
-She administered Resident #2's scheduled 3:00pm simbrinza eyedrops but she thought her documentation of medication administration was not syncing to the eMAR.
-She was unable to bypass a scheduled medication administration without documenting

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D 358	Continued From page 17 something on the eMAR. Interview with the Manager on 10/30/24 at 2:17pm revealed: -She knew about the blank spaces on the eMAR for Resident #2's simbrinza. -MAs were responsible to administer and document medications as ordered. Attempted telephone interview with the Administrator on 10/30/24 at 2:43pm unsuccessful.	D 358		