STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011373	A. BUILDING: _____ B. WING _____	R-C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND HILL ASSISTED LIVING # 4	95 RICHMOND HILL ROAD ASHEVILLE, NC 28806

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 05/06/25-05/08/25.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews, the facility failed to ensure the facility was free of hazards related to oxygen tanks stored in a storage room not secured in a steadying device to prevent them from being knocked over. The findings are: Review of the US Occupational Health and Safety Administration's (OSHA) regulations on the storage of compressed gas cylinders dated 05/21/12 revealed: -Compressed gas cylinders should be in secured	D 079		

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D 079	Continued From page 1	D 079		

in an upright position at all times.
-A steadying device should be used to keep cylinders from being knocked over.
-Compressed gas cylinders should not be intentionally dropped, struck, or permitted to strike each other violently.

Review of the current National Center for Patient Safety (compressed gas) Cylinder Hazard Summary revealed:
-A compressed gas cylinder can be turned into a missile if the cylinder is fractured.
-Escaping gas will propel the cylinder with enough force to penetrate cinder block walls.

Observation during the initial facility tour on 05/06/25 at 10:25am revealed there were seven small, one medium, and one large oxygen tanks setting on the floor of an unlocked storage room adjacent to resident room #8 that were not secured in a crate or steady device to keep them from being knocked over.

Observation in the facility on 05/06/25 at 12:16pm revealed:
-The storage room adjacent to resident room #8 was unlocked and the door to the room was open.
-There were nine oxygen tanks on the floor of the room.
-The oxygen tanks were not secured in a storage crate or a steadying device to prevent them from being knocked over.

Interview with the RCC on 05/07/25 at 8:15am revealed:
-The oxygen tanks stored in the storage room adjacent to resident room #8 had not been secured in a storage crate.
-She had not yet been able to find a storage

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D 079	Continued From page 2 crate. Observation in the facility on 05/07/25 at 8:45am revealed: -The storage room adjacent to resident room #8 was unlocked and the door to the room was open. -There were nine oxygen tanks on the floor of the room. -The oxygen tanks were not secured in a storage crate or a steadying device to keep them from being knocked over. Interview with the Administrator on 05/07/25 at 12:02pm revealed: -Her staff made her aware on 05/06/25 there were unsecured oxygen tanks in the facility. -The medication aides (MA) were responsible for notifying the durable medical equipment provider (DME) when they had used oxygen tanks available for pickup. -The DME should remove the empty oxygen tanks whenever they brought a new supply of oxygen tanks. Observation in the facility on 05/07/25 at 3:27pm revealed: -The storage room adjacent to resident room #8 was unlocked and the door to the room was open. -There were seven small, one medium, and one large oxygen tanks on top of a dresser on the right side of the room. -The oxygen tanks were not secured in a storage crate or steadying device to keep them from being knocked over. Interview with the RCC on 05/07/25 at 3:32pm revealed: -They had moved the oxygen tanks to the top of	D 079		

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D 079	Continued From page 3	D 079		

the dresser to keep them from possibly falling over.
-She would call the DME to request they bring out storage crates or stands for the oxygen tanks.

Observation in the facility on 05/08/25 at 8:35am revealed:
-The storage room adjacent to resident room #8 was unlocked and the door to the room was open.
-There were nine unsecured oxygen tanks in the floor of the room beside a dresser.
-The oxygen tanks were not in a storage crate or steadying device to keep them from being knocked over.

Interview with the Administrator on 05/08/25 at 8:42am revealed:
-She had spoken with the Supervisor of a sister facility on the property and asked him to look on property for an oxygen storage crate.
-She called the local DME in the afternoon on 05/07/25 to request some oxygen tank holders.

Telephone interview with the local DME on 05/08/25 at 9:02am revealed:
-The facility was responsible for letting them know they needed storage crates for the oxygen tanks.
-Their delivery drivers had limited space on their vans.
-The drivers needed advance notice as to what the facility needed so they could add the appropriate sized storage crates to their vans.
-The DME received a call from the facility in the afternoon on 05/07/25.
-The facility had requested an additional oxygen storage crate on 05/07/25.
-The oxygen storage crate requested on 05/07/25 would be delivered to the facility today (05/08/25).

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D 079	Continued From page 4 The facility failed to properly secure nine oxygen tanks from 05/06/25 to 05/08/25 in a crate or steadying device to prevent them from being knocked over resulting in a substantial risk of harm to all of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/08/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 7, 2025.	D 079		
D 105	10A NCAC 13F .0311 (a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility's washer and dryer were maintained in an operating condition. The findings are: Interview with a resident on 05/06/25 at 9:06am during the initial tour revealed: -The facility's washer and dryer had been "broken" for "weeks."	D 105		

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-Residents had to wash and dry their clothes at two sister facilities located on the same campus.
-Staff would wash and dry clothes for residents who were not able to do their own laundry or who did not want to do their laundry at the sister facilities.
-She preferred to do her own laundry in the facility where she lived instead of taking it to another building.
-She did not like having to wait until her scheduled time to wash her clothes.
-Laundry access had to be scheduled to give access to all the residents who needed it.
-She and the other residents had to share the laundry with 5 residents in one building and 12 residents in the other building.

Interview with a second resident on 05/06/25 at 9:08am during the initial tour revealed:
-The washer and dryer had not worked "in over a month."
-He was not sure of the status of the repairs.

Interview with a third resident on 05/06/25 at 9:37am during the initial tour revealed:
-The washer and dryer were "broken."
-He went to a sister facility on the same campus to do his laundry.

Interview with a fourth resident on 05/06/25 at 9:46am during the initial tour revealed:
-The washer and dryer in the facility had been broken for "over a week."
-Management was aware the washer and dryer needed to be repaired.

Interview with a fifth resident on 05/06/25 at 9:49am during the initial tour revealed:
-The washer and dryer had not been working for a week.

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D 105	Continued From page 6 -He took his clothes to a sister facility on the same campus to do his laundry. Interview with a sixth resident on 05/06/25 at 10:02am during the initial tour revealed the washer and dryer stopped working a "few days ago." Interview with a seventh resident on 05/07/25 at 9:00am revealed: -The washer was not working. -Management had been replacing parts for "about a year". Interview with an eighth resident on 05/07/25 at 3:35pm revealed the washer had been having parts replaced periodically but the parts never lasted very long and then it needed to be fixed again. Interview with a personal care aide (PCA) on 05/07/25 at 3:30pm revealed: -The washer and dryer had not been working properly for about a month. -She thought the maintenance person was supposed to be ordering parts. Interview with the Administrator on 05/07/25 at 12:47pm revealed: -She knew the washer in the facility recently would not adequately spin the water out of the clothes, requiring multiple dry cycles. -The Maintenance Director repaired the dryer "several times" in the past. Observation in the facility laundry room on 05/08/25 at 8:38am revealed: -The washer was half full of dirty water and the spin cycle would not operate in order to empty the dirty water.	D 105		

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D 105	Continued From page 7 -The dryer would turn on but would only blow cold air. Interview with the Maintenance Director on 05/08/25 at 3:16pm revealed: -The dryer was repaired about four months ago. -A dryer from a sister facility was moved into the building about a month ago when it had stopped working again. -As far as he knew the washer had never been repaired before, but he planned to replace it since it could not be fixed.	D 105		
D 124	10A NCAC 13F .0402 Qualifications Of Manager 10A NCAC 13F .0402 Qualifications Of Manager The facility shall designate a manager when the administrator is absent from the facility. The manager, is responsible for carrying out the day-to-day operations of an adult care home in the absence of the administrator. The administrator remains ultimately responsible for the adult care home, and the manager shall serve under the direction and supervision of the administrator. The manager shall meet the following requirements: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program, or if hired before September 1, 2024, have passed the alternative examination established by the Department; (3) have six months training or experience related to management or supervision in long term care or health care settings or be a licensed health professional such as a mental health professional, nurse practitioner, physician assistant, or registered nurse, a nursing home administrator certified pursuant to G.S. 90-276(4),	D 124		

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D 124	Continued From page 8 or an assisted living administrator certified pursuant to G.S. 90-288.14; and (4) earn 12 hours a year of continuing education credits in the management of adult care homes or care of the elderly and individuals with physical, intellectual, or developmental disabilities, cognitive impairment, and mental illness. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the managers (Staff A, B and C) who were responsible for carrying out the day-to-day operations of the facility in the absence of the Administrator, earned 12 hours of continuing education credits related to management or care of the residents. The findings are: Review of the facility management roster received on 5/6/25 at 10:33am revealed: -Staff B was identified as the Property Manager. -Staff A and C were identified as manager with the facility title of "Clinical Team". 1. Review of Staff A's personnel record revealed: -She was hired on 10/07/23 as a medication aide. -There was no documentation of 12 hours of continuing education related to management of the residents. Refer to the interview with the Administrator on 05/08/25 at 11:07am. 2. Review of Staff B's personnel record revealed: -She was hired on 07/01/24 as a medication aide/Property Manager.	D 124		

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D 124	Continued From page 9 -There was no documentation of 12 hours of continuing education related to management of the residents. Interview with Staff B on 05/07/25 at 4:00pm revealed: -She was responsible for managing the facility when the Administrator was not at the facility on the weekend. -Staff A and C were responsible for managing the facility when the Administrator was not at the facility during the week. Refer to the interview with the Administrator on 05/08/25 at 11:07am. 3. Review of Staff C's personnel record revealed: -She was hired on 10/10/23 as a medication aide. -There was no documentation of 12 hours of continuing education related to management of the residents. Interview with Staff C on 5/6/25 at 4:45pm revealed she became the Resident Care Coordinator (RCC) about 3 weeks ago. Refer to the interview with the Administrator on 05/08/25 at 11:07am. _____ Interview with the Administrator on 05/08/25 at 11:07am. revealed: -She was not in the facility from 05/02/25 through 05/06/25. -Staff A and Staff C managed the facility in her absence during the week and Staff B managed the facility on the weekend. -Staff A and Staff C never had any official training but she thought they were qualified to manage the facility as both were RCCs at other facilities in the past.	D 124		

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D 124	Continued From page 10 -She thought she could designate someone from the management team to be in charge while she was absent and did not know they needed specific management training.	D 124		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up for 3 of 4 sampled residents (Residents #2, #3, and #4) related to notifying the primary care provider (PCP) concerning right lower extremity swelling (#3), missed doses of a medication used to treat high blood sugar (#3), a missed hospital follow-up appointment with pulmonology (#2), missed doses of a scheduled anti-anxiety medication (#2), and a missed pre-operative appointment for cataract surgery (#4). The findings are: 1. Review of Resident #3's current FL2 dated 03/12/25 revealed: -Diagnoses included intracranial injury and weak gait. -There was an order for Farxiga (used to treat high blood sugar) 10mg daily. Review of Resident #3's podiatry note dated	D 273		

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01/27/25 revealed Resident #3 had diabetes and was treated for a left toe ulcer in December 2024.

a. Interview with Resident #3 on 05/06/25 at 3:23pm and 05/07/25 at 9:00 am revealed:
-His right foot had been swollen since last week.
-He told a staff member "four or five days ago", but he could not remember what staff he told.
-He did not realize there was a sore on the bottom of his foot.
-He did not realize it was important to have his foot evaluated because the doctor had not said anything to him.

Observation of Resident #3 on 05/06/25 at 3:24pm revealed:
-Resident #3 was seated in a wheelchair outside the facility in the parking lot.
-Resident #3's right foot and ankle were swollen until the skin was stretched taut.
-Resident #3 was attempting to slide his bare right foot into a slide-on shoe on the pavement in front of him.
-Resident #3 was only able to get half of his foot into the shoe, leaving the heel portion of his foot resting on the pavement.
-Resident #3 lifted his right foot exposing a one inch diameter reddened area on the bottom of the foot in the arch of his foot.
-The skin was missing from reddened area and clear fluid oozed and dripped from the area.
-There were streaks of intact reddened skin radiating from the bottom of the resident's foot to the top of the resident's foot.

Interview with the Property Manager on 05/06/25 at 3:27pm and 3:35pm revealed:
-Resident #3's swollen foot was reported "over the weekend" to all staff through a group chat by a personal care aide (PCA) that included the

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Administrator.
-She was not sure if the Primary Care Provider (PCP) was contacted about it.
-She was not aware there was a sore on the bottom of the foot, only that it was swollen.
-She sent a picture to the Administrator a few moments ago and the Administrator.
-She did not take any action regarding Resident #3's swollen foot.

Interview with a PCA on 05/08/25 at 1:06pm revealed:
-She noticed Resident #3's swollen foot on 05/03/25 and took a picture of it at 6:43am and sent a group chat about it to all the staff.
-The Resident Care Coordinator (RCC) replied in the group chat and asked if Resident #3 would go to the hospital for evaluation.
-She asked him three times if he wanted to go to the hospital and he "always refused".
-She informed the RCC that he refused to go to the hospital.
-The RCC told her she would reach out to the doctor that day.
-She assumed management would reach out to the PCP.

Interview with the RCC on 05/07/25 at 8:30am revealed:
-A PCA sent a group chat out to all the staff about Resident #3's swollen foot on 05/03/25.
-She was not told about a sore on the bottom of the foot, only that it was swollen.
-The PCA asked Resident #3 if he wanted to go to the hospital for his swollen foot and he declined.
-She informed the Administrator, who was out of town at the time, and she thought the Administrator was going to contact the PCP.

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D 273	Continued From page 13 Interview with the Administrator on 05/07/25 at 1:32pm revealed: -The first time she was informed Resident #3 had a swollen foot was on 05/06/25 and she was told at that time that the resident refused to go to the hospital for treatment. -She left a voice message for the PCP on 05/06/25, informing him of the swollen foot but she did not receive a reply from him. -She looked to see what time she sent the message on 05/06/25 while she was speaking with this writer and realized she sent the message to the PCP's personal phone instead of his work phone, so she immediately sent the PCP a picture of the foot and the sore to the correct number. -The PCP immediately replied and requested Resident #3 be sent to the hospital for evaluation. -She was told a PCA sent out a group chat on 05/03/25 about the swollen foot but she did not contact the PCP because she was out of town and did not realize the group chat message had been sent. -The PCA and RCC probably assumed she would contact the PCP since she was included in the group chat. -The RCC and the MAs were authorized to contact the PCP so she did not know why they did not call him if they thought he might need to go to the hospital. Telephone interview with a nurse from the local hospital on 05/08/25 at 2:20pm revealed: -Resident #3 was admitted to the hospital on 05/07/25 for cellulitis (a bacterial skin infection) of the lower extremity and congestive heart failure. -Rocephin (an antibiotic used to treat infections) was initiated to treat cellulitis and Lasix (a medication used to treat edema) was initiated to treat congestive heart failure.	D 273		

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D 273	Continued From page 14 -He was scheduled to remain in the hospital for another one or two days. Telephone interview with Resident #3's PCP on 05/07/25 at 3:00pm and 05/08/25 at 2:36pm revealed: -Resident #3 had a history of congestive heart failure and was treated for a diabetic toe ulcer in December 2024. -Earlier today (05/07/25) was the first time anyone from the facility contacted him about Resident #3's foot, when he was told his foot was swollen and he received a picture of the bottom of his foot. -He requested Resident #3 be evaluated at the hospital because he could not determine what the problem was from a picture. -He should have been contacted last week when the swelling was first identified. -He did not understand why he was not contacted earlier because facility staff called him regularly for other things. -Cellulitis, (a bacterial skin infection) if not treated, could lead to the infection spreading further up his leg or could result to sepsis, (a serious blood infection). -If he had been contacted earlier Resident #3 could have started treatment sooner. b. Interview with Resident #3 on 05/06/25 at 9:08am revealed: -Sometimes he ran out of medications. -He could not remember the names of the medications. -He thought he ran out of medications because the pharmacy did not deliver them. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/06/25 at 3:53pm revealed:	D 273		

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-Resident #3 was ordered Farxiga 10mg daily on 12/11/24.
-Resident #3's insurance allowed Farxiga 10mg to be dispensed 3 tablets at a time because a prior authorization (PA) was needed in order to send enough for a month.
-The pharmacy sent 3 tablets on 24 different occasions for a total of 72 tablets; 15 tablets in December 2024, 18 tablets in January 2025, 12 tablets in February 2025, 15 tablets in March 2025 and 12 tablets in April 2025.

Review of the facility's undated medication administration policy revealed notify the prescribing provider if a medication is not available.

Interview with the Administrator on 05/07/25 at 1:47pm revealed:
-She did not realize Resident #3 missed multiple doses of Farxiga.
-She never communicated with Resident #3's Primary Care Provider (PCP) about Resident #3's missed doses of Farxiga.

Interview with Resident #3's PCP on 05/07/25 at 3:00pm revealed:
-Resident #3 was prescribed Farxiga, a medication to treat diabetes, after he was treated for a diabetic toe ulcer in the hospital in December 2024 .
-Blood sugars could increase if he did not receive Farxiga routinely.
-He was not aware Resident #3 was not receiving Farxiga routinely.

2. Review of Resident #2's current FL2 dated 05/20/24 revealed diagnoses included chronic obstructive pulmonary disease (COPD), essential hypertension, anemia, and obesity.

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D 273	Continued From page 16 a. Review of Resident #2's hospital discharge summary dated 01/02/25 revealed: -The discharge diagnoses were acute on chronic respiratory failure with hypoxia and pneumonia. -There was an order to follow-up with a local pulmonary office in one to two weeks. Interview with Resident #2 on 05/06/25 at 9:30am revealed: -She was hospitalized at the end of December 2024 and was released from the hospital at the first of January 2025. -She was supposed to follow up with a pulmonologist after being discharged from the hospital. -She had not yet seen the pulmonologist. -She was told by the Resident Care Coordinator (RCC) the pulmonary appointment had been cancelled. -The RCC did not tell her why the appointment had been cancelled. -The RCC told her she would reschedule the pulmonary appointment. -The RCC did not tell her when the new pulmonary appointment had been rescheduled. -The facility was responsible for arranging appointments and scheduling transportation to take her to her appointments. Telephone interview with a representative from Resident #2's pulmonary office on 05/06/25 at 4:24pm revealed: -Resident #2's original appointment was scheduled for 03/04/25. -The appointment was documented as having to be cancelled due to a lack of transportation. -The new appointment was rescheduled for 07/17/25 at 1:30pm.	D 273		

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D 273	Continued From page 17 Interview with the RCC on 05/06/25 at 4:45pm revealed: -She had become the new RCC "three weeks ago." -Resident #2's pulmonology appointment on 03/04/25 was cancelled by the former RCC due to transportion issues. -The RCC was responsible for arranging transportation for residents to their appointments. -The RCC was supposed to call three days ahead to arrange transportation for residents to local appointments. -Resident #2's primary care physician (PCP) was the one who had brought it to her attention that Resident #2 needed a follow up appointment with pulmonary. -She had made the pulmonary appointment scheduled on 07/17/25 for Resident #2 after being prompted by Resident #2's PCP. Interview with the Administrator on 05/07/25 at 12:02pm revealed: -The former RCC had been responsible for scheduling resident appointments and arranging transportation to those appointments. -Resident #2's original appointment had been scheduled on 03/04/25. -The appointment was cancelled due to a lack of transportation. -The new appointment had been rescheduled for 7/17/25 by the current RCC after Resident #2's PCP saw a communication left for him by the former RCC. -The RCC should have scheduled transport for the appointment as soon as Resident #2 returned to the facility from the hospital. Telephone interview with Resident #2's PCP on 05/08/25 at 3:11pm revealed: -He was not aware Resident #2 had missed the	D 273		

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pulmonary follow up appointment scheduled for 03/04/25 until a recent visit to the facility.
-On this visit, he asked the current RCC to reschedule another pulmonary appointment for Resident #2.
-If Resident #2 began having trouble breathing, she would need the pulmonary appointment "sooner" than 07/17/25.

b. Review of Resident #2's physician's order dated 02/27/25 revealed clonazepam (used to treat anxiety) 1mg three times a day.

Review of Resident #2's verbal order dated 04/28/25 revealed:
-Discontinue clonazepam.
-Hold clonazepam until 05/28/25, will reassess.
-The order was not signed by the mental health provider .

Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.
-The clonazepam was documented as administered as ordered for 74 occurrences out of 93 opportunities.
-The clonazepam was documented as not administered from 03/07/25-03/09/25 at 2:00pm, from 03/21/25 at 2:00pm-03/25/25 at 2:00pm, and 3/31/25 at 2:00pm and 8:00pm due to "needs refills/waiting on refill from Provider."

Review of Resident #2's April 2025 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm.

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D 273	Continued From page 19 -The clonazepam was documented as administered as ordered for 77 occurrences out of 82 opportunities. -The clonazepam was documented as not administered from 04/01/25-04/02/25 due to arriving from the contracted facility pharmacy. Review of Resident #2's May 2025 eMAR revealed: -There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm was documented as on hold until 05/28/25. -There were no documented administrations of clonazepam. Observation of Resident #2's medications on 05/06/25 at 3:32pm revealed there were eight clonazepam 1mg tablets available. Observation of Resident #2's medication on 05/08/25 at 8:34am revealed: -There were 84 clonazepam 1mg tablets available. -The dispense date was 04/24/25. Interview with Resident #2 on 05/06/25 at 9:30am revealed: -Her clonazepam had recently been discontinued. -No one had explained why. -She did not know which one of her provider's wrote the order to discontinue the clonazepam. -She had taken the clonazepam for "years." Interview with Resident #2 on 05/08/25 at 9:35am revealed: -She felt really "anxious inside" when she did not receive the clonazepam. -It made her "skin crawl" when she went without the clonazepam.	D 273		

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D 273	Continued From page 20 -She had a hard time sleeping when she did not receive the clonazepam. Telephone interview with Resident #2's mental health provider (MHP) on 05/08/25 at 9:20am and at 3:57pm revealed: -She ordered clonazepam for Resident #2 to treat bipolar disorder, anxiety disorder, and insomnia. -She ordered the clonazepam to be administered to Resident #2 scheduled three times a day. -Resident #2 would experience increased anxiety without the medication. -She did not know Resident #2 missed 19 doses of clonazepam in March and 5 doses of clonazepam in April. -She had not been informed Resident #2 needed a refill for the clonazepam in March until the Administrator emailed her on 03/24/25 for a refill. -She sent a clonazepam refill to the pharmacy on 04/02/25 with three refills. -The verbal order she provided on 04/28/25 was to hold the clonazepam until the medication arrived from the pharmacy. -If the clonazepam was available, she wanted it to be administered to Resident #2. -Resident #2 could go through withdrawals if she did not receive the clonazepam as ordered. -Withdrawal from clonazepam could cause increased anxiety and delirium (a serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings). Interview with the Administrator on 05/07/25 at 12:02pm revealed: -She had reached out to Resident #2's MHP on 03/24/25 to request a refill on the clonazepam. -The clonazepam was received from the pharmacy on 03/25/25. -The MHP "probably knew" Resident #2 had	D 273		

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missed doses of clonazepam in March since she was contacted with a refill request.

3. Review of Resident #4's FL2 dated 09/09/24 revealed diagnoses included essential tremors, chronic obstructive pulmonary disease, muscle weakness, and Barrette's esophagus.

Review of Resident #4's Physician order dated 08/12/24 revealed:
-Schedule cataract surgery in July per patient request for insurance suitability.
-Please make an appointment with ophthalmology.

Interview with Resident #4 on 05/06/25 at 9:06am revealed:
-She had a pre-operative appointment for cataract surgery on 10/10/24.
-The appointment was cancelled by the facility staff due to difficulties resulting from Hurricane Helene.
-As far as she knew, the pre-operative appointment was not rescheduled.
-Her vision was blurrier in the eye with the cataract.
-She had spoken with the former Resident Care Coordinator (RCC), the current RCC, and the Administrator about rescheduling the appointment.
-No one had let her know if another pre-operative appointment had been scheduled.

Telephone interview with a representative from Resident #4's ophthalmology office on 05/07/25 at 9:25am revealed:
-Resident #4 was last seen in their office on 08/08/23.
-Resident #4 was supposed to be seen on 10/10/24 for a cataract pre-operative visit,

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D 273	Continued From page 22 however the appointment was cancelled due to Hurricane Helene. -Someone called in March 2025 to reschedule the appointment and an appointment for a full eye exam was scheduled for 10/09/25. -Resident #4 would have to go through the full eye exam again prior to a pre-operative visit for cataract surgery. Interview with the Administrator on 05/07/25 at 12:02pm revealed: -It was the responsibility of the RCC to schedule appointments for residents. -She expected the former RCC to call back to the ophthalmology office in December or January to reschedule the eye appointment. Telephone interview with Resident #4's Primary Care Physician (PCP) on 05/08/25 at 3:11pm revealed: -He wrote the order for a referral to ophthalmology on 08/12/24 for Resident #4. -The referral was made to evaluate Resident #4's cataract. -Cataract surgery was not an "emergency" situation and the rescheduled appointment for 10/09/25 did not concern him. -There were often many issues trying to get an appointment with an ophthalmology office. _____ The facility failed to notify the PCP of Resident #3's right lower extremity swelling and redness which delayed treatment for four days resulting in the resident being admitted to the hospital with cellulitis that required intravenous antibiotics and failed to inform the PCP Resident #3 was not receiving Farxiga as ordered to treat elevated blood sugars. This failure put Resident #3 at substantial risk of serious physical harm and constitutes a Type A2 Violation.	D 273		

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D 273	Continued From page 23 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/07/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 7, 2025.	D 273		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are, supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and	D 316		

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D 316	Continued From page 24 other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to prepare and post a monthly activity calendar by the first day of the month. The findings are: Observation of a bulletin board in the facilty's hallway on 05/06/25 at 9:20am revealed: -An activity calendar for April 2025 was posted on the board. -No May 2025 activity calendar was available. Interview with a resident on 05/06/25 at 9:46am revealed: -The residents were offered an outing to a local discount store once a month. -She never knew when the outing to the local discount store would occur as it was never written on the activity calendar. Interview with a personal care aide (PCA) on 05/07/25 at 9:34am revealed: -The Administrator was responsible for posting the monthly activity calendar and it was usually posted at the beginning of the month. -The May 2025 calendar was not posted because the Administrator was very busy. -She had not asked the Administrator when the calendar was going to be posted. Interview with the Administrator on 05/07/25 at 1:25pm revealed: -She currently was the acting activity director and she was responsible for making and posting the	D 316		

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D 316	Continued From page 25 activity calendar at the beginning of each month. -It came to her attention the prior week that she needed to modify the calendar, and she had not yet had time to modify it and post it in the facility.	D 316		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure a minimum of 14 hours of a variety of group activities activities were provided each week for the residents. The findings are: Interview with a resident on 05/06/25 at 9:08am revealed: -There was nothing to do at the facility. -He was not sure what he did each day, but "the hours just go by". -He spent a lot of time outside. Interview with another resident on 05/06/25 at 9:37am revealed all he did was go outside, watch television or play on his phone because there was nothing else to do. Interview with another resident on 05/06/25 at 10:23am revealed he went outside and smoked since there was nothing else to do.	D 317		

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D 317	Continued From page 26 Interview with a personal care aide (PCA) on 05/07/25 at 9:34am revealed: -The PCA was responsible for conducting the activities posted on the calendar. -Since the May 2025 calendar was not posted she did not know what activities to do with the residents. Interview with the Administrator on 05/07/25 at 1:25pm revealed: -She was the acting activity director and PCAs were responsible for conducting activities in the facility. -Since the May 2025 calendar was not posted she thought she told the staff on 05/05/25 to gather ideas from the residents about what activities they wanted to do but since she could not locate the message she must not have told them. -She thought the Property Manager told staff what activities to conduct on Tuesday 05/06/25. Observations during the survey conducted from 05/06/25 through 05/08/25 revealed no activities were conducted.	D 317		
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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D 358	Continued From page 27 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#1, #2, and #3) related to a medication used to treat high blood sugar (#3), used to treat anxiety and high blood sugar (#2), and oxygen used to treat shortness of breath (#1). The findings are: 1. Review of Resident #3's current FL2 dated 03/12/25 revealed: -Diagnoses included intracranial injury and weak gait. -An order for Farxiga (used to control blood dglucose levels), 10mg daily. Review of Resident #3's physician orders revealed an order dated 12/11/25 for Farxiga, 10mg daily. Interview with Resident #3 on 05/06/25 at 9:08am revealed: -Sometimes he ran out of medications but he could not remember the names of them. -He thought he ran out of medications because the pharmacy did not deliver them. Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Farxiga, 10mg daily with a start date of 12/11/24. -Farxiga was documented as not administered on 12/25/24, 12/26/24 and 12/31/24 with the reason documented as "medication on order".	D 358		

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D 358	Continued From page 28 Review of Resident #3's January 2025 eMAR revealed: -There was an entry for Farxiga, 10mg daily with a start date of 12/11/24. -Farxiga was documented as not administered on 01/09/25 and 01/23/25 because he was out of the facility. -There was documentation Resident #3 refused Farxiga on 01/01/25 and 01/02/25 but no other medications were documented as refused at that same medication administration time. -Farxiga was documented as not administered on 01/10/25 - 01/12/25, 01/29/25 and 01/30/25 with the reason documented as "needs refills/waiting on refill from Provider" or "not on cart". Review of Resident #3's February 2025 eMAR revealed: -There was an entry for Farxiga, 10mg daily with a start date of 12/11/24. -Farxiga was documented as not administered on 02/18/25, 02/25/25 and 02/26/25 with the reason documented as "needs refills/waiting on refill from Provider" or "on order". Review of Resident #3's March 2025 eMAR revealed: -There was an entry for Farxiga, 10mg daily with a start date of 12/11/24. -Farxiga was documented as not administered on 03/02/25 - 03/04/25 with the reason documented as "needs refills/waiting on refill from Provider" or "on order". Review of Resident #3's April 2025 eMAR revealed: -There was an entry for Farxiga, 10mg daily with a start date of 12/11/24. -Farxiga was documented as not administered on 04/20/25 - 04/23/25 and 04/29/25 with the reason	D 358		

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documented as "needs refills/waiting on refill from Provider" or "on order".

Review of Resident #3's May 2025 eMAR revealed:
-There was an entry for Farxiga, 10mg daily with a start date of 12/11/24.
-Farxiga was documented as not administered on 05/03/25 - 05/06/25 with the reason documented as "needs refills/waiting on refill from Provider".

Interview with a pharmacy technician from the facility's contracted pharmacy on 05/06/25 at 3:53pm revealed:
-Farxiga was used to treat Resident #3's diabetes.
-The original order was submitted electronically by the prescribing physician on 12/11/24 and only 3 were sent to the facility because a prior authorization (PA) was needed in order to send enough for a month.
-PA requests were sent to the facility and to the prescribing physician and she could not locate documentation that the PA was returned so they continued to send 3 tablets for each refill.
-The pharmacy dispensed 3 tablets on 24 different occasions for a total of 72 tablets; 12/15/24, 12/20/24, 12/26/24, 12/31/24, 01/02/25, 01/11/25, 01/15/25, 01/16/25, 01/24/25, 01/29/25, 02/02/25, 02/07/25, 02/14/25, 02/17/25, 03/02/25, 03/09/25, 03/15/25, 03/24/25, 03/31/25, 04/02/25, 04/04/25, 04/07/25 and 04/21/25.
-The last electronic refill request was received from the facility on 04/21/25 and 3 tablets were sent to the facility on 04/22/25.

Observation of Resident #3's medication on hand on 05/06/25 at 3:40pm revealed Farxiga was not available for administration.

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D 358	Continued From page 30 Interview with the Property Manager on 05/06/25 at 3:40pm revealed: -She was a medication aide (MA). -Resident #3's Farxiga was always delivered from the pharmacy with only 3 tablets in the medication card. -She did not know why they did not send more than three tables. -When she received the medication, she immediately submitted another electronic refill request since she knew only 3 would be delivered. - It only took a couple days to receive medications after an electronic refill request was submitted. Review of Resident #3's Farxiga facility electronic reorder history revealed: -There was no documentation the Property Manager submitted an electronic refill request. -There was documentation an electronic refill request was submitted 12/15/24, 12/20/24, 12/26/24, 12/31/24, 01/02/25, 01/11/25, 01/15/25, 01/16/25, 01/24/25, 01/29/25, 02/02/25, 02/07/25, 02/14/25, 02/17/25, 03/02/25, 03/09/25, 03/15/25, 03/24/25, 03/31/25, 04/02/25, 04/04/25, 04/07/25 and 04/21/25. Interview with the Administrator on 05/07/25 at 1:47pm revealed: -Resident #3's Farxiga was delivered 3 tablets at a time and she did not know why he never received more than 3 tablets. -The MAs were responsible for electronically reordering medications when they were low. -If a PA was received via fax from the pharmacy the previously employed Resident Care Coordinator (RCC) was probably the one to receive it. -She never called the pharmacy to inquire why only three tablets were sent for each request	D 358		

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made.

Interview with Resident #3's Primary Care Physician (PCP) on 05/07/25 at 3:00pm revealed:
-Resident #3 was prescribed Farxiga, a medication to treat diabetes, after he was in the hospital in December 2024 being treated for a diabetic toe ulcer, a complication due to elevated blood sugars.
-He could not remember if he was ever contacted by the facility about the need for a PA and since he was not the prescribing provider he probably did not receive one from the pharmacy.
-Blood sugars could increase if he did not receive Farxiga routinely.
-He was not aware Resident #3 was not receiving Farxiga routinely.

2. Review of Resident #2's current FL2 dated 05/20/24 revealed diagnoses included chronic obstructive pulmonary disease, essential hypertension, anemia, and obesity.

a. Review of Resident #2's physician's order dated 01/07/25 revealed clonazepam (used to treat anxiety) 1mg three times a day.

Review of Resident #2's physician's order dated 02/27/25 revealed clonazepam 1mg three times a day.

Review of Resident #2's prescription dated 04/02/25 revealed clonazepam 1mg one tablet three times a day quantity 90 tablets with three refills.

Review of Resident #2's verbal medication order dated 04/28/25 revealed:
-Discontinue clonazepam.
-Hold clonazepam 1mg until 05/28/25, will

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reassess.
-The order was not signed by the mental health provider (MHP) who initiated the verbal order.

Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm with a start date of 01/31/25 and an end date of 04/28/25.
-Clonazepam 1mg was documented as administered as ordered for 77 occurrences out of 84 opportunities.
-Clonazepam 1mg was documented as not administered from 02/01/25-02/02/25 due to medication discontinued and on 02/28/25 due to not arriving from the contracted facility pharmacy.

Review of Resident #2's March 2025 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm with a start date of 01/31/25 and an end date of 04/28/25.
-Clonazepam 1mg was documented as administered as ordered for 74 occurrences out of 93 opportunities.
-Clonazepam 1mg was documented as not administered from 03/07/25-03/09/25 at 2:00pm, from 03/21/25 at 2:00pm, 03/25/25 at 2:00pm, and 3/31/25 at 2:00pm and 8:00pm due to "needs refills/waiting on refill from provider."

Review of Resident #2's April 2025 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm with a start date of 01/31/25 and an end date of 04/28/25.

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-Clonazepam 1mg was documented as administered as ordered for 77 occurrences out of 82 opportunities.
-Clonazepam 1mg was documented as not administered from 04/01/25-04/02/25 due to not arriving from the contracted facility pharmacy.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry for clonazepam 1mg one tablet three times a day scheduled at 8:00am, 2:00pm, and 8:00pm was documented as on hold until 05/28/25.
-There was no documentation clonazepam 1mg was administered 05/01/25-05/08/25.

Observation of Resident #2's medications on 05/06/25 at 3:32pm revealed:
-There were eight clonazepam 1mg tablets available.
-The dispense date was 04/02/25.

Observation of Resident #2's medication on 05/08/25 at 8:34am revealed:
-There were 84 clonazepam 1mg tablets available.
-The dispense date was 04/24/25.

Telephone interview with the facility's contracted pharmacy on 05/08/25 at 10:08am revealed:
-The pharmacy dispensed clonazepam 1mg tablets in a quantity of 18 tablets on 03/06/25, 03/13/25, and 03/21/25 for Resident #2.
-The pharmacy dispensed clonazepam 1mg tablets in a quantity of 84 tablets on 04/02/25 and 04/24/25 for Resident #2.

Interview with Resident #2 on 05/06/25 at 9:30am revealed:
-Her clonazepam had recently been discontinued.

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-No one had explained why.
-She did not know who wrote the order to discontinue the clonazepam.
-She had taken the clonazepam for "years."

Interview with Resident #2 on 05/08/25 at 9:35am revealed:
-She felt really "anxious inside" when she did not receive the clonazepam.
-It made her "skin crawl" when she went without the clonazepam.
-She had a hard time sleeping when she did not receive the clonazepam.

Interview with a medication aide (MA) on 05/06/25 at 3:52pm revealed:
-She documented the entries on 03/21/25 at 2:00pm and 8:00pm and on 03/23/25 at 2:00pm and 8:00pm on Resident #2's eMAR.
-She did not administer the clonazepam to Resident #2 at 2:00pm and 8:00pm on 03/21/25 and 03/23/25 because there was no clonazepam available to administer.
-The clonazepam was not available because they were waiting on a refill from the pharmacy.
-The MAs were able to reorder medications through the eMAR.
-Once the MAs electronically demanded a refill from the pharmacy and the medication did not arrive within two days, they were supposed to let the Resident Care Coordinator (RCC) know the medication was not available.
-It was the RCC or the Administrator's responsibility to contact the pharmacy and find out why the medication had not been delivered.
-The RCC or the Administrator was responsible for contacting the PCP to obtain new prescriptions if needed.
-The RCC or the Administrator were responsible for notifying the prescriber of missed doses of a

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medication.
-She did not know if the facility had access to a backup pharmacy.

Telephone interview with Resident #2's mental health provider (MHP) on 05/08/25 at 9:20am and at 3:57pm revealed:
-She ordered clonazepam for Resident #2 to treat bipolar disorder, anxiety disorder, and insomnia.
-She ordered the clonazepam to be administered to Resident #2 scheduled three times a day.
-Resident #2 would experience increased anxiety without the medication.
-She did not know Resident #2 missed 19 doses of clonazepam in March and 5 doses of clonazepam in April.
-She had not been informed Resident #2 needed a refill for the clonazepam until the Administrator emailed her on 03/24/25.
-She sent a clonazepam refill to the pharmacy on 04/02/25.
-The clonazepam prescription prior was written on 01/06/25 and would have been enough clonazepam to cover
-The verbal order she provided on 04/28/25 was to hold the clonazepam until the medication arrived from the pharmacy.
-If the clonazepam was available, she wanted it to be administered to Resident #2.
-Resident #2 could go through withdrawals if she did not receive the clonazepam as ordered.
-Withdrawal from clonazepam could cause increased anxiety and delirium.

Interview with the Administrator on 05/07/25 at 12:02pm revealed:
-She did not know Resident #2 had missed 19 doses of clonazepam in March and 5 doses in April.
-She did not know how that happened as the

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MHP sent electronic prescriptions to the pharmacy for refills.
-She became aware Resident #2 needed a refill for clonazepam on 03/24/25.
-She reached out to Resident #2's MHP on 03/24/25 to request a clonazepam refill.
-The clonazepam was received from the pharmacy on 03/25/25.
-The former RCC was responsible for weekly medication cart audits.
-Medication cart audits helped to identify problems with medication availability.
-The last documentation of a medication cart audit she could find was from December 2024.
-She did not know if the former RCC had completed any medication cart audits after December 2024.

b. Review of Resident #2's physician's order dated 02/27/25 revealed Ozempic (used to regulate blood sugar levels) 4mg/3ml inject 1mg subcutaneously once a week.

Review of Resident #2's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Ozempic 4mg/3ml inject 1mg subcutaneously once a week scheduled at 8:00am with a start date of 02/27/25.
-There was no documentation Ozempic 1mg was administered 02/01/25-02/28/25.

Review of Resident #2's March 2025 eMAR revealed:
-There was an entry for Ozempic 4mg/3ml inject 1mg subcutaneously once a week scheduled at 8:00am with a start date of 02/27/25.
-The Ozempic was documented as administered on two occurrences out of five opportunities from 03/01/25-03/31/25.

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-On 03/17/25, Ozempic was documented as not administered due to resident refusal.
-On 03/24/25, Ozempic was documented as not administered due to awaiting delivery from pharmacy.
-On 03/31/25, Ozempic was documented as not administered due to resident refusal.

Review of Resident #2's April 2025 eMAR revealed:
-There was an entry for Ozempic 4mg/3ml inject 1mg subcutaneously once a week scheduled at 8:00am.
-The Ozempic was documented as administered as ordered on 04/07/25, 04/14/25, 04/21/25, and 04/28/25.

Review of Resident #2's May 2025 eMAR revealed:
-There was an entry for Ozempic 4mg/3ml inject 1mg subcutaneously once a week scheduled at 8:00am with a start date of 02/27/25.
-Ozempic was documented as administered as ordered on 05/05/25.

Observation of Resident #2's medications on hand on 05/06/25 at 3:32pm revealed there was one Ozempic 4mg/3ml pen available with a dispense date of 04/28/25.

Telephone interview with the facility's contracted pharmacy on 05/08/25 at 10:08am revealed:
-The pharmacy dispensed one Ozempic 4mg/3ml pen on 02/27/25, 03/24/25, and on 03/28/25 for Resident #2.
-One Ozempic 3ml pen provided a 28-day supply of the medication.

Interview with Resident #2 on 05/08/25 at 9:35am revealed:

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D 358	Continued From page 38 -She had never refused the Ozempic medication. -She did not know why the Ozempic was documented as refused on 03/17/25 and 03/31/25. Interview with the Administrator on 05/07/25 at 12:02pm revealed: -She did not know why Resident #2's Ozempic was not administered on 03/24/25. -There should have been enough Ozempic available that had already been sent from the pharmacy. Telephone interview with Resident #2's Physician on 05/08/25 at 3:11pm revealed: -Ozempic was ordered to control diabetes. -He sent an electronic prescription to the pharmacy on 02/27/25 with three refills. -He did not know why the facility ran out of the Ozempic, because the prescription provided an adequate supply. -The facility should have asked for a refill from the pharmacy, and they would have delivered it to them. 3. Review of Resident #1's current FL2 dated 04/10/25 revealed: -Diagnoses included hypertension and post-traumatic stress disorder (PTSD). -The section labeled "Respiration" was blank. -There was not an order for oxygen. Review of Resident #1's Resident Register dated 02/20/25 revealed he was admitted to the facility from home. Review of Resident #1's record revealed no subsequent provider orders for oxygen administration.	D 358		

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	HAL011373	A. BUILDING: _____ B. WING _____	R-C 05/08/2025

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D 358	Continued From page 39 Observation of Resident #1 during the initial facility tour on 05/06/25 at 9:08am revealed he was sitting in his recliner and using a nasal canula that was attached to an operating oxygen concentrator. Interview with the Administrator on 05/07/25 at 12:53pm revealed: -She did not know Resident #1 was on oxygen. -There was no order found for Resident #1 for the use of an oxygen concentrator. -She did not know how the oxygen concentrator was placed in Resident #1's room. Interview with Resident #1's Primary Care Physician (PCP) on 05/07/25 at 3:09pm revealed: -He did not know Resident #1 was using oxygen via an oxygen concentrator. -He did not agree the oxygen was medically necessary. Interview with a representative from Resident #1's home care agency on 05/07/25 at 3:15pm revealed: -Home Care worked with Resident #1 prior to his residency at this facility. -Resident #1 did not use oxygen prior to moving to the facility. -She was not sure when he began using oxygen. Interview with Resident #1 on 05/07/25 at 3:20pm revealed: -He brought the oxygen concentrator to the facility from home. -He did not let the Administrator know that he brought the oxygen. -He uses oxygen to manage anxiety. -He could not recall who prescribed the oxygen concentrator.	D 358		

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D 358	Continued From page 40 Interview with a representative from Resident #1's oxygen supply company on 05/08/25 at 9:50am revealed: -Resident #1 had orders for the oxygen and the oxygen concentrator dated 09/28/2020. -No updated order had been received from the ordering provider. _____ The facility failed to administer a medication used to control high blood sugar to Resident #3 who had a history of high blood sugars with resulting diabetic complications including a diabetic toe ulcer. This failure was a substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/07/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 07, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	D 367		

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D 367	Continued From page 41	D 367		

documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to accurately document the administration of medication on the electronic medication administration record (eMAR) for 1 of 3 sampled resident (#3) related to a medication to treat elevated blood sugars.

The findings are:

Review of the facility's undated medication administration policy revealed:
-If a medication is not available, in the Quick MAR system click on the medication that is not available and at the next screen click on "arriving from pharmacy".
-Notify the prescribing provider.

Review of Resident #3's current FL2 dated 03/12/25 revealed:
-Diagnoses included intracranial injury and weak gait.
-An order for Farxiga (used to treat high blood sugars), 10mg daily.

Further review of Resident #3's record revealed Farxiga was originally ordered on 12/11/24.

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D 367	Continued From page 42 Interview with Resident #3 on 05/06/25 at 9:08am revealed: -Sometimes he ran out of medications but he could not remember the names of them. -He thought he ran out of medications because the pharmacy did not deliver them. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/06/25 at 3:53pm revealed: -Resident #3 was ordered Farxiga 10mg daily on 12/11/24 and 3 were sent to the facility. -The pharmacy continued to send 3 tablets for a total of 72 tablets sent on 24 occasions; 15 tablets in December 2024, 18 tablets in January 2025, 12 tablets in February 2025, 15 tablets in March 2025 and 12 tablets in April 2025. -The last electronic refill request was received from the facility on 04/21/25 and the last 3 tablets were sent to the facility on 04/22/25. Review of Resident #3's eMARs from 12/11/24 through 05/06/25 revealed Farxiga was documented as administered on 118 occasions. Telephone interview with a medication aide (MA) on 05/08/25 at 9:24am revealed: -He probably was just not thinking when he documented administration if Farxiga was not available to be administered. -He usually documented administration as he popped the tablet into the cup and he assumed he did that by accident. Interview with another MA on 05/08/25 at 11:27am revealed: -If she documented administration in error it probably was during a time she was helping another MA and they were rushing.	D 367		

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D 367	Continued From page 43 -She was trained correctly how to document administration of medications but she knew sometimes the MAs did it wrong. Interview with the Resident Care Coordinator (RCC) on 05/08/25 at 9:35am revealed she did not know why she documented administration of Farxiga if the medication was not available. Interview with the Administrator on 05/08/25 at 9:31am revealed: -Staff were expected to document administration of a medication only if the medication was available. -All MAs had been trained properly in medication administration documentation.	D 367		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and	D 433		

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D 433	Continued From page 44 (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain resident records in the adult care home that were readily available for review for 7 of 7 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7). The findings are: Observation in the facility on 05/06/25, 05/07/25, and 05/08/25 revealed there were no resident records available in the facility. Interview with a personal care aide (PCA) on 05/06/25 at 9:00am revealed: -The resident records were kept at the business office in another building.	D 433		

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D 433	Continued From page 45 -The Resident Care Coordinator (RCC) would deliver resident records to the facility upon request or they could be obtained at the business office. Interview with the Administrator on 05/07/25 at 12:47pm revealed: -The resident records were kept locked in the business office in a separate building from the facility. -The resident records were moved to the business office because documents from the resident records had "gone missing." -They were in the process of taking the resident records back to the facility to be stored. -There was a storage alcove for the resident records on the back hallway of the facility. -They needed to get a secure lock for the alcove and a key for the medication aides before storing the resident records in the building again.	D 433		