Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL042005	A. BUILDING: _____ B. WING _____	C 05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation from 05/14/25 to 05/16/25.	D 000		
D 119	10A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that a hand bell or other signaling device was in place for multiple residents. The findings are: Observation of a resident room on 05/14/25 at 8:40am revealed there was no hand bell or signaling device in the bedroom. Interview with the resident on 05/14/25 at 8:40am revealed: -He did not have a hand bell in his room. -He needed assistance with incontinence care. -If he needed help he would call out for staff or just wait until a staff member came to check on him. Observation of a second resident's room on 05/14/25 at 8:50am revealed there was no hand	D 119	Resident Call Bells For resident rooms not equipped with an electronic call system, hand bells will be provided. Residents will be instructed to use these bells to signal staff when assistance is needed. Staff are responsible for daily monitoring to ensure hand bells are present and functional in all rooms. This daily oversight will be monitored by the Manager and Resident Care Coordinator (RCC).	5/17/25

Reviewed and Acknowledged SJS 6/18/25

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bell or signaling device in the bedroom.

Interview with the second resident on 05/14/25 at 8:50am revealed:
-Her hand bell broke about two months ago.
-She needed assistance with incontinence care.
-She was in a wheelchair.
-If she needed assistance from staff she would just yell until someone came to assist her.

Observation of a third resident's room on 05/14/25 at 10:15am revealed there was no hand bell or signaling device in the bedroom.

Interview with the third resident on 05/14/25 at 10:15am revealed:
-She never had a hand bell or any signaling device.
-She was in a wheelchair.
-She did not know what she would do if she needed assistance from staff.

Interview with a personal care aide (PCA) on 05/14/25 at 11:20am
-The residents that did not have call bells in their rooms were more independent and did not need assistance.
-The residents that did not have hand bells in their rooms had no way of alerting staff if they needed assistance.

Interview with the Resident Care Coordinator (RCC) on 05/14/25 at 11:30am revealed:
-The older wing of facility did not have electric call bells.
-All of the residents on the older wing of the facility should have hand bells in their rooms.
-It was important for all residents to have a way to call staff if they needed assistance.
-If a resident fell or had an accident and need

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D 119	Continued From page 2 assistance they needed a way to alert staff. Interview with the Administrator on 05/14/25 at 11:40am revealed: -All residents should have hand bells in their room. -There were heavy care residents on the wing of the facility without electric call bells. -It was important that each resident have a hand bell to alert staff if they needed assistance. -If residents did not have a way to alert staff they could not get assistance in a timely manner.	D 119		
D 229	10A NCAC 13F .0702 (g) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary; (2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and (A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the facility administrator or their designee shall contact the local adult care home resident discharge team as defined in G.S. 131D 4.8(e) to assist with placement; and	D 229	When a resident is discharged, the facility will ensure the resident or their responsible party receives comprehensive information regarding the discharge. This includes a copy of the discharge notice explaining why the discharge is necessary and identifying an appropriate discharge destination that can meet the resident's needs. If the facility can't find suitable placement or the resident declines assistance, the facility will contact the local adult care home resident discharge team for help. Residents or their responsible parties will be informed of their right to ask the Regional Long-Term Care Ombudsman to join the adult care home resident discharge team.	

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D 229	Continued From page 3 (B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible person of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and (3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's most current assessment and care plan; (C) a list of referrals to licensed health professionals, including mental health; (D) a copy of the resident's current physician orders; (E) a list of the resident's current medications; (F) the resident's current medications; and (G) a record of the resident's vaccinations and TB screening; (4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule: (A) the regional long-term care ombudsman; and (B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities; (5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the	D 229	con't Upon discharge, the resident or responsible party will receive the following documents: • The most current FL-2 form. • The most current assessment and care plan. • A list of referrals to licensed health professionals, including mental health services. • A copy of the resident's current physician orders. • A list of the resident's current medications, along with the medications themselves. • A record of the resident's vaccinations and TB screening. this will monitored on a case by case basis by the facility manager to assure compliance	05/17/25

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D 229	Continued From page 4 discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure a safe and orderly discharge for 1 of 1 resident (#8), who received hospice services, was wheelchair bound, with a large amount of cash, narcotic pain medications, and was observed smoking while on oxygen. The findings are: Review of the facility's undated discharge policy revealed: -There was a discharge policy in the resident handbook provided to residents and their responsible party (RP) when the Resident Register was completed at admission to the facility. -If the resident or responsible person initiated discharge, he/she would give the facility a 14 day written notice. -If the resident left before the 14-day written notice was up, the facility reserved the right to charge the resident for the entire 14 days. -The facility would initiate discharge if it was believed that discharge was necessary for the following reasons, the resident's welfare and needs could not be met in the facility, the resident's health had improved and the resident no longer needed the services, the safety of other	D 229		

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D 229	Continued From page 5 residents in the facility was endangered, the health of other individuals in the facility was endangered, failure to pay the cost of services by the due date, and except for discharge of non-payment, copies of documentation by the resident's physician, physician assistance, or nurse practitioner will be provided, which substantiates the need for discharge. -Notice of discharge would be for at least 30 days when practicable. -Discharge may be immediate, if the health or safety of the resident, or other individuals were at risk and the resident's urgent medical needs could not be met. -The Adult Care Home Notice of Discharge and the Adult Care Home Hearing Request Form would be given or delivered to the resident, RP, or legal representative on the same day the Notice of Discharge is dated. -The facility would assist the resident to assure a safe and orderly discharge by notifying the local county Department of Social Services (DSS), explaining to the resident, RP and/or legal representative, why the discharge was necessary, and inform the resident, RP and/or legal representative about an appropriate discharge destination. -If requested, upon discharge the facility would provide current copies of the resident's FL-2, assessment and care plan, physician's orders, list of current medications, all medications belonging to the resident, a record of the resident's vaccinations and tuberculous (TB) screening. -If the resident or RP appealed the discharge and requested a hearing, the facility would provide copies of all documents and records the facility intended to use at least 5 days before a hearing. -The facility would not discharge the resident before the final decisions resulting from the appeal except when it was believed and	D 229		

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D 229	Continued From page 6 substantiated by a physician/physician assistant, or nurse practitioner that the health and/or safety of other individuals in the facility were at risk and/or the resident's welfare and urgent medical needs could not be met. Review of the facility's resident rights policy dated 10/12/24 revealed: -The Administrator and staff will make every effort to assist residents to know and exercise their rights, the adult care home resident's bill of rights. -To not be transferred or discharged from a facility except for medical reasons, the residents' welfare, nonpayment for the stay, or when the transfer is mandated state or federal law. -The resident shall be given at least 30 days advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the facility. -The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the medical care commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. -The medical care commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as state and federal rule and regulations governing the transfer or discharge of residents from nursing homes. Review of Resident #8's current FL-2 dated 10/02/24 revealed: -Diagnoses included chronic pain, chronic pulmonary embolism, and depressive episodes. -The resident was constantly disoriented and semi-ambulatory. -The resident was continent of bladder and	D 229		

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bowel.
-The resident's current level of care was Assisted Living (AL).

Review of Resident #8's Resident Register revealed an admission date of 10/05/23 and listed the responsible party as a family member.

Review of Resident #8's current care plan dated 01/30/25 revealed:
-The resident required limited assistance with toileting, ambulation, bathing, dressing, grooming, and transfers.
-The resident was oriented, and his memory was adequate.

Review of Resident #8's hospice physician certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss.

Review of Resident #8's hospice recertification plan of care dated 03/27/25 revealed:
-The resident was wheelchair bound.
-Resident #8 had crippling dyspnea at rest which was worsened with exertion (Dyspnea is shortness of breath).
-The resident had intractable pain which was managed by medications prescribed by the hospice medical director (Intractable pain is pain that persists despite aggressive medical treatments and is characterized by being constant, intense, and debilitating pain).
-The resident had an increased need for assistance with activities of daily living (ADLs) and had increased weakness and fatigue due to his pain medication.

Review of the hospice aide care plan dated

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D 229	Continued From page 8 03/27/25 revealed Resident #8 required assistance with bathing, dressing, toileting, grooming, oral care, shampooing his hair, and meal setup. Review of an Accident and Incident (A/I) report dated 05/02/25 revealed: -Resident #8 became irritated because he thought a male resident had stolen something from his room. -Resident #8 went to find the male resident and began punching the resident in the head. -The medication aide (MA) got in between the two resident's and Resident #8 reached around the MA and pulled the male resident's hair. -During the process of completing the A/I report, the male resident that Resident #8 hit called local law enforcement. -Local law enforcement arrived at the facility, the MA explained what occurred, and the MA completed the A/I report. Review of an undated progress note attached to the A/I report dated 05/02/25 revealed: -The progress note was made by a MA. -Resident #8 hit a male resident on his head after accusing the resident of taking a snack can from his room. -The male resident called local law enforcement who arrived at the facility, the male resident wanted to press charges against Resident #8. Review of a local law enforcement dispatch report dated 05/02/25 revealed: -Dispatch received a call from a male resident on 05/02/25 at 8:11pm stating he was assaulted by Resident #8. -The caller reported he was currently in the dining room at the facility.	D 229		

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D 229	Continued From page 9 Review of an A/I report dated 05/03/25 revealed: -A personal care aide (PCA) wrote the A/I report and the Facility Manager signed the A/I report. -The PCA was transporting a male resident to their room, when walking down the hallway Resident #8 attempted to hit the male resident in the back of the head. -The PCA "blocked" the hit and asked Resident #8 to please not hit the male resident, the PCA turned her back and proceeded to transport the male resident. -When the PCA turned her back, Resident #8 called her a racial slur and threw hot coffee on the PCA. Attempted telephone interview with the PCA who completed the A/I report on 05/16/25 at 1:19pm was unsuccessful. Review of Resident #8's notice of transfer/discharge dated 05/03/25 revealed: -The transfer/discharge was necessary for the safety of the resident or other individuals in the facility were endangered, the resident was a danger to others. -Resident #8's responsible party (RP) and hospice were notified of the discharge, there was no date or time listed. -The planned discharge location was initially the resident's family members home, prior to a local hotel. -The long term care ombudsman's name and telephone number were listed on the discharge form. -Attached to the discharge notice was a copy of Adult Care Licensure Services 10A NCAC 13F .0702 Discharge of Residents with .0702(b)(3) highlighted. -The highlighted portion of 10A NCAC 13F .0702(b)(3) listed the safety of the resident or	D 229		

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other individuals in the facility was endangered as determined by the facility at the direction of the Administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner.
-There was a copy of a check made out to Resident #8 dated 05/03/25 for "refund check," in the amount of $1,227.48.
-There was a copy of a check made out to Resident #8 dated 05/03/25 for "resident payor," in the amount of $905.00.
-Below the copy of the check for $905.00 there was a "Resident Account Cash Receipt" dated May 3, 2025 that was signed by Resident #8.
-There was a signature page for the discharge with the notice of transfer/discharge dated 05/03/25.
-The discharge was initiated by the Administrator and the reason for the discharge was the resident was a danger to himself and others.
-The date of discharge was 05/03/25.
-The new address listed was the address of a family member of Resident #8.
-There was documentation the resident was discharged to "other," with the name of a local hotel and hotel room number listed.
-A copy of the discharge notice was given to the person identified by the resident in Section A #12 of the transfer/discharge form as required by general statute 131D-4 87, there was a box that could be checked "yes."
-The box was checked "yes."
-Below that there was a handwritten note was "Pt (patient) waives 14 day notice."
-The resident signed the form dated 05/03/25.
-The Facility Manager signed below the resident, and it was dated 05/03/25.
-The third page of the transfer/discharge documentation included an area for the resident or the resident's RP to sign under a signature

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heading.
-The signature heading revealed, "The resident or his/her responsible party should be asked to sign this form only after Sections A-E have been completed, the Administrator or Supervisor in Charge/Administrator in charge should review this form with the resident or his/her responsible person at least once a year and revise it as needed using Section H, Section G to be completed at the time the resident was discharged or transfers from the facility.
-There was a space for the resident or the resident's responsible party to date and sign, and there was a space for the Administrator or Supervisor in Charge/Administrator in Charge to date and sign.
-There was only an "X" placed at the Resident or Resident' Responsible Party signature line, and an "X" placed at the date.
-There was no signature by the Administrator or the Facility Manager.
-There was no documentation that the right to appeal was provided with the discharge notice.

Review of a statement written by a staff person on 05/05/25 revealed:
-She documented the statement based on what the male resident reported occurred with the altercation with Resident #8 on 05/03/25.
-Resident #8 got mad because he accused me of going into his room.
-Resident #8 punched him in the head for no reason, because the resident had not been in Resident #8's room.
-Resident #8 tried to throw coffee on him, the PCA blocked it and coffee was thrown on her back.

Review of an undated statement written by a MA revealed:

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CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

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D 229	Continued From page 12 -The PCA came to tell her that Resident #8 threw hot coffee on her back. -The PCA reported that Resident #8 and a male resident were passing each other in the hall and Resident #8 attempted to hit the male resident. -The PCA blocked Resident #8's arm and turned around to move the male resident when Resident #8 threw coffee on her back. -The MA found the PCA a dry shirt and then called Resident #8's responsible party (RP) to inform her of the incident. -The RP asked the MA to tell the PCA she was sorry this occurred. -The MA then called the Facility Manager and the Assistant Facility Manager to report what had occurred. -Approximately 10 minutes later the Facility Manager called her back and told her to notify local law enforcement. -Once local law enforcement arrived, she informed them of the incident. -The MA called the Facility Manager so she could speak with local law enforcement. -The MA called the Assistant Facility Manager to come to the facility to get the rule book. -After local law enforcement left, the Facility Manager arrived and went to talk with Resident #8 in his room. -The Facility Manager then called the MA and a second MA into her office and directed them to get the resident's medications ready so he could be discharged. Review of a progress note by the MA dated 05/03/25 at 2:24pm revealed: -The PCA notified her that Resident #8 was "about to fight" with a male resident. -Resident #8 swung his arm and the PCA blocked him so that he could not hit the male resident. -When the PCA turned around, Resident #8 threw	D 229		

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D 229	Continued From page 13 coffee on her back. -The MA called the resident's RP and she talked with Resident #8. Review of a statement written by the Assistant Facility Manager revealed: -On 05/03/25 at 2:35pm she received a text message from the MA that Resident #8 had thrown coffee on a PCA. -The Assistant Facility Manager directed the MA to call the Facility Manager and for the PCA to call local law enforcement if she desired. -The MA then called the Assistant Facility Manager and reported that local law enforcement were at the facility and that she needed to let her into the office so she could get the rule book. -The Assistant Facility Manager arrived at the facility and the MA printed two papers that the "regional boss" (Administrator) had sent to her to complete. -Local law enforcement informed the Assistant Facility Manager that they were unable to remove the resident from the facility because he was on hospice. -The Administrator was called and local law enforcement explained to the Administrator why they were unable to remove the resident from the facility. Review of an undated statement written by the Facility Manager revealed: -On 05/03/25 she returned to the facility to speak with Resident #8. -Resident #8 decided he wanted to leave the facility after the incident with a male resident and a PCA. -The resident stated at the time he was going to his brother's house, and the manager asked the resident what staff member he preferred to pack his belongings.	D 229		

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D 229	Continued From page 14 -The resident was asked who he wanted to help him pack his items, and the resident requested a staff person who assisted the resident pack his belongings. -The Facility Manager brought the resident to her office and gave him the money he had in the safe, wrote a check for his resident account, and wrote a refund check for the month of May. -Resident #8 signed the discharge papers and medication release form. -She transported the resident with a family member of hers to the resident's family's home. -She blew the horn four times, and no one came out of the house. -Resident #8 stated "just let me out," and she explained that she could not just let him out and asked where he would like to go. -The resident said a hotel. -The Facility Manager stopped at two local hotels where there were no "bottom rooms" available. -There was a handicap room available at the third hotel she went to, and the resident paid for a two day stay. -She ensured the resident's oxygen was connected, gave the resident his medications, and asked if he wanted something to eat. -The resident declined to get something to eat. -She gave the resident her business card, the hospice telephone number and told him if he needed anything before getting in contact with his family to call her. -The resident then asked for a hug and stated that she had been good to him, and she left. Review of a written statement dated 05/05/25 by the Facility Manager revealed: -She called the local Department of Social Services (DSS) and spoke with a staff person to report the incident with Resident #8 and that he had been discharged.	D 229		

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D 229	Continued From page 15 -She was transferred to another staff person with adult services at DSS and reported the incident with Resident #8 and that he had been discharged. -She was transferred to a third staff person in adult services and reported the incident with Resident #8 and that he had been discharged. -The third staff person directed her to fax all paperwork and notes to DSS. -She also left a voicemail for the local ombudsman at 9:20am. Review of a local law enforcement dispatch report police report dated 05/03/25 revealed: -Dispatch received a call from the MA at the facility at 2:57pm on 05/03/25. -The MA reported that Resident #8 assaulted an employee with hot coffee, and they wanted the resident removed from the premises. -There were no weapons involved at the time of the call. Review of an Incident/Investigation Report from local law enforcement revealed: -Resident #8's family member called local law enforcement to file a report on 05/08/25 at 11:32am regarding elder abuse at the facility. -The resident's family member reported to emergency dispatch that Resident #8 was on hospice care and was kicked out of the facility on 05/03/25, placed in a hotel, and family was not notified. -The resident's family member reported that she spoke with DSS and a worker there advised her that she needed to contact local law enforcement to file a report of neglect. -The resident's family member reported she was notified by a MA that there was an incident on 05/03/25 with Resident #8 and that he threw coffee on an PCA.	D 229		

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D 229	Continued From page 16 -The family member reported that she told the MA to apologize to the PCA for Resident #8's behaviors. -The family member reported that Resident #8 was of advanced age, was wheelchair bound, and was on oxygen. -The family member did not receive any other telephone calls from the facility on 05/03/25. -She received a telephone call from Resident #8 on 05/03/25 at 6:38pm, when he stated the facility manager dropped him off at a local hotel and he provided her with the room number. -Resident #8 informed his family member that the Facility Manager checked him into the local hotel and he had to pay for two nights. -The family member attempted to reach hospice the evening of 05/03/25 but was unsuccessful. -On 05/04/25, hospice sent a nurse to assess Resident #8 and his living conditions. -The hospice nurse deemed that Resident #8 was not safe in the hotel room due to being dropped off with narcotic medications, as well as the physical condition of being wheelchair bound and on oxygen. -The hospice nurse had Resident #8 transported to a local emergency department (ED). -On 05/05/25 Resident #8 left the hospital and had someone drop him off at another family members' home. -The family member was notified by a representative with DSS that the Facility Manager had called DSS to cancel all payments to the facility due to Resident #8 no longer residing at the facility. -Resident #8 was placed at another AL on 05/08/25. -The law enforcement officer attempted to speak with the Facility Manager but was informed by a MA at the facility that she was not available. -The MA at the facility informed her she was	D 229		

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present when Resident #8 assaulted a PCA on 05/03/25.
-The MA explained that Resident #8 got into an argument with a male resident and the PCA stepped in between the two residents to attempt to break them up, and Resident #8 threw a cup of coffee on the PCA.
-The MA called 911 and notified Resident #8's family member of the incident since the family member was the emergency contact and medical power of attorney.
-The MA reported that the Facility Manager took Resident #8 to his family members' home to her knowledge, and the Facility Manager called the resident's family member about getting the resident off the property.
-A sergeant noted at the end of the local law enforcement report that the employee of the rest home was not the target of the assault nor did anyone else complain about the assault.
-The assisted living facility (ALF) could be held accountable for placing Resident #8 somewhere without proper care.

Review of hospital records for Resident #8 revealed:
-The resident was seen at a local emergency department (ED) on 05/04/25 at 7:18pm.
-The resident was transported to the local ED by emergency medical services (EMS) from a hotel.
-The resident was removed from the ALF on 05/03/25 due to a physical altercation with another resident and staff.
-Per the hospice nurse, staff from the ALF took the resident to a hotel and left the resident there.
-The resident spent the night at a local hotel on 05/03/25.
-The resident has a history of metastatic cancer and received hospice care for comfort care only.
-The residents past medical history included

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arthritis, chronic pancreatitis, chronic obstructive pulmonary disease, hepatic cirrhosis, and substance abuse.
-The resident reported to local ED staff that a resident at the facility stole money from him on 05/03/25, he and the resident got into an argument which escalated to a physician confrontation, and Resident #8 reported that he punched the other resident after the resident swung at him.
-The residents' mental status seemed normal on 05/04/25 at 7:55pm.
-The resident did not want to be stuck with any needles, declined blood tests, and x-rays.
-The resident was prescribed multiple pain medications for his cancer.
-The hospice team was unable to find placement for Resident #8 and hospice requested that the ED keep the resident at least overnight until the ED case manager could help with placement in the morning.
-On 05/04/25 at 9:00pm the resident had 2 checks and cash that was inventoried at the local ED.
-The resident had two $50.00 bills, ninety-five $20.00 bills, one check for $1,227.48, and one check for $905.00 which was secured in a safe by hospital staff on 05/04/25 at 10:06pm.
-On 05/04/25 at 10:28pm the hospice nurse reported to a hospital staff member that the resident had taken all of his Methadone and Oxycodone out of the pharmacy packaged blister packs and placed them in different prescription bottles (Methadone is a controlled substance used to treat moderate to severe pain and Oxycodone is a controlled substance used to treat moderate to severe pain).
-One prescription bottle was labeled Lorazepam, however there was a quantity of 34 Oxycodone HCL 15mg pills in the bottle (Lorazepam is a

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controlled substance used to treat anxiety).
-A second prescription bottle was labeled Dexamethasone 2mg, however there was a quantity of 62 and 2 half pills of Methadone HCL 5mg in the prescription bottle (Dexamethasone is used to treat inflammation and pain of the skin, joints, lungs, and other organs).
-There was documentation the resident requested pain medication on 05/05/25 at 4:15am.
-There was documentation the resident requested Oxycodone and Methadone on 05/05/25 at 8:09am.
-The nurse informed the resident that his Methadone was not scheduled until 10:00am and he would have to wait for his Methadone.
-The resident became upset and stated that he did not understand why he had to wait for his Methadone.
-There was documentation that the resident was unable to be located in his room or on the hospital floor on 05/05/25 at 9:14am.
-The nurse went outside and observed the resident in his wheelchair in the hospital parking lot with the charge nurse, the case manager and hospital security.
-The resident reported that he wanted to ambulate in his wheelchair far enough away from the hospital so he could smoke a cigarette.
-The nurse assessed the resident's cognitive status by asking do you know where you are right now, what is your name, what year is it, and what season is it.
-The resident answered the four questions correctly and was allowed to smoke his cigarette accompanied by hospital security.
-The resident returned to his room on 05/05/25 at 9:27am with hospital security.
-A nurse heard the resident yelling and observed the resident signing discharge paperwork with his

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hospice nurse on 05/05/25 at 1:19pm.
-The resident left the hospital Against Medical Advice (AMA) on 05/05/25 at 4:26pm.

Telephone interview with Resident #8 on 05/15/25 at 5:00pm revealed:
-He observed a male resident on Saturday (05/03/25) come out of his room.
-He could not find $40.00 that he left on his bed by accident and thought the male resident had stolen his money.
-He asked the male resident for his money back, and the male resident stood up "like he was gonna hit me, he got in my face."
-A PCA hit him in the back of the head and told him to stop arguing with the male resident.
-The Facility Manager came to his room and told him that he was leaving, to get what he wanted to take with him.
-The Facility Manager gave him his money from a safe and two checks made out to him.
-The Facility Manager drove him to a family members' home, but no one was home so she went to look for a hotel.
-He was left at a hotel on the first floor with his pain medications and his oxygen.

Review of a hotel reservation invoice that was printed on 05/15/25 at 1:05pm revealed:
-Resident #8 was listed as the individual making the hotel reservation for two nights.
-The check in was on 05/03/25 at 1:18pm.
-The check out was on 05/04/25 at 4:26pm.
-The reserved room was #121 in Building #2.
-$238.56 was paid for the hotel room.

Observation of the hotel, Room 121 at Building #2 on 05/15/25 at 1:15pm revealed:
-The door for room 121 exited onto a sidewalk with a curb at the edge of the sidewalk.

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D 229	Continued From page 21 -One hotel door down there was a handicap area to exit to the parking lot, without a curb at the edge of the sidewalk. -There was a slight incline from Building #2 to the front lobby. -There was a bathtub with a shower in the room with a grab bar, but no shower chair was present. Interview with a MA on 05/15/25 at 2:36pm revealed: -She worked the day Resident #8 threw coffee on a PCA but was in the medication room when it occurred. -She then called the Assistant Facility Manager and the Facility Manager to update them on the incident. -The Facility Manager directed her to call 911. -Local law enforcement arrived at the facility, and she called her Facility Manager so she could speak with them and tell them that they needed the resident removed from the facility for physically assaulting an employee. -Local law enforcement were not able to remove the resident from the facility because he was wheelchair bound and on hospice services. -Once the Facility Manager arrived at the facility, she spoke privately with the resident and then instructed her and a second MA to gather the resident's medications so he could be discharged. Telephone interview with a second MA on 05/16/25 at 1:19pm revealed: -She never had any problems interacting with Resident #8. -When she observed the resident become agitated or upset, she was able to talk with him to calm him down. Interview with the Assistant Facility Manager on	D 229		

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D 229	Continued From page 22 05/15/25 at 3:00pm revealed: -She had worked at the facility for almost 2 years. -Resident #8 had been "acting out almost the whole time he's been here." -On 05/03/25 she received a telephone call from the MA on duty that Resident #8 had been in an altercation. -She instructed the MA to call the Facility Manager. -The Assistant Facility Manager called the Facility Manager to ensure the MA had notified her of the incident with Resident #8. -She received a text message from the Administrator that contained discharge summary forms. -She was instructed by the Administrator to print the discharge summary forms. -When she arrived at the facility, she asked the MA to print the discharge summary forms. -Once she arrived at the facility law enforcement were present. -She heard a law enforcement officer ask the MA if Resident #8 could take care of himself, and the MA responded yes. -The law enforcement officer asked if the resident could take care of himself then why was he at the facility. -The law enforcement officer informed her and the MA that they could not remove the resident from the property because he was on hospice and was wheelchair bound. -She and the MA reported to the Administrator that law enforcement were not able to remove the resident from the property. -She left the discharge forms on her desk and left the facility. Interview with the Facility Manager on 05/14/25 at 8:54am revealed: -Resident #8 was discharged from the facility on	D 229		

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05/03/25 due to his behavior.
-The resident got into an altercation with another male resident, and when a PCA got in between the two residents, Resident #8 spilled coffee on the PCA.
-The altercation on 05/03/25 "was the last straw" for Resident #8.
-Resident #8 was a danger to other residents and the facility had no choice but to discharge the resident.

Second interview with the Facility Manager on 05/14/25 at 4:00pm revealed:
-Resident #8 assaulted a resident on 05/02/25.
-Local law enforcement were notified by the resident that Resident #8 assaulted on 05/02/25.
-Resident #8 attempted to assault the same resident again on 05/03/25, because he thought the resident had stolen something from his room.
-During the altercation on 05/03/25 a PCA got in between the two residents to diffuse the situation and Resident #8 threw coffee on the PCA.
-Local law enforcement were notified by staff about Resident #8 throwing coffee on the PCA.
-She notified the Administrator about Resident #8's aggressive behaviors that occurred on 05/02/25 and 05/03/25.
-The Administrator instructed her to discharge the resident to his family's home, and the facility could not wait to discharge Resident #8 on Monday due to his behavior of putting staff and residents at risk.
-She was on her way back to the facility on 05/03/25 and received numerous calls from staff that something had to be done with Resident #8 due to his behaviors.
-She had heard from staff for two years that "he's gotta go," referring to Resident #8 and his difficult behaviors.
-When she arrived at the facility, there were

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already 3 deputies at the facility.
-She met with Resident #8 in his room and explained that he had four options.
-She explained the resident could go to the hospital, a family members home, a homeless shelter, or a hotel.
-The resident wanted to go to his family's home.
-She provided Resident #8 with cash the facility kept in a safe, wrote him two checks from the facility, reviewed his medications and gave the resident his discharge papers.
-She and her family member transported Resident #8 to his brother's home, they blew the horn four times and no one came to the door.
-She then transported the resident to two hotels that did not have a vacancy for a handicap accessible room.
-She located a handicap accessible room at the third hotel.
-She went into the hotel with the resident and requested two nights, the resident paid for the room with his cash.
-She assisted the resident to his hotel room, reviewed his medications and ensured his oxygen concentrator was working.
-She provided the resident with her business card and instructed him to call her if he had not spoken with his family in two days.
-She notified the resident's RP and the hospice agency by telephone that the resident had been discharged to a local hotel, and she provided the resident's room number on 05/03/25.

Interview with the Facility Manager on 05/16/25 at 2:55pm revealed:
-She issued Resident #8 two checks when he was discharged.
-Resident #8 had an identification card which he used to check into a local hotel.
-If the resident wanted to cash the checks issued

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CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

(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 229	Continued From page 25	D 229		

by the facility he could cash them at the facility's bank.

Telephone interview with a hospice nurse on 05/14/25 at 2:31pm revealed:
-She was the on-call hospice nurse from 05/02/25 to 05/04/25 and was also Resident #8's regular nurse.
-She was notified by her Clinical Manager on 05/04/25 at 5:30pm to inform her that Resident #8 was taken to a local hotel by facility staff and left with his oxygen concentrator, his money, a few clothes and his medications.
-She arrived at the resident's hotel room on 05/04/25 at 6:20pm.
-She observed the resident in his wheelchair on the sidewalk outside his hotel room with the door open, wearing his oxygen and he had a lit cigarette to his lips.
-She asked the resident to dispose of his cigarette due to the safety issue of smoking with oxygen.
-The resident put his cigarette out and went back into the hotel room and laid his oxygen canula at the foot of his bed.
-The resident then returned to the sidewalk without his oxygen and lit another cigarette.
-She provided education to the resident of the dangers of smoking while wearing oxygen.
-The resident had a history of drug abuse.
-When she observed the resident's medications, she observed that the resident had removed his narcotic pain medications Oxycodone and Methadone from blister packs and placed the pills in prescription bottles.
-The resident did not relabel the prescription bottles with what pills he added to the bottles.
-She called the resident's RP to see if she or other family were able to take care of Resident #8, and family was unable to provide care to the

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D 229	Continued From page 26 resident. -She spoke with her Clinical Manager by telephone on 05/04/25 at 6:39pm and at 7:08pm. -She and her Clinical Manager both agreed that the resident was not safe to stay at the hotel. -The resident was at risk of an overdose from his pain medications because he had taken his pain medication too soon, being robbed because he had a large amount of cash with him, lack of food and the ability to get food, and needed re-education on the importance of not smoking while he used his oxygen. -She was concerned for Resident #8's safety because he was unable to safely administer his pain medication correctly. -Due to the resident's chronic pain, the resident would take the pain medication when he felt like it and she was concerned he would overdose. -She and her Clinical Manager were able to persuade the resident to go to the local ED. -She transported the resident's belongings to the hospital at approximately 7:00pm. -The resident was able to stand from his wheelchair, turn and pivot. -The resident was considered a fall risk and had shortness of breath when he stood. -Resident #8 was alert and oriented, however he had moments of confusion and lack of clarity due to his anxiety and did not think rationally. -He was dependent on facility staff for bathing, toileting and meal preparation. Second interview with Resident #8's hospice nurse on 05/14/25 at 3:40pm revealed: -The only food the resident had in his hotel room on 05/04/25 were two to go plates of food. -The resident could call his RP to order him food or bring him food, but otherwise he did not have enough food.	D 229		

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D 229	Continued From page 27 Telephone interview with the Clinical Manager from the hospice agency on 05/16/25 at 10:45am revealed: -Resident #8's RP notified the hospice social worker on 05/03/25 by text that the facility had discharged the resident to a local hotel. -The social worker was not on call and checked her work cell phone on 05/04/25 and saw the text message from the resident's RP that the facility had discharged the resident to a local hotel. -The hospice social worker notified the Clinical Manager and spoke with Resident #8's family member on 05/04/25. -She contacted the on-call hospice nurse to notify her that Resident #8 had been discharged by the facility to a local hotel. -She directed the on-call hospice nurse to assess the resident's safety at the hotel. -The on-call hospice nurse notified her that the resident was not safe at the hotel because he was wheelchair bound, unable to provide personal care for himself, unable to prepare meals, he was in possession of narcotic medications, he was observed smoking while on oxygen, had a large amount of cash with him and was at risk of being robbed. -She notified the hospice Administrator for guidance, who directed her to get the resident to a safe location to ensure his safety. -She was able to obtain an order from the hospice medical director (physician) to transport the resident from the hotel room to the local ED. -The hospice agency was not notified by facility staff that Resident #8 had been discharged to a local hotel until 05/04/25. -The hospice agency had an on-call system that operated 24 hours a day, 7 days a week. -The on-call system operator documented the date, time, name of individual that called, the name of the hospice patient and what the need	D 229		

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was at the time of the call.
-She had reviewed the on-call logs for 05/02/25 to 05/24/25 and there were no calls from the facility or facility staff regarding the discharge of Resident #8 on 05/03/25.

Second telephone interview with the Clinical Manager from the hospice agency on 05/16/25 at 1:09pm revealed:
-The hospice agency on-call services were not notified by staff at the facility that Resident #8 had been discharged to a local hotel on 05/03/25.
-The on-call log for 05/02/25 revealed there were two calls at 8:09pm, and 9:10pm; neither call were related to Resident #8.
-The on-call log for 05/03/25 revealed there were four calls at 6:43am, 7:46am, 10:43pm, and 1:49pm and no calls were related to Resident #8.
-The on-call log for 05/04/25 revealed there was one call at 2:43pm and the call was not related to Resident #8.
-The hospice agency was never notified by the facility that Resident #8 had been discharged to a hotel.

Telephone interview with a pharmacist from a local pharmacy on 05/16/25 at 9:41am revealed:
-Resident #8 was on hospice and his medications were filled by their pharmacy.
-The resident's family member picked up his medications and delivered them to the facility.
-Resident #8 was on two strong pain management medications which included Oxycodone and Methadone.
-If Resident #8 missed a dose of his pain medication he would have withdrawal symptoms due to the high dose of his narcotic pain medications.
-Resident #8 would experience sweating, body tremors, anxiety, agitation, and possibly an

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increase in aggressive behaviors.
-The resident would have felt physically sick due to withdrawals from his narcotic pain medication.

Interview with the Facility Manager on 05/15/25 at 8:33am revealed:
-Resident #8's behaviors became progressively worse.
-She used to only get called by staff to the facility due to Resident #8's behaviors once every two months, but his temper tantrums and verbally abusive behaviors escalated with time.
-Staff called her every two months, but then every month, every two weeks, to every other day due to the residents' behaviors.
-She would talk with the resident to deescalate his agitation which usually calmed him down.
-After the resident had a behavioral incident, he would usually apologize for his behaviors after he calmed down.
-Resident #8 was known for being verbally abusive if he did not get his way.
-Resident #8 had a history of temper tantrums and usually apologized for his behavior shortly after he had a temper tantrum.

Telephone interview with the Administrator on 05/14/25 at 4:55pm revealed:
-She thought the resident's were supposed to be given a 14 day notice before being discharged from a facility.
-Resident #8 waived his two weeks notice for a discharge.
-The resident wanted to be discharged from the facility.

Attempted interview with Resident #8's RP on 05/14/25 at 1:52pm was unsuccessful.

_____

The facility failed to ensure a safe and orderly

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D 229	Continued From page 30 discharge for Resident #8 who was wheelchair bound, on oxygen, and was a hospice patient. The resident was discharged from the facility to a local hotel. The hospice agency was contacted by the resident's family member and upon arrival found the resident to be smoking while wearing oxygen, the resident had two plates of food, and narcotic pain medications unlabeled bottles. The hospice nurse deemed the resident's living conditions to be unsafe, and the resident was transported to the local emergency department for his safety. The facility's failure resulted in neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/25. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 15, 2025.	D 229		
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 record reviews and interviews, the facility failed to ensure follow-up to meet the health care needs of 4 of 6 sampled residents related to failing to notify hospice of a resident's behavioral episodes, failure to notify hospice when a resident was discharged to a hotel (#8), failure to coordinate follow up labs (#5), failure to	D 273		

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D 273	Continued From page 31 schedule a follow up cardiologist appointment (#2), and failure to notify the primary care provider of finger stick blood sugars (FSBS) outside of parameters (#4). The findings are: Review of the facility healthcare policy dated 10/12/04 revealed the facility will make appropriate arrangements for health care as needed. 1. Review of Resident #8's current FL-2 dated 10/02/24 revealed: -Diagnoses included chronic pain, chronic pulmonary embolism, and depressive episodes. -The resident was constantly disoriented and semi-ambulatory. Review of a hospital discharge summary dated 05/05/25 revealed Resident #8 had a history of substance abuse. Review of Resident #8's current care plan dated 01/30/25 revealed: -The resident required limited assistance with toileting, ambulation, bathing, dressing, grooming, and transfers. -The resident was oriented, and his memory was adequate. Review of Resident #8's hospice physician certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss. Review of Resident #8's hospice recertification plan of care dated 03/27/25 revealed: -Resident #8 had crippling dyspnea at rest which	D 273	To ensure the facility provides referral and follow up as required by rule the facility shall Communicate with the resident / responsible party the need for referral or follow up Ensure residents are referred to appropriate healthcare providers (physicians, specialists, hospitals, home health, hospice, mental health providers) in a timely manner when their condition or needs warrant it. Maintain thorough documentation of all referrals made, including: Reason for referral. Date of referral. Name of the referred provider/facility. Confirmation of appointment scheduling. Establish a system to track all scheduled healthcare appointments and ensure residents attend them. This includes transportation arrangements if needed. Maintain clear and timely communication with healthcare providers regarding resident's condition, changes, and any orders or recommendations. Ensure that all orders and recommendations from healthcare providers are implemented promptly and accurately Document all follow-up actions, including appointment attendance, communication with providers, and implementation of orders. This also includes reviewing hospital discharge documents for follow-up orders or appointments. Ensure staff are trained on the facility's policies and procedures for healthcare referral and follow-up	6/1/25

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D 273	Continued From page 32 was worsened with exertion (Dyspnea is shortness of breath). -The resident had intractable pain which was managed by medications prescribed by the hospice medical director (Intractable pain is pain that persists despite aggressive medical treatments and is characterized by being constant, intense, and debilitating pain). -The resident had an increased need for assistance with activities of daily living (ADLs) and had increased weakness and fatigue due to his pain medication. Review of the hospice aide care plan dated 03/27/25 revealed Resident #8 required assistance with bathing, dressing, toileting, grooming, oral care, shampooing his hair, and meal setup. Review of an Accident and Incident (A/I) report dated 05/02/25 revealed: -Resident #8 became irritated because he thought a male resident had stolen something from his room. -Resident #8 went to find the male resident and began punching the resident in the head. -The medication aide (MA) got in between the two resident's and Resident #8 reached around the MA and pulled the male resident's hair. -During the process of completing the A/I report, the male resident that Resident #8 hit called local law enforcement. -Local law enforcement arrived at the facility, the MA explained what occurred, and the MA completed the A/I report. Review of an undated progress note attached to the A/I report dated 05/02/25 revealed: -The progress note was made by a MA. -Resident #8 hit a male resident on his head after	D 273	Con't this will monitored on a daily basis by RCC with oversight from facility manager	06/01/25

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accusing the resident of taking a snack can from his room.
-The male resident called local law enforcement who arrived at the facility, the male resident wanted to press charges against Resident #8.

Review of an A/I report dated 05/03/25 revealed:
-A personal care aide (PCA) wrote the A/I report and the Facility Manager signed the A/I report.
-The PCA was transporting a male resident to their room, when walking down the hallway Resident #8 attempted to hit the male resident in the back of the head.
-The PCA "blocked" the hit and asked Resident #8 to please not hit the male resident, the PCA turned her back and proceeded to transport the male resident.
-When the PCA turned her back, Resident #8 called her a racial slur and threw hot coffee on the PCA.

Telephone interview with Resident #8 on 05/15/25 at 5:00pm revealed:
-He was discharged from the facility after he got into an altercation with another resident and spilled coffee on a personal care aide (PCA) that intervened in the altercation.
-He received hospice services for pain management and his shortness of breath.
-He was taken to a hotel by the Facility Manager, had to pay for a two night stay and was left alone at the hotel on 05/03/25.

Telephone interview with a hospice nurse on 05/14/25 at 2:31pm revealed:
-She was notified on 05/04/25 by her Clinical Manager that Resident #8 had been discharged to a hotel.
-She went to check on the safety of Resident #8 on 05/04/25 at 6:20pm.

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D 273	Continued From page 34 -When she arrived, she observed the resident outside on the sidewalk in his wheelchair, wearing his oxygen with a lit cigarette to his mouth. -The facility did not notify her that the resident was discharged to the hotel and she was not notified that the resident had an altercation at the facility on 05/02/25 and 05/03/25. Telephone interview with the Clinical Manager from the hospice agency on 05/16/25 at 10:45am revealed: -The hospice agency was not aware that Resident #8 had been discharged by the facility to a local hotel until 05/04/25. -Resident #8's family member sent a text message to the hospice social worker on 05/03/25. -She contacted the on-call hospice nurse to notify her that Resident #8 had been discharged by the facility to a local hotel. -She directed the on-call hospice nurse to assess if the resident was safe at the location where the facility discharged him. -The on-call hospice nurse notified her that the resident was not safe at the hotel because he was wheelchair bound, unable to provide personal care for himself, unable to prepare meals, he was in possession of strong narcotic medications, was on oxygen, had a large amount of cash with him and was at risk of being robbed. Second telephone interview with the Clinical Manager from the hospice agency on 05/16/25 at 1:09pm revealed: -The hospice agency on-call services were not notified by staff at the facility that Resident #8 had been discharged to a local hotel on 05/03/25. -The on-call log for 05/02/25 revealed there were two calls at 8:09pm, and 9:10pm; neither call were related to Resident #8.	D 273		

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D 273	Continued From page 35 -The on-call log for 05/03/25 revealed there were four calls at 6:43am, 7:46am, 10:43pm, and 1:49pm and no calls were related to Resident #8. -The on-call log for 05/04/25 revealed there was one call at 2:43pm and the call was not related to Resident #8. -The hospice agency was never notified by the facility that Resident #8 had been discharged to a hotel. -The hospice agency was never notified by the facility that Resident #8 had been discharged to a hotel, and they were not notified of his behaviors that led up to his discharge. Interview with the Facility Manager on 05/14/25 at 8:54am revealed: -Resident #8 was discharged from the facility on 05/03/25 due to his behaviors. -The resident got into an altercation with another resident and threw his coffee on a PCA. -The resident was a danger to other residents and the facility had no choice but to discharge the resident. Interview with the Facility Manager on 05/15/25 at 8:33am revealed: -Resident #8's verbal and physical aggressiveness became worse over time. -The resident had frequent tantrums if he did not get his way. -Resident #8 did things for spite, such as write curse words on another resident's door. 2. Review of Resident #5's current FL-2 dated 11/21/24 revealed: -Diagnoses included Parkinson's Disease, epilepsy, schizophrenia, dementia, and psychosis. -He was intermittently disoriented. -He was semi-ambulatory.	D 273		

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D 273	Continued From page 36 Review of Resident #5's Resident Register revealed he was admitted to the facility on 12/12/23. Review of Resident #5's primary care provider (PCP) progress notes dated 07/11/24 revealed: -Patient was new to establish care. -Treatment plan included ordering labs for complete blood count (CBC) with differential, comprehensive metabolic panel (CMP), thyroid stimulating hormone (TSH) Lipid, glycated hemoglobin (A1C), Vitamin D, Vitamin B12, and a phenytoin level. -Treatment plan included a follow-up in 4 weeks with PCP. Review of Resident #5's PCP progress notes dated 09/05/24 revealed: -The resident was seen for elevated liver enzymes. -His labs tracking liver health were elevated alanine aminotransferase (ALT): 127, normal range 0-40, aspartate aminotransferase (AST) 70, normal range 14-20, and Vitamin D 19.8. -The treatment plan included ordering a computed tomography (CT) of abdomen/pelvis with contrast due to elevated liver enzymes. -The following labs were to be ordered: Amylase, Lipase, Gamma-Glutamyl Transferase (GGT), Hepatitis Panel, and HIV Panel. -The treatment plan included considering a gastrointestinal (GI) referral at follow-up visit. -The treatment plan included a follow-up visit in 4 weeks with the PCP. Review of Resident #5's accident and incident reports on 01/29/25 revealed: -At 3:25pm, the resident was found on the bathroom floor and said he fell while trying to use	D 273		

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the bathroom.
-At 3:36pm, the resident was found on the floor beside his bed and said his arms were weak and he was sent to hospital.

Review of Resident #5's hospital admission/discharge summary revealed:
-He was admitted to the emergency room on 1/30/25.
-He was admitted to the emergency department due to multiple falls.
-Upon arrival he was noted to have persistent fever at 102.7 and heart rate of 101.
-He had a blood glucose of 177, with mildly elevated AST and ALT at 14 and 101.
-His respiratory panel was positive for influenza.
-He was discharged to a skilled nursing facility on 02/11/25.

Review of Resident #5's skilled nursing admission/discharge record dated 02/11/25 revealed:
-He was admitted to the skilled nursing facility on 02/11/25.
-His admission diagnoses information included seizures, thrombocytopenia, type 2 diabetes, schizophrenia, muscle weakness, repeated falls and influenza.
-His treatments included physical therapy (PT) and occupational therapy (OT).
-He was discharged to an assisted living facility on 03/06/25.

Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 2:45pm revealed:
-She was responsible for making doctor appointments and follow-up visits for residents in the facility.
-She was responsible for reading all visit summaries and if there was a follow-up needed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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she scheduled them and wrote it in the schedule book.
-She believed that the PCP was going to schedule labs and a follow-up visit for Resident #5.
-Resident #5 should have gotten a CT of abdomen/pelvis and labs scheduled and completed.
-It was very important to schedule resident appointments and follow-up appointments for resident health.

Interview with the Assistant Facility Manager on 05/16/25 at 3:10pm revealed:
-The RCC and medication aides (MA) were responsible for reading resident visit summaries.
-The RCC and MAs were responsible for documenting and follow-up visits needed in the schedule book.
-After the follow-up appointment was made a copy of the after visit summary was placed on her desk to be filed.
-She did not review the after-visit summaries.

Interview with the Facility Manager on 05/16/25 at 3:40pm revealed:
-The RCC was responsible for reviewing resident after-visit summaries.
-The RCC should have made a follow-up appointment for Resident #5 or called the PCP for clarification if she was unsure.
-Resident #5 should have gotten CT of abdomen/pelvis and labs scheduled and completed.
-Resident #5 should have had a follow-up appointment scheduled within 4 weeks of the 09/05/24 visit.
-She was concerned about a resident not getting a follow-up appointment because it was a form of neglect.

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D 273	Continued From page 39 Telephone interview with Resident #5's PCP on 05/15/25 at 1:30pm revealed: -Resident #5's last visit was 09/05/24. -She requested a follow-up 4 weeks after the 09/05/24 visit because he had elevated liver enzymes. -She requested a CT of abdomen/pelvis with contrast due to elevated liver enzymes and labs which included Amylase, Lipase, Gamma-Glutamyl Transferase (GGT), Hepatitis Panel, and HIV Panel. -It was imperative that he follow-up with her to see what was going on with his liver. -She expected the facility to schedule orders and follow-up visits. -There was a possibility that his lack of following up on orders could have contributed to what caused him to be sent out of the facility. Based on observations, record review, and interviews with staff, it was determined that Resident #3 was not interviewable. 3. Review of Resident #2's current FL-2 dated 04/30/25 revealed: -Diagnoses included coronary artery disease, atrial fibrillation with rapid ventricular response, hypertension, and multiple sclerosis. -The resident was ambulatory. -There was no information about the resident's orientation status. Review of Resident #2's Resident Register revealed he was admitted to the facility on 04/16/25. Review of a hospital discharge summary for Resident #2 dated 04/16/25 revealed: -The resident was admitted to the hospital for	D 273		

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chest pain and abdominal pain.
-The resident was diagnosed with unstable angina, multivessel coronary artery disease, and hypertension.

Review of a primary care provider (PCP) visit note dated 05/01/25 revealed:
-Resident #2 was seen for his initial visit with the PCP after admission to the facility.
-Resident #2 was last seen by his cardiologist 1 ½ months ago.
-The resident had one cardiac stent placed and a history of aortic valve stenosis.
-The resident was assessed with coronary artery arteriosclerosis, localized edema, multiple sclerosis, and incisional hernia, without obstruction or gangrene.
-Treatment for coronary artery arteriosclerosis included: please make sure resident follows up with cardiology.

Interview with Resident #2 on 05/14/25 at 9:15am revealed:
-He was admitted to the facility approximately 3 weeks ago from a hospital approximately 2 hours away.
-He had numerous cardiology problems and was concerned that he had not been scheduled to see a cardiologist.
-He had spoken with the Facility Manager at least three times and asked when he would have his appointment with a cardiologist scheduled.
-The Facility Manager told him they would get to it.
-He felt that his needs were being ignored by management.

Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 10:02am revealed:
-There was an appointment in the facility

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appointment book for Resident #2 to see a cardiologist on 04/28/25.
-She was not sure how the appointment was missed.
-She called a local cardiologist today (05/16/25) and made an appointment for Resident #2 to see a cardiologist on 05/16/25 as a new patient.
-She was responsible for scheduling resident's appointments and overlooked the resident's cardiology appointment.

Interview with the Facility Manager on 05/15/25 at 3:38pm revealed:
-Resident #2 had a cardiologist visit scheduled on 04/28/25 at an office that was approximately 2 hours away from the facility.
-The RCC was responsible for scheduling appointments and coordinating transportation.
-The RCC should have scheduled the resident with a local cardiologist to ensure PCP orders were followed.

Telephone interview with Resident #2's PCP on 05/15/25 at 1:42pm revealed:
-She was not aware that the facility had not scheduled a cardiologist appointment for Resident #2 and that the resident had not been seen by a cardiologist.
-The facility staff should have scheduled a cardiologist appointment for Resident #2.
-The resident was last seen by a cardiologist 1 ½ months ago and it was important that he follow up with a cardiologist after his hospitalization.

4. Review of Resident #4's current FL-2 dated 04/17/25 revealed:
-Diagnoses included diabetes and cerebrovascular accident.
-There was an order to check fingerstick blood sugar (FSBS) three times a day.

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D 273	Continued From page 42 Review of signed physician orders dated 03/25/25 revealed: -There was an order to check FSBS three times a day, at 6:00am, 11:00am, and 4:00pm. -There was an order to notify the primary care provider (PCP) if the resident's FSBS was below 80 or greater than 180 consistently. Review of Resident #4's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times a day, scheduled at 6:00am, 11:00am, and 4:00pm. -There was an entry to call the PCP if FSBS was below 80 or greater than 180 consistently. -FSBS was documented as 190 at 11:00am on 03/01/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 308 at 4:00pm on 03/02/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 303 at 11:00am on 03/03/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 313 at 4:00pm on 03/03/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 306 at 11:00am on 03/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was	D 273		

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D 273	Continued From page 43 over 180. -FSBS was documented as 262 at 4:00pm on 03/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 75 at 6:00am on 03/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 360 at 11:00am on 03/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 314 at 4:00pm on 03/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 181 at 6:00am on 03/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 251 at 11:00am on 03/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 231 at 4:00pm on 03/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 214 at 11:00am on 03/09/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was	D 273		

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over 180.
-FSBS was documented as 214 at 4:00pm on 03/09/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 332 at 4:00pm on 03/10/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 200 at 4:00pm on 03/11/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 69 at 6:00am on 03/12/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.
-FSBS was documented as 201 at 4:00pm on 03/12/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 76 at 6:00am on 03/13/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.
-FSBS was documented as 67 at 6:00am on 03/16/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.
-FSBS was documented as 77 at 6:00am on 03/17/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was

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D 273	Continued From page 45 less than 80. -FSBS was documented as 45 at 6:00am on 03/18/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 254 at 4:00pm on 03/18/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 231 at 11:00am on 03/19/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 279 at 4:00pm on 03/19/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 251 at 11:00am on 03/20/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 200 at 4:00pm on 03/20/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 218 at 4:00pm on 03/21/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 182 at 6:00am on 03/24/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was	D 273		

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over 180.
-FSBS was documented as 200 at 4:00pm on 03/24/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 210 at 6:00am on 03/25/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 390 at 11:00am on 03/25/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 185 at 4:00pm on 03/25/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 78 at 6:00am on 03/26/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.
-FSBS was documented as 290 at 11:00am on 03/26/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 181 at 4:00pm on 03/29/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.
-FSBS was documented as 289 at 4:00pm on 03/31/25.
-There was no documentation that Resident #4's PCP was notified that the resident's FSBS was

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D 273	Continued From page 47 over 180. Review of Resident #4's April 2025 eMAR revealed: -There was an entry to check FSBS three times a day, scheduled at 6:00am, 11:00am, and 4:00pm. -There was an entry to call the PCP if FSBS was below 80 or greater than 180 consistently. -FSBS was documented as 233 at 4:00pm on 04/01/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 64 at 6:00am on 04/02/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 209 at 11:00am on 04/02/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 283 at 4:00pm on 04/02/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 69 at 6:00am on 04/03/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 337 at 11:00am on 04/03/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 184 at 4:00pm on 04/03/25.	D 273		

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D 273	Continued From page 48 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 69 at 6:00am on 04/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 187 at 11:00am on 04/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 182 at 4:00pm on 04/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 200 at 11:00am on 04/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 202 at 4:00pm on 04/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 63 at 6:00am on 04/07/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 215 at 4:00pm on 04/07/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 55 at 6:00am on 04/08/25.	D 273		

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D 273	Continued From page 49 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 254 at 11:00am on 04/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 231 at 4:00pm on 04/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 203 at 4:00pm on 04/09/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 74 at 6:00am on 04/11/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 214 at 4:00pm on 04/11/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 69 at 6:00am on 04/12/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 301 at 11:00am on 04/12/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 56 at 6:00am on 04/13/25.	D 273		

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D 273	Continued From page 50 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 190 at 11:00am on 04/13/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 63 at 6:00am on 04/14/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 75 at 11:00am on 04/14/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 76 at 6:00am on 04/15/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 256 at 11:00am on 04/15/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 287 at 4:00pm on 04/15/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 251 at 11:00am on 04/16/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 216 at 4:00pm on 04/16/25.	D 273		

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	HAL042005	A. BUILDING: _____ B. WING _____	C 05/16/2025

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D 273	Continued From page 51 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 56 at 6:00am on 04/17/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 247 at 11:00am on 04/17/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 368 at 4:00pm on 04/17/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 247 at 11:00am on 04/18/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 200 at 4:00pm on 04/18/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 69 at 6:00am on 04/20/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 201 at 11:00am on 04/20/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 327 at 11:00am on 04/21/25.	D 273		

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D 273	Continued From page 52 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 335 at 4:00pm on 04/21/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 363 at 11:00am on 04/22/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 391 at 4:00pm on 04/22/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 320 at 11:00am on 04/23/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 338 at 4:00pm on 04/23/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 347 at 11:00am on 04/24/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 324 at 4:00pm on 04/24/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 327 at 11:00am on 04/25/25.	D 273		

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D 273	Continued From page 53 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 258 at 4:00pm on 04/25/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 230 at 11:00am on 04/26/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 197 at 11:00am on 04/27/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 200 at 11:00am on 04/28/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 253 at 4:00pm on 04/28/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 261 at 11:00am on 04/29/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 66 at 6:00am on 04/30/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 266 at 11:00am on 04/30/25.	D 273		

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D 273	Continued From page 54 -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. Review of Resident #4's May 2025 eMAR revealed: -There was an entry to check FSBS three times a day, scheduled at 6:00am, 11:00am, and 4:00pm. -There was an entry to call the PCP if FSBS was below 80 or greater than 180 consistently. -FSBS was documented as 79 at 6:00am on 05/01/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 190 at 11:00am on 05/01/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 189 at 4:00pm on 05/02/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 185 at 11:00am on 05/03/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 76 at 6:00am on 05/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 77 at 11:00am on 05/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.	D 273		

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D 273	Continued From page 55 -FSBS was documented as 263 at 4:00pm on 05/04/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 77 at 6:00am on 05/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 263 at 11:00am on 05/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 266 at 4:00pm on 05/05/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 306 at 11:00am on 05/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 343 at 4:00pm on 05/06/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 54 at 6:00am on 05/07/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 288 at 11:00am on 05/07/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180.	D 273		

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D 273	Continued From page 56 -FSBS was documented as 326 at 4:00pm on 05/07/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 73 at 6:00am on 05/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 297 at 11:00am on 05/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 303 at 4:00pm on 05/08/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 71 at 6:00am on 05/09/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 296 at 11:00am on 05/09/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 332 at 11:00am on 05/10/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 77 at 4:00pm on 05/11/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80.	D 273		

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D 273	Continued From page 57 -FSBS was documented as 288 at 4:00pm on 05/12/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 62 at 6:00am on 05/13/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was less than 80. -FSBS was documented as 251 at 11:00am on 05/13/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 268 at 4:00pm on 05/13/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 252 at 11:00am on 05/14/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. -FSBS was documented as 279 at 4:00pm on 05/14/25. -There was no documentation that Resident #4's PCP was notified that the resident's FSBS was over 180. Review of Resident #4's progress notes revealed there was no documentation that Resident #4's PCP was notified of FSBSs less than 80 or greater than 180 in March 2025, April 2025, and May 2025. Interview with a medication aide (MA) on 05/16/25 at 1:38pm revealed: -She notified Resident #4's PCP when her FSBS	D 273		

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D 273	Continued From page 58	D 273		

was outside of the parameters as ordered.
-She usually completed a progress note with the date and time the PCP was notified and was not sure why there were not any progress notes for the times she notified the PCP of the resident's FSBSs.
-She and the other MAs were supposed to notify the resident's PCP when her FSBSs were outside of parameters, because they were supposed to follow physician orders.

Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 10:02am revealed:
-When a resident's FSBS was outside of parameters and there was an order to notify the resident's PCP, the MAs were expected to notify the PCP.
-The MAs documented in the progress notes that the PCP was notified of a FSBS outside of the parameters.

Interview with the Facility Manager on 05/16/25 at 3:06pm revealed:
-She was not aware that the MAs had not notified Resident #4's PCP when her FSBSs were outside of parameters.
-MAs and the Resident Care Coordinator (RCC) were expected to notify the resident's PCP when her FSBSs were outside of parameters, because they were expected to follow physician orders.

Attempted telephone interview with Resident #4's PCP on 05/16/25 at 1:15pm was unsuccessful.

Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable.

_____

The facility failed to ensure referral and follow up for 4 of 6 sampled residents including failure to

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D 273	Continued From page 59 notify a hospice agency that a resident had two altercations on 05/02/25 and on 05/03/25, who was discharged to an unsafe location at a hotel on 05/03/25 (#8), failure to schedule an appointment for lab work due to elevated enzymes, which could have contributed to the resident being hospitalized and later admitted to a nursing home (#5), failure to schedule a cardiologist appointment for a resident that was discharged to the facility from a hospital with chest pains, a stent and a history of cardiac issues (#2), and failure to notify a resident's primary care provider (PCP) that a resident's FSBSs were outside of parameters with FSBS ranging from 45 to 390 (#4). The facility's failure put residents at 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 05/16/25 for this violation. THE CORRECTIVE DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED June 15, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 60 Based on observations, record reviews and interviews, the facility failed to ensure implementation of orders for 1 of 6 sampled residents (#2) who had an order for thromboembolic deterrent hose. The findings are: Review of Resident #2's current FL-2 dated 04/30/25 revealed: -Diagnoses included coronary artery disease, atrial fibrillation with rapid ventricular response, hypertension, and multiple sclerosis. -The resident was ambulatory. -There was no information about the resident's orientation status. Review of Resident #2's Resident Register revealed he was admitted to the facility on 04/16/25. Review of a Licensed Health Professional Support (LHPS) Initial Evaluation for Resident #2 dated 04/30/25 revealed: -The resident had edema in his lower extremities. -The registered nurse (RN) recommended TED hose. -Changes and follow up recommended to meet the residents' needs included recommendation of TED hose due to circulation issues. Review of a primary care provider (PCP) visit note dated 05/01/25 revealed: -Resident #2 was seen for his initial visit with the PCP after admission to the facility. -Resident #2 had bilateral edema and requested an order for thromboembolic deterrent hose (TED hose). -Treatment for localized edema included an order to apply TED hose in the morning and remove in	D 276	The facility will ensure that all orders are obtained promptly from the physician or other licensed health professional Facility will establish consistent location in resident's record for all physician orders. Facility will maintain the original written orders or a clear, legible copy. All orders be filed chronologically All treatments will be documented in the resident file. Documentation will include the date, time, type of treatment, relevant parameters, and the signature/initials of the staff performing the treatment. Staff will document in progress notes observations related to the resident's response to procedures, treatments, or medications. This includes charting any changes in condition, adverse reactions, effectiveness of interventions, and communication with the physician. All staff will be trained to understand the importance of accurate and timely documentation. Charting should occur as soon as possible after the care is provided. The facility will provide regular and comprehensive training to all staff involved in receiving, documenting, and implementing physician orders. This will monitored on a daily basis by RCC with oversight of facility manager	6/01/2025

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D 276	Continued From page 61 the evening; facility to order appropriate size TED hose. Observation of Resident #2 on 05/16/25 at 11:55am revealed the resident was sitting in the front lobby wearing mid-calf length socks and was not wearing TED hose. Interview with Resident #2 on 05/14/25 at 9:15am revealed: -He saw the facility's PCP the first of May 2025 and asked if he could have an order for TED hose. -He was upset that he still had not received TED hose and did not know if the facility had ordered them. Interview with the Resident Care Coordinator (RCC) on 05/16/25 at 10:02am revealed: -She was responsible for ordering Resident #2's TED hose. -She had not measured the resident for TED hose until today (05/16/25) and faxed the PCP order to the facility's contracted pharmacy. Telephone interview with Resident #2's PCP on 05/15/25 at 1:42pm revealed: -She was not aware that Resident #2 did not have TED hose yet. -She expected the facility to follow the order to measure the resident for TED hose so the order could be placed. -Resident #2 required TED hose to help reduce bilateral edema.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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D 338	Continued From page 62 all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 7 sampled residents (#8) were treated with respect and dignity and were free from neglect and discharged a resident to a hotel in unsafe conditions. The findings are: Review of the facility's resident rights policy dated 10/12/24 revealed: -The Administrator and staff will make every effort to assist residents to know and exercise their rights, the adult care home resident's bill of rights. -To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. -To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. -To be free of mental and physical abuse, neglect and exploitation. -To not be transferred or discharged from a facility except for medical reasons, the residents' welfare, nonpayment for the stay, or when the transfer is mandated state or federal law. -The resident shall be given at least 30 days advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the facility.	D 338	Implement mandatory and ongoing training for all staff (including direct care, dietary, housekeeping, administrative) on resident rights, person-centered care, dignity, and privacy. This will include examples and discussions on how to apply rights in daily interactions. Recognize and respect each resident's individuality, preferences, and cultural background. Promote choices in daily routines, activities, and personal care. • A resident will only be discharged for specific, allowed reasons such as: o Medical reasons such as the resident's needs cannot be met in the facility, or health has improved sufficiently. Documentation by a physician, physician assistant, or nurse practitioner is required. o The resident's own welfare or the welfare of other residents is endangered. o Nonpayment for the stay, after proper written notice of warning. o Except in cases of immediate jeopardy to the health or safety of the resident or others, the resident will be given at least 30 days' advance written notice of the transfer or discharge. o The notice will include: the date of notice, date of transfer/discharge, reason for discharge, planned discharge location (if known), appeal rights, and contact information for the Long-Term Care Ombudsman. o A copy of the "Adult Care Home Notice of Discharge" and Adult Care Home Hearing Request Form will be hand-delivered or sent by certified mail to the resident and/or their responsible person/legal representative.	5/17/2025

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D 338	Continued From page 63 -The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the medical care commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. -The medical care commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as state and federal rule and regulations governing the transfer or discharge of residents from nursing homes. Review of Resident #8's current FL-2 dated 10/02/24 revealed: -Diagnoses included chronic pain, chronic pulmonary embolism, and depressive episodes. -The resident was constantly disoriented and semi-ambulatory. -The resident's current level of care was Assisted Living (AL). Review of Resident #8's current care plan dated 01/30/25 revealed: -The resident required limited assistance with toileting, ambulation, bathing, dressing, grooming, and transfers. -The resident was oriented, and his memory was adequate. Review of Resident #8's hospice physician's certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss. Review of Resident #8's hospice recertification plan of care dated 03/27/25 revealed: -Resident #8 was wheelchair bound. -Resident #8 had crippling dyspnea at rest which	D 338	Con't The resident will be made aware they have the right to appeal the facility's attempt to transfer or discharge them. o The resident will be allowed to remain in the facility until the resolution of the appeal, unless their continued presence poses a documented jeopardy to health or safety. o The facility will provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge. o The facility will Assist in identifying and informing the resident and responsible person about an appropriate discharge destination that can meet the resident's needs. Documentation of contacts with possible discharge locations and their responses must be maintained. o The facility will provide essential medical and care information to thecaregiver or facility receiving the resident upon discharge. This includes: ▪ Copy of the resident's most current FL-2 ▪ Most current assessment and care plan. ▪ Current physician orders. ▪ List of current medications, along with the actual current medications. ▪ Record of vaccinations and TB screening. This will be monitored on a case by case basis by the facility manager	

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was worsened with exertion (Dyspnea is shortness of breath).
-The resident had intractable pain which was managed by medications prescribed by the hospice medical director (Intractable pain is pain that persists despite aggressive medical treatments and is characterized by being constant, intense, and debilitating pain).
-The resident had an increased need for assistance with activities of daily living (ADLs) and had increased weakness and fatigue due to his pain medication.

Review of the hospice aide care plan dated 03/27/25 revealed Resident #8 required assistance with bathing, dressing, toileting, grooming, oral care, shampooing his hair, and meal setup.

Telephone interview with Resident #8 on 05/15/25 at 5:00pm revealed:
-He became upset with another male resident because he thought the resident had stolen his money.
-When he asked for his money back the male resident got in his face and stood up like "he was gonna hit me."
-A personal care aide (PCA) got in between the two residents to de-escalate the situation.
-He accidentally spilled his coffee on the PCA.
-The Facility Manager came to his room and told him that he was being discharged and to gather items he wanted to take with him.
-The Facility Manager drove him to a family members' home, but no one was home, so she went to look for a hotel.
-He was left at a hotel on the first floor with his pain medications and his oxygen.
-He felt like he was "thrown out," and felt the staff "treated me like a dog," when he was taken to a

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hotel room.
-He was so upset he wanted to cut his wrists and "felt like a dog the way they treated me."
-He contemplated overdosing with his narcotic pain medications but was unable to do so.
-He took an Ativan shortly after he was left at the hotel because he felt nervous (Ativan is a medication used to treat anxiety).
-His pain became worse after he was left at the hotel because he did not know how he would get food because he could not cross several lanes of traffic.
-His stomach hurt, and he had a "whole lot of pain."
-He rated his pain over a 10 when he was left at the hotel (The Numerical Rating Pain Scale grades pain levels from 0 no pain to 10 worst pain possible).

Interview with a male resident on 05/16/25 at 1:31pm revealed:
-Resident #8 became upset with him earlier this month because the resident thought he had stolen money from his room.
-Resident #8 had a history of arguing with other residents.
-He stated that facility staff "said they were going to get rid of him."

Review of a local law enforcement dispatch report police report dated 05/03/25 revealed:
-Dispatch received a call from the medication aide (MA) at the facility at 2:57pm on 05/03/25.
-The MA reported that Resident #8 assaulted an employee with hot coffee, and they wanted the resident removed from the premises.

Review of an Incident/Investigation Report from local law enforcement revealed:
-Resident #8's family member called local law

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enforcement to file a report on 05/08/25 at 11:32am regarding elder abuse at the facility.
-The resident's family member reported to emergency dispatch that Resident #8 was on hospice care and was kicked out of the facility on 05/03/25, placed in a hotel, and the family was not notified.
-The resident's family member reported that she spoke with Department of Social Services (DSS) and a worker there advised her that she needed to contact local law enforcement to file a report of neglect.
-The family member reported that Resident #8 was of advanced age, was wheelchair bound, and was on oxygen.
-She received a telephone call from Resident #8 on 05/03/25 at 6:38pm, when he stated the Facility Manager dropped him off at a local hotel and he provided her with the room number.
-Resident #8 informed his family member that the Facility Manager checked him into the local hotel and he had to pay for two nights.
-On 05/04/25 hospice sent a nurse to assess Resident #8 and his living conditions.
-The hospice nurse deemed that Resident #8 was not safe in the hotel room due to being dropped off with all his narcotic medications, as well as the physical condition of being wheelchair bound and on oxygen.
-A sergeant noted at the end of the local law enforcement report that the employee of the rest home were not the target of the assault nor did anyone else complain about the assault.
-The assisted living facility (ALF) could be held accountable for placing Resident #8 somewhere without proper care.

Review of hospital records for Resident #8 revealed:
-The resident was seen at a local emergency

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department (ED) on 05/04/25 at 7:18pm.
-The resident was removed from the ALF on 05/03/25 due to a physical altercation with another resident and staff.
-Per the hospice nurse, staff from the ALF took the resident to a hotel and left the resident there.
-The resident spent the night at a local hotel on 05/03/25.
-The resident was on hospice care for comfort care only.
-The resident had a past medical history of metastatic cancer, arthritis, chronic pancreatitis, chronic obstructive pulmonary disease, hepatic cirrhosis, and substance abuse.

Observation of the hotel, Room 121 at Building #2 on 05/15/25 at 1:15pm revealed:
-The door for room 121 exited onto a sidewalk with a curb at the edge of the sidewalk.
-One hotel door down there was a handicap area to exit to the parking lot, without a curb at the edge of the sidewalk.
-There was a slight incline from Building #2 to the front lobby.
-There was a bathtub with a shower in the room with a grab bar but no shower chair was present.

Interview with the front desk representative at a hotel on 05/15/25 at 1:00pm revealed:
-Resident #8 was escorted by a female to the front desk on 05/03/25.
-The resident came to the front lobby several times on 05/03/25 to get coffee.
-The front desk representative would notice the resident wheeling himself in the parking lot to the front lobby and he would open two doors for the resident since the hotel did not have automatic doors.
-The resident would get a cup of coffee and return to his room with the coffee and was

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observed sitting outside his room on the sidewalk most of the day.

Telephone interview with a hospice nurse on 05/14/25 at 2:31pm revealed:
-She went to check on the safety of Resident #8 on 05/04/25 at 6:20pm.
-When she arrived, she observed the resident outside on the sidewalk in his wheelchair, wearing his oxygen with a lit cigarette to his mouth.
-The resident had a history of drug abuse.
-The resident was on two narcotic pain medications, oxycodone and methadone (Oxycodone and Methadone are controlled substances used to treat moderate to severe pain).
-When she reviewed the resident's medications, she observed that he had removed his narcotic pain medications from the blister packs and placed the pills in two prescription bottles.
-The resident did not relabel the prescription bottles with what pills he added to the bottles.
-The resident was at risk of an overdose from his pain medications because he had taken his pain medication too soon.
-The resident was at risk of mistakenly taking too much medication which could cause respiratory distress or death.
-She reported to her Clinical Manager that the resident was not safe to stay at the hotel.
-Resident #8 was taken to the local emergency department (ED) because he did not have enough food, had barriers to accessing food, was smoking while wearing his oxygen, had taken his narcotic pain medication too soon, was at risk of an overdose intentionally, or unintentionally due to his chronic pain and history of drug abuse, carrying a large amount of cash and at risk of being robbed, was a fall risk and had shortness of breath when he stood up and he required

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assistance with bathing, toileting, and meal preparation.
-Resident #8 was alert and oriented, however he had moments of confusion and lack of clarity due to his anxiety and did not think rationally.

Telephone interview with the Clinical Manager from the hospice agency on 05/16/25 at 10:45am revealed:
-The hospice agency was not aware that Resident #8 had been discharged by the facility to a local hotel until 05/04/25.
-Resident #8's family member sent a text message to the hospice social worker on 05/03/25.
-The hospice social worker was not on call and happened to check her work cellular telephone on 05/04/25.
-The hospice social worker notified the Clinical Manager and spoke with Resident #8's family member on 05/04/25.
-She contacted the on-call hospice nurse to notify her that Resident #8 had been discharged by the facility to a local hotel.
-She directed the on-call hospice nurse to assess if the resident was safe at the location where the facility discharged him.
-The on-call hospice nurse notified her that the resident was not safe at the hotel because he was wheelchair bound, unable to provide personal care for himself, unable to prepare meals, he was in possession of strong narcotic medications, was on oxygen, had a large amount of cash with him and was at risk of being robbed.
-She notified the hospice Administrator for guidance, who directed her to get the resident to a safe location to ensure his safety.

Interview with a MA on 05/15/25 at 2:36pm revealed she worked the day Resident #8 was

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D 338	Continued From page 70 involved in an altercation with another resident. Interview with the Facility Manager on 05/15/25 at 8:33am revealed: -Resident #8's verbal and physical aggressiveness became worse over time. -The resident had frequent tantrums if he did not get his way. -Resident #8 did things for spite, such as write curse words on another resident's door. Interview with the Facility Manager on 05/14/25 at 8:54am revealed: -Resident #8 was discharged from the facility on 05/03/25 due to his behaviors. -Resident #8 was a danger to other residents and the facility had no choice but to discharge the resident, and the altercation on 05/03/25 "was the last straw." _____ The facility failed to ensure Resident #8, a hospice patient, was treated with respect and dignity and was free from neglect after he was discharged to a hotel wheelchair bound, on oxygen, was observed smoking while wearing his oxygen, had two plates of food the second day he was at the hotel, was left by facility staff with narcotic pain medications, the resident had suicidal ideation, anxiety, fear and felt degraded when he was left at a hotel. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/25. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 15, 2025.	D 338		

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D 358	Continued From page 71 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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 1 sampled residents (#8) related to a medication for pain control. The findings are: Review of Resident #8's current FL-2 dated 10/02/24 revealed diagnoses included chronic pain, chronic pulmonary embolism, and depressive episodes. Review of Resident #8's hospice physician certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss. Review of Resident #8's physician order dated 04/14/25 revealed there was an order for Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours. Review of Resident #8's April 2025 electronic	D 358	• medications and treatments will be administered only upon valid, current orders from a licensed prescribing practitioner. All medications will be administered correctly as ordered by LHP. • Medication orders must include o Medication name o Strength of medication o Dosage of medication to be administered o Route of administration o Specific directions for use, including frequency of administration o For PRN medications, a stated indication for use • All orders must be maintained in the resident's record. • All current medication and treatment orders, including standing orders and orders for self-administration, must be reviewed and signed by the resident's prescribing practitioner Medication Aide Training: For unlicensed staff, this typically involves: 1. Medication aides and other relevant staff must maintain ongoing competency, often Right Resident: Verify identity 2. Right Medication: Compare the medication to the order on the MAR and the pharmacy label. 3. Right Dose: Ensure the correct quantity/strength is prepared and administered. 4. Right Time: Administer medications within the prescribed timeframe 5. Right Route: Administer via the correct pathway 6. Right Documentation: Accurately record administration immediately after the medication is given and the resident takes it (no pre-charting).	6/1/25
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D 358	Continued From page 72 medication administration record (eMAR) revealed: -There was an entry for Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours at 8:00am and 8:00pm. -Methadone HCL 5mg was documented as not administered on 04/30/25 at 8:00pm. -Methadone HCL 5mg was documented with a zero with a line drawn through the zero on 04/30/25 at 8:00pm. -There was an entry on the eMAR exceptions that Methadone HCL 5mg was not administered, waiting on refill, on 04/30/25. Review of Resident #8's May 2025 eMAR revealed: -There was an entry for Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours at 8:00am and 8:00pm. -Methadone HCL 5mg was documented as not administered on 05/01/25 at 8:00am -Methadone HCL 5mg was documented with a zero with a line drawn through the zero on 05/01/25 at 8:00am. -There was an entry on the eMAR exceptions that Methadone HCL 5mg was not administered, waiting on refill, on 05/01/25. Telephone interview with a pharmacist with the resident's pharmacy on 04/16/25 at 9:41am revealed: -Resident #8's medications were filled by their local pharmacy since he was on hospice services. -The resident's family member picked up his medications and delivered them to the facility. -The pharmacy dispensed 70 tablets of Methadone HCL 5mg for Resident #8 on 04/14/25 for a 28 day supply. -The pharmacy dispensed 75 tablets of	D 358	Con"t (MAR) must be accurate and complete and include resident name, medication name, strength/dosage, instructions, PRN justification/effect, date/time, omissions, and staff initials/name. • Documentation of any medication discrepancies, errors, or adverse reactions will be documented immediately • This will be monitored on a daily basis by RCC and facility manager.	

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D 358	Continued From page 73 Methadone HCL 5mg for Resident #8 on 05/01/25 for a 30 day supply. -Methadone HCL 5mg, 12.5mg every 12 hours was a high dose of narcotics. -If an individual had been on Methadone HCL 12.5mg for an extended period of time and missed two consecutive doses, they could experience withdrawal symptoms such as sweating, body tremors, anxiety, agitation, negative behaviors could be increased, and the individual would feel physically ill. Interview with a medication aide (MA) on 04/16/25 at 1:38pm revealed: -She compared the eMAR with the resident's medications on hand and the controlled substance log (CSL). -When she administered Resident #8 his Methadone HCL 5mg, she documented that she administered the medication in the eMAR and then in the CSL. -She could not remember why Resident #8 did not receive his Methadone HCL 5mg on 04/30/25 and 05/01/25. -She was not sure if the resident's family member was late picking up the medications or if they were late notifying the pharmacy that they needed a refill on his Methadone. Interview with the Facility Manager on 05/16/25 at 3:06pm revealed: -She was not aware that Resident #8 had missed Methadone doses on 04/30/25 and 05/01/25. -She expected the MAs to administer all medications as ordered. -Resident #8 was on Methadone to help with his pain management.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REST HOME	1361 CAROLINA REST HOME ROAD ROANOKE RAPIDS, NC 27870

(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 367	Continued From page 74	D 367		
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 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 ensure the medication administration records were accurate for 1 of 1 sampled residents (#8) including inaccurate documentation of a controlled substance. The findings are: Review of Resident #8's current FL-2 dated 10/02/24 revealed diagnoses included chronic pain, chronic pulmonary embolism, and	D 367	The facility shall assure the resident medication record accurately reflects (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 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 will be monitored on a daily basis by the RCC and facility manager	06/01/25

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D 367	Continued From page 75 depressive episodes. Review of Resident #8's hospice physician certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss. a. Review of Resident #8's physician order dated 03/29/25 revealed: -The physician order was signed by the hospice physician. -There was an order for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed for pain (Oxycodone HCL is used to manage moderate to severe pain when other pain treatments are inadequate). Review of Resident #8's physician order dated 04/17/25 revealed: -The physician order was signed by the hospice physician. -There was an order for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed for pain. Review of Resident #8's March 2025 controlled substance log (CSL) revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed. -Oxycodone HCL 15mg was documented as administered on 03/31/25 at 8:00am, 2:00pm, and 8:00pm. Review of Resident #8's March 2025 electronic medication record (eMAR) revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed. -Oxycodone HCL 15mg was documented as administered on 03/31/25 at 1:24pm, 5:20pm, and 8:31pm.	D 367		

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D 367	Continued From page 76 Review of Resident #8's April 2025 CSL revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed. -Oxycodone HCL 15mg was documented as administered on 04/01/25 at 8:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/02/25 at 12:00am, 4:00am, 8:00am, 1:30pm, 4:30pm, 7:30pm, and 10:30pm. -Oxycodone HCL 15 mg was documented as administered on 04/03/25 at 12:00am, 8:00am, 2:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/04/25 at 8:00am, 11:00am, 2:00pm, 3:38pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/05/25 at 8:00am, 2:00pm, 6:00pm, and 9:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/06/25 at 12:00am, 4:00am, 8:00am, 2:00pm, 5:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/07/25 at 2:00am, 8:00am, 2:00pm, 5:00pm, 8:00pm, 11:00pm, 8:00am, and 2:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/08/25 at 5:06pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/09/25 at 3:00am, 6:00am, 9:00am, 12:00pm, 3:00pm, and 6:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/10/25 at 12:00am, 3:00am, 8:00am, 11:00am, 2:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/29/25 at 8:00am, 12:00pm, 4:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/30/25 at 2:00am, 5:00am,	D 367		

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D 367	Continued From page 77 8:00am, 12:00pm, 2:00pm, 5:00pm, and 8:00pm. Review of Resident #8's April 2025 eMAR revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed. -Oxycodone HCL 15mg was documented as administered on 04/01/25 at 8:53am and 3:55pm. -Oxycodone HCL 15 mg was documented as administered on 04/02/25 at 4:59am, 8:22am, and 1:33pm. -Oxycodone HCL 15 mg was documented as administered on 04/03/25 at 1:53am, 8:06am, 1:43pm, and 10:57pm. -Oxycodone HCL 15 mg was documented as administered on 04/04/25 at 12:42pm and 8:37pm. -Oxycodone HCL 15 mg was documented as administered on 04/05/25 at 12:25pm. -Oxycodone HCL 15 mg was documented as administered on 04/06/25 at 1:02am and 2:39am. -Oxycodone HCL 15 mg was documented as administered on 04/07/25 at 8:29am, 2:49pm, and 8:53pm. -Oxycodone HCL 15 mg was documented as administered on 04/08/25 at 1:16pm and 11:10pm. -Oxycodone HCL 15 mg was documented as administered on 04/09/25 at 3:19pm. -Oxycodone HCL 15 mg was documented as administered on 04/10/25 at 11:38am, 1:10pm, 8:25pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 04/29/25 at 8:43pm. -Oxycodone HCL 15 mg was documented as administered on 04/30/25 at 4:52pm. Review of Resident #8's May 2025 CSL revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed.	D 367		

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D 367	Continued From page 78 -Oxycodone HCL 15mg was documented as administered on 05/01/25 at 8:00am, 2:00pm, 4:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 05/02/25 at 2:00am, 5:00am, 8:00am, 11:00am, 2:00pm, 4:00pm, 8:00pm, and 11:00pm. -Oxycodone HCL 15 mg was documented as administered on 05/03/25 at 8:00am, 12:00am, and 3:00pm. Review of Resident #8's May 2025 eMAR revealed: -There was an entry for Oxycodone HCL 15mg, take 1 tablet every 3 hours as needed. -Oxycodone HCL 15mg was documented as administered on 05/01/25 at 11:32am and 4:10pm. -Oxycodone HCL 15mg was documented as administered on 05/02/25 at 11:31am and 2:09pm. -Oxycodone HCL 15 mg was documented as administered on 05/03/25 at 9:41am and 12:41pm. Refer to interview with a medication aide (MA) on 05/16/25 at 1:38pm. Refer to interview with the Facility Manager on 05/16/25 at 3:06pm. b. Review of Resident #8's physician order dated 03/29/25 revealed: -The physician order was signed by the hospice physician. -There was an order for Methadone HCL 10mg, take 1 tablet twice a day (Methadone is used to manage moderate to severe pain when other pain treatments are inadequate).	D 367		

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D 367	Continued From page 79 Review of Resident #8's March 2025 controlled substance log (CSL) revealed: -There was an entry for Methadone HCL 10mg, take one tablet at 8:00am and 8:00pm. -Methadone HCL 10mg was documented as administered on 03/31/25 at 8:00am and 8:00pm. Review of Resident #8's March 2025 electronic medication record (eMAR) revealed: -There was an entry for Methadone HCL 10mg, take one tablet at 8:00am and 8:00pm. -Methadone HCL 10mg was documented as administered on 03/31/25 at 8:00pm. -There was an "X" documented on 03/31/25 at 8:00am. Refer to interview with a medication aide (MA) on 05/16/25 at 1:38pm. Refer to interview with the Facility Manager on 05/16/25 at 3:06pm. _____ Interview with a medication aide (MA) on 045/16/25 at 1:38pm revealed: -She documented that she administered medications in the eMAR and also on the CSL after she administered medications to Resident #8. -When a Oxycodone or Methadone were administered, and she documented it on the eMAR, the time was recorded on the eMAR. -She was not sure why the times that Oxycodone and Methadone were administered were not documented with the same times on the eMAR and on the CSL. Interview with the Facility Manager on 05/16/25 at 3:06pm revealed: -MAs were supposed to document the	D 367		

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D 367	Continued From page 80 administration of controlled substances in the eMAR and on the CSL. -The times that controlled substances were administered should match on the eMAR and the CSL.	D 367	Receipt of Controlled Substances: The facility shall maintain a clear, chronological log for every controlled substance received. This will include: Date of receipt. Name of the controlled substance. Strength and dosage form. Quantity received Upon receipt, immediately reconcile the quantity received against the invoice or packing slip. Any discrepancies should be investigated and documented. Ensure controlled substances are immediately placed in a securely locked storage area. II. Administration of Controlled Substances: The MAR is used as the primary document for administration. It will include: Resident's full name. Name of the medication or treatment order. Strength and dosage or quantity of medication administered. Instructions for administering the medication Date and exact time of administration. Reason or justification for the administration of PRN medications and the resulting effect on the resident Documentation of any omission of medications or treatments and the reason for the omission Name or initials of the person administering the medication. If initials are used, a signature equivalent to those initials must be documented and maintained with the MAR.	
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the administration of a controlled substance for 1 of 1 resident (#8) sampled residents. The findings are: Review of Resident #8's current FL-2 dated 10/02/24 revealed diagnoses included chronic pain, chronic pulmonary embolism, and depressive episodes. Review of Resident #8's hospice physician certification of terminal illness dated 03/07/25 revealed the resident's hospice diagnosis was chronic obstructive pulmonary disease (COPD) with abnormal weight loss. Review of Resident #8's physician order dated 04/11/25 revealed there was an order for	D 392		

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D 392	Continued From page 81 Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours. Review of Resident #8's controlled substance log (CSL) for 04/16/25 revealed: -The CSL was dated 04/16/25. -There was a handwritten entry for Methadone HCL 5mg, take 2 ½ tablets every 12 hours for pain. -There was a handwritten note that there were 70 tablets of Methadone HCL 5mg dispensed. -There was an entry that 1 tablet of Methadone HCL 5mg was administered on 04/16/25 at 8:00pm, when there should have been documentation that 2 ½ tablets were administered. -The amount of Methadone HCL 5mg tablets remaining was documented as 69 tablets, when it should have been documented that there were 66.5 tablets remaining. -There was an entry that 1 tablet of Methadone HCL 5mg was administered on 04/17/25 at 8:00am, when there should have been documentation that 2 ½ tablets were administered. -The amount of Methadone HCL 5mg tablets remaining was documented as 68, when it should have been documented that there were 64 tablets remaining. -This error was repeated 21 times from 04/18/25 to 04/30/25. -There was an entry that 2 ½ tablets of Methadone HCL 5mg was administered on 04/17/25 at 8:00pm. -The amount of Methadone HCL 5mg tablets remaining was documented as 67 tablets, when it should have been documented that there were 62.5 tablets remaining. -This error was repeated 4 times from 4/19/25 to 04/21/25.	D 392	Narcotic Count Sheets: Will be separate logs used for each controlled substance to track doses removed from the main stock. Each removal should be documented with: Date and time of removal. Quantity removed. Balance remaining in the container. Name/signature of the person administering the dose. Shift Counts: Regular counts of controlled substances will be performed by two authorized staff members. Both individuals must verify the count and sign the inventory record. Any discrepancies must be immediately investigated and reported. If a partial dose is administered or a dose is wasted, a second authorized staff member must witness the waste. Both individuals must sign the documentation confirming the waste, noting the quantity wasted and the method of disposal.	06/1/25

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D 392	Continued From page 82 Review of Resident #8's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours at 8:00am and 8:00pm. -Methadone HCL 5mg was documented as administered from 04/01/25 to 04/29/25 at 8:00am and 8:00pm. -Methadone HCL 5mg was documented as not administered on 04/30/25 at 8:00pm. Review of Resident #8's CSL for 05/01/25 revealed: -The CSL was dated 05/01/25. -There was a handwritten entry for Methadone HCL 5mg, take 2 ½ tablets every 12 hours for pain. -There was a handwritten note that there were 31 tablets of Methadone HCL 5mg dispensed. -There was an entry that 2 ½ tablets of Methadone HCL 5mg was administered on 05/01/25 at 8:00pm. -The amount of Methadone HCL 5mg tablets remaining was documented as 28 tablets, when it should have been documented that there were 28.5 tablets remaining. -This error was repeated 2 times from 05/02/25 to 05/03/25. Review of Resident #8's May 2025 eMAR revealed: -There was an entry for Methadone HCL 5mg, take 2 ½ (12.5mg) every 12 hours at 8:00am and 8:00pm. -Methadone HCL 5mg was documented as administered on 05/01/25 at 8:00am, 05/02/25 at 8:00am and 8:00pm, and 05/03/25 at 8:00am. -Methadone HCL 5mg was documented as not	D 392	Con't The facility shall maintain a clear, chronological log for every controlled substance received. This will include: Date of receipt. Name of the controlled substance. Strength and dosage form. Quantity received Upon receipt, immediately reconcile the quantity received against the invoice or packing slip. Any discrepancies should be investigated and documented. Ensure controlled substances are immediately placed in a securely locked storage area. II. Administration of Controlled Substances: The MAR is used as the primary document for administration. It will include: Resident's full name. Name of the medication or treatment order. Strength and dosage or quantity of medication administered. Instructions for administering the medication Date and exact time of administration. Reason or justification for the administration of PRN medications and the resulting effect on the resident Documentation of any omission of medications or treatments and the reason for the omission Name or initials of the person administering the medication. If initials are used, a signature equivalent to those initials must be documented and maintained with the MAR.	06/1/25

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D 392	Continued From page 83 administered on 05/01/25 at 8:00am. Telephone interview with a pharmacist with the resident's pharmacy on 04/16/25 at 9:41am revealed: -Resident #8's medications were filled by their local pharmacy since he was on hospice services. -The resident's family member picked up his medications and delivered them to the facility. -The pharmacy dispensed 70 tablets of Methadone HCL 5mg for Resident #8 on 04/14/25 for a 28 day supply. -The pharmacy dispensed 75 tablets of Methadone HCL 5mg for Resident #8 on 05/01/25 for a 30 day supply. Interview with a medication aide (MA) on 04/16/25 revealed: -She compared the eMAR with the resident's medications on hand and the controlled substance log. -The resident's Methadone HCL 5mg was packaged in blister packs by the pharmacy and there were 2 ½ pills in each section of the blister package. -When she administered Resident #8 his Methadone HCL 5mg, she documented that she administered the medication in the eMAR and then in the CSL. -When she administered Resident #8 his Methadone HCL 5mg, even though there were 2 ½ tablets in each section of the blister package, she documented on the CSL that the resident received one dose, because she considered the 2 ½ tablets as "one dose" of the medication. Interview with the Facility Manager on 05/16/25 at 3:06pm revealed: -She was not aware that Resident #8's CSL had	D 392	CON'T Narcotic Count Sheets: Will be separate logs used for each controlled substance to track doses removed from the main stock. Each removal should be documented with: Date and time of removal. Quantity removed. Balance remaining in the container. Name/signature of the person administering the dose. Shift Counts: Regular counts of controlled substances will be performed by two authorized staff members. Both individuals must verify the count and sign the inventory record. Any discrepancies must be immediately investigated and reported. If a partial dose is administered or a dose is wasted, a second authorized staff member must witness the waste. Both individuals must sign the documentation confirming the waste, noting the quantity wasted and the method of disposal.	06/1/25

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D 392	Continued From page 84 two different quantities listed when the resident's Methadone HCL 5mg was administered. -She expected the MAs to document the actual number of pills they dispensed and administered to the resident. -The MAs should have documented that they administered Resident #8 2 ½ tablets of Methadone HCL 5mg to ensure accuracy of the CSL.	D 392	Facility will provide a training stressing Key Principles for Assuring Accuracy: "If it's not documented, it wasn't done": This adage is paramount for controlled substances. Every step of the process must be clearly and accurately recorded. Timeliness: Documentation should be completed at the time of the action (receipt, administration, waste) to ensure accuracy. Legibility and Clarity: All entries should be legible and unambiguous. No Blank Spaces: Avoid leaving blank spaces on forms where information is required. Correcting Errors: Errors should be corrected according to facility policy (e.g., a single line through the error, initialed and dated, with the correct entry made). Never use correction fluid or obliterate entries. Designated Personnel: Only authorized and appropriately trained personnel should handle and document controlled substances. Audits and Reconciliation: Regular, unannounced internal audits and reconciliation of controlled substance inventory with documentation are crucial to identify discrepancies and prevent diversion.	06/1/25