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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on August 13, 2025 through August 15, 2025.	D 000		
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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION. Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 5 sampled residents (#1, #3) related to failure to notify the primary care provider of finger stick blood sugars (FSBS) outside of parameters (#3) and failure to notify the primary care provider of a resident's refusal to see the mental health provider (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 04/16/25 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, syncope and collapse and acidosis. -The resident was semi-ambulatory.	D 273		

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D 273	Continued From page 1 Review of Resident #3's Resident Register revealed she was admitted to the facility on 10/12/23. Review of Resident #3's care plan dated 01/06/25 revealed: -She was independent with ambulation and transferring. -She required supervision with toileting, dressing, and grooming. -She required limited assistance with bathing. Review of Resident #3's physician's order dated 07/15/25 revealed: -There was an order to check Resident #3's blood glucose twice daily at 5:30am and 8:00pm and record on the medication administration record (MAR) and report if the blood glucose was less than 60 or greater than 500. -There was an order for Lantus Solostar 100 unit/ML Inject 18 units subcutaneously once daily at bedtime. If daily blood glucose reading is above 250 contact the Provider for dose increase on insulin. (Lantus Solostar is a long acting insulin to lower blood sugar.) Review of Resident #3's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check Resident #3's blood glucose twice daily at 5:30am and 8:00pm and record on the medication administration record (MAR) and report if the blood glucose was less than 60 or greater than 500. -There was an entry for Lantus Solostar 100 unit/ML Inject 18 units subcutaneously once daily at bedtime. If daily blood glucose reading is above 250 contact the Provider for dose increase on insulin. -Resident #3's finger stick blood sugar (FSBS)	D 273		

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D 273	Continued From page 2 was 423 at 5:30am on 06/02/25. -Resident #3's FSBS was 350 on 06/03/25 at 5:30am. -Resident #3's FSBS was 368 on 06/09/25 at 5:30am. -Resident #3's FSBS was 447 on 06/24/25 at 5:30am. -Resident #3's FSBS was 261 on 06/27/25 at 5:30am. -Resident #3's FSBS was 365 on 06/29/25 at 5:30am. -Resident #3's FSBS was 505 on 06/02/25 at 8:00pm. -Resident #3's FSBS was 350 on 06/03/05 at 8:00pm. -Resident #3's FSBS was 355 on 06/04/25 at 8:00pm. -Resident #3's FSBS was 300 on 06/05/25 at 8:00pm. -Resident #3's FSBS was 408 on 06/06/25 at 8:00pm. -Resident #3's FSBS was 267 on 06/07/25 at 8:00pm. -Resident #3's FSBS was 300 on 06/11/25 at 8:00pm. -Resident #3's FSBS was 300 on 06/12/25 at 8:00pm. -Resident #3's FSBS was 278 on 06/18/25 at 8:00pm. -Resident #3's FSBS was 300 on 06/19/25 at 8:00pm. -Resident #3's FSBS was 300 on 06/20/25 at 8:00pm. -Resident #3's FSBS was 305 on 06/24/25 at 8:00pm. -Resident #3's FSBS was 302 on 06/25/25 at 8:00pm. -Resident #3's FSBS was 296 on 06/26/25 at 8:00pm. -Resident #3's FSBS was 255 on 06/27/25 at	D 273		

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8:00pm.
-Resident #3's FSBS was 325 on 06/30/25 at 8:00pm.
-Resident #3's FSBS was 505 at 8:00pm on 06/02/25.
-There were 21 times in June that Resident #1's FSBS was greater than 250.
-There was 1 time in June that Resident #1's FSBS was greater than 500.
-There was no documentation on the eMAR showing that Resident #3's primary care provider (PCP) was notified of FSBS readings greater than 250 or greater than 500.

Review of Resident #3's July 2025 eMAR revealed:
-There was an entry to check Resident #3's blood glucose twice daily at 5:30am and 8:00pm and record on the MAR and report if the blood glucose was less than 60 or greater than 500.
-There was an entry for Lantus Solostar 100 unit/ML Inject 18 units subcutaneously once daily at bedtime. If daily blood glucose reading is above 250 contact the Provider for dose increase on insulin.
-Resident #3's FSBS was 404 on 07/01/25 at 5:30am.
-Resident #3's FSBS was 280 on 07/05/25 at 5:30am.
-Resident #3's FSBS was 322 on 07/06/25 at 5:30am.
-Resident #3's FSBS was 360 on 07/07/25 at 5:30am.
-Resident #3's FSBS was 299 on 07/09/25 at 5:30am.
-Resident #3's FSBS was 300 on 07/11/25 at 5:30am.
-Resident #3's FSBS was 286 on 07/14/25 at 5:30am.
-Resident #3's FSBS was 307 on 07/14/25 at

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8:00pm.
-Resident #3's FSBS was 285 on 07/15/25 at 8:00pm.
-Resident #3's FSBS was 256 on 07/17/25 at 8:00pm.
-Resident #3's FSBS was 300 on 07/18/25 at 8:00pm.
-Resident #3's FSBS was 263 on 07/21/25 at 8:00pm.
-Resident #3's FSBS was 267 on 07/22/25 at 8:00pm.
-Resident #3's FSBS was 269 on 07/27/25 at 8:00pm.
-Resident #3's FSBS was 289 on 07/28/25 at 8:00pm.
-Resident #3's FSBS was 267 on 07/29/25 at 8:00pm.
-There were 16 times in July that Resident #1's FSBS was greater than 250.
-There was no documentation on the eMAR that Resident #3's PCP was notified of FSBS readings greater than 250.

Review of Resident #3's August 2025 eMAR from 08/01/25 -08/12/25 revealed:
-There was an entry to check Resident #3's blood glucose twice daily at 5:30am and 8:00pm and record on the MAR and report if the blood glucose was less than 60 or greater than 500.
-There was an entry for Lantus Solostar 100 unit/ML Inject 18 units subcutaneously once daily at bedtime. If daily blood glucose reading is above 250 contact the Provider for dose increase on insulin.
-Resident #3's FSBS was 274 at 5:30am on 08/03/25, 435 at 5:30am on 08/10/25 and 376 at 5:30am on 08/11/25.
-Resident #3's FSBS was 398 at 8:00pm on 08/12/25.
-There were 5 times in August that Resident #3's

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FSBS was greater than 250.
-There was no documentation that Resident #3's PCP was notified of FSBS readings greater than 250.

Review of Resident #3's handwritten facility progress notes revealed:
-There was documentation on 06/24/25 at 8:00am that Resident #3's FSBS was 268, was rechecked and 306, and was 447 on the 3rd FSBS check.
-Resident #3's PCP was sent a fax regarding the FSBS.
-A message was left for Resident #3's PCP on 06/24/25 at 9:33am and 10:18am
-At 10:31am on 06/24/25, staff spoke with someone at the PCP office who advised they would call back once the PCP gave instructions on what to do regarding Resident #3's FSBS.
-There was documentation on 06/24/25 at 8:15am that Resident #3's PCP called back to increase the Lantus Solostar to 18 units.
-Resident #3's PCP was notified of blood glucose readings of 409 and 357 on 07/01/25 at 8:00am.
-There was no documentation of the PCP's response to the 07/01/25 blood glucose readings.
-Resident #3's PCP was notified of blood glucose readings over 250 on 08/11/25 at 8:37am.
-Resident #3 was sent to the hospital on 08/11/25 due to a blood glucose reading of 379 at 8:37am and a second blood glucose reading that read "high" on the glucometer at 10:00am.
-There was no further documentation that Resident #3's FSBS readings of over 250 or 500 were reported to the PCP.

Review of the facility's FSBS book revealed there was a standing order for Resident #3 dated 06/12/25 to notify the provider of the FSBS was over 350 and administer medication as ordered.

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D 273	Continued From page 6 Observation of the medication cart on 08/15/25 at 9:41am revealed: -There was a large note on the cart with general instructions regarding residents with FSBS. -On weekends, if FSBSs were above 300, staff were to re-check and put in progress notes in the resident's record. -If the FSBS was below 70, staff were to give orange juice, re-check and document in progress notes in the resident's record. -The words "Fax the DR" had stars beside it with an arrow pointing to a statement that said "They will get it on Monday." Review of Resident #3's After Visit Summary dated 08/12/25 revealed Resident #3 was seen for diabetic ketoacidosis (DKA) (a condition that develops when the body does not have enough insulin), Type 2, not at goal. Review of Resident #3's Discharge Summary dated 08/12/25 revealed: -Resident #3 was admitted to the hospital on 08/11/25. -Resident #3 presented to the emergency department (ED) with elevated blood sugar. -Resident #3 had elevated blood sugars at the facility which prompted the ED visit. -Resident #3's blood glucose reading was 665. -Resident #3 was admitted for further evaluation and management of diabetic ketoacidosis. -Resident #3 was to follow up with the PCP for further recommendations. Telephone interview with Resident #3's family member on 08/14/25 at 11:07am revealed: -Resident #3 had been a diabetic for a few years. -Resident #3's blood sugar was high for some reason.	D 273		

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-Resident #3 took insulin.
-He was unsure how long Resident #3 had been having high FSBS readings.
-He attended all medical appointments with Resident #3.
-The facility reported Resident #3's FSBS readings to the PCP.
-Resident #3's FSBS reading had never been as high as it was when he last went to the hospital.

Interview with a medication aide (MA) on 08/14/25 at 12:09pm revealed:
-MAs were responsible for checking FSBS.
-She reported FSBS to the PCP if the reading was low below 60 and over 300.
-Resident #3's FSBS checks were in the morning and at night.
-When she arrived to work, Resident #3's FSBS was already checked by a 3rd shift (11pm to 7am) MA.
-She worked from 7:00am to 3:00pm.
-She looked at the documented FSBS reading when she got to work.
-She and the outgoing MA discussed when the FSBS was high or low.
-If a resident's FSBS was low or high, the outgoing MA told her what to do.
-She re-checked the FSBS 30 minutes after being informed of the reading and if the reading was still low or high, she notified the Resident Care Coordinator (RCC).
-The RCC notified the resident's PCP to get further instructions on what to do.
-If the FSBS was still high after administering insulin, it was re-checked 30 minutes later and the RCC was notified of the FSBS was still high.
-If a resident's FSBS reading was over 300, the resident was sent out whether the PCP responded or not.
-The above had been the process for FSBS since

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she started working at the facility in January 2025.
-MAs did not document when they reported FSBS to the RCC all the time; sometimes they made a note in the comments on the eMAR but most notifications to the RCC were verbal.
-Documentation to the PCP when the FSBS was over 300 should be in the resident's record.
-She was not aware of the order to notify the PCP when the FSBS was over 500 for Resident #3.
-She knew the PCP was to be notified of any FSBS over 300 for any resident with diabetes.
-She checked Resident #3's FSBS only if it was too high or too low when she arrived at work.
-She did not recall Resident #3's FSBS parameters.
-Resident #3's FSBS parameters did not pop up when she opened the eMAR.

Interview with a second MA on 08/14/25 at 3:28pm revealed:
-If Resident #3's FSBS was over 350, they were to call the hospital.
-Resident #3 had no other FSBS orders that she was aware of.
-Orders popped up on the eMAR when it was time for administration.
-She administered insulin to Resident #3 at 8:00pm because she was on the medication cart at that time.
-Resident #3's order said she was to call the provider if the FSBS was over 350.
-When administering medication, she matched the medication to the eMAR.
-The order just told her how many units of insulin to give but did not say anything else.
-When shown the order to contact the provider if the FSBS was greater than 500, the MA advised she was familiar with the parameters of 500 but she went by the order that was in the facility's

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FSBS book.
-When she was shown the Lantus Solostar order to report the FSBS to the provider if the reading was over 250, she advised she was not aware of the different parameter orders prior to today.
-She did not notice the parameters on the eMAR for Resident #3 when administering medication.
-If she had noticed the parameters for Resident #3 she would have notified the provider or left a note for the RCC and the Manager to notify the provider.

Interview with the RCC on 08/14/25 at 2:32pm and 4:55pm revealed:
-The MAs checked FSBS at 7:00am.
-If the FSBS reading was low, the MA gave the resident orange juice and re-checked the FSBS after 30 minutes.
-If the FSBS was high, she made contact with the PCP.
-Low FSBS was under 70 and high FSBS was over 350.
-When she arrived at work at 8:00am, she checked the FSBS book and if the reading was high, she contacted the PCP and wrote a progress note.
-If the FSBS reading was low when she checked the FSBS book, she asked the MA if they re-checked the FSBS and if the reading came up over 70; and she documented the response.
-She was not aware of Resident #3's orders for parameters.
-She had been using the facility's standard FSBS book, which was where they kept each resident's FSBS order.
-Resident #3 had an order in the FSBS book to contact the provider if the FSBS was below 70 or greater than 350.
-If she had known about the order to report the FSBS if the reading was over 250 she would have

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followed the order.
-The MAs should have caught the parameters for Resident #3 because they administer the medications.
-She had not seen either FSBS order for Resident #3.

Interview with the Manager on 08/14/25 at 4:35pm revealed:
-She was aware of the order to notify the PCP if Resident #3's FSBS was greater than 500.
-She was not aware of the order to notify the PCP if Resident #3's FSBS was greater than 250.
-She felt that if they notified the provider of the FSBS when it was greater than 350 then the 500 would be covered.
-She, the RCC and the Administrator completed chart reviews last week.
-The facility used a Resident Chart Review checklist.
-The concern with Resident #3's FSBS not being reported was that he could go into a diabetic coma which would look like shivering and inability to talk.
-The RCC was responsible for contacting the PCP regarding FSBSs in the morning.
-The MA was responsible for contacting the PCP regarding FSBSs when they were on the cart.
-If the PCP's office was closed at night and the FSBS was high, the MA was supposed to call the emergency department (ED) for advice on what to do.
-The RCC was responsible for orders.
-The RCC placed notes on all medication carts and in the medication room, informing the MAs of new orders, and she left the note on the carts for 1 week.

Second interview with the Manager and the RCC on 08/15/25 at 9:07am and 1:10pm revealed:

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-The facility had no policy related to FSBS.
-Glucometers went up to 600.

Third interview with the RCC on 08/15/25 at 9:25am revealed:
-When new orders were received, she added the order along with the resident's name and any directions to blank slips of paper and wrote "New Order" at the top of the slip.
-She put a copy of the slips with the resident's new order on each medication cart and on the medication room computer.
-She also verbally informed the MAs that the resident had a new order.

Interview with the Administrator on 08/14/25 at 3:42pm revealed:
-She was not aware of the orders or parameters for Resident #3.
-The MAs checked the FSBS and should have seen the parameters.
-She was unsure if the order with parameters popped up on the eMAR screen when medications were administered.
-She, along with the MA, RCC, and pharmacy, should have noticed the FSBS orders for Resident #3.
-Chart reviews were completed last week on all residents by her, the RCC and the Manager and none of them noticed the FSBS orders and parameters.
-Staff told her they did called the PCP regarding FSBS but did not document the calls.
-The RCC was responsible for processing orders and communicating them to the MA.
-She was not aware of how orders were processed and communicated to the MA.

Telephone interview with the licensed practical nurse (LPN) at Resident #3's PCP office on

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D 273	Continued From page 12 08/15/25 at 11:30am revealed: -Resident #3's PCP was called and received multiple faxes from the facility regarding his FSBS readings. (No dates were provided.) -The PCP had a discussion with Resident #3's family and did not want to adjust the medication aggressively or over medicate. Based on observations, interviews and record reviews, it was determined that Resident #3 was not interviewable. 2. Review of Resident #1's current FL-2 dated 04/30/25 revealed diagnoses included coronary artery disease, atrial fibrillation with rapid ventricular response, hypertension, gastro-esophageal reflux disease, benign prostatic hypertrophy, and multiple sclerosis. Review of a hospital discharge summary for Resident #1 dated 04/16/25 revealed additional primary diagnoses included unstable angina, anxiety disorder, history of major depression, and history of subdural hematoma. Review of Resident #1's Resident Register revealed he was admitted to the facility on 04/16/25. Review of Resident #1's primary care provider (PCP) visit note dated 05/22/25 revealed: -Resident #1 was seen for follow up to an emergency room visit. -The resident complained of anxiety and mood disorder. -There were staff reports that Resident #1 had been to the emergency room nine times from April to May 2025. -Staff were asking for a psychiatric referral due to increased behaviors.	D 273		

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D 273	Continued From page 13 -Staff reported that Resident #1 would call 911 and would go to the emergency room when he became angry (no specific behaviors identified). -Resident #1 was assessed to have a mood disorder due to known physiological condition with manic features. -The PCP treatment plan was to refer Resident #1 to a psychiatric provider due to increased behaviors. Review of incident /accident reports for Resident #1 revealed: -On 05/05/25, Resident #1 was seen walking behind or near females grabbing and playing with his genitals in a sexual manner. -On 05/18/25, Resident #1 walked around in the facility talking about getting the staff fired and trying to record all the staff members' conversation, and the resident called 911 complaining of headache, chest pain, and dizziness, and reported not getting his medications. -On 05/24/25, Resident #1 walked by a staff member and "gave me the middle finger" after getting upset with the staff. -On 06/01/25, Resident #1 was disrespectful to another resident. When staff redirected Resident #1, he used foul language and called the staff [expletive] as he walked throughout the halls in the facility. -On 06/15/25, Resident #1 was redirected by staff when the resident used foul language in the dining room during the lunch meal. -On 06/22/25, Resident #1 used foul language in the dining room. Review of Resident #1's record revealed there was no documentation for a psychiatric referral appointment completed or of any notification to the PCP regarding the completion of the	D 273		

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psychiatric referral.

Interview with Resident #1 on 08/13/25 at 4:16pm revealed:
-He was transported to a psychiatric appointment by a named staff (former Resident Care Coordinator (RCC)).
-He thought he was transported to the psychiatric provider in June 2025.
-He was not supposed to be seen for a psychiatric evaluation.
-He thought he was being transported to a provider for assistance to obtain housing.
-There was no reason for him to be seen by the psychiatric provider.
-He declined to be evaluated by the psychiatric provider.

Telephone interview with the psychiatric provider's Administrative Assistant on 08/13/25 at 4:23pm revealed:
-Resident #1 came for an assessment on 06/25/25.
-Resident #1 refused the services.
-The resident was supposed to have a clinical comprehensive assessment completed.
-The resident said there was nothing wrong with his mentality.

Interview with the former RCC on 08/14/25 at 12:57pm revealed:
-She transported Resident #1 to the psychiatric provider's office for the assessment on 06/25/25.
-She was in the lobby when the resident suddenly returned, stating "this not for me" and there was nothing wrong with him mentally.
-Resident #1 refused to be serviced by the mental health provider.
-She transported Resident #1 back to the facility.
-She informed the current RCC and manager that

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Resident #1 refused the mental health provider services.
-She did not document anything because she did not think she had to document anything.
-She did not know Resident #1 had been referred by the PCP for mental health and thought the resident was at the provider's office for assistance with getting an apartment because the provider's office assisted with those services also.
-She did not contact the PCP to notify of Resident #1's refusal of the mental health provider assessment.

Interview with the current RCC on 08/14/25 at 4:50pm revealed:
-She was not the RCC when Resident #1 was transported to the mental health provider for the assessment.
-Nothing had been reported to her about the refusal of the mental health evaluation.
-The RCC was responsible for documenting when a resident attended a doctor's appointment.
-The RCC was responsible for scheduling resident appointments.
-She had not contacted Resident #1's PCP, since becoming the RCC, prior to 08/14/25.

Interview with the Facility Manager on 08/14/25 at 1:05pm revealed:
-Resident #1 had the right to refuse treatment.
-There was no facility written policy regarding refusals.
-She had not contacted the PCP about Resident #1's refusal of the mental health assessment.
-The "majority of the time", the facility was supposed to contact the PCP about refusals.
-She was not sure why the PCP was not contacted about Resident #1's refusal for the mental health assessment but it was possible that one person at the facility thought another person

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D 273	Continued From page 16 at the facility contacted the PCP and documented the refusal and PCP contact. Interview with the Administrator on 08/14/25 at 3:15pm revealed: -Resident #1's PCP should have been notified that the resident refused to have the mental health assessment. -She expected staff to follow up with the PCP when a referral was requested and the services were not completed because of a resident refusal. Attempted telephone interview with Resident #1's PCP on 08/14/25 at 11:35am was unsuccessful. _____ The facility failed to ensure follow-up to meet the acute health care needs of a resident (#3) by failing to inform the primary care provider (PCP) that the resident had FSBS readings over 250 38 times and 1 reading of 505 from June 2025 through August 2025 and the resident ended up in the hospital due to diabetic ketoacidosis in August 2025. These failures were detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 08/14/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 09/20/25.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained	D 338		

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D 338	Continued From page 17 and may be exercised without hindrance. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION. Based on observations, interviews, and record reviews the facility failed to treat residents with respect and dignity related to the tone used when speaking to the residents after they requested assistance (#7, #10) and the words used to describe a resident to another staff member after the resident asked for assistance (#7). The findings are: 1. Review of Resident #7's current FL-2 dated 01/15/25 revealed: -Diagnoses included dementia, diabetes, hypertension and coronary artery disease (CAD). -She was intermittently disoriented. -She was incontinent of bowel and bladder. -She was ambulatory. Review of Personnel Records on 08/15/25 at 10:29am revealed: -Staff B completed training on Resident Rights on 07/28/22. -A job description for Staff B signed by Staff B on 07/01/14 listed a responsibility for helping maintain the self-respect and personal dignity of each resident. Observations of Resident #7 on 08/14/25 at 7:55am revealed:	D 338		

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-Resident #7 was heard in the hallway saying, "I need to use the bathroom, but I can't."
-Staff B told Resident #7 in a rude tone that there was another bathroom on the hall.
-Staff B proceeded down to the hall to the room of another resident where there was a personal care aide (PCA) assisting with feeding.
-Staff B stated, "I'm talking to this woman who wanna be a [expletive]. She knows the rules."

Interview with Resident #7 on 08/14/25 at 8:56am revealed she did not recall seeing or speaking to Staff B.

Interview with Staff B on 08/14/25 at 8:20am revealed:
-Resident #7's floor was wet because she had just finished mopping the room.
-They usually allowed the floor to dry for 15 to 20 minutes before returning to the room.
-Resident #7 was in the dining room eating while she was mopping.
-Resident #7 acted like her room was the only place she could use the bathroom.
-There was a bathroom right across from Resident #7's room that was available for all residents to use.
-Resident #7 threatened her when she cleaned her room all the time.
-Resident #7 did not threaten her today (08/14/25).
-She felt comfortable making the statement about Resident #7 in the presence of another resident because she knew the resident for a long time and he knew she was just letting off steam.
-This was the first time she made an inappropriate comment about a resident.
-She had no concern about the comment she made because she did not make the statement to Resident #7.

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D 338	Continued From page 19 Interview with a PCA on 08/14/25 at 9:12am revealed: -She was assisting a resident with feeding when she heard Staff B say something about a resident just wanting to be an [expletive]. -She did not know what resident Staff B was referring to. -Staff B talked about the floor and bathroom being wet but she was unsure which bathroom she was referring to. -She had never heard Staff B say anything like that before in reference to a resident or anyone else. -The resident she was assisting at the time that Staff B made the comment did not respond. -She knew it was inappropriate, and she did not engage in conversations like that. Interview with the Resident Care Coordinator (RCC) on 08/14/25 at 8:28am revealed: -Staff B had been employed with the facility for over 15 years and had never been reported for being rude to residents. -Staff B's behavior was not appropriate. -She expected all residents to be treated with respect and not have their rights violated. -The residents were to be treated as if the facility was their home and not the home of the staff. Interview with the Manager on 08/14/25 at 8:34am and 10:21am revealed: -Being rude to the residents was not normal behavior for the housekeeper. -Staff B had never been reported to be rude or disrespectful to residents. -Staff should not have spoken about a resident in the way she did. -Resident #7 still had a right to use the bathroom in her room.	D 338		

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D 338	Continued From page 20 -It had been a while since Staff B received Residents Rights training as they usually concentrated more on direct care staff. -Staff B had Resident Rights training, but she did not recall the date. Interview with the Administrator on 08/14/25 at 11:54am revealed: -Staff B admitted to making a statement about a resident just wanting to be an [expletive]. -Staff B stated she did not make the statement to the residents and was not talking to anyone when she made the statement. -It did not matter why Staff B made the statement. -Staff B's behavior was not acceptable. -She expected all residents to be treated with dignity and respect. 2. Review of Resident #10's current FL-2 dated 06/05/25 revealed: -Diagnoses included left side weakness, hypertension, hyperlipidemia, depression, reflux, and fall risk. -The resident's orientation was not listed. -The resident was semi-ambulatory. -The resident was incontinent of bladder and continent of bowel. Review of Personnel Records on 08/15/25 at 10:29am revealed: -There was a job description signed by Staff E on 04/17/25. -Staff E's job description listed Performance Standards of: Providing patience, understanding, and tact in dealing with the residents and showing genuine concern for the elderly and/or facility residents. Observations of Resident #10 on 08/15/25 at 8:18am revealed:	D 338		

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D 338	Continued From page 21 -Resident #10 was heard ringing his handheld call bell. -Staff E was heard calling the resident's name and telling him to stop ringing his bell, that she was helping someone else and she would get to him. -Resident #10 started ringing his call bell vigorously. -Staff E was heard telling Resident #10 in a rude and loud tone to stop ringing his bell and that she was not a slave. -Staff E was observed to have an angry and frowned look on her face. Interview with Resident #10 on 08/15/25 at 8:56am revealed: -He rang his call bell when he needed incontinence care or wanted something to drink. -He rang his bell this morning because he needed incontinence care. -Staff E told him she was not his slave. -Staff E had never spoken to him like that before; that was not her normal behavior. -Staff E's statement made him wonder what she was talking about because he never said she was his slave. -He tried to show everyone respect and the PCA's statement made him feel like he was disrespecting her. -Someone provided incontinence care for him about 10 minutes after the incident with Staff E. Interview with Staff E on 08/15/25 at 9:16am revealed: -She was laughing with Resident #10 when she asked him if it was "slave trade today." -She took good care of Resident #10. -She never neglected any of the residents. -She provided incontinence care for Resident #10 this morning (08/15/25).	D 338		

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D 338	Continued From page 22 -She and Resident #10 "play" all the time and the conversation this morning was them playing. Interview with the Resident Care Coordinator (RCC) and Manager on 08/15/25 at 9:08am revealed: -Resident #10 always rang his bell. -It was Staff E's job to assist the residents. -Staff E's behavior was not her typical behavior. Telephone interview with the Administrator on 08/15/25 at 12:23pm revealed: -She was informed by the Manager of the statement made to Resident #10 by Staff E. -Staff E's behavior was not appropriate. Interview with a resident on 08/15/25 at 9:11am revealed: -A staff person spoke to the resident in a tone that made the resident feel bad. -The resident verbalized two occasions when they were made to feel bad by the named staff. -When the resident addressed management staff, they did not feel heard by management. -The resident had never told anyone how they felt. Observations of the resident during the above interview revealed the resident became emotional and began to cry. _____ The facility failed to ensure residents were treated with respect and dignity related to the tone when speaking to the residents which caused residents to feel bad about having to ask for assistance, as well as the words used when speaking to the residents that made the residents feel bad and there were derogatory words used to refer to a resident in the presence of another resident and staff member. These failures were detrimental to	D 338		

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D 338	Continued From page 23 the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 08/15/25. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 09/20/25.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. 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 2 of 4 residents (#8, #9), observed during the medication administration passes on 08/13/25 and 08/14/25, including medications used to treat constipation and behaviors (#8), and a topical medication used to treat pain (#9). The findings are: 1. Review of Resident #8's current FL-2 dated 05/15/25 revealed diagnoses included osteoarthritis, dementia, metabolic encephalopathy, constipation, and alcoholic cirrhosis of liver.	D 358		

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D 358	Continued From page 24 a. Review of Resident #8's current physician orders revealed there was a physician's order dated 07/18/25 for Bupropion (generic for Wellbutrin) HCL SR (a sustained release medication used to treat symptoms associated with depression) 100mg tablet every day. Observation of the 8:00am medication pass on 08/14/25 at 7:37am revealed: -The medication aide (MA) removed a multi-dose package (MDP) of medications from the medication cart for Resident #8. -The MA opened the MDP and dropped a circular red tablet on the top of the medication cart. -The MA placed the circular red tablet in a separate medication cup from the remainder of pills prepared for Resident #8. Interview with the MA on 08/14/25 at 7:38am revealed: -She dropped the Bupropion on the top of the medication cart. -She normally would not administer a dropped medication. -She would document why the medication was not administered, crush the medication, and dispose of the medication by flushing it. Observations of the MA on 08/14/25 at 7:45am revealed: -The MA administered medications to Resident #8 that included 5 pills and a cup with liquid medication. -Resident #8 was not administered Bupropion. Observations of the MA on 08/14/25 at 7:46am revealed the MA poured the circular red tablet in the shower room commode, flushed the commode, and washed her hands with soap and	D 358		

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D 358	Continued From page 25 water. Review of Resident #8's August 2025 eMAR revealed: -There was a printed entry to the eMAR for Bupropion HCL SR HCL 100mg tablet take one tablet every day, scheduled at 8:00am. -There was a symbol key for "not administered, see notes" in the section for documenting the administration of the Bupropion 100mg tablet for 08/14/25. -There was an entry to the medication notes section dated 08/14/25 at 8:00am that the Bupropion HCL SR 100mg tablet was "dropped/flushed." -There were no additional notes entered on the August 2025 EMAR for the 08/14/25 dose of Bupropion scheduled at 8:00am. Telephone interview with the PCP's nurse on 08/14/25 at 12:05pm revealed she did not see any communication in the provider office notes regarding any behaviors exhibited by Resident #8. Second telephone interview with the PCP's office nurse on 08/14/25 at 3:41pm revealed missing one dose of the Bupropion would not make the resident go through withdrawal symptoms, but the PCP did not want Resident #8 to continue missing doses of the Bupropion because the resident's depression could worsen Interview with the facility Manager on 08/14/25 at 2:45pm revealed: -The MA spoke to her about the 08/14/25 8:00am wasted dose of Bupropion for Resident #8. -She instructed the MA to contact the PCP notifying about the 08/14/25 8:00am wasted dose of Bupropion and to call the pharmacy for a	D 358		

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	HAL042005	A. BUILDING: _____ B. WING _____	R 08/15/2025

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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replacement dose after removing the Bupropion 100mg tablet from the last MDP.

Refer to the interview with the Administrator dated 08/14/25 at 3:03pm.

b. Review of Resident #8's current physician orders revealed there was a physician's order dated 07/18/25 for Lactulose (used to treat constipation and disorders associated with liver disease) 10grams (gm) /15 milliliters (ml) solution take three tablespoonsful (45 ml) by mouth three times a day.

Observation of the 8:00am medication pass on 08/14/25 at 7:37am revealed:
-The medication aide (MA) removed a pharmacy labeled bottle of Lactulose solution from the medication cart labeled for
Resident #8.
-The MA opened and measured 15mls of the Lactulose solution into a clear plastic liquid medication cup and administered the medication to Resident #8.

Review of Resident #8's August 2025 eMAR revealed there was a printed entry to the eMAR for Lactulose 10gm/15ml solution take 3 tablespoonsful (45ml) by mouth three times a day, scheduled at 8:00am, 2:00pm, and 8:00pm.

Telephone interview with Resident #8's PCP nurse on 08/14/25 at 12:05pm revealed:
-On 07/18/25, the resident was last prescribed Lactulose 10 gms/15 mls take 45mls three times a day.
-There was a big difference in the amount being administered if Resident #8 was only being administered Lactulose 15mls instead of 45mls three times a day.

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-The Lactulose helped the body to reduce the amount of ammonia in the body.
-High ammonia levels could cause symptoms of altered mental status such as hallucinations, talking out of his head, and combative behavior.
-She did not see any communication in the provider office notes regarding any behaviors exhibited by Resident #8.

Second telephone interview with Resident #8's PCP office nurse on 08/14/25 at 3:41pm revealed:
-The PCP wanted Resident #8's Lactulose to be administered as prescribed, "meaning not 15mls but 45mls three times a day."
-Resident #8 could become confused and agitated if the ammonia level became elevated.

Interview with the MA on 08/14/25 at 12:30pm revealed:
-She administered Resident #8 15mls of the Lactulose 10gms/15mls the morning of 08/14/25 at 8:00am medication pass.
-She read the medication label wrong.
-She read the dosage for the Lactulose 10gm/15ml as 15mls instead of 45mls.
-She did not know why she missed seeing that Resident #8 was prescribed Lactulose 10gms/15mls take three tablespoonsful (45mls).
-She thought the slash mark (/) meant "either/or" and did not understand what the slash mark meant.

Refer to the interview with the Administrator on 08/14/25 at 3:03pm.

2. Review of Resident #9's current FL-2 dated 05/15/25 revealed diagnoses included covid pneumonia, community acquired pneumonia, diabetes, hypertension, gastro-esophageal reflux

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D 358	Continued From page 28 disease, hyperlipidemia, and nicotine dependence. Review of physician orders for Resident #9 revealed there was a physician's order dated 07/21/25 for GS Arthritis Pain 1% gel (a topical medication used to treat joint pain) apply 2 grams (gm) to affected area on right foot four times daily *measure using dosing card*. Observation of the 8:00am medication pass on 08/14/25 at 7:31am revealed: -The medication aide (MA) removed a pharmacy labeled carton for of Arthritis Pain Diclofenac Gel from the medication cart labelled for Resident #9. -The MA approached Resident #9 in the dining room and administered 12 pills and informed the resident that the Arthritis Pain Diclofenac Gel would be administered when the resident returned to her room. Observations of the MA on 08/14/25 at 7:54am revealed: -The MA entered Resident #9's room where the resident was seated in her wheelchair. -The MA gloved both hands. -The MA applied the Arthritis Pain Diclofenac 1% Gel to her index fingertip and rubbed the gel around Resident #9's right foot and ankle. -The MA did not measure the GS Arthritis Pain Diclofenac 1% Gel using a dosing card, or any other measurement source. Review of Resident #9's August 2025 eMAR revealed there was a printed entry to the eMAR for GS Arthritis Pain 1% Gel Voltaren 1% Gel apply 2 gms to affected area on right foot four times daily *measure using card*, scheduled and documented as administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.	D 358		

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D 358	Continued From page 29 Second observation of the MA on 08/14/25 at 11:42am revealed the MA entered Resident #9's room and instructed the resident that she (MA) was getting ready to apply the voltaren gel. Interview with the MA on 08/14/25 at 11:42am revealed: -She knew how much of the Voltaren Gel 1% to apply because she measured in on her fingertip. -The pharmacy labeled instructions read "2%". Continued observations of the MA on 08/14/25 at 11:45am revealed: -The MA applied gloves to her hands. -The MA applied an approximate nickel size amount of the GS Arthritis Pain Diclofenac 1% Gel to Resident #9's right foot and ankle. -The MA returned to the medication cart and documented the administration of the GS Arthritis Pain Diclofenac 1%. Interview with the MA on 08/14/25 at 11:50am revealed: -She did not realize there was a dosing card on the inside of the medication carton until 08/14/25 because she had not seen the dosing card. -She always measured the gel by using her fingertip and had never used the dosing card. -She had not measured out enough gel to equal 2.25 inches which was the amount per the dosing card. -Resident #9 would tell her the gel was working. Interview with the facility Manager on 08/14/25 at 11:55am revealed: -She expected the MAs to follow directions when administering medications. -The PCP would need to be notified of the medication error.	D 358		

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D 358	Continued From page 30 -She expected the MA to use the dosing card provided with the GS Arthritis Pain Diclofenac 1% Gel. Telephone interview on 08/14/25 at 3:46pm with the nurse for Resident #9's orthopedic provider revealed: -The MAs were supposed to use the dosing card provided with the Diclofenac Gel. -If the dosing card was not being used, the resident would not be getting enough of the topical pain gel applied which would result in no pain relief for the resident. -The resident was prescribed an application of the GS Arthritis Pain Diclofenac 1% Gel four times a day and there was no major concern. Interview with Resident #9 on 08/14/25 at 11:40am revealed: -The MAs rubbed the arthritis gel around her ankle and right foot. -Her ankle and right foot felt "pretty good now." -She thought she could have the arthritis pain gel applied at least two times a day. -She thought the arthritis pain gel was applied once a day. Refer to the interview with the Administrator on 08/14/25 at 3:03pm. _____ Interview with the Administrator on 08/14/25 at 3:03pm revealed she was concerned that the MA was not following procedure for medication administration which could result in detrimental effects to a resident.	D 358		