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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 11/13/24 to 11/15/24.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a resident's room and shared bathroom in the special care unit (SCU) were maintained in a clean and orderly manner. The findings are: Observation of Resident #1's bedroom and shared bathroom during tour of the special care unit (SCU) on 11/13/24 at 9:55am revealed: -The door to Resident #1's room led into a suite with two separate bedrooms and a shared bathroom on the left closer to Resident #1's bedroom, which was on the left side of the suite. -Resident #1 was sitting on the side of his bed on top of a fitted sheet in his bedroom. -There were scattered smeared brown stains on top of the fitted sheet. -There was dirt particles scattered on top of the fitted sheet.	D 079		

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D 079	Continued From page 1 -The box spring mattress was covered in a thick coating of dust and dirt. -There was a white top sheet on the floor in the left corner of the room. -The white top sheet had multiple areas with a thick brown substance smeared on the sheet. -The walls and baseboard around the bedroom had a thick coating of brownish colored stains and drip marks down the walls. -There was dirt particles scattered on the floor throughout the bedroom. -There were clothes scattered on the floor across from the bed. -There was a partial piece of a cigarette with five circles of dark gray ashes smeared into the floor near the resident's left front and in front of the wall air conditioning unit. -There was a whole unlit cigarette on the floor in front of the opened closet door. -There were multiple blackish brown cigarette burn marks on the floor in the bathroom on the right side of the toilet below the toilet paper holder. -There were cigarette ashes on the floor on the right side of the toilet. -There was a partially smoked cigarette with ashes in the toilet bowl. -There were brown splatter and drip stains running down the walls beside and behind the toilet. -There were dried brown stains and rust colored stains inside the toilet bowl. -There was a brown substance smeared on the toilet near the toilet handle. -There were yellowish brown stains on the floor near the toilet. -There was a urine and smoke odor in the bathroom. Interview with Resident #1 on 11/13/24 at 9:55am	D 079		

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revealed:
-He had lived at the facility for about 4 years.
-He denied smoking in his bedroom or bathroom.
-He was not sure what the brown stains were on the bedsheets or how long they had been there.
-He was not sure how often his room was cleaned.
-He did not know when his room was last cleaned.

Interviews with a medication aide (MA) on 11/13/24 at 1:05pm and 11/15/24 at 12:50pm revealed:
-The personal care aides (PCAs) changed bedsheets at least every 2 days.
-Sometimes staff tried to clean Resident #1's room but he would not let them.
-If staff took the resident to another area in the facility, they could usually clean the resident's room.

Interview with a PCA on 11/15/24 at 1:49pm revealed:
-She tried to keep Resident #1's room clean.
-She last cleaned his room on Tuesday, 11/12/24.
-She put clean sheets on the bed and there were no clothes on the floor at that time.
-The resident would let staff clean his room, but the resident would go right back in the room and mess it up after cleaning.

Interview with a housekeeper in the SCU on 11/13/24 at 2:36pm revealed:
-She had worked at the facility about a year.
-She usually cleaned Resident #1's room and bathroom every day.
-The resident usually let her clean his room every day because she talked nice to him.
-There had always been cigarette burn holes on the floor in the resident's bathroom since she

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started working at the facility.
-Her daily cleaning usually included wiping down the windowsills, the heater unit, and closet shelves; cleaning the toilet, sink, and mirror; taking out the trash; wiping out the chairs; and sweeping and mopping all residents' bedrooms and bathrooms.
-She was working down the hall and had not gotten to Resident #1's room yet that morning, 11/13/24.
-She tried to deep clean 2 residents' rooms per day.
-Deep cleaning included taking everything out of the room, cleaning the bedframe and mattresses, and sweeping and mopping.
-She did not know the last time Resident #1's bedroom had been deep cleaned.

Interview with the Maintenance Manager on 11/13/24 at 2:39pm revealed:
-The housekeepers were responsible for daily cleaning tasks in the facility.
-Cigarette burn holes had been on the floor in the resident's bathroom since he started working at the facility in 2022.
-He was in the process of replacing the flooring in the resident's bathroom, probably next week.

Interview with the Special Care Coordinator (SCC) on 11/13/24 at 10:09am revealed:
-Cigarette burn marks on the floor in Resident #1's bathroom had been there since the resident was first admitted to the SCU (could not recall date).
-Resident #1 sometimes smeared feces on his bed.
-The resident saw "liquid demons" and he would not let staff in his room to clean.
-Staff was supposed to clean the resident's room and bathroom when the resident was out of the

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room.

Interview with the Administrator on 11/13/24 at 10:15am revealed:
-The staff should clean Resident #1's room while the resident was out of the room.
-If staff tried to clean while the resident was in the room, it sometimes triggered some mental health behaviors.
-Resident #1's room was considered at "hot" room meaning it needed to be checked often and cleaned often because it never stayed clean.
-Resident #1's room was to be checked throughout the day for cleanliness by the housekeeping staff and the PCAs.
-Resident #1 slept with his shoes on which caused dirt to get on his bedsheets.
-The condition of Resident #1's room this morning was unacceptable, and it needed to be cleaned.

Interview with Resident #1's primary care provider (PCP) on 11/14/24 at 12:00pm revealed:
-The resident had mental health issues and talked about demons all the time.
-The resident sometimes smeared feces on the walls.
-She had often observed the resident's room unclean and unkempt during her visits.
-The facility could do a better job keeping the resident's room clean.

Telephone interview with Resident #1's mental health provider (MHP) on 11/15/24 at 3:40pm revealed:
-Resident #1 had severe cognitive and psychiatric deficits with fixed delusions about demons.
-The resident could get agitated and aggressive "pretty quickly".
-From time to time, she had observed either the

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D 079	Continued From page 5 resident had no bedsheets, or he was sleeping under a fitted sheet. -The resident's room had never been neat and orderly when she visited the resident.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#1) who demonstrated the need for increased supervision related to smoking in his room and bathroom located in the special care unit (SCU) and while smoking outside due to dropping lit cigarettes in his lap causing burn holes in his clothing. The findings are: Review of the facility's current census report dated 11/13/24 revealed: -The facility's current census was 54 residents. -There were 21 residents who resided in the special care unit (SCU) of the facility. -There were 33 residents who resided in the assisted living (AL) side of the facility.	D 270		

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D 270	Continued From page 6 Review of the facility's Smoking Policy in the Resident Agreement effective 05/23/16 revealed: -To protect the health and safety of the facility's residents and employees, the facility was a smoking restricted environment. -Smoking use may occur only in designated areas and in accordance with state law and requirements (if any) set forth in the resident's service plan. Review of the facility's Tobacco Use Policy in the Resident Agreement revised 04/01/24 revealed: -The "No Smoking" policy was reviewed with residents and their representatives at admission. -Each resident at admission was assessed for ability to smoke safely through interview of resident and representative and through staff observation. -Assessments were repeated monthly as needed to assure safe practices. -Staff were in-serviced to provide ongoing assessment of resident smoking habits and to report to their supervisor any change in ability to smoke safely. -Residents assessed to need supervision would be supervised while smoking by staff. -Smoking materials would be secured by facility staff who would supervise materials during use. -The facility reserved the right to confiscate smoking materials and tobacco products in the interests of safety and sanitation. -Residents who smoked safely, outside the building, would be allowed to access smoking materials to be used during the times they were outside the building. -Residents who smoked may do so only n the facility's designated smoking area, which was located outside the building. -This was the only location where residents were permitted to smoke.	D 270		

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D 270	Continued From page 7 Review of Resident #1's current FL-2 dated 07/18/24 revealed: -Diagnoses included vascular dementia, altered mental status, schizophrenia, wandering, type 2 diabetes, drug-induced subacute dyskinesia, Vitamin D deficiency, and thiamine deficiency. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory and had wandering behaviors. -The resident required assistance with bathing and dressing. -The resident's level of care was documented as SCU. Review of Resident #1's Resident Register dated 05/13/20 revealed: -The resident was admitted to the facility on 05/13/20. -The resident required assistance with orientation to time and place. -The resident was forgetful and needed reminders. -Smoking was not checked off in the section for personal habits. Interview with the Special Care Coordinator (SCC) on 11/14/24 at 2:04pm revealed: -Resident #1 was admitted to the AL side of the facility when he was first admitted. -Resident #1 was moved to the SCU on 01/05/23. Review of Resident #1's current assessment and care plan dated 04/17/24 revealed: -The resident was documented as having wandering behaviors, being verbally abusive, and resisting care. -The resident was documented as having a history of mental illness and being injurious to	D 270		

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property.
-The resident was ambulatory and required no assistive devices.
-The resident's vision was documented as limited and he wore eyeglasses.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required limited assistance by staff with eating.
-The resident required supervision by staff with toileting, ambulation, bathing, dressing, grooming, and transferring.
-There was no documentation regarding the resident's care needs or supervision needs for smoking.

Review of Resident #1's Smoking Risk Assessment dated 11/30/23 revealed:
-The resident smoked cigarettes.
-The resident borrowed cigarettes from others.
-The resident smoked more than once per hour.
-There were no problems documented with the resident smoking in unauthorized areas.
-There were no problems documented with the resident being careless with smoking materials, including dropping cigarette butts or matches on the floor, furniture, self, or others.
-There were no problems documented with the resident inappropriately providing smoking materials to others.
-There were no problems with the resident begging or stealing smoking materials from others.
-There were no problems documented with the resident's general awareness and orientation, including the ability to understand safe smoking policy.
-There were no problems with the resident's mobility and he did not need assistance getting to the designated smoking area.

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-There was minimal problem with the resident following the safe smoking policy.
-Under the clinical judgement section for resident was not capable of even supervised smoking and smoking would result in danger to self or others, it was marked as "false".
-The resident's score was 1 with the scale of 0-9 = safe smoker.
-The plan of action was safe smoker - resident holds own material.

Review of Resident #1's Smoking Risk Assessment dated 02/29/24 revealed:
-The resident smoked cigarettes.
-The resident did not borrow cigarettes from others.
-The resident smoked more than once per hour.
-There were no problems documented with the resident smoking in unauthorized areas.
-There were no problems documented with the resident being careless with smoking materials, including dropping cigarette butts or matches on the floor, furniture, self, or others.
-There were no problems documented with the resident inappropriately providing smoking materials to others.
-There were no problems with the resident begging or stealing smoking materials from others.
-There was a minimal problem with the resident's general awareness and orientation, including the ability to understand safe smoking policy.
-There were no problems with the resident's mobility, and he did not need assistance getting to the designated smoking area.
-There was minimal problem with the resident following the safe smoking policy.
-Under the clinical judgement section for resident was not capable of even supervised smoking and smoking would result in danger to self or others, it

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was marked as "false".
-The resident's score was 2 with the scale of 0-9 = safe smoker.
-The plan of action was safe smoker - resident holds own material.

Review of Resident #1's facility progress notes for January 2024 through November 2024 revealed there was no documentation of any concerns or non-compliance with the resident's smoking.

Observation of Resident #1's bedroom and shared bathroom during tour of the SCU on 11/13/24 at 9:55am revealed:
-The door to Resident #1's room led into a suite with two separate bedrooms and a shared bathroom on the left closer to Resident #1's bedroom, which was on the left side of the suite.
-Resident #1 was sitting on the side of his bed on top of a fitted sheet in his bedroom.
-There was a partial piece of a cigarette with five circles of dark gray ashes smeared into the floor near the resident's left foot and in front of the wall air conditioning unit.
-There was a whole unlit cigarette on the floor in front of the opened closet door.
-There was a pack of cigarettes and a lighter on the bottom shelf of the opened closet with some gray cigarette ashes scattered in the middle of the bottom shelf.
-There was a second pack of cigarettes on the second shelf of the opened closet.
-There was a burn hole in the resident's jogging pants near the crotch area at the top of the right upper leg.
-There were smeared gray cigarette ashes down the right side of his jogging pants.
-There were multiple blackish brown cigarette burn marks on the floor on the right side of the toilet below the toilet paper holder.

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-There were cigarette ashes on the floor on the right side of the toilet.
-There was a partially smoked cigarette with ashes in the toilet bowl.
-There was a very strong odor of smoke in the bathroom.

Interview with Resident #1 on 11/13/24 at 9:55am revealed:
-He had lived at the facility for about 4 years.
-He only smoked outside.
-There was no smoking in the facility.
-Sometimes facility staff kept his cigarettes and lighter and sometimes he kept it.
-He had some cigarettes and a lighter in his coat pocket currently.
-He did not want to show the cigarettes and lighter in his coat pocket.
-When asked about the cigarette in the toilet and the smoke odor in the bathroom, the resident denied smoking in his room or the bathroom.
-He did not comment when asked about the cigarette burn hole in his pants or the burn marks on the floor in the bathroom.

Interview with the SCC on 11/13/24 at 10:09am revealed:
-Residents were only supposed to smoke outside.
-Cigarette burn marks on the floor in Resident #1's bathroom had been there since the resident was first admitted to the SCU (could not recall date).
-Resident #1 was supposed to be supervised while smoking.
-Resident #1 was not supposed to have cigarettes or lighters.
-The resident's smoking materials were supposed to be kept locked in the medication cart.
-She was not aware the resident had burn holes in his clothing.

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-The medication aides (MAs) or personal care aides (PCAs) were supposed to observe the resident while he smoked.
-She was responsible for doing smoking assessments for residents.
-She would complete a new smoking assessment for Resident #1 today, 11/13/24.

Review of Resident #1's Smoking Risk Assessment dated 11/13/24 revealed:
-The resident smoked cigarettes.
-The resident borrowed a light from others.
-The resident smoked more than once per hour.
-There was a moderate problem with the resident smoking in unauthorized areas.
-There was a moderate problem with the resident being careless with smoking materials, including dropping cigarette butts or matches on the floor, furniture, self, or others.
-There were no problems documented with the resident inappropriately providing smoking materials to others.
-There was a moderate problem with the resident begging or stealing smoking materials from others.
-There was a severe problem with the resident's general awareness and orientation, including the ability to understand safe smoking policy.
-There were no problems with the resident's mobility, and he did not need assistance getting to the designated smoking area.
-There was moderate problem with the resident following the safe smoking policy.
-Under the clinical judgement section for resident was not capable of even supervised smoking and smoking would result in danger to self or others, it was marked as "true".
-The resident's score was 1 with the scale of 0-9 = safe smoker.
-The plan of action was unsafe smoker - staff

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would provide supervision during designated smoking breaks.

Interview with the Administrator on 11/13/24 at 10:15am revealed:
-The MAs or PCAs were supposed to stay with Resident #1 while he smoked.
-Resident #1 had a history of smoking in his room.
-Resident #1 should not be keeping his own smoking materials.
-The resident's smoking materials should be kept locked in the medication cart.
-It was possible that visitors may be bringing smoking materials to the resident.
-The facility staff did routine 2-hour checks for all residents, including Resident #1.
-They tried to do " a little bit more" supervision with Resident #1 depending on his behavior and if he got agitated each day.
-There were cigarette burn marks on the floor in Resident #1's bathroom when she first started working at the facility in April 2022.
-Resident #1 was the only smoker in the SCU and there was no specific smoking schedule.

Interview with a MA on 11/13/24 at 10:52am revealed:
-Resident #1 smoked cigarettes all day long.
-The staff had to put in the code to unlock the door for the resident to go outside in the enclosed courtyard in the SCU to smoke.
-The facility staff did not usually stay with the resident while he smoked outside.
-The facility staff would go back and forth to the door periodically to check on the resident while he was outside smoking.
-The resident's smoking materials were kept locked in the medication cart.
-They did not usually give the smoking materials

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to the resident.
-She did not know how the resident obtained the smoking material found in his room that morning, 11/13/24.
-Cigarette burn holes had been on the floor in the resident's bathroom for a long time (could not recall a date).
-When the resident first came to the facility, he was smoking in the bathroom and caused the burn holes in the floor.
-That was when they started keeping his smoking materials in the medication cart.
-She had seen burn holes in the resident's clothing.
-She had seen the resident drop hot ashes in his lap while he was outside smoking.
-She redirected the resident and reminded him to put ashes in the ashtray.
-The resident would curse when she tried to redirect him.
-She had never been instructed to stay outside with the resident while he smoked.
-She would go to the door to check on him about every 15 minutes when the resident was outside smoking.
-It would be difficult to stay with Resident #1 while he smoked outside because staff was busy with other residents who were at risk for falls.

Interview with a second MA on 11/13/24 at 1:05pm revealed:
-The MAs or PCAs gave Resident #1 cigarettes every 2 hours and staff would light the cigarette for him.
-The MAs or PCAs would stay outside with Resident #1 while he smoked.
-She never saw Resident #1 smoke inside the facility.
-She had not noticed burn holes in the resident's clothing.

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-Staff checked on Resident #1 during routine 2-hour checks, the same as the other residents.
-She had not been instructed to supervise the resident more often that every 2 hours.
-Resident #1 was the only smoker in the SCU to her knowledge.
-She had no idea how the resident obtained the cigarettes and lighter that were found in his room today, 11/13/24.

Interview with a third MA on 11/14/24 at 12:18pm revealed:
-Resident #1 wanted cigarettes every 2 to 3 minutes.
-When she worked, she put the resident on a smoking schedule, after meals and at snack times.
-The resident's cigarettes and lighter were kept locked in the medication cart.
-She usually gave the resident 1 or 2 cigarettes at a time and either she or one of the PCAs would light the resident's cigarettes and then bring the lighter back to the medication cart.
-Sometimes, the PCAs used their own lighter to light the resident's cigarettes.
-The resident smoked outside in the enclosed courtyard in the SCU and was usually outside about 15 - 20 minutes.
-The MAs or PCAs would watch the resident every few minutes from the door or window.
-She thought sometimes the PCAs may forget to bring the cigarettes and lighter back to the medication cart.
-She saw the resident walking down the hall in the SCU about 2 or 3 months ago with cigarettes and a lighter, so she took the items from the resident.
-She did not recall documenting it but she thought she may have reported it to the SCC but she was not sure.

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-She was not sure how the resident got the cigarettes and lighter that were found in his room on 11/13/24.
-She had not noticed any burn holes in the resident's clothing or cigarettes and ashes in the resident's room.
-No one had instructed her to supervise or stay with Resident #1 while he was smoking.
-Resident #1 was on every 2-hour checks like all other resident's in the SCU.
-Resident #1 had not asked to go outside to smoke today and he currently did not have any cigarettes in the medication cart.

Interview with a PCA on 11/15/24 at 1:49pm revealed:
-When the resident was first admitted to the SCU (could not recall date), she saw cigarettes, ashes, and burn holes on the floor in the resident's bathroom.
-After that, they started keeping the resident's cigarettes and lighter in the medication cart.
-Resident #1 sometimes asked to smoke every 30 minutes.
-The PCAs or the MAs let the resident outside to smoke.
-The PCAs or MAs would light the resident's cigarettes for him.
-She sometimes used her own lighter to light the resident's cigarettes.
-The resident dropped ashes on his clothing in his lap "all the time".
-She had seen him drop ashes on his clothing and she had seen burn holes on the resident's pants.
-The resident had not complained of being burned.
-She usually stood outside by the door while the resident smoked outside in the courtyard.
-She did not know how the resident obtained the

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cigarettes and lighter that were found in the resident's room on 11/13/24.

Interview with a housekeeper in the SCU on 11/13/24 at 2:36pm revealed:
-She had worked at the facility about a year.
-She usually cleaned Resident #1's room and bathroom every day.
-She had not noticed any smoke odors in the resident's room or bathroom.
-She had not observed Resident #1 smoking in the facility.
-There had always been cigarette burn holes on the floor in the resident's bathroom since she started working at the facility.
-She was working down the hall and had not gotten to Resident #1's room yet that morning, 11/13/24, when the cigarettes and lighter were found in the resident's room.

Interview with the Maintenance Manager on 11/13/24 at 2:39pm revealed:
-Resident #1 was smoking in the bathroom and setting off the alarm in 2022 before he started working at the facility.
-Cigarette burn holes had been on the floor in the resident's bathroom since he started working at the facility in 2022.
-He was in the process of replacing the flooring in the resident's bathroom, probably next week.
-Resident #1 was the only resident in the SCU who smoked except one other resident who only smoked occasionally.

Interview with the resident who resided in the same suite as Resident #1 on 11/15/24 at 2:05pm revealed:
-He did not smoke but his roommate did smoke.
-Resident #1 sometimes smoked in their shared bathroom, "once in a while".

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-He could not recall the last time he had observed Resident #1 smoking in the shared bathroom.

Interview with Resident #1's primary care provider (PCP) on 11/14/24 at 12:00pm revealed:
-She was not aware Resident #1 was a smoker until yesterday, 11/13/24.
-The facility should let her know about the resident smoking in the facility and about the burn holes in his clothing.
-Cognitively, Resident #1 needed one-on-one supervision while smoking because the resident was at risk of being burned.
-The resident had mental health issues and talked about demons all the time.
-She had never seen cigarettes or lighters in the resident's room during visits with the resident.
-She was concerned about the resident smoking in his room and bathroom.
-She was concerned for the resident's safety because the resident could catch the bed on fire.
-She was concerned about the safety of the other residents in the SCU including the resident who lived in the room next door in the same suite as Resident #1.
-The resident in the same suite as Resident #1 had to be encouraged to move and get up so she was extra concerned about his safety as well.
-Resident #1 could cause a fire in the facility which could put residents in danger, could hurt Resident #1 or could result in the resident or others losing their lives.

Telephone interview with Resident #1's mental health provider (MHP) on 11/15/24 at 3:40pm revealed:
-She was not aware that Resident #1 smoked or that he had been smoking in his room.
-She was not aware of any issues in the past with the resident smoking in the facility.

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D 270	Continued From page 19 -Resident #1 had severe cognitive and psychiatric deficits with fixed delusions about demons. -The resident could get agitated and aggressive "pretty quickly". -The facility staff should supervise the resident one-on-one while he was smoking. -She had never seen cigarettes or a lighter in the resident's room during her visits. -The resident should not keep his own cigarette and lighters for safety reasons. -The resident could set fire to himself, the facility, or others. _____ The facility failed to ensure Resident #1 who resided in the special care unit (SCU) and had a history of smoking in his room was supervised while smoking at all times, resulting in the resident having possession of smoking materials, including a lighter, in his room. The resident had cigarette burn holes in his clothing and multiple cigarette burn holes on the floor in his bathroom below the toilet paper holder beside the toilet. There were partially smoked cigarettes and ashes on the floor in his bedroom near the bed and the toilet in his shared bathroom along with a very strong odor of cigarette smoke on 11/13/24, which could lead to the resident with vascular dementia and mental health behaviors causing a fire, putting himself and other at risk for injury or loss of life. The facility's failure placed residents at substantial risk of serious physical harm or death and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 15, 2024.	D 270		

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#4) including failure to coordinate an orthopedic referral for a broken arm caused by a fall and failure to obtain x-ray of the ribs for an injury from another fall. The findings are: Review of Resident #4's current FL-2 dated 06/13/24 revealed: -Diagnoses included early onset dementia, hypertension, high cholesterol, and gastroesophageal reflux disease. -The resident required assistance with bathing and dressing. -The resident was ambulatory. -The resident was documented as being constantly disoriented. Review of Resident #4's current assessment and care plan dated 04/04/24 revealed: -The resident was ambulatory and used a wheelchair. -The resident had limited range of motion in his right arm. -The resident was oriented and his memory was adequate. -The resident required total assistance by staff with eating. -The resident required supervision by staff with	D 273		

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toileting.
-The resident required limited assistance by staff with ambulation, bathing, dressing, grooming, and transferring.

a. Review of Resident #4's accident / incident (A/I) report dated 06/03/24 at 6:00am revealed:
-The resident had an unwitnessed fall without injury in his bathroom at 6:00am.
-The resident did not exhibit or complain of pain and/or injury related to this fall.
-The resident was not sent to the emergency room (ER).
-The resident was to follow-up with his primary care provider (PCP).
-The resident was to be monitored for 72 hours for any change in condition and for vital sign checks every shift for 72 hours.

Review of Resident #4's A/I report dated 06/04/24 at 4:52pm revealed:
-The resident was observed in pain holding his right arm.
-The resident had a previous fall so the resident was transported by emergency medical services (EMS) to the hospital ER.
-The resident was diagnosed with a closed fracture of proximal end of the right humerus (fractured right arm).
-The resident was to follow-up with the PCP.

Review of Resident #4's hospital ER visit documents dated 06/04/24 revealed:
-The resident was seen for a fall and diagnosed with a closed right arm fracture.
-The resident's arm was put in a sling.
-There resident was to follow-up with an orthopedic provider.

Review of Resident #4's provider visit notes and

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progress notes dated June 2024 - November 2024 revealed no documentation of the resident being seen by an orthopedic provider.

Interview with Resident #4 on 11/15/24 at 5:04pm revealed:
-He broke his arm in June 2024 when he fell.
-His arm started hurting a couple of days later and it was x-rayed.
-He had an arm sling, but he did not recall if he went to an orthopedic provider.
-He still had right upper arm pain.

Interview with the Resident Care Coordinator (RCC) on 11/15/24 at 5:41pm revealed:
-She and the Special Care Coordinator (SCC) were responsible for setting up referrals.
-Resident #4 was living in the assisted living (AL) side of the facility at the time of the orthopedic referral in June 2024.
-She was responsible for setting up referrals for residents living in the AL side of the facility.
-She remembered seeing the order for Resident #4's orthopedic referral.
-She remembered the physical therapist (PT) also wanted the resident to see an orthopedic provider.
-She thought she called to try to set up an appointment with an orthopedic provider, but it was going to be August 2024 or September 2024 before the resident could be seen.
-She could not recall which orthopedic provider she contacted, and she did not recall making the appointment.
-She did not have any documentation related to trying to set up an orthopedic appointment.

Interview with the Administrator on 11/15/24 at 5:20pm revealed:
-Resident #4 lived on the AL side of the facility in

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June 2024 so the RCC would have been responsible for ensuring the resident was seen by an orthopedic provider.
-Resident #4's orthopedic referral should have been completed.

Telephone interview with Resident #4's PCP on 11/15/24 at 5:47pm revealed:
-She was not aware Resident #4 never saw an orthopedic provider for his broken arm in June 2024.
-The resident had not complained of arm pain to her recently.
-It was important for the resident to see an orthopedic provider after the arm fracture.
-The resident's arm could have not healed properly and could need to be surgically repaired.

b. Review of Resident #4's accident / incident (A/I) report dated 11/01/24 11:30am revealed:
-The resident had an unwitnessed fall in his bathroom.
-The resident complained of right-side pain.
-There was no injury noted.
-The resident was not sent to the emergency room (ER).
-The resident's primary care provider (PCP) was contacted and was aware of the fall.
-The resident was to follow-up with the PCP.

Review of Resident #4's PCP visit note dated 11/07/24 revealed:
-The resident was seen for an acute visit due to a fall in the bathroom.
-The resident had a fall in the bathroom on his right side.
-The resident complained of pain on the right side of his ribs.
-An x-ray was ordered for the affected area the results were not available at this time.

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-The resident described the pain as initially severe, but now mild, especially with movement.
-The resident denied pain during today's visit and had take Tylenol (for mild to moderate pain) for pain management.
-The resident was no transported to the hospital as the resident felt it was unnecessary.

Review of Resident #4's provider visit notes, progress notes, and lab results for November 2024 revealed no documentation of the x-ray of the resident's ribs being done.

Interview with Resident #4 on 11/15/24 at 5:04pm revealed:
-He had a fall recently (could not recall the date) and hurt his side.
-He did not recall getting his ribs x-rayed.
-He denied any current pain in his right side.

Interview with the Special Care Coordinator (SCC) on 11/15/24 at 5:26pm revealed:
-She was responsible for calling and setting up mobile x-ray for x-ray orders.
-She overlooked Resident #4's order to get his ribs x-rayed.
-Resident #4's ribs should have been x-rayed as ordered.
-The resident had not complained to her of any rib pain.

Interview with the Administrator on 11/15/24 at 5:20pm revealed:
-Resident #4 lived in the special care unit (SCU) so the SCC was responsible for making sure x-rays were completed as ordered.
-Resident #4 should have had an x-ray of his ribs completed when ordered.

Telephone interview with Resident #4's PCP on

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D 273	Continued From page 25 11/15/24 at 5:47pm revealed: -She was not aware Resident #4's ribs had not been x-rayed. -She had been told by facility staff the x-ray had been done. -She was told by the resident on 11/07/24 that he was getting better. -The x-ray needed to be done to determine if he had any broken ribs. -If the resident had a rib fracture, it could cause him pain and if he turned wrong, it could puncture his lung. -It could also cause malalignment if broken and limit the resident's movement.	D 273		
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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#1, #2) including errors with a resident with dementia and a history of mental illness missing doses of a medication for agitation and anxiety (#1) and a resident with diabetes not receiving the correct dosage of a rapid-acting	D 358		

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sliding scale insulin on multiple occasions and the resident's long-acting insulin not being decreased as ordered (#2).

The findings are:

1. Review of Resident #2's FL-2 dated 08/22/24 revealed diagnoses type 2 diabetes mellitus with hyperglycemia, hypertension, hypokalemia, dysphasia, altered mental status, sleep apnea, and history of seizures.

a. Review of Resident #2's Endocrinologists' orders dated 02/22/24 revealed:
-There was an order to change the sliding scale for breakfast and lunch.
-There was an order to see the attached scale; sliding scale revealed 70 or below= treat the low blood sugar. Recheck blood glucose in 15 minutes. If sugar is more than 70, then take the number of units of insulin in the 71- 90 row, before a meal. 71-90= 10 units, 91-130= 20 units (base dose), 131-150= 21 units, 151- 200= 22 units, 201-250= 23 units, 251- 300= 24 units, 301-350= 25 units, 351- 400= 26 units, 401- 450= 26 units, 451 or above= 26 units.
-The progress notes stated Resident #2's blood sugars were low.

Review of Resident #2's Endocrinologists' orders dated 09/17/24 revealed:
-There was an order to continue Humalog sliding scale with meals. (Humalog is a fast-acting insulin used to control blood sugar in people with diabetes).
-The progress note stated Resident #2 was still having hypoglycemia mostly throughout the night.

Review of Resident #2's physician's orders dated 11/14/24 revealed there was an order for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 Humalog Kwik pen Insulin (Insulin Lispro) at 8:30am and 12:30pm; check blood sugar twice daily and inject subcutaneously as directed per sliding scale: 71-90= 10 units, 91-130= 20 units, 131-150= 21 units, 151-200= 22 units, 201-250= 23 units, 251-300= 24 units, 301- 350= 25 units, 351- 400= 26 units, 401-450= 26 units, 450 and up= call MD. If the blood sugar is less than 71, give orange juice and recheck blood sugar in 15 minutes. Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwik pen Insulin (Insulin Lispro) scheduled for 8:30am and 12:30pm; check blood sugar twice daily and inject subcutaneously as directed per sliding scale: 71-90 row, before a meal. 71-90= 10 units, 91-130= 20 units, 131-150= 21 units, 151- 200= 22 units, 201-250= 23 units, 251- 300= 24 units, 301-350= 25 units, 351- 400= 26 units, 401- 450= 26 units, 450 plus= call MD. -On 09/01/24 at 8:30am the blood sugar reading was 79; 8 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 79. -On 09/01/24 at 12:30pm the blood sugar reading was 128; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 128. -On 09/05/24 at 8:30am the blood sugar reading was 136; 18 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 21 units of Humalog should have been administered	D 358		

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for a reading of 136.
-On 09/05/24 at 12:30pm the blood sugar reading was 107; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 107.
-On 09/10/24 at 8:30am the blood sugar reading was 84; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 84.
-On 09/10/24 at 12:30pm the blood sugar reading was 183; 20 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 183.
-On 09/11/24 at 8:30am the blood sugar reading was 71; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 71.
-On 09/11/24 at 12:30pm the blood sugar Humalog reading was 89; 8 units of Lispro were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 89.
-On 09/14/24 at 8:30am the blood sugar reading was 97; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 97.
-On 09/14/24 at 12:30pm the blood sugar reading was 159; 20 units of Humalog were documented as administered.

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-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 159.
-On 09/17/24 at 8:30am the blood sugar reading was 86; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 86.
-On 09/17/24 at 12:30pm the blood sugar reading was 90; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 90.
-On 09/18/24 at 8:30am the blood sugar reading was 166; 20 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 166.
-On 09/18/24 at 12:30pm the blood sugar reading was 196; 20 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 196.
-On 09/19/24 at 8:30am the blood sugar reading was 81; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 81.
-On 09/19/24 at 12:30pm the blood sugar reading was 86; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 86.
-On 09/23/24 at 12:30pm the blood sugar reading

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was 160; 20 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 160.
-On 09/27/24 at 8:30am the blood sugar reading was 95; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 95.
-On 09/30/24 at 8:30am the blood sugar reading was 84; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 84.
-On 09/30/24 at 12:30pm the blood sugar reading was 75; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 75.

Review of Resident #2's October 2024 eMAR revealed:
-There was an entry for Humalog Kwik pen Insulin (Insulin Lispro) scheduled for 8:30am and 12:30pm; check blood sugar twice daily and inject subcutaneously as directed per sliding scale: 71-90 row, before a meal. 71-90= 10 units, 91-130= 20 units, 131-150= 21 units, 151- 200= 22 units, 201-250= 23 units, 251- 300= 24 units, 301-350= 25 units, 351- 400= 26 units, 401- 450= 26 units, 450 plus= call MD.
-On 10/01/24 at 8:30am the blood sugar reading was 90; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered

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for a reading of 90.
-On 10/01/24 at 12:30pm the blood sugar reading was 95; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 95.
-On 10/07/24 at 12:30pm the blood sugar reading was 186; 21 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 186.
-On 10/09/24 at 12:30pm the blood sugar reading was 128; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 128.
-On 10/10/24 at 8:30am the blood sugar reading was 95; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 95.
-On 10/10/24 at 12:30pm the blood sugar reading was 96; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 96.
-On 10/11/24 at 8:30am the blood sugar reading was 91; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 91.
-On 10/11/24 at 12:30pm the blood sugar reading was 188; 20 units of Humalog were documented as administered.

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D 358	Continued From page 32 -According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 188. -On 10/13/24 at 8:30am the blood sugar reading was 95; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 95. -On 10/13/24 at 12:30pm the blood sugar reading was 75; 8 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 75. -On 10/14/24 at 8:30am the blood sugar reading was 82; 8 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 82. -On 10/14/24 at 12:30pm the blood sugar reading was 102; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 102. -On 10/15/24 at 8:30am the blood sugar reading was 126; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 126. -On 10/15/24 at 12:30pm the blood sugar reading was 94; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 94. -On 10/16/24 at 8:30am the blood sugar reading	D 358		

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was 147; 18 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 21 units of Humalog should have been administered for a reading of 147.
-On 10/17/24 at 8:30am the blood sugar reading was 145; 18 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 21 units of Humalog should have been administered for a reading of 145.
-On 10/18/24 at 8:30am the blood sugar reading was 116; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 116.
-On 10/22/24 at 8:30am the blood sugar reading was 89; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 89.
-On 10/22/24 at 12:30pm the blood sugar reading was 203; 22 units of Lispro were documented as administered.
-According to the sliding scale on the eMAR 23 units of Humalog should have been administered for a reading of 203.
-On 10/26/24 at 8:30am the blood sugar reading was 127; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 127.
-On 10/26/24 at 12:30pm the blood sugar reading was 146; 18 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 21 units of Humalog should have been administered

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for a reading of 146.
-On 10/27/24 at 8:30am the blood sugar reading was 113; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 113.
-On 10/27/24 at 12:30pm the blood sugar reading was 96; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 96.
-On 10/28/24 at 8:30am the blood sugar reading was 81; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 81.
-On 10/28/24 at 12:30pm the blood sugar reading was 129; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 129.
-On 10/29/24 at 8:30am the blood sugar reading was 113; 16 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 113.
-On 10/29/24 at 12:30pm the blood sugar reading was 92; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 92.
-On 10/30/24 at 8:30am the blood sugar reading was 104; 16 units of Humalog were documented as administered.

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D 358	Continued From page 35 -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 104. -On 10/30/24 at 12:30pm the blood sugar reading was 77; 8 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 77. 141. Review of Resident #2's November 2024 eMAR revealed: -There was an entry for Humalog Kwik pen Insulin (Insulin Lispro) scheduled for 8:30am and 12:30pm; check blood sugar twice daily and inject subcutaneously as directed per sliding scale: 71-90 row, before a meal. 71-90= 10 units, 91-130= 20 units, 131-150= 21 units, 151- 200= 22 units, 201-250= 23 units, 251- 300= 24 units, 301-350= 25 units, 351- 400= 26 units, 401- 450= 26 units, 450 plus= call MD. -On 11/05/24 at 8:30am the blood sugar reading was 89; 8 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 89. -On 11/05/24 at 12:30pm the blood sugar reading was 96; 16 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 20 units of Humalog should have been administered for a reading of 96. -On 11/09/24 at 8:30am the blood sugar reading was 160; 20 units of Humalog were documented as administered. -According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 89.	D 358		

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-On 11/09/24 at 12:30pm the blood sugar reading was 212; 22 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 23 units of Humalog should have been administered for a reading of 212.
-On 11/10/24 at 8:30am the blood sugar reading was 71; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 71.
-On 11/10/24 at 12:30pm the blood sugar reading was 83; 8 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 10 units of Humalog should have been administered for a reading of 83.
-On 11/14/24 at 8:30am the blood sugar reading was 169; 20 units of Humalog were documented as administered.
-According to the sliding scale on the eMAR 22 units of Humalog should have been administered for a reading of 169.

Interview with a medication aide (MA) on 11/15/24 at 12:34pm revealed:
-Resident #2 had a paper with her sliding scale insulin listed.
-She used the paper with the sliding scale that Resident #2 gave her to administer her Humalog.
-The sliding scale on the eMAR was different from the sliding scale on the paper.
-She should follow the sliding scale on the eMAR but Resident #2 would cry if she did not use the sliding scale on the paper.

Interview with a second MA on 11/15/24 at 1:01pm revealed:
-She used the sliding scale on the eMAR to

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determine the number of insulin units to administer to Resident #2.
-She had looked at the paper with the sliding scale Resident #2 had.
-She used the paper sometimes to administer the insulin units because Resident #2 would get upset if she did not.
-She had not told the Resident Care Coordinator (RCC) she was using Resident #2's handout to administer insulin units.

Interview with the RCC on 11/15/24 at 1:13pm revealed:
-She was responsible for ensuring the residents' medication orders matched the eMAR and physician's orders.
-She was notified yesterday, 11/14/24, Resident #2 was not receiving her insulin as ordered.
-She had never reviewed the amount of insulin Resident #2 had been administered.
-She notified Resident #2's primary care provider (PCP) on 11/15/24 that the resident was not administered her insulin per orders.
-She did not notify Resident #2's Primary Care Provider (PCP) that the resident had a paper with a sliding scale.
-The MAs notified her on 11/14/24 they were not following the sliding scale on the eMAR because Resident #2 told them it was wrong.
-The MAs followed the paper Resident #2 had because she had behaviors, and they did not want to upset her.

Interview with Resident #2 on 11/15/24 at 1:55pm revealed:
-She received a handout with a sliding scale insulin from her Endocrinologist and kept a copy in her room; 70 or below= treat the low blood sugar. Recheck blood glucose in 15 minutes. If sugar is more than 70, then take the number of

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units of insulin in the 71- 90 row, before a meal. 71-90= 8 units, 91-130= 16 units (base dose), 131-150= 18 units, 151- 200= 20 units, 201-250= 22 units, 251- 300= 24 units, 301-350= 26 units, 351- 400= 28 units, 401- 450= 30 units, 451 or above= 30 units.
-She did not notify her PCP about the handout because her Endocrinologist was taking care of her diabetes diagnosis.
-She made sure the MAs used the handout she provided them to administer her insulin.

Telephone interview with Resident #2's PCP on 11/15/24 at 2:05pm revealed:
-She was not aware the facility was not following Resident #2's sliding scale insulin that was ordered.
-She was not aware Resident #2 had a handout of a sliding scale insulin in her room.
-She was not aware Resident #2 was seen by an Endocrinologist.
-She would have liked to know about the sliding scale insulin changes from the Endocrinologist to ensure Resident #2's organs were functioning appropriately.
-Resident #2 was at risk of organ damage, uncontrollable blood sugars, neuropathy, retinopathy, damage to the optic nerve causing the resident to go blind, risk of heart attack and kidney failure due to not being administered the correct amount of insulin.

Telephone interview with a Medical Doctor (MD) at Resident #2's Endocrinologist' office on 11/15/24 at 4:16pm revealed:
-The facility should have notified the Endocrinologist they were not following the sliding scale insulin as ordered.
-Resident #2's hypoglycemia could cause her to have seizures and ultimately death.

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SCOTLAND HOUSE	27669 HIGHWAY 125 SCOTLAND NECK, NC 27874

(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 358	Continued From page 39 Interview with the Administrator on 11/15/24 between 2:20pm and 4:10pm revealed: -She was not aware until yesterday, 11/15/24, Resident #2 provided a handout of a sliding scale to the MAs. -She expected the MAs to follow the eMAR to administer Resident #2's insulin. b. Review of Resident #2's physician's orders dated 08/22/24 revealed there was an order for Tresiba FlexTouch U-100 insulin pen; 100 unit/ml (3 mL); subcutaneous; inject 58 units subcutaneously at bedtime; scheduled at 9:00pm. (Tresiba is a long-acting insulin used to help manage blood sugar between meals and overnight). Review of Resident #2's Endocrinologists' order dated 09/17/24 revealed: -There was a diagnosis of type 2 diabetes mellitus and comment that stated Resident #2 was on insulin. -There was an order to decrease Tresiba to 45 units at bedtime. -There was an order to continue Humalog sliding scale insulin with meals. -The progress note stated Resident #2 was still having hypoglycemia mostly throughout the night. Review of Resident #2's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tresiba FlexTouch U-100 insulin pen; 100 unit/ml (3 mL); subcutaneous; inject 58 units subcutaneously at bedtime; scheduled at 9:00pm. -Tresiba inject 58 units was documented as administered from 09/17/24 to 09/30/24. -Blood sugars ranged from 71 to 196.	D 358		

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D 358	Continued From page 40 Review of Resident #2's October 2024 eMAR revealed: -There was an entry for Tresiba FlexTouch U-100 insulin pen; 100 unit/ml (3 mL); subcutaneous; inject 58 units subcutaneously at bedtime; scheduled at 9:00pm. -Tresiba inject 58 units was documented as administered from 10/01/24 to 10/31/24. -Blood sugars ranged from 75 to 305. Review of Resident #2's November 2024 eMAR revealed: -There was an entry for Tresiba FlexTouch U-100 insulin pen; 100 unit/ml (3 mL); subcutaneous; inject 58 units subcutaneously at bedtime; scheduled at 9:00pm. -Tresiba inject 58 units was documented as administered from 11/01/24 to 11/14/24. -Blood sugars ranged from 71 to 226. Interview with the Resident Care Coordinator on 11/15/24 at 5:20pm revealed: -She thought she had changed the Tresiba order from 58 to 50 in the eMAR system. -She did not realize the Tresiba order should have been changed from 58 to 45. Telephone interview with a Medical Doctor (MD) at Resident #2's Endocrinologist' office on 11/15/24 at 4:16pm revealed: -The facility should contact the Endocrinologist about not decreasing the Tresiba from 58 to 45 because that was a significant drop. -The Endocrinologist needed to determine if the Tresiba not being decreased, and the facility not following the sliding scale as ordered caused Resident #2's hypoglycemia. Interview with the Administrator on 11/15/24 at	D 358		

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D 358	Continued From page 41 4:10pm revealed: -The RCC and the Special Care Coordinator (SCC) were responsible for ensuring orders were put into the eMAR system. -The order for the Tresiba was never sent to the pharmacy. 2. Review of Resident #1's current FL-2 dated 07/18/24 revealed diagnoses included vascular dementia, altered mental status, schizophrenia, wandering, type 2 diabetes, drug-induced subacute dyskinesia, Vitamin D deficiency, and thiamine deficiency. Review of Resident #1's mental health provider (MHP) order dated 09/23/24 revealed an order for Lorazepam 0.25mg twice a day for possible dystonia (involuntary muscle contractions that cause repetitive or twisting movements.) (Lorazepam is used to treat anxiety and agitation.) Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg take ½ tablet (0.25mg) twice daily for dystonia. -Lorazepam 0.5mg 1/2 tablet was scheduled to be administered at 8:00am and 8:00pm. -Lorazepam 0.5mg 1/2 tablet was documented as not administered from 8:00am on 10/25/24 - 8:00am on 10/27/24 and from 8:00am on 10/28/24 - 8:00am on 10/30/24, for a total of 10 doses due to waiting on physician's order. -There was an entry for Lorazepam 1mg 1 tablet twice a day as needed (prn) for anxiety. -The prn Lorazepam was documented as administered on 3 occasions when the resident did not receive scheduled Lorazepam due to it being unavailable. -The prn Lorazepam was documented as	D 358		

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D 358	Continued From page 42	D 358		

administered on 10/27/24 at 1:35am, 10/28/24 at 7:52am, and 10/29/24 at 7:51am due to behavior issue.

Review of Resident #1's controlled substance (CS) logs for October 2024 revealed:
-There were 30 doses (15-day supply) of Lorazepam 0.5mg (1/2 tablets = 0.25mg) received by the facility on 10/08/24.
-The last of those 30 doses were documented on the CS log as administered on 10/24/24.
-The next supply of Lorazepam 0.5mg 1/2 tablet was documented as received on 10/30/24 at 1:17pm with 30 doses.

Review of Resident #1's pharmacy dispensing records dated 10/01/24 - 11/15/24 revealed:
-There was a supply of 15 Lorazepam 0.5mg tablets (cut in half to equal 30 doses of 0.25mg) dispensed on 10/07/24, a 15-day supply.
-There was a supply of 15 Lorazepam 0.5mg tablets (cut in half to equal 30 doses of 0.25mg) dispensed on 10/29/24, a 15-day supply.

Interview with Resident #1 on 11/13/24 at 9:55am revealed:
-He was unsure which medications he received, and he did not know if the facility had run out of any medications.
-He complained of his neck hurting at times.

Interview with a medication aide (MA) on 11/14/24 at 3:35pm revealed:
-She did not know why Resident #1's scheduled Lorazepam ran out and was unavailable in October 2024.
-The MAs were supposed to order controlled substances when there were 10 pills remaining.
-Resident #1 talked about having demons inside of him and he would get agitated at times.

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D 358	Continued From page 43 Interview with the Special Care Coordinator (SCC) on 11/15/24 at 5:34pm revealed: -The MAs were responsible for ordering medications when the supply got down to the blue strip on the bubble card. -If the MAs did not receive the medication once it was ordered, they should let her know. -She would contact the pharmacy or prescribing provider. Interview with the Administrator on 11/14/24 at 4:00pm revealed: -The MAs were responsible for notifying the SCC or the Resident Care Coordinator (RCC) when there were 10 tablets remaining for controlled substances. -The SCC or the RCC would then order the medication. -The facility's contracted providers had a 24-hour line where the facility could request a 3-day supply of any medication, including controlled substances, to prevent a resident from running out of medication. Telephone interview with Resident #1's MHP on 11/15/24 at 3:40pm revealed: -She ordered the scheduled Lorazepam in September 2024 because the resident continued to have delusions about demons and for possible dystonia (complained of a stiff neck). -She was not aware the resident missed doses of Lorazepam due to the medication being unavailable. -Missing doses of the scheduled Lorazepam could cause the resident to have acute exacerbations of agitation and dystonia. -There was also a risk of withdrawal symptoms such as increased blood pressure or heart rate, sweating, agitation, seizures, and delirium.	D 358		

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D 358	Continued From page 44 -Her office was available 24-hours a day and the facility could request a refill for a medication at any time. _____ The facility failed to administer medications as ordered to 2 of 3 residents sampled. Resident #2, who was diagnosed with diabetes, did not receiving rapid-acting sliding scale insulin as ordered on multiple occasions and the resident's long-acting insulin was not decreased as ordered in September 2024. This put the resident as risk of hypoglycemia (low blood sugar) which could lead to seizures and death. This also put the resident at risk for organ damage, including heart attack and kidney failure. Resident #1 who had dementia and mental health disorders, missed 10 doses of a scheduled controlled substance for agitation, anxiety, and dystonia (stiff muscles). The resident required 3 doses of an as needed (prn) controlled substance for behavior issues during the time he missed the 10 scheduled doses of medication. Missing the doses of medication put the resident at risk of withdrawal symptoms including increased vital signs, agitation, seizures, and delirium. This also put the resident at risk of acute exacerbations of agitation and dystonia. The failure of the facility to administer medications as ordered placed residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/15/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 15, 2024.	D 358		

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D 392	Continued From page 45	D 392		
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 accurate reconciliation of a controlled substance for 1 of 5 residents (#1) sampled with a controlled substance used to treat moderate to severe pain resulting in 30 unaccounted for dosages of the medication. The findings are: Review of Resident #1's current FL-2 dated 07/18/24 revealed diagnoses included vascular dementia, altered mental status, schizophrenia, wandering, type 2 diabetes, drug-induced subacute dyskinesia, Vitamin D deficiency, and thiamine deficiency. Review of Resident #1's primary care provider (PCP) electronic prescription dated 10/14/24 revealed: -There was an order for Tramadol 50mg 1 tablet twice a day as needed (prn) for pain. (Tramadol is a controlled substance used to treat moderate to severe pain.) -The prescription was written for a quantity of 60 tablets (30-day supply) with no refills. -There was an electronic note by pharmacy staff dated 10/14/24 that indicated 30 tablets (15-day	D 392		

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supply) were dispensed with a quantity of 30 tablets remaining on the prescription.

Review of Resident #1's PCP electronic prescription dated 10/25/24 revealed:
-There was an order for Tramadol 50mg 1 tablet three times a day for chronic pain.
-The prescription was written for a quantity of 90 tablets (30-day supply) with no refills.

Review of Resident #1's pharmacy dispensing records for Tramadol for 10/01/24 - 11/15/24 revealed:
-There were 30 (15-day supply) Tramadol 50mg tablets dispensed on 10/14/24.
-There were 90 (30-day supply) Tramadol 50mg tablets dispensed on 10/25/24.

Review of Resident #1's October 2024 electronic medication administration record (eMAR) revealed:
-There was no entry for Tramadol 50mg 1 tablet twice a day prn pain listed on the eMAR.
-There was no documentation of any prn Tramadol being administered in October 2024.
-There was an entry for Tramadol 50mg 1 tablet three times daily for chronic pain scheduled at 8:00am, 2:00pm, and 8:00pm.
-Documentation for the administration of scheduled Tramadol 50mg 1 tablet 3 times a day started at 8:00am on 10/28/24 through 8:00pm on 10/31/24.
-There were 11 doses of scheduled Tramadol 50mg 3 times a day from 10/28/24 - 10/31/24 and 1 dose documented as refused at 2:00pm on 10/31/24.

Review of Resident #1's November 2024 eMAR revealed:
-There was no entry for Tramadol 50mg 1 tablet

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twice a day prn pain listed on the eMAR.
-There was no documentation of any prn Tramadol twice daily being administered in November 2024.
-There was an entry for Tramadol 50mg 1 tablet three times daily for chronic pain scheduled at 8:00am, 2:00pm, and 8:00pm.
-Documentation for the administration of scheduled Tramadol 50mg 1 tablet 3 times a day started at 8:00am on 11/01/24 through 8:00am on 11/14/24.
-There were 34 doses of scheduled Tramadol 50mg 3 times a day from 11/01/24 - 11/12/24.

Review of Resident #1's controlled substance (CS) records dated 10/01/24 - 11/14/24 for Tramadol revealed:
-There was no CS record to account for and reconcile the 30 Tramadol 50mg tablets 1 tablet twice a day prn pain dispensed on 10/14/24.
-There was a CS record for the 90 tablets of scheduled Tramadol 50mg tablets dispensed on 10/25/24, indicating 90 tablets were received on 10/28/24.
-There was a total of 45 of 90 doses documented as administered, leaving a total of 45 tablets.

Observation of Resident #1's medications on hand on 11/14/24 at 3:25pm revealed:
-There was a supply of Tramadol 50mg tablets dispensed on 10/25/24 with 45 of 90 tablets remaining.
-The instructions were to take 1 tablet 3 times daily for chronic pain.
-There was no supply of Tramadol 50mg tablets take 1 tablet 2 times daily prn pain that were dispensed on 10/14/24.
-None of the 30 tablets of Tramadol 50mg dispensed on 10/14/24 were on hand and accounted for.

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D 392	Continued From page 48 Interview with a medication aide (MA) on 11/14/24 at 3:25pm revealed: -She was not aware Resident #1 had an order for prn Tramadol on 10/14/24. -She did not recall seeing the order dated 10/14/24 as an entry in the eMAR system. -She did not recall seeing any other supplies of Tramadol in the medication cart other than the supply dispensed on 10/25/24. Interview with the Administrator on 11/15/24 at 10:57am revealed: -She did not think Resident #1's prn Tramadol tablets dispensed on 10/14/24 were ever sent to the facility. -She thought the order may have been put on hold but she was not sure and did not see a hold order. -She could not find a delivery sheet indicating the Tramadol was delivered to the facility. -The Special Care Coordinator (SCC) and the Resident Care Coordinator (RCC) were responsible for sending orders to the pharmacy. -The pharmacy entered the orders into the eMAR system. -The SCC and RCC were responsible for reviewing and approving the medication orders in the eMAR system prior to the orders becoming active. -If the SCC or RCC did not see an order in the eMAR system, they should check with the pharmacy to see if they received the order. -Resident #1's prn Tramadol order was overlooked. Telephone interview with a certified pharmacy technician at the facility's contracted pharmacy on 11/15/24 at 11:08am revealed: -The pharmacy's policy was to only send 30	D 392		

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doses of prn controlled medications at a time.
-Resident #1's PCP wrote the prescription dated 10/14/24 for 60 Tramadol 50mg tablets but the pharmacy only dispensed 30 tablets on 10/14/24 per policy, which left 30 tablets remaining on the prescription.
-The 30 Tramadol 50mg tablets were delivered to the facility on 10/15/24 prior to 2:00pm.
-The prn Tramadol 50mg order was entered into the electronic system and he could see it in the pharmacy's computer system.
-He was not sure why the prn Tramadol order was not showing up on the facility's eMAR system.
-The pharmacy never dispensed the 30 remaining Tramadol 50mg tablets for the prn order dated 10/14/24.
-He did not see any electronic record of any Tramadol 50mg tablets being returned to the pharmacy.
-If the prn Tramadol had been returned to the pharmacy, the pharmacy staff would have reversed the insurance claim but that had not been done.
-He was working on finding the proof of delivery form but had not located it yet.

Second interview with the Administrator on 11/15/24 at 6:00pm revealed:
-She had been unable to locate a pharmacy packing slip at the facility for Resident #1's prn Tramadol 50mg tablets dispensed on 10/14/24.
-She contacted the pharmacy and they sent a copy of the packing slip but it was not signed by anyone.
-The MA on duty at the time a pharmacy delivery was received was responsible for signing for the medications.
-She requested a copy of the signed packing slip from the pharmacy to help determine if it was

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D 392	Continued From page 50 delivered and who signed for it, but no signed packing slip was received. -She could not account for the 30 Tramadol 50mg tablets dispensed on 10/14/24.	D 392		