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LYNNDALE SENIOR LIVING HOME	6628 KEYSTONE DR RALEIGH, NC 27612

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C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey on November 20, 2024 and November 21, 2024.	C 000		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled staff (Staff C) had a criminal background check completed upon hire. The findings are: Review of Staff C, medication aide's personnel record on 11/20/24 revealed: -Staff C's hire date was documented as 08/26/24. -There was no documentation of a criminal background check prior to 11/20/24 at 4:12pm. Interview with Staff C on 11/20/24 at 3:19pm revealed: -She was a manager and medication aide. -She administered medications at the facility. Review of residents' medication administration records revealed Staff C documented the administration of medications on 09/13/24, 09/14/24, 09/15/24, and 11/17/24. Interview with the Administrator on 11/20/24 at	C 147		

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C 147	Continued From page 1 4:00pm revealed: -He was responsible for requesting a criminal background check on staff. -He completed the criminal background check when the potential staff completed the application. -Staff C completed her application when she was opening a facility and he thought a criminal background check was completed then, so he did not pursue performing another criminal background check for Staff C. Interview with the Administrator on 11/21/24 at 1:09pm revealed he had not located documentation for a criminal background check for Staff C.	C 147		
C 204	10A NCAC 13G .0702 (c) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination and Immunizations (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the medical examination documented on the resident's FL-2 was no more than 90 days prior to admission for 1 of 3	C 204		

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C 204	Continued From page 2 sampled residents (Resident #1). The findings are: Review of the facility license to operate a family care home (FCH) posted at the entrance of the facility at 8:30am on 11/20/24 revealed the current license was effective August 23, 2024 through February 23, 2025. Review of a previous license on 11/20/24 for the facility to operate a FCH revealed the previous license was effective April 20, 2023 through October 20, 2023. Review of Resident #1's FL-2 revealed: -The FL-2 was dated 04/23/24. - Diagnoses included chronic dementia and burn involving 10-19% body surface with 3rd degree burn 04/08/24. - Resident #1's recommended level of care was an assisted living facility. Review of Resident #1's Resident Register revealed an admission date of 05/06/24. Review of Resident #1's record on 11/20/24 revealed there was no documented FL-2 for Resident #1 since 04/23/24. Interview with the Administrator on 11/20/24 at 9:49am revealed: -Resident #1 lived in the home when the home was previously licensed as a family care home (FCH). -He received the 04/23/24 FL-2 for Resident #1 when the resident originally came to live in the home after hospitalization for burns to his body. -Resident #1 never left the home after the previous FCH license expired.	C 204		

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C 204	Continued From page 3 -He did not know Resident #1 needed to be considered as a new admission once the home received a new license to operate as a FCH beginning August 2024. Interview with the Administrator on 11/21/24 at 8:30am revealed: -He requested a new FL-2 for Resident #1 on 11/20/24. -He had not received another FL-2 for Resident #1. -He contacted the primary care provider's (PCP) office earlier today (11/21/24) and was waiting for the PCP to authorize another office physician to sign the FL-2. Second interview with the Administrator on 11/21/24 at 11:20am revealed: -He made sure there was a FL-2 for the resident. -He reviewed the FL-2. -He thought once the FL-2 was signed by the physician, the FL-2 was "okay". Telephone interview with Resident #1's PCP on 11/21/24 at 12:34pm revealed: -She was a new provider for the facility. -Her initial visit to the facility was at the end of October 2024. -She received a request for an FL-2 for Resident #1 on 11/20/24. -She had not received a request for an FL-2 for Resident #1 prior to 11/20/24. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.	C 204		
C 240	10A NCAC 13G .0802(e) Resident Care Plan	C 240		

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C 240	Continued From page 4 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the residents' physician signed and dated care plans within 15 days of the assessment for 2 of 3 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's FL-2 dated 04/23/24 revealed: - The resident's diagnoses included chronic dementia and burn involving 10-19% body surface with 3rd degree burn 04/08/24. -The resident was documented as constantly disoriented. -The resident was documented as ambulatory. -There was no documentation regarding personal care assistance needed. Review of Resident #1's Resident Register revealed an admission date of 05/06/24. Review of Resident #1's current assessment and care plan on 11/20/24 revealed: -The assessor completed and dated the assessment and care plan on 05/06/24. -The resident required daily dressing changes to	C 240		

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a wound on the upper back.
-The resident was documented as always disoriented.
-The resident was documented as having a significant memory loss and must be directed.
-The assessment and care plan were signed and dated by the primary care provider (PCP) on 10/31/24.

Refer to interview with the Owner/Administrator on 11/20/24 at 11:30am.

Refer to telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am.

2. Review of Resident #2's FL-2 dated 08/28/24 revealed:
- The resident's diagnoses included early onset Alzheimer's dementia with behavioral disturbance, mixed hyperlipidemia, and seizure disorder.
-The resident was documented as constantly disoriented.
-The resident was documented as ambulatory with wandering behavior.
-The resident was documented as requiring assistance with bathing, dressing, and feeding.

Review of Resident #2's Resident Register revealed an admission date of 09/03/24.

Review of Resident #2's current assessment and care plan on 11/20/24 revealed:
-The assessor completed and dated the assessment and care plan on 09/18/24.
-The resident was documented as requiring total assistance with eating, dressing, toileting, bathing, grooming, ambulation, and transferring.
-The resident was documented as always disoriented.

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C 240	Continued From page 6 -The resident was documented as having a significant memory loss and must be directed. -The assessment and care plan were signed and dated by the primary care provider (PCP) on 10/31/24. Refer to interview with the Owner/Administrator on 11/20/24 at 11:30am. Refer to telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am. _____ Interview with the Owner/Administrator on 11/20/24 at 11:30am revealed: -He was responsible for completing the care plan assessment. -He recently obtained services of a new Primary Care Provider (PCP) for facility visits and care of the residents. -Once he completed the assessments and care plans, he left them at the facility for the PCP to sign during her facility visits. Telephone interview with the facility's contracted PCP on 11/21/24 at 11:51am revealed: -She was a new provider for the facility. -Her initial visit to the facility was at the end of October 2024. -She asked the facility staff about care plans being completed when she visited the facility. -She usually received the care plan forms once the assessment was completed.	C 240		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	C 342		

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C 342	Continued From page 7 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 2 of 3 residents (#1, #2) including a medication used for seizure disorders (#2) and a medication used for pain (#1). The findings are: Review of the facility medication administration policy revealed: -Resident's medication administration records (MARs) would be accurate. -The reason or justification of medications or treatments as needed (PRN) would be documented and include the resulting effect. -Omission of medications or treatments and the reason for the omissions would be documented.	C 342		

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C 342	Continued From page 8 1. Review of Resident #2's current FL-2 dated 08/28/24 revealed diagnoses included early onset Alzheimer's dementia with disturbance, mixed hyperlipidemia, and seizures. Review of a physician's order for Resident #2 dated 10/04/24 revealed an order to start Levetiracetam (generic for Keppra used to treat seizure disorders) 500mg tablet every 12 hours. Review of the October 2024 medication administration records (MARs) for Resident #2 revealed there was no entry transcribed to the MARs for Keppra 500mg tablet every 12 hours. Interview with the medication aide (MA) on 11/21/24 at 10:55am revealed: -She administered the Keppra to Resident #2 when it was received at the facility because she knew the primary care provider (PCP) had given an order for the Keppra. -She knew the PCP ordered the Keppra because she participated in the video call with the PCP. -When a new medication arrived at the facility from the pharmacy, she would ask the Administrator about the order for the medication before she administered the medication. -The pharmacy was responsible for sending an updated MAR when new medications were prescribed or there were changes in medication orders. Interview with the Administrator on 11/21/24 at 11:20am revealed he was responsible for ensuring that medication administration orders were accurately transcribed to the MARs. Telephone interview with the contracted provider pharmacy on 11/21/24 at 10:14am revealed:	C 342		

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-A supplemental MAR was sent to the facility with new medications.
-Keppra was dispensed to the facility on 10/08/24 for Resident #2.

Telephone interview with the PCP on 11/21/24 at 12:05pm revealed:
-She looked at medications when she made visits to the facility.
-The Keppra for Resident #2 was prescribed by the neurologist.
-If Resident #2's Keppra medication had not been administered, the resident would be at risk for seizure activity.
-She had not been made aware of Resident #2 having any seizures.
-She was aware Resident #2 was hospitalized in January 2024 but not aware of any hospitalizations since then.

Attempted telephone interview with the neurologist on 11/21/24 at 12:48pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

Refer to the interview with a MA on 11/21/24 at 9:32am.

Refer to second interview with a MA on 11/21/24 at 10:55am.

Refer to the interview with the Administrator on 11/21/24 at 9:39am.

2. Review of Resident #1's FL-2 dated 04/23/24 revealed:
-Diagnoses included dementia and burn involving

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10-19 percent of body surface with third degree burns - 04/08/24.
-There was an incomplete physician's order for Tylenol (used to treat pain) 650mg tablet "q 4" (every 4).

Review of an FL-2 for Resident #1 dated 11/21/24 revealed a physician's order for acetaminophen (generic for Tylenol) 325mg two tablets every 4 hours as needed.

Review of the November 2024 medication administration records (MARs) for Resident #1 revealed:
-There was a printed entry transcribed to the MARs for acetaminophen 325mg tablet take two tablets every 4 hours as needed for fever or pain.
-There was documentation for administration of the acetaminophen 325mg tablets on 11/02/24, 11/05/24, 11/08/24, and 11/19/24.
-There were no entries or notes documenting the reason or results/effectiveness of the as needed acetaminophen administration.

Interview with the medication aide (MA) on 11/21/24 at 12:30pm revealed:
-She remembered administering the as needed acetaminophen to Resident #1.
-She was supposed to acknowledge if the as needed medication was effective after 30 minutes to one hour had passed.
-She did not think to document the effectiveness of the as needed acetaminophen.
-She did not know where she was supposed to document the effectiveness of the as needed acetaminophen.

Interview with the Administrator on 11/21/24 at 12:34pm revealed:
-He administered the as needed acetaminophen

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C 342	Continued From page 11 to Resident #1 on 11/02/24, 11/05/24, and 11/08/24. -He was supposed to document the reason for administration of the as needed acetaminophen. -He forgot to document the reason the as needed acetaminophen was administered each time he administered it. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. Refer to a interview with a MA on 11/21/24 at 9:32am. Refer to second interview with a MA on 11/21/24 at 10:55am. Refer to the interview with the Administrator on 11/21/24 at 9:39am. _____ Interview with a medication aide (MA)) on 11/21/24 at 9:32am revealed: -The MAs were not responsible for transcribing orders to the medication administration records (MARs). -The primary care provider sent medication orders to the contracted pharmacy provider. -The contracted pharmacy provider was responsible for sending a new MAR with any new medication ordered. Second interview with a MA on 11/21/24 at 10:55am revealed: -She did not think she had seen a medication administration policy. -She remembered discussing medication administration with the Administrator prior to the current licensing of the facility. -She was instructed to check the medications	C 342		

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C 342	Continued From page 12 against the MARs before administering. Interview with the Administrator on 11/21/24 at 9:39am revealed: -He received the new medication administration records from the contracted pharmacy provider. -He was responsible for checking the MARs to ensure accuracy and ensure medications listed on the MARs were available in the medication cart. -If there was a discrepancy with the MARs, he contacted the contracted pharmacy provider. -He had not had any issue with MAR discrepancy.	C 342		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side	C 375		

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C 375	Continued From page 13 effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a licensed pharmacist, provider, or registered nurse completed a quarterly on-site medication review for 1 of 1 sampled resident (#1) that met requirement for a quarterly medication review. The findings are: Review of Resident #1's FL-2 revealed: -The FL-2 was dated 04/23/24. -Diagnoses included chronic dementia and burn involving 10-19%body surface with 3rd degree burn 04/08/24. -The FL-2 was generated from a hospital with the recommended level of care documented for an assisted living facility. -There were fourteen medication orders listed on the FL-2. Review of the Resident Register for Resident #1 revealed the resident's admission date was documented as 05/06/24. Review of Resident #1's record revealed: -There was a visit summary dated 05/30/24 from a local hospital clinic.	C 375		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNNDALE SENIOR LIVING HOME	6628 KEYSTONE DR RALEIGH, NC 27612

(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
C 375	Continued From page 14 -There was a telehealth visit conducted on 10/09/24 by a mental health provider. -There was no documentation of a quarterly medication review. Interview with the Administrator on 11/20/24 at 9:49am revealed: -Resident #1 lived in the home when the home had a previous license number. -The resident was the only resident living at the home until the home received the current license to operate as a family care home beginning August 23, 2024. Telephone interview with the contracted pharmacy provider on 11/21/24 at 10:12am revealed: -The pharmacy offered medication reviews to contracted facilities. -There had not been a request from the facility to complete any pharmacy reviews. Interview with the Administrator on 11/21/24 at 1:22pm revealed: -There were no pharmacy reviews conducted for Resident #1. -He did not know anything about pharmacy reviews.	C 375		