STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted an annual and follow-up survey on 03/25/25 through 03/26/25.	D 000		
D 318	10A NCAC 13F .0905 (e) Activities Progam 10A NCAC 13F .0905 Activities Program (e) Residents shall have the opportunity to participate in activities involving one to one interaction and activity by oneself that promote enjoyment, a sense of accomplishment, increased knowledge, learning of new skills, and creative expression. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents had the opportunity to participate in activities involving one-to-one interaction that promote enjoyment each week. The findings are: Review of the facility's monthly activities calendar on 03/25/25 at 10:00am revealed: -The March 2025 activity calendar was posted on the wall in the facility. -There were 14 hours of scheduled activities weekly. -There was an activity scheduled for rolling relay basketball on 03/25/25 at 10:00am. -There was an activity scheduled for a card game on 03/25/25 at 1:00pm. -There was an activity scheduled for a sing-along	D 318		

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on 03/25/25 at 3:00pm.
-There was an activity scheduled for a game of go fish scheduled for 03/26/25 at 10:00am.

Observation of activities on 03/25/25 from 10:15am to 10:30am revealed:
-There were 30 residents in the activity room.
-There were two staff members standing in the activity room.
-There were no residents or staff engaged in an activity.
-There was no relay basketball activity observed.

Observation of activities on 03/25/25 from 3:00pm to 3:15pm revealed:
-There were 23 residents in the activity room.
-There were two staff members walking around the activity room.
-There was one staff member sitting in a chair.
-Music was playing through a speaker.
-The television was on with captions but no sound.
-There were no residents engaged in a singing activity.
-There were no staff members singing songs.
-There was no sing-along activity observed.

Observation of activities on 03/26/25 from 10:10am to 10:15am revealed:
-There were 25 residents in the activity room.
-There were two staff members in the activity room sitting in a chair.
-There were no residents engaged in a go fish game.
-There were no staff members engaged with residents.
-Six residents were asleep in their chairs.
-There was no game of go fish observed.

Interview with a resident on 03/26/25 at 10:17am

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D 318	Continued From page 2 revealed she did not do any activities today. Interview with second residents on 03/26/25 at 10:20am revealed: -He did not play a go fish game today. -He sat in his wheelchair and watched television most of the day. Interview with medication aide (MA) on 03/26/25 10:35pm revealed: -Staff did not do activities with residents every day. -The last activity she saw was a pizza toss game one day last week. -It was the Activity Director's (AD) responsibility to make the activity schedule. -Staff were supposed to take turns doing activities and complete an activity attendance sheet upon completing the activity. -The completed activity attendance sheets were placed in a folder for the AD to pick up daily. Interview with a personal care aid (PCA) on 03/26/25 at 10:45am revealed: -Residents were supposed to have a planned activity every day. -The AD would assign activities for staff to complete each day. -The PCAs and MAs were responsible for completing an activity attendance sheet to be placed in an activity folder. -She had not done an activity with residents this week. -The last activity she observed was a pizza toss game done by the AD last week. Interview with the AD on 03/26/25 at 10:55am revealed: -She was responsible for completing the monthly activity calender.	D 318		

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-She was aware residents should participate in 14 hours of weekly activities.
-Each month, she created an activity assignment sheet for the MA and PCA staff to follow.
-The PCAs and MAs were responsible for completing an activity attendance sheet to be placed in a folder.
-She was responsible for collecting the forms to ensure the activities were completed.
-She was aware the activity scheduled for rolling relay basketball on 03/25/25 at 10:00am did not happen because she had a schedule conflict.
-She did not assign a staff member to do the activity in her absence.
-She was not concerned about the staff not singing with the residents for the sing-along and just playing music because of their cognition.
-She was aware the activity scheduled for a game of go fish scheduled for 03/26/25 at 10:00am did not occur because she was out of the facility.
-She did not assign a staff member to do the activity in her absence.

Observation of the activity attendance sheet on 03/26/25 at 11:05 revealed:
-The activity for rolling relay basketball scheduled on 03/25/25 at 10:00am was changed to television time.
-The activity lasted for ten minutes, and all residents participated.
-The activity for a card game on 03/25/25 at 1:00pm was changed to music.
-The activity lasted for one hour and all residents participated.
-There was no activity attendance sheet for 03/26/2025.

Interview with the Administrator on 03/26/25 at 11:30am revealed:
-The AD was responsible for creating the monthly

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D 318	Continued From page 4 activity calender. - She was aware the activity scheduled for rolling relay basketball on 03/25/25 at 10:00am did not occur due to the AD assisting with transportation. - She was aware the activity scheduled for a game of go fish scheduled for 03/26/25 at 10:00am did not occur due to the AD assisting with getting information for the survey. -Her expectation would be the PCAs, and MAs assist with activities in the absence of the AD. -MAs and PCAs were assigned activities to do with the residents daily. -The AD was responsible for checking the activity assignment forms to ensure the activities occurred.	D 318		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 5 residents (#6, #7, and #8) observed during the 8:00am/9:00am medication pass including two eye drops (#6); an antipsychotic (#7); and a stool softener (#8). The findings are:	D 358		

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D 358	Continued From page 5 The medication error rate was 13% as evidenced by the observation of 4 errors out of 30 opportunities during the 8:00am/9:00am medication pass on 03/25/25. 1. Review of Resident #6's current FL-2 dated 03/19/25 revealed diagnoses included syncope, aggressive behavior due to dementia, cerebrovascular accident (CVA), and hypertension. a. Review of Resident #6's current FL-2 dated 03/19/25 revealed there was an order for latanoprost 0.005% (used to treat glaucoma) one drop into both eyes at bedtime. Observation of the morning medication pass on 03/25/25 at 8:54am revealed: -The medication aide (MA) pulled Resident #6's latanoprost eye drops from the medication cart. -She administered latanoprost one drop to each eye of Resident #6. Review of Resident #6's March 2024 electronic medication administration record (eMAR) on 03/25/25 revealed: -There was an entry for latanoprost 0.005% one drop in both eyes at bedtime with a scheduled administration time of 8:00pm. -There was no documentation latanoprost was administered at 8:00am on 03/25/25. Interview with the MA on 03/25/25 at 11:10am revealed: -She administered the wrong eye drops to Resident #6 at 8:00am. -She did not realize she administered the wrong eye drops to Resident #6 until the surveyor told her.	D 358		

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D 358	Continued From page 6 -She needed to be more careful when administering medications. Telephone interview with a representative from the facility's contracted pharmacy on 03/26/25 at 11:41am revealed: -Resident #6 had an order for latanoprost 0.005% one eye drop to each eye at bedtime. -The pharmacy had not dispensed latanoprost for Resident #6. Telephone interview with Resident #6's Primary Care Provider (PCP) on 03/25/25 at 3:25pm revealed: -Latanoprost was used to treat glaucoma. -She would not want the latanoprost to be administered at bedtime tonight, since it had been administered this morning. -She expected medications to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 03/28/25 at 8:10am revealed resident #6 brought his eye drops with him when he was admitted about one week ago. b. Review of Resident #6's signed physician order dated 03/21/25 revealed there was an order for Refresh eye drops 1.4-0.6% (used to treat itching of eyes caused by allergies) one drop in both eyes twice daily. Observation of the morning medication pass on 03/25/25 at 8:54am revealed the MA did not administer Refresh eye drops to Resident #6 as ordered. Review of Resident #6's March 2025 eMAR on 03/25/25 revealed: -There was an entry for Refresh eye drops one	D 358		

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drop to both eyes twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Refresh eye drops were administered at 8:00am on 03/25/25.

Interview with the MA on 03/25/25 at 11:10am revealed:
-She did not administer Refresh eye drops to Resident #6 during the morning medication pass.
-She administered a different eye drop that was ordered at bedtime.
-She documented she administered the refresh eye drops.
-She did not realize she administered the wrong eye drops until the surveyor told her.

Telephone interview with Resident #6's PCP on 03/25/25 at 3:25pm revealed:
-She ordered refresh eye drops for Resident #6 for dry, itchy eyes.
-Resident #6's eye could be uncomfortable if he missed several doses of refresh eye drops.

Telephone interview with a representative from the facility's contracted pharmacy on 03/26/25 at 11:41am revealed:
-The pharmacy had an order for refresh eye drops in each eye twice daily.
-The pharmacy had the order profiled but had not dispensed the medication.

Refer to the interview with the RCC on 03/26/25 at 8:10am.

Refer to the interview with the Administrator on 03/28/25 at 8:48am.

2. Review of Resident #7's current FL-2 dated 01/17/25 revealed:
-Diagnoses included dementia with behavioral

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disturbance, insomnia, and anxiety.
-There was an order for risperidone 2mg (used to help regulate mood, behaviors, and thoughts) twice daily.

Observation of the morning medication pass on 03/25/25 at 9:09am revealed:
-The medication aide (MA) pulled Resident #7's weekly multi-dose pack from the medication cart and tore off two multi-dose packs labeled Tuesday morning, 03/25/25.
-One multi-dose pack contained 10 pills, and the second multi-dose pack contained 3 pills.
-One of the pills in the multi-dose pack of 10 pills was risperidone 2mg.
-The MA pulled two punch cards from the medications cart and popped one pill from each punch card, for a total of 15 pills.
-One of the punch cards contained risperidone 2mg.
-The MA was ready to administer the medication when she was stopped by the surveyor, who pointed out risperidone 2mg was in the multi-dose pack and that the MA had popped a second risperidone 2mg from the punch card for administration.
-The MA removed and discarded one risperidone 2mg tablet from the medication cup.
-She administered 14 pills to Resident #7.

Review of Resident #7's March 2025 eMAR on 03/25/25 revealed:
-There was an entry for risperidone 2mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation risperidone 2mg was administered at 8:00am on 03/25/25.

Interview with the MA on 03/25/25 at 11:10am revealed:

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D 358	Continued From page 9 -Resident #7's risperidone 2mg was not in the multi-dose pack last week. -The pharmacy sent a punch card with risperidone 2mg to administer. -She did not realize risperidone 2mg was in the multi-dose pack this week. -She should have checked Resident #7's medication again to ensure she had the correct medication and dosage. -She could have administered a double dose of medication if she had not been stopped prior to administering the medication. Telephone interview with a representative at the facility's contracted pharmacy on 03/26/25 at 11:41am revealed: -The pharmacy had an order for risperidone 2mg twice daily. -The pharmacy did not place the risperidone in the multi-dose pack the previous week because there were no refills left on the prescription. -Once the pharmacy received a new prescription for risperidone 2mg twice daily, the pharmacy sent a punch card of risperidone 2mg to be administered until the cycle fill multi-dose pack was due. Telephone interview with Resident #6's Primary Care Provider (PCP) on 03/25/25 at 3:25pm revealed: -Risperidone was an anti-psychotic and used for resident with dementia with psychosis. -If Resident #6 had been administered two risperidone 2mg, he would be sleepy most of the day. -She expected medications to be administered as ordered. Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 8:10am revealed Resident	D 358		

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D 358	Continued From page 10 #6 could have been lethargic or "off-balance" if he had received a double dose of risperidone. Refer to the interview with the RCC on 03/26/25 at 8:10am. Refer to the interview with the Administrator on 03/28/25 at 8:48am. 3. Review of Resident #8's current FL-2 dated 08/19/24 revealed diagnoses included dementia, anemia, aphasia, and hyperlipidemia. Review of Resident #8's signed physician order dated 01/08/25 revealed there was an order for polyethylene glycol 3350 mix 1 capful (17 grams) in 8 ounces of fluid daily for constipation. Observation of the morning medication pass on 03/25/25 at 8:36am revealed: -The medication aide (MA) pulled 2 pill bottles for Resident #8 from the medication cart, removed one tablet from each bottle, and placed them in a medication cup. -She administered the 2 pills to Resident #8. -She did not administer any other medication to Resident #8. Review of Resident #8's March 2025 eMAR on 03/25/25 revealed: -There was an entry for polyethylene glycol 17 grams in 8 ounces of fluid daily for constipation with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered at 8:00am on 03/25/25. Interview with the MA on 03/25/25 at 11:10am revealed: -She did not give Resident #8 polyethylene glycol during the morning medication pass.	D 358		

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D 358	Continued From page 11 -She forgot to administer the polyethylene glycol to Resident #8. -She did not realize she had forgotten to administer the polyethylene glycol until the surveyor told her. Telephone interview with a representative at the facility's contracted pharmacy on 03/26/25 at 11:41am revealed: -The pharmacy had an order for polyethylene glycol 17grams in 8 ounces of water daily. -The pharmacy dispensed a bottle of polyethylene glycol on 02/27/25. Telephone interview with Resident #6's Primary Care Provider (PCP) on 03/25/25 at 3:25pm revealed: -Resident #8 was ordered polyethylene glycol because of constipation. -She was not concerned with one dose of polyethylene being missed. Refer to the interview with the RCC on 03/26/25 at 8:10am. Refer to the interview with the Administrator on 03/28/25 at 8:48am. _____ Interview with the RCC on 03/26/25 at 8:10am revealed: -The MA should check each medication three times before administering the medications to ensure what was being administered was correct. -The MA should compare the medication on the medication cart with the entry on the eMAR to ensure it was the same. -The MAs should be using the scanner to scan all medications when preparing medications for administration. -The scanner would alert the MA if a medication	D 358		

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D 358	Continued From page 12 was a duplicate or if the medication was discontinued. -The MA needed to be careful when administering medications to ensure she was administering the correct medications. -Medication cart audits were done daily. -Each MA on each shift would audit the medications for 2 to 3 residents each day. -The MAs used the physician orders, compared the orders to the eMAR and the medications. -If there was a discrepancy between the physician orders and the medication, she would be notified and she would contact the pharmacy. -She had a monthly meeting with the MAs and reviewed medication pass techniques. -She would do a medication pass with a MA monthly. Interview with the Administrator on 03/28/25 at 8:48am revealed: -The MA should use the scanner to scan all medications that were being administered. -The MA should check the medication three times and compare the medication to the eMAR to ensure the correct medication was being administered. -She expected the MAs to administer medication as ordered.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

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This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who popped and poured pills into her bare hand prior to administration and who checked a fingerstick blood sugar (FSBS) and administered eye drops and failed to wash/sanitize her hands before or after donning and doffing gloves.

The findings are:

Review of the facility's medication administration policy and procedures dated September 2023 revealed:
-Staff would perform hand hygiene before putting on gloves and after taking gloves off.
-Staff would perform hand hygiene after touching or were around blood or any other body fluid or mucus membranes.
-Staff should change gloves and perform hand hygiene between fingerstick procedures.
-Staff should change gloves that have potentially touched blood contaminated objects or fingerstick wounds before touching clean surfaces.
-Staff should perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use of other persons.

Observation of the morning medication pass on 03/25/25 between 8:36am and 9:09am revealed:
-At 8:36am, the MA prepared two pills to administer to a resident by pouring one pill into her bare hand from two bottles then placing the pills in the medication cup.
-At 8:42, the MA popped a pill from a punch card into her bare hand for a second resident and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041072	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON OAKS	3004 DEXTER AVENUE GREENSBORO, NC 27407

(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 371	Continued From page 14	D 371		

placed the pill in a medication cup.
-At 8:48am, the MA donned her gloves, attempted a FSBS check on the second resident which was unsuccessful.
-At 8:51am, the MA removed her gloves, did not wash/sanitize her hands, walked to the medication room to obtain alcohol swabs, and returned to the medication cart.
-At 8:53, the MA donned her gloves and attempted a second and third FSBS check, obtaining the FSBS on the third attempt, she removed her gloves, but did not wash/sanitize her hands.
-At 8:54am, the MA donned gloves, administered an eye drops to the second resident, removed her gloves, but did not wash/sanitize her hands after the administration of the eye drops.
-At 9:09am, the MA popped a pill from a punch card into her bare hand for a third resident and placed the pill in a medication cup.

Interview with the MA on 03/25/25 at 11:10am revealed:
-She usually sanitized her hands before administering medication to the next resident.
-Sometimes she did not wear gloves because she did not want the residents to think they were "sick".
-She should wash/sanitize her hands after she took her gloves off.
-She routinely popped pills from a punch card and poured pills from a bottle into her hands.
-She did not realize she could not pour medications in her hands.

Interview with the Resident Care Coordinator (RCC) on 03/26/25 at 8:10am revealed:
-The MA should sanitize her hands after administering medications to a resident.
-The MA should wash her hands with soap and

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D 371	Continued From page 15 water after administering medications to 3 residents. -This was the way the MAs were trained to cleanse their hands. -The MA should wear gloves when administering eye drops and performing FSBS checks. -The MA should wash her hands after removing her gloves. -The medications should not physically touch the skin of the MA. -If the MA was going to pop or pour pills into her hands, the MA should wear gloves. -The MA should pay closer attention to detail when administering medications. Interview with the Administrator on 03/28/25 at 8:48am revealed: -She expected the MAs to wash their hands before and after donning and doffing gloves. -The MAs should not pop or pour pills into their bare hands; they should wear gloves. -The MAs should use hand sanitizer if the they were not close to a sink to use soap and water.	D 371		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications left on top of the	D 378		

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D 378	Continued From page 16	D 378		

medication cart were locked when not under the direct supervision of a medication aide (MA) observed during the 8:00am/9:00am medication pass on 03/25/25.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for a capacity of 85 Special Care Unit (SCU) beds.

Review of the facility's resident census report dated 03/25/25 revealed there was a census of 41 residents.

Review of the facility's undated medication storage policy revealed all medications, including over the counter medications, were always kept in locked storage and accessible to staff responsible for medication administration.

Observation of the medication pass on 03/25/25 at 8:51am revealed:
-The MA locked the medication cart, walked to the medication room, leaving a bottle of eye drops and a bottle of pills on top of the medication cart without direct supervision of a MA.
-There were 14 residents sitting in the day room; there were no staff in the day room.

Interview with the MA on 03/25/25 at 11:10am revealed:
-She walked to the medication room to get alcohol pads for the fingerstick blood sugar.
-She did not realize she left medications on the top of the medication cart.
-She should have placed the eye drops and bottle of pills in the medication cart and locked it.

Interview with the Resident Care Coordinator

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D 378	Continued From page 17 (RCC) on 03/26/25 at 8:10am revealed: -The MA should ensure the medications were placed inside the medication cart and the cart was locked when the MA walked away from the medication cart. -This was a SCU and a resident could walk by and pick up a medication left sitting on top of the medication cart. -Medications should not be left within reach of the residents. Interview with the Administrator on 03/28/25 at 8:48am revealed: -The MAs should not leave medication out and within reach of the residents. -She expected all medications to be locked in the medication cart and away from the residents.	D 378		