

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2021
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a follow up survey from 04/14/21 through 04/15/21.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees Fahrenheit (F) as evidenced by hot water temperatures higher than 116 degrees F for 6 of 6 fixtures. The findings are: Observation of the residents' common hall bathroom on 04/14/21 at 9:35am revealed: -The hot water temperature at the sink was 120 degrees Fahrenheit (F). -The hot water temperature in the bathtub/shower was 120 degrees F. -No steam was observed. A second observation of the residents' common hall bathroom on 04/14/21 at 10:15am revealed:	C 105		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 105	Continued From page 1 -The hot water temperature at the sink was 122 degrees F. -The hot water temperature in the bathtub/shower was 122 degrees F. -No steam was observed. Observation of the bathroom in resident room #4 (shared by 2 residents) on 04/14/21 at 10:19am revealed: -The hot water temperature at both sinks was 120 degrees F. -The hot water temperature in the shower was 120 degrees F. -No steam was observed. Interview with a medication aide/personal care aide (MA/PCA) on 04/14/21 at 12:13pm revealed: -The staff assisted all residents to the bathroom for toileting, bathing, and washing their hands. -Staff adjusted the water temperature for the residents since all the residents had dementia. -She had not noticed any issues with the water temperatures being too hot or too cold because she could adjust the temperature at the fixture. Interview with the Administrator on 04/14/21 at 10:24am revealed: -She was not aware the hot water in the facility was too hot. -She did not have a water temperature log because she did not check hot water temperatures. -The hot water temperature was checked by the health inspector during the facility's annual health inspections. -The health inspector last came to the facility in February 2020 and no issues with the hot water temperatures were noted. -She did not know what the hot water temperature range was supposed to be according	C 105			

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C 105	Continued From page 2 to the rules. -A plumber was at the facility "a couple of weeks ago" (could not recall date) to check the washing machine and the kitchen faucet because they were having a hard time getting hot water in the kitchen. -A part on the faucet was clogged and the plumber repaired it. -The plumber did not check any of the bathroom fixtures during the visit because they were not aware of any issues with those fixtures at that time. -All 5 residents in the facility had dementia and required physical assistance by staff for toileting and bathing, including washing their hands. -All 5 residents usually had staff with them while in the bathrooms. -She would contact the plumber and post warning signs. Interview with the Administrator on 04/14/21 at 10:30am revealed: -She just contacted the plumbing company and the plumber would come today, 04/14/21, to adjust the hot water heaters. -The receptionist at the plumbing company told her the plumber usually set the thermostats on hot water heaters on 120 degrees F. -The facility had two hot water heaters to her knowledge. -No staff or residents had reported the water being too hot; it was usually too cold. Observation of the kitchen on 04/14/21 at 10:35am revealed: -The hot water temperature at the sink was 124 degrees F. -The Administrator's thermometer also registered 124 degrees F at the kitchen sink. -No steam was observed.	C 105		

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C 105	Continued From page 3 Interview with the Administrator on 04/14/21 at 10:35am revealed: -All 5 residents ate in the dining room beside the bar next to the kitchen sink. -No residents used the kitchen sink independently because the residents needed assistance by staff for ambulation. -Staff usually took the residents to the bathroom to wash their hands. Interview with the Administrator on 04/14/21 at 10:56am revealed: -The plumber had just left the facility. -He turned down the thermostat on the hot water heater. Telephone interview with the plumber on 04/14/21 at 10:58am revealed: -He came to the facility about 2 to 5 months ago (could not recall date) and cleaned the aerators at the faucets in the kitchen and he thought the bathrooms also. -He did not make any adjustments to the thermostat on the hot water heater during the previous visit because he was not aware of the water being too hot at that time. -The hot water heater used to supply every fixture in the facility had a thermostat with a temperature scale of 90 degrees F to 125 degrees F. -There were no markings on the scale between the two numbers so he had to estimate where he set the thermostat. -When he arrived at the facility today, 04/14/21, the hot water heater was set at the maximum, 125 degrees F. -He adjusted the thermostat to what he estimated to be between 105 degrees F - 110 degrees F. Recheck of the residents' common hall bathroom	C 105		

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C 105	Continued From page 4 on 04/14/21 at 4:07pm revealed: -The hot water temperature at the sink was 114 degrees F. -The hot water temperature in the bathtub/shower was 116 degrees F. Recheck of the bathroom in resident room #4 (shared by 2 residents) on 04/14/21 at 4:13pm revealed: -The hot water temperature at both sinks was 114 degrees F. -The hot water temperature in the shower was 114 degrees F. Recheck of the kitchen sink on 04/14/21 at 4:23pm revealed the hot water temperature was 114 degrees F. Observation of the resident's common hall bathroom on 04/15/21 at 4:25pm revealed: -There was a sign posted on the entrance door with "Water Hot". -There was a notification on the sign that reminded staff to always check the water prior to use. -There was a notification on the sign with the temperature range of 110 degrees F to 116 degrees F; any temperature over 116 degrees F was too hot. -Staff were expected to document the date, time, and water temperature each shift. -Staff were expected to notify the Administrator if the water temperature was below 100 degrees F or above 116 degrees F. _____ The facility failed to ensure hot water temperatures for 6 of 6 fixtures in the facility including 2 bathrooms used by residents and the kitchen sink which was accessible to residents were maintained between 100 - 116 degrees F.	C 105		

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C 105	Continued From page 5 The water temperatures ranged from 118 degrees F to 124 degrees F. All 5 residents in the facility had a diagnosis of dementia. A water temperature of 124 degrees F could result in a first degree burn in 2 minutes and a second degree burn in 4.2 minutes. This failure of the facility was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/14/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 30, 2021.	C 105		
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 in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 staff sampled (A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented for Staff A. -There was a job description for medication aide /	C 147		

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C 147	Continued From page 6 personal care aide (MA/PCA) in Staff A's record. -There was no documentation of a consent to complete a criminal background check. -There was no documentation of any criminal background check for Staff A. Observations on second shift on 04/14/21 and 04/15/21 revealed Staff A was working on both days providing personal care to the residents and cooking meals for the residents. Interview with Staff A on 04/15/21 at 6:05pm revealed: -She started as "prn" (as needed) staff at the facility in October 2020 or November 2020. -She worked every other weekend at night and sometimes second shift (3:00pm - 11:00pm) when she was a prn staff person. -She started working full time in March 2021 (did not know date). -She administered medications, cooked, and provided personal care to the residents. -She did not know if a criminal background check had been completed for her. Interview with the Administrator on 04/15/21 at 6:03pm revealed: -Staff A was hired full-time on 03/15/21 and started working full-time on 03/29/21. -She was responsible for the personnel files including getting criminal background checks on staff. -She had not done a criminal background check on Staff A. -She thought Staff A would have to go to the local sheriff's office to get fingerprinted and she was not sure if the sheriff's office was doing that because of the COVID-19 pandemic. -She had not contacted the sheriff's office to ask and she had not attempted to do any criminal	C 147		

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C 147	Continued From page 7 background check for Staff A. -She had no excuse and the criminal background check for Staff A should have been done.	C 147		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a registered nurse completed an on-site Licensed Health Professional Support (LHPS) review and physical assessment evaluation on a quarterly basis for 3 of 3 residents (#1, #2, #3) sampled with required	C 254		

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C 254	Continued From page 8 LHPS tasks including ambulation with physical assistance (#1, #2, #3), transferring semi-ambulatory and non-ambulatory residents (#1, #2, #3), applying and removing compression hose and/or braces (#1, #2), and bowel and bladder program (#1, #2, #3). The findings are: 1. Review of Resident #2's current FL-2 dated 02/14/21 revealed: -Diagnoses included dementia without behavioral disturbance, altered mental status, hypernatremia, and urinary tract infection without hematuria. -The resident was constantly disoriented and semi-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required personal care assistance by staff with bathing, dressing, and feeding. -There was an order for bowel and bladder program every 2 hours (facility staff would take the resident to the bathroom). Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 09/25/18. -The resident required assistance for dressing, bathing, nail care, getting in/out of bed, toileting, hair/grooming, mouth care, and scheduling appointments. -The resident had significant memory loss and must be redirected. Review of Resident #2's current assessment and care plan dated 10/26/20 revealed: -The resident was ambulatory with aide or device (type of device not noted).	C 254		

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C 254	Continued From page 9 -The resident had no problems with the strength or range of motion of her upper extremities. -The resident was always disoriented, forgetful, and needed reminders. -The resident required supervision by staff for eating, ambulation, and transferring. -The resident required extensive assistance by staff for toileting, bathing, dressing, and grooming. -Thromboembolic deterrent (TED) hose on in the mornings and off in the evenings was listed as a licensed health professional support (LHPS) task on the care plan. (TED hose are compression hose used to treat swelling in the legs and prevent blood clots.) Review of Resident #2's primary care provider (PCP) visit note dated 12/02/19 revealed: -The reason for visit was a follow-up. -The resident's edema (swelling) was noted to be at baseline. -The PCP ordered TED hose on in the morning and off in the evening. Review of Resident #2's LHPS review dated 10/28/20 revealed: -LHPS tasks documented by the registered nurse (RN) included bowel and bladder training program and TED hose. -The RN documented the resident had non-stop urinary tract infections (UTIs) and was receiving a maintenance antibiotic. -The resident had UTIs "on and off" since admission to the facility. -Staff had changed the resident's soap and had provided incontinence care frequently to try and help but "doctor stated she will keep them and it is her body". -There was no documentation regarding the bowel and bladder program being used for the	C 254		

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C 254	Continued From page 10 resident. -There was no documentation of health status, care provided, a physical assessment, or progress to care provided related to the LHPS task of TED hose. -The tasks of ambulation and transferring that required physical assistance were not included on the LHPS review and were not addressed by the RN. -There were no recommendations documented. Review of Resident #2's record revealed only one other LHPS review dated 03/03/20 and no LHPS reviews after 10/28/20 for the resident. Review of Resident #2's February 2021 - April 2021 medication administration records (MARs) revealed: -There was a handwritten entry on each MAR for "order date 12/02/19" TED hose on in the morning at 8:00am and off in the evening at 8:00pm. -TED hose were documented as put on daily at 8:00am and removed at 8:00pm from 02/01/21 - 02/26/21. -TED hose were documented as put on daily at 8:00am and removed at 8:00pm from 03/01/21 - 03/31/21. -TED hose were documented as put on daily at 8:00am and removed at 8:00pm from 04/01/21 - 04/14/21 except for 2 omissions on 04/02/21 and 04/11/21. Observation of Resident #2 on 04/14/21 at 11:08am revealed: -A medication aide / personal care aide (MA/PCA) assisted Resident #2 with transferring from a sitting position in a chair in the dining room to a standing position. -The MA/PCA held Resident #2's hand and	C 254		

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C 254	Continued From page 11 guided the resident as the resident walked to the bathroom with no assistive device. -The MA/PCA stayed in the bathroom with the resident to assist with toileting. Observation of Resident #2 on 04/14/21 at 3:09pm revealed: -The resident was not wearing TED hose. -The resident's left ankle was slightly swollen while the right ankle was not swollen. Observation of Resident #2 on 04/14/21 at 5:37pm revealed: -A PCA physically assisted Resident #2 with transferring from a seated position on the couch to a standing position. -The PCA held Resident #2's hands and guided the resident with walking to the dining room. Interview with a MA/PCA on 04/14/21 at 3:11pm revealed the resident was not wearing TED hose today because the hose were being washed. Interview with the Administrator on 04/14/21 at 4:34pm revealed: -Prior to Resident #2's hospitalization on 02/12/21, the resident ambulated and transferred independently. -After the resident returned to the facility (on 02/14/21), Resident #2 was weak and needed physical assistance with ambulation and transferring since then. -Resident #2 usually wore TED hose every day. -She did not know why the LHPS nurse did not address all of the resident's LHPS tasks and did not do a physical assessment for the resident's LHPS for the review completed in October 2020. Telephone interview with the LHPS nurse on 04/14/21 at 4:25pm revealed:	C 254		

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C 254	Continued From page 12 -She was not sure why all of Resident #2's LHPS tasks were not addressed on the October 2020 LHPS review. -She could not answer any more questions about Resident #2's LHPS reviews without looking at the reviews herself. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to telephone interview with the LHPS nurse on 04/14/21 at 4:25pm. Refer to interview with the Administrator on 04/14/21 at 4:34pm. Refer to a second interview with the Administrator on 04/14/21 at 4:45pm. 2. Review of Resident #3's current FL-2 dated 07/23/20 revealed: -Diagnoses included dementia, generalized weakness, chronic kidney disease stage III, hyperparathyroidism, coronary artery disease, hypokalemia, and atrial fibrillation - new onset. -The resident was constantly disoriented. -The resident required extensive assistance with ambulation and transferring. -The resident required limited assistance with eating, dressing, and bathing. -The resident was incontinent of bladder. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on 12/18/19. -The resident required assistance for dressing, bathing, nail care, correspondence, toileting, hair/grooming, skin care, mouth care, scheduling	C 254			

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C 254	Continued From page 13 appointments, and orientation to time and place. -The resident had significant memory loss and must be redirected. Review of Resident #3's current assessment and care plan dated 10/29/20 revealed: -The resident used a rolling walker with limited ability for ambulation. -The resident had no problems with the strength or range of motion of her upper extremities. -The resident was sometimes disoriented with adequate memory. -The resident was independent with eating, ambulation, and transferring. -The resident required supervision by staff with toileting. -The resident required limited assistance by staff with bathing, dressing, and grooming. Observation of Resident #3 on 04/15/21 at 10:15am revealed: -Resident #3 was pushed in a wheelchair by staff to her room. -Two medication aides / personal care aides (MAs/PCAs) transferred Resident #3 from the wheelchair to the bed by each staff putting an arm under the resident's arm and lifting her together onto the bed. Interview with a MA/PCA on 04/15/21 at 10:15am revealed: -Resident #3 required two persons to assist with transferring her. -The resident also required assistance with ambulating with the wheelchair. -The resident was provided incontinence care at least every 2 hours. Interview with a second MA/PCA on 04/15/21 at 10:15am revealed Resident #3 required physical	C 254		

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NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
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C 254	Continued From page 14 assistance with transferring and ambulating with a wheelchair. Telephone interview with Resident #3's power of attorney (POA) on 04/15/21 at 4:16pm revealed: -Resident #3 needed assistance with all activities of daily living. -Since Resident #3 returned from the hospital in July 2020, the resident could not walk or stand on her own. Review of Resident #3's licensed health professional support (LHPS) review dated 10/28/20 revealed: -LHPS tasks documented by the registered nurse (RN) included bowel and bladder training program. -The RN documented the resident was doing well and eating had improved over the last several weeks. -There was no documentation regarding the bowel and bladder program being used for the resident. -The tasks of ambulation and transferring that required physical assistance were not included on the LHPS review and were not addressed by the RN. -There were no recommendations documented. Review of Resident #3's record revealed only one other LHPS review dated 03/03/20 and no LHPS reviews after 10/28/20 for the resident. Interview with the Administrator on 04/15/21 at 10:03am revealed: -LHPS reviews were done in December 2020 but she could not find the December 2020 LHPS review for Resident #3. -Resident #3 had declined after a hospitalization in July 2020 and required assistance with	C 254			

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C 254	Continued From page 15 ambulation and transferring. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to telephone interview with the LHPS nurse on 04/14/21 at 4:25pm. Refer to interview with the Administrator on 04/14/21 at 4:34pm. Refer to a second interview with the Administrator on 04/14/21 at 4:45pm. 3. Review of Resident #1's FL-2 dated 10/28/20 revealed: -Diagnoses included dementia, coronary artery disease, peripheral artery disease, chronic obstructive pulmonary disease, chronic pain, colitis, and acute kidney injury. -The resident was intermittently disoriented. -The resident was incontinent of bowel and bladder. -The resident required personal care assistance by staff with bathing and dressing. -The resident was non-ambulatory -The resident was verbally abusive. -There was an order for bowel and bladder program every 2 hours (facility staff would take the resident to the bathroom). Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 03/18/19. -The resident was forgetful and needed reminders. -The resident required assistance with bathing, nailcare and getting out of bed.	C 254		

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C 254	Continued From page 16 Review of Resident #1's current care plan dated 10/28/20 revealed: -Resident #1 was incontinent of bowel and bladder. -Resident #1 was able to take 4-5 steps with her walker with staff assistance. -Resident #1 was sometimes disoriented and needed reminders. -Resident #1 required extensive assistance with toileting, ambulation, grooming and transferring. -Resident #1 required limited assisted with bathing and dressing. Observation of Resident #1 on 04/14/21 at 9:22am revealed she was seated in a wheelchair at the kitchen table. Review of Resident #1's licensed health professional support (LHPS) review dated 10/28/20 revealed: -Resident #1 required assistance with a bowel and bladder training program to regain continence. -Resident #1 had a brace to use on her right lower leg due to a foot drop, use when in chair or in bed. -LHPS Personal Care Tasks Provided included bowel and bladder and on/off leg brace. -The tasks of ambulation and transferring that required physical assistance were not included on the LHPS review and were not addressed by the RN. -There were no recommendations documented. Review of Resident #1's record revealed no LHPS reviews after 03/03/20 until 10/28/20, and none since 10/28/20. Based on observations, interviews, and record	C 254			

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C 254	Continued From page 17 review it was determined Resident #1 was not interviewable. Refer to telephone interview with the LHPS nurse on 04/14/21 at 4:25pm. Refer to interview with the Administrator on 04/14/21 at 4:34pm. Refer to a second interview with the Administrator on 04/14/21 at 4:45pm. Telephone interview with the LHPS nurse on 04/14/21 at 4:25pm revealed: -She had done "a couple of" LHPS reviews for the facility. -She did the LHPS reviews whenever the Administrator needed her to do the reviews. -She did on-site LHPS reviews for all of the residents when she went to the facility. -She last did LHPS reviews at the facility in the middle of December 2020 (could not recall exact date). -She reviewed the residents' records and assessed the residents when she did the LHPS reviews. -She interviewed staff and reviewed the residents' records to determine each resident's LHPS tasks. -She kept copies of the LHPS reviews but she did not currently have access to the LHPS reviews she completed in December 2020. -She always left a copy of the LHPS reviews in the Administrator's folder before leaving the facility so the facility should have a copy of the December 2020 LHPS reviews. Interview with the Administrator on 04/14/21 at 4:34pm revealed: -The facility's former LHPS nurse was going to be out in January 2021 when the LHPS reviews were	C 254			

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C 254	Continued From page 18 due, so she had the former LHPS nurse to do the reviews in December 2020. -She could not locate the LHPS reviews done in December 2020. -After that, the former LHPS nurse was no longer doing the LHPS reviews. -She forgot to hire a new LHPS nurse to do the reviews in March 2021. A second interview with the Administrator on 04/14/21 at 4:45pm revealed: -She was responsible for making sure LHPS reviews were done quarterly. -It was an "oversight"; she should have had the LHPS reviews done in March 2021. -She would hire a new consultant nurse to do the LHPS reviews.	C 254		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by:	C 315		

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C 315	Continued From page 19 Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 residents sampled (#2) including medications for sleep, constipation, anxiety, and agitation. The findings are: Review of Resident #2's current FL-2 dated 02/14/21 revealed: -Diagnoses included dementia without behavioral disturbance, altered mental status, hyponatremia, and urinary tract infection without hematuria. -The medication order section had documentation to "continue same medications from prior to admission and add antibiotics". Review of Resident #2's after visit summary from the hospital dated 02/14/21 revealed: -Instructions included, change how you take Trazodone (how much you take). (Trazodone is used to treat insomnia.) -The medication list included Trazodone 50mg take ½ tablet (25mg) nightly. -The resident last received Trazodone 25mg in the hospital on 02/13/21 at 8:24pm. -The form was not electronically signed by a prescribing practitioner. Review of Resident #2's physician's order dated 02/15/21 revealed the primary care provider (PCP) ordered Trazodone 25mg at bedtime. Review of Resident #2's previous physician's orders dated 03/02/20 revealed: -There was an order for Colace 100mg ½ tablet (50mg) twice daily. (Colace is a stool softener.) -There was an order for Miralax powder mix 17 grams (one capful) with 8 ounces of juice/water	C 315		

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C 315	Continued From page 20 and drink daily as needed for constipation. (Miralax is a laxative.) -There was an order for Lorazepam 0.5mg 1 tablet every 4 hours as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of Resident #2's previous FL-2 dated 10/26/20 revealed: -There was an order for Colace 100mg twice a day. -There was an order for Trazadone 50mg at bedtime-There was an order for Miralax powder, 17 grams with water as needed (no indication noted). -There was an order for Lorazepam 0.5mg as needed for agitation (no frequency or maximum dosage noted). Review of Resident #2's physician's orders revealed no documentation the PCP was contacted to clarify the incomplete orders or discrepancies in the orders. Review of Resident #2's February 2021 medication administration record (MAR) revealed: -There was an entry for Colace 100mg ½ tablet twice daily scheduled for 8:00am and 8:00pm. -Documentation for Colace was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -Colace 100mg ½ tablet was documented as administered twice daily from 02/01/21 - 02/26/21 except from 8:00pm on 02/12/21 - 8:00am on 02/14/21 when the resident was in the hospital. -There was an entry for Trazadone 50mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Trazodone was blank on 02/27/21 and 02/28/21 with no reason for the omissions.	C 315		

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C 315	Continued From page 21 -Trazodone 50mg was documented as administered at bedtime from 02/01/21 - 02/26/21 except for 02/12/21 and 02/13/21 when the resident was in the hospital. -There was an entry for Miralax powder mix 17 grams (one capful) with 8 ounces of juice or water and drink daily as needed for constipation. -No Miralax was documented as administered from 02/01/21 - 02/28/21. -There was no entry on the MAR for Lorazepam 0.5mg to be administered. Review of Resident #2's March 2021 MAR revealed: -There was a handwritten entry for Colace 100mg ½ tablet twice daily scheduled for 8:00am and 8:00pm. -Colace 100mg ½ tablet was documented as administered twice daily from 03/01/21 - 03/31/21. -There was a handwritten entry for Trazadone 50mg 1 tablet every night at bedtime scheduled for 8:00pm. -Trazodone 50mg was documented as administered at bedtime from 03/01/21 - 03/31/21. -There was a handwritten entry for Miralax powder mix 17 grams (one capful) with 8 ounces of juice or water and drink daily as needed for constipation. -No Miralax was documented as administered from 03/01/21 - 03/31/21. -There was no entry on the MAR for Lorazepam 0.5mg to be administered. Review of Resident #2's April 2021 MAR revealed: -There was a handwritten entry for Colace 100mg ½ tablet twice daily scheduled for 8:00am and 8:00pm.	C 315		

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C 315	Continued From page 22 -Colace 100mg ½ tablet was documented as administered twice daily from 04/01/21 - 04/14/21 except for 2 occasions. -Documentation for Colace was blank on 04/02/21 at 8:00pm and 04/11/21 at 8:00am with no reason for the omissions. -There was a handwritten entry for Trazadone 50mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Trazodone was blank on 04/02/21 with no reason for the omissions. -Trazodone 50mg was documented as administered at bedtime from 04/01/21 - 04/13/21. -There was a handwritten entry for Miralax powder mix 17 grams (one capful) with 8 ounces of juice or water daily as needed for constipation. -No Miralax was documented as administered from 04/01/21 - 04/14/21. -There was no entry on the MAR for Lorazepam 0.5mg to be administered. Observation of Resident #2's medications on hand on 04/14/21 at 5:10pm revealed: -There was Colace 100mg ½ tablets packaged in the resident's 8:00am and 8:00pm multi-dose packs with instructions to take 1/2 tablet twice daily. -There was Trazodone 50mg tablets packaged in the resident's 8:00pm multi-dose packs with instructions to take 1 tablet every night at bedtime. -There was one unopened bottle of Miralax powder with 510 grams of powder dispensed on 04/24/20 with instructions to take 17g with 8 ounces of juice or water and drink daily as needed for constipation. -There was one bubble pack of Lorazepam 0.5mg tablets dispensed on 04/22/20 with 90 of 90 tablets remaining with instructions to take 1	C 315		

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C 315	Continued From page 23 tablet every 4 hours as needed for agitation. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 3:10pm revealed: -She administered Trazodone and Colace according to the MAR and the medication labels. -She had not noticed the most current order for Trazodone and Colace did not match the entries on the MAR or the medication labels. -The resident had not been administered any Miralax or Lorazepam to her knowledge. Interview with the Administrator on 04/14/21 at 5:42pm revealed: -She usually got the PCP to sign physician's orders every 6 months for the residents. -She could not find any current 6 months order sheets for Resident #2's medications that might clear up some of the order discrepancies. -She would contact the resident's PCP to clarify the orders for Trazodone, Lorazepam, Miralax, and Colace. Review of Resident #2's clarification orders dated 04/15/21 revealed: -There was an order discontinue the Lorazepam. -There was an order for Trazodone 50mg at bedtime. -There was an order for Miralax 17 grams mixed with water or juice daily as needed for constipation. -There was no order to clarify the Colace. A second interview with the Administrator on 04/15/21 at 9:15am: -She or the MAs were responsible for reviewing FL-2s and clarifying medication orders. -She forgot to request clarification for Resident #2's Colace order but she would contact the PCP again to clarify the order.	C 315		

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C 315	Continued From page 24 Telephone interview with Resident #2's PCP on 04/15/21 at 4:31pm revealed: -She had decreased Resident #2's Trazodone to 25mg because of daytime somnolence (sleepiness). -She clarified the order back to Trazodone 50mg (on 04/15/21) because it was now her understanding the resident's mental health provider (MHP) wanted the resident to take 50mg instead of 25mg. -She was not contacted by the facility to clarify the Trazodone, Miralax, or Lorazepam orders prior to 04/14/21. -She was contacted today, 04/15/21, to clarify the Colace order. -She had not seen the written request yet but she would review it and clarify the order. -She did not have any concerns about the resident's current Colace dosage because the resident was not having any issues with constipation or diarrhea to her knowledge. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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.	C 330		

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C 330	Continued From page 25 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents sampled (#1, #2, #3) including medications for glaucoma and Vitamin D deficiency (#3); medications for arthritis pain (#2); and medication for high blood pressure (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 07/23/20 revealed diagnoses included dementia, generalized weakness, chronic kidney disease stage III, hyperparathyroidism, coronary artery disease, hypokalemia, and atrial fibrillation - new onset. a. Review of Resident #3's retina center eye visit dated 02/04/20 revealed: -The resident's glaucoma was not being well managed with the current Timolol drop. (Timolol is used to treat glaucoma.) -The physician added Cosopt (a combination eye drop with Dorzolamide and Timolol) to attempt to reduce eye pressures without adding a third drop to the daily regimen. Review of Resident #3's physician's order dated 02/24/20 revealed: -There was an order to discontinue Timolol eye drops. -There was an order to start Cosopt (Dorzolamide with Timolol) eye drops 1 drop in both eyes twice a day.	C 330		

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C 330	Continued From page 26 Review of Resident #3's current FL-2 dated 07/23/20 revealed an order for Cosopt eye drops 1 drop in both eyes twice a day. Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Timolol 0.05% 1 drop in both eyes twice a day scheduled for 8:00am and 2:00pm. -Timolol was documented as administered twice daily from 02/01/21 - 02/26/21. -There was no entry for Cosopt eye drops on the MAR. Review of Resident #3's March 2021 MAR revealed: -There was a handwritten entry for Timolol 0.05% 1 drop in both eyes twice a day scheduled for 8:00am and 2:00pm. -Timolol was documented as administered twice daily from 03/01/21 - 03/31/21. -There was no entry for Cosopt eye drops on the MAR. Review of Resident #3's April 2021 MAR revealed: -There was a handwritten entry for Timolol 0.05% 1 drop in both eyes twice a day scheduled for 8:00am and 2:00pm. -Timolol was documented as administered twice daily from 04/01/21 - 04/14/21 except 4 blanks from 8:00am on 04/10/21 - 8:00pm on 04/11/21 with no reason for the omissions. -There was no entry for Cosopt eye drops on the MAR and no documentation any had been administered. Observation of Resident #3's medications on hand on 04/15/21 at 11:20am revealed: -There was an opened 5ml bottle of Timolol 0.5%	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2021
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
(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 330	Continued From page 27 eye drops dispensed on 07/28/20. -There were 3 unopened bottles of Cosopt (Dorzolamide/Timolol) eye drops dispensed on 12/27/20, 02/23/21, and 03/30/21. -There was one opened bottle of Cosopt (Dorzolamide/Timolol) eye drops dispensed on 10/01/20 approximately 3/4ths full. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -She used the opened bottle of Timolol eye drops for Resident #3. -She transcribed orders on the MARs including the Timolol eye drop order. -She must have overlooked the order to discontinue Timolol and start Cosopt. -She had not noticed the supply of Cosopt (Dorzolamide / Timolol) was different from the Timolol eye drop bottles. -The Cosopt eye drops had not been opened or used. Interview with the Administrator on 04/15/21 at 9:15am revealed: -The facility's contracted pharmacy did not print orders on MARs for Resident #3 because the resident got her medications from an online pharmacy. -The MAs would handwrite Resident #3's medication orders on the paper MARs. Telephone interview with Resident #3's primary care provider (PCP) on 04/15/21 at 4:31pm revealed: -She remembered when the Timolol eye drops were changed to Cosopt because it contained two medications to lower intraocular eye pressure. -She did not monitor Resident #3's intraocular eye pressure so she could not say how the	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2021
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C 330	Continued From page 28 resident was affected by not receiving Cosopt with the combination therapy. -In general, over time, increased intraocular eye pressure could lead to blindness. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. b. Review of Resident #3's after visit summary and hospital discharge summary dated 07/23/20 revealed there was an order for Xalatan 1 drop in each eye once daily. (Xalatan is used to treat glaucoma.) Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Xalatan 1 drop in each eye scheduled for 12:00pm. -Xalatan was documented as administered from 02/01/21 - 02/26/21. Review of Resident #3's March 2021 MAR revealed: -There was a handwritten entry for Xalatan 1 drop in each eye scheduled for 12:00pm. -Xalatan was documented as administered daily from 03/01/21 - 03/31/21. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Xalatan 1 drop in each eye scheduled for 12:00pm. -Xalatan was documented as administered daily from 04/01/21 - 04/14/21 except 1 occasion. Observation of Resident #3's medications on hand on 04/15/21 at 11:20am revealed: -There were 4 bottles of Xalatan eye drops; one dispensed on 07/29/20 and 3 dispensed on	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2021
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C 330	Continued From page 29 07/17/20. -All 4 bottles of Xalatan were opened with no open date documented to determine when the eye drops expired. -The open date stickers on the bottles were blank. (Xalatan eye drops expire 6 weeks after opening and should be discarded.) Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -She was not aware Xalatan eye drops expired 6 weeks after opening. -She used any of the opened bottles of Xalatan to administer to the resident. -She did not know when the bottles of Xalatan were opened but they could have been opened when they were dispensed in July 2020. Telephone interview with Resident #3's primary care provider (PCP) on 04/15/21 at 4:31pm revealed: -The MAs should not administer Xalatan eye drops if they were expired. -To get the full effect of the eye drop, it should be administered before it expired. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. c. Review of Resident #3's after visit summary and discharge summary dated 07/23/20 revealed there was an order for Vitamin D 50,000 units every 14 days. (Vitamin D is used to treat Vitamin D deficiency.) Review of Resident #3's nephrology visit notes dated 11/20/20 revealed there was an order for Vitamin D 50,000 units per week.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/15/2021
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C 330	Continued From page 30 Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Vitamin D 50,000 units 1 capsule every 2 weeks scheduled for 8:00am. -Vitamin D 50,000 units was documented as administered once on 02/15/21. Review of Resident #3's March 2021 MAR revealed: -There was a handwritten entry for Vitamin D 50,000 units 1 capsule every 2 weeks scheduled for 8:00am. -Vitamin D 50,000 units was documented as administered on 03/15/21 and 03/28/21. Review of Resident #3's April 2021 MAR revealed: -There was a handwritten entry for Vitamin D 50,000 units 1 capsule every 2 weeks scheduled for 8:00am. -Vitamin D 50,000 units was documented as due to be administered on 04/15/21. Observation of Resident #3's medications on hand on 04/15/21 at 11:20am revealed: -There was a multi-dose package dated 04/11/21 - 05/10/21. -There was one Vitamin D 50,000 unit capsule packaged in the multi-dose pack for once a week on Saturdays. -There was a supply of Vitamin D 50,000 units dispensed on 07/14/20 with 2 of 5 capsules remaining. Interview with the Administrator on 04/15/21 at 9:15am revealed: -All FL-2s were faxed to the facility's contracted pharmacy for dispensing purposes and updates to the MARs.	C 330		

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C 330	Continued From page 31 -The facility's contracted pharmacy did not print orders on MARs for Resident #3 because the resident got their medications from an online pharmacy. -The MAs would handwrite Resident #3's medication orders on the paper MARs. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -She transcribed orders on the MARs including the Vitamin D order. -She had not noticed the Vitamin D entry on the MAR did not match the Vitamin D instructions on the medication label. -She was not sure how long Resident #3's Vitamin D had been coming in the multi-dose packs for weekly administration. -Prior to the multi-packs they administered the Vitamin D from the bottles and would have administered it every 2 weeks as indicated on the MARs. Telephone interview with Resident #3's primary care provider (PCP) on 04/15/21 at 4:31pm revealed: -Resident #3's Vitamin D was low (could not recall exact level) when she checked it a month or two ago. -The resident's Vitamin D level was chronically low and failing to increase the Vitamin D dosage from every 2 weeks to once a week could contribute to lower Vitamin D levels. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. 2. Review of Resident #2's current FL-2 dated 02/14/21 revealed: -Diagnoses included dementia without behavioral	C 330		

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C 330	Continued From page 32 disturbance, altered mental status, hypernatremia, and urinary tract infection without hematuria. -The medication order section had documentation to "continue same medications from prior to admission and add antibiotics". Review of Resident #2's physician's orders dated 03/02/20 and 10/26/20 revealed orders for Tylenol 500mg every morning. (Tylenol is for pain and fever.) Review of Resident #2's February 2021 medication administration record (MAR) revealed: -There was an entry for Tylenol 500mg 1 tablet every day scheduled for 8:00am. -Documentation for Tylenol was blank on 02/27/21 and 02/28/21 with no reason for the omissions. Review of Resident #2's March 2021 MAR revealed: -There was a handwritten entry for Tylenol 500mg 1 tablet every day scheduled for 8:00am. -Tylenol 500mg was documented as administered daily from 03/01/21 - 03/31/21. Review of Resident #2's April 2021 MAR revealed: -There was a handwritten entry for Tylenol 500mg 1 tablet every day scheduled for 8:00am. -Tylenol 500mg was documented as administered daily from 04/01/21 - 04/14/21. Review of Resident #2's pharmacy dispensing records dated 08/01/20 - 04/15/21 revealed there were 30 Tylenol 500mg tablets dispensed on 08/03/20, 09/01/20, 09/29/20, 11/02/20, 11/30/20, 12/28/20, 01/26/21, 02/23/21, and 03/29/21 for a total of 270 tablets.	C 330		

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C 330	Continued From page 33 Observation of Resident #2's medications on hand on 04/14/21 at 5:10pm revealed: -There were 3 different supplies of Tylenol 500mg on hand for Resident #2. -There was a bubble card of Tylenol 500mg dispensed on 11/02/20 with 23 of 30 tablets remaining. -There was a bubble card of Tylenol 500mg dispensed on 02/23/21 with 8 of 30 tablets remaining. -There was a bubble card of Tylenol 500mg dispensed on 03/29/21 with 30 of 30 tablets remaining. -There was a total of 61 Tylenol 500mg tablets on hand. -There was no Tylenol 500mg tablets packaged in the resident's multi-dose packs. Review of Resident #2's pharmacy dispensing records, MARs, and medications on hand revealed: -There were 270 Tylenol 500mg tablets (270-day supply) dispensed from 08/01/20 - 04/14/21 (257-day time period.) -There were 61 of 270 tablets remaining on 04/14/21. -There were 209 of the 270 tablets used in the 257-day time period. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 3:10pm revealed: -Tylenol was only packaged in the bubble cards and it was not included in the 8:00am multi-dose packs. -She did not know why there were so many Tylenol on hand for the resident. -She usually administered the Tylenol to the resident every morning and the resident did not refuse medications.	C 330		

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C 330	Continued From page 34 Interview with the Administrator on 04/14/21 at 5:29pm revealed: -She did not know why there were so many Tylenol 500mg tablets on hand for Resident #2. -Since Tylenol was not packaged in the multi-dose packs, the MAs should get the Tylenol from the bubble cards to administer. -The MAs may not have noticed the Tylenol was not packaged in the 8:00am multi-dose packs. -The MAs had been trained to compare the medication labels to the MARs when administering medications and she expected the MAs to do that. Telephone interview with Resident #2's primary care provider (PCP) on 04/15/21 at 4:31pm revealed: -Resident #2's Tylenol was ordered for arthritis pain. -She expected the Tylenol to be administered as ordered to help with the resident's arthritis pain. -The Tylenol should be given daily as ordered since the resident had dementia and may not be able to indicate if she was in pain. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 3. Review of Resident #1's FL-2 dated 10/28/20 revealed diagnoses included dementia, coronary artery disease, peripheral artery disease, chronic obstructive pulmonary disease, chronic pain, colitis, and acute kidney injury. Review of Resident #1's provider progress notes dated 02/28/20 revealed there was an order for Metoprolol Tartrate 25mg tablet, take 1/2 tablet (12.5mg) twice a day; hold if systolic blood	C 330		

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C 330	Continued From page 35 pressure (SBP) is less than (<) 110. (Metoprolol Tartrate is a medication used to treat high blood pressure.) Review of Resident #1's progress notes dated 02/01/21 revealed there was a form for medication aides (MAs) to check her blood pressure two times a day before administering Metoprolol Tartrate 12.5mg and to document her blood pressure readings at 8:00am and 8:00pm. Review of Resident #1's February 2021 medication administration record (MAR) and vital signs form revealed: -There was an entry for Metoprolol Tartrate 25mg take 0.5 (one-half) tablet twice daily, hold for SBP < 110 as directed with scheduled administration times of 8:00am and 8:00pm. -There was documentation of Metoprolol Tartrate 12.5mg being administered 9 times from 02/06/21 - 02/15/21 without taking the blood pressure prior to administration of Metoprolol Tartrate. -There was documentation of Metoprolol Tartrate 12.5mg being administered on 02/06/21 at 8:00am and 8:00pm, 02/07/21 at 8:00am and 8:00pm, 02/12/21 at 8:00pm, 02/13/21 at 8:00am and 8:00pm, 02/14/21 at 8:00am and 02/15/21 at 8:00pm without the blood pressure being taken prior to administering the medication. -When checked, the resident's blood pressure ranged from 118/70 - 134/71. Review of Resident #1's March 2021 MAR and vital signs form revealed: -There was an entry for Metoprolol Tartrate 25mg take 0.5 (one-half) tablet twice daily, hold for SBP < 110 as directed with scheduled administration times of 8:00am and 8:00pm. -There was documentation of Metoprolol Tartrate 12.5mg being administered 10 times from	C 330			

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C 330	Continued From page 36 03/06/21-03/21/21 with taking the blood pressure prior to administration of Metoprolol Tartrate. -There was documentation of Metoprolol Tartrate 12.5mg being administered on 03/06/21 at 8:00am, 03/08/21 at 8:00pm, 03/13/21 at 8:00am and 8:00pm, 03/14/21 at 8:00am and 8:00pm, 03/20/21 at 8:00am and 8:00pm, and 03/21/21 at 8:00am and 8:00pm without the blood pressure being taken prior to administering the medication. -When checked, the resident's blood pressure ranged from 120/70 - 133/68. Review of Resident #1's April 2021 MAR and vital signs form revealed: -There was an entry for Metoprolol Tartrate 25mg take 0.5 (one-half) tablet twice daily, hold for SBP < 110 as directed with scheduled administration times of 8:00am and 8:00pm. -There was documentation of Metoprolol Tartrate 12.5mg being administered 9 times from 04/02/21 -04/15/21 without taking her blood pressure prior to administration of metoprolol tartrate. -There was documentation of Metoprolol Tartrate 12.5mg being administered on 04/02/21 at 8:00pm, 04/03/21 at 8:00am and 8:00pm, 04/04/21 at 8:00am and 8:00pm, 04/06/21 at 8:00pm, 04/12/21 at 8:00pm, 04/13/21 at 8:00pm, and 04/15/21 at 8:00pm without the blood pressure being taken prior to administering the medication. -When checked, the resident's blood pressure ranged from 120/70 - 134/64. Interview with a MA on 04/15/21 at 9:58am revealed: -She always checked Resident #1's blood pressure before administering the Metoprolol Tartrate. -She documented the blood pressure on a daily vital signs form.	C 330			

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C 330	Continued From page 37 -Resident #1's primary care provider (PCP) ordered the resident's blood pressure to be obtained twice a day prior to administering the blood pressure medication. Telephone interview with Resident #1's PCP on 04/15/21 at 3:55pm revealed: -Resident #1 would be at an increased risk for falls if her SBP was less than 110 and she was administered the Metoprolol Tartrate because it would cause her blood pressure to drop too low. -He expected staff to check the resident's blood pressure prior to administering the Metoprolol Tartrate to ensure the resident did not become hypotensive (the blood pressure becomes too low). -Resident #1 could become dizzy and faint if she were overtreated with Metoprolol Tartrate. Interview with the Administrator on 04/15/21 at 5:49pm revealed: -She expected the MAs to follow Resident #1's PCP orders to check her blood pressure twice a day. -She expected the MAs to hold the Metoprolol Tartrate if her SBP was under 110 per PCP's order. _____ The facility failed to administer medications as ordered for 3 of 3 residents sampled (#1, #2, #3). Resident #3 did not receive eye drops for glaucoma as ordered due to staff failing to implement an order from February 2020 for a combination eye drop used to lower intraocular pressure in the eye and the facility administered a second glaucoma eye drop to the resident after it was expired. Resident #2's Tylenol was not administered daily for arthritis pain as evidenced by an oversupply of medication on hand. Resident #1's blood pressure medication required	C 330		

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C 330	Continued From page 38 the blood pressure to be taken to determine if the medication should be held for low blood pressure but the blood pressure was not taken on multiple occasions when the medication was administered without the parameter to determine if it should be held putting the resident at risk for symptoms of low blood pressure. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 30, 2021.	C 330		
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 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	C 342		

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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
C 342	Continued From page 39 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, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate and complete for 3 of 3 residents sampled (#1, #2, #3) including a resident who received medications for prevention of blood clots, heart arrhythmias, prevention of heart disease, high blood pressure, acid reflux, glaucoma, appetite stimulant, diarrhea, and vitamin supplement (#3); a resident with medications for pain, constipation, sleep, agitation, infection, and vitamin supplement (#2); and a resident with medications for high cholesterol, pain, lung disease, and prevention of heart disease (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 07/23/20 revealed diagnoses included dementia, generalized weakness, chronic kidney disease stage III, hyperparathyroidism, coronary artery disease, hypokalemia, and atrial fibrillation - new onset. a. Review of Resident #3's after visit summary and hospital discharge summary dated 07/23/20 revealed: -The resident's discharge diagnoses included weakness, chronic kidney disease - stage 3, new onset atrial fibrillation, and deep vein thrombosis (blood clot) in the left lower extremity. -There was an order for Apixaban 2.5mg twice a day. (Apixaban is blood thinner used to treat and	C 342		

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C 342	Continued From page 40 prevent blood clots.) Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Apixaban 2.5mg 1 tablet twice a day scheduled for 8:00am and 5:00pm. -Documentation for Apixaban was blank on 02/27/21 and 02/28/21 with no reason for the omissions. Review of Resident #3's March 2021 MAR revealed: -There was a handwritten entry for Apixaban 2.5mg 3 times a day as needed for "diarrhea". -No Apixaban was documented as administered. -There was no entry for Apixaban 2.5mg 1 tablet twice a day scheduled for 8:00am and 5:00pm. Review of Resident #3's April 2021 MAR revealed: -There was a handwritten entry for Apixaban 2.5mg 3 times a day as needed for "diarrhea". -No Apixaban was documented as administered. -There was no entry for Apixaban 2.5mg 1 tablet twice a day scheduled for 8:00am and 5:00pm. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -She was responsible for transcribing orders on the MARs. -When she transcribed the Apixaban order onto the March 2021 MAR, she must have gotten it confused with another order. -She had not noticed there was no entry for Apixaban 2.5mg twice a day. -Apixaban 2.5mg was being administered twice a day because it was packaged in the resident's multi-dose packs from the resident's online pharmacy.	C 342		

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C 342	Continued From page 41 -It was a transcription error and it carried over to the April 2021 MAR because she copied the entries on the previous month's MARs. -She checked the MARs daily and she had not noticed the Apixaban entry was incorrect. Observation of Resident #3's medications on hand on 04/15/21 at 11:20am revealed: -There was a multi-dose package dated 04/11/21 - 05/10/21. -There was one Apixaban 2.5mg tablet in the 8:00am and 8:00pm multi-dose packs with instructions to take 1 tablet twice daily. Telephone interview with Resident #3's power of attorney (POA) on 04/15/21 at 4:16pm revealed she ordered Resident #3's medications through an online pharmacy and the medications were delivered to the facility via mail. Review of online pharmacy shipment tracking forms provided by Resident #3's POA on 04/15/21 revealed: -Apixaban was documented as being delivered to the facility on 04/05/21, 02/26/21, 01/29/21, 12/30/20, and 10/03/20. -The quantity delivered was not specified. Telephone interview with Resident #3's primary care provider (PCP) on 04/15/21 at 4:31pm revealed: -She was not aware staff had transcribed the Apixaban order incorrectly on the MAR and were not documenting it was administered twice a day. -It was important to show the Apixaban was being administered because if it was not being administered, it could increase the risk of blood clots. Based on observations, interviews, and record	C 342		

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C 342	Continued From page 42 reviews, it was determined Resident #3 was not interviewable. b. Review of Resident #3's after visit summary and hospital discharge summary dated 07/23/20 revealed: -There was an order for Amiodarone 200mg twice a day with meals. (Amiodarone is for heart arrhythmias.) -There was an order for Aspirin 81mg once daily. (Aspirin may be used to prevent heart disease.) -There was an order for B Complex Vitamins 1 tablet daily. (B Complex is a vitamin supplement.) -There was an order for Coreg 3.125mg twice a day. (Coreg lowers for blood pressure.) -There was an order for Dronabinol 2.5mg twice a day 30 minutes before a meal. (Dronabinol is a controlled substance used to stimulate appetite.) -There was an order for Xalatan 1 drop in each eye once daily. (Xalatan is used to treat glaucoma.) Review of Resident #3's physician's order dated 08/10/20 revealed an order for Protonix 20mg once daily. (Protonix is for acid reflux.) Review of Resident #3's physician's order dated 11/23/20 revealed an order for Lomotil 2.5mg 3 times a day as needed for diarrhea. (Lomotil is a controlled substance used to treat diarrhea.) Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Amiodarone 200mg daily scheduled for 8:00pm. -Documentation for Amiodarone was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for Aspirin 81mg	C 342		

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C 342	Continued From page 43 1 tablet daily scheduled for 8:00am. -Documentation for Aspirin was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for B Complex Vitamin 1 tablet daily scheduled for 8:00am. -Documentation for B Complex Vitamin was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for Coreg 3.125mg 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Documentation for Coreg was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for Dronabinol 2.5mg 1 capsule twice a day 30 minutes before meals scheduled for 7:30am and 4:30pm. -Documentation for Dronabinol was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for Xalatan 1 drop in each eye scheduled for 12:00pm. -Documentation for Xalatan was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was a handwritten entry for Protonix 20mg 1 tablet daily scheduled for 8:00pm. -Documentation for Protonix was blank on 02/27/21 and 02/28/21 with no reason for the omissions. Review of Resident #3's April 2021 MAR revealed: -There was a handwritten entry for Amiodarone 200mg daily scheduled for 8:00pm. -Documentation for Amiodarone was blank from 04/02/21 - 04/04/21 with no reason for the omissions. -There was a handwritten entry for Aspirin 81mg 1 tablet daily scheduled for 8:00am. -Documentation for Aspirin was blank on 04/02/21	C 342		

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C 342	Continued From page 44 with no reason for the omission. -There was a handwritten entry for Coreg 3.125mg 1 tablet twice a day scheduled for 8:00am and 8:00pm. -Documentation for Coreg was blank on 04/02/21 at 8:00pm with no reason for the omission. -There was a handwritten entry for Dronabinol 2.5mg 1 capsule twice a day 30 minutes before meals scheduled for 7:30am and 4:30pm. -Dronabinol was documented as administered twice daily from 04/01/21 - 04/14/21 except for 3 occasions. -Documentation for Dronabinol was blank on 04/02/21 at 8:00pm and 04/10/21 and 04/11/21 at 8:00am with no reason for the omissions. -There was a handwritten entry for Xalatan 1 drop in each eye scheduled for 12:00pm. -Xalatan was documented as administered daily from 04/01/21 - 04/14/21 except 1 occasion. -Documentation for Xalatan was blank on 04/02/21 with no reason for the omission. -There was a handwritten entry for Protonix 20mg 1 tablet daily scheduled for 8:00pm. -Documentation for Protonix was blank on 04/02/21 with no reason for the omission. -There was no entry for prn Lomotil. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -The MAs were supposed to initial the MARs after they observed Resident #3 take her medications. -Resident #3 did not refuse medications. -She checked the MARs daily and if there were "holes" on the MARs, she would notify the MAs so they could fill in the blanks on the MARs. -She had not noticed any omissions on the MARs for February 2021 - April 2021. Interview with the Administrator on 04/15/21 at 11:42am revealed:	C 342		

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C 342	Continued From page 45 -A former staff person worked on the weekend of 02/27/21 and 02/28/21 and must have forgotten to document on the MARs. -The MAs were supposed to document on the MARs immediately after administered medications to a resident. -She had not audited the MARs so she had not noticed the omissions on the MARs for Resident #3. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. 2. Review of Resident #2's current FL-2 dated 02/14/21 revealed: -Diagnoses included dementia without behavioral disturbance, altered mental status, hypernatremia, and urinary tract infection without hematuria. -The medication order section had documentation to "continue same medications from prior to admission and add antibiotics". -There was an order for Omnicef 300mg every 12 hours for 5 days. (Omnicef is an antibiotic for infection.) Review of Resident #2's pharmacy dispensing records dated 08/01/20 - 04/15/21 revealed there were 10 Omnicef 300mg tablets dispensed on 02/15/21. Review of Resident #2's previous FL-2 dated 10/26/20 revealed: -There was an order for Tylenol 500mg every morning. (Tylenol is for pain and fever.) -There was an order for Colace 100mg twice a day. (Colace is a stool softener.) -There was an order for Trazadone 50mg at bedtime. (Trazadone is used to treat insomnia.)	C 342			

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C 342	Continued From page 46 -There was an order for Mirtazapine 30mg at bedtime. (Mirtazapine is used to treat insomnia.) -There was an order for Lorazepam 0.5mg as needed for agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.) Review of Resident #2's physician's order dated 02/26/21 revealed an order for Vitamin B12 1,000mcg 1 tablet daily. (Vitamin B12 is a supplement used to treat Vitamin B12 deficiency.) Review of Resident #2's February 2021 medication administration record (MAR) revealed: -There was handwritten entry for Omnicef 300mg 1 capsule "every 12 hours for 5 days" scheduled for 8:00am and 8:00pm. -The first dose was documented at 8:00pm on 02/16/21 and the last dose was documented as administered at 8:00pm on 02/21/21. -There were 11 doses of Omnicef documented as administered but only 10 doses were ordered. -There was an entry for Tylenol 500mg 1 tablet every day scheduled for 8:00am. -Documentation for Tylenol was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was an entry for Colace 100mg ½ tablet twice daily scheduled for 8:00am and 8:00pm. -Documentation for Colace was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was an entry for Trazadone 50mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Trazodone was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -There was an entry for Mirtazapine 30mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Mirtazapine was blank on	C 342		

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C 342	Continued From page 47 02/27/21 and 02/28/21 with no reason for the omissions. -There was no entry on the MAR for Lorazepam 0.5mg to be administered. -There was a handwritten entry for "new order" (no date) Vitamin B12 1,000mcg 1 tablet once daily scheduled for 8:00am. -Documentation for Vitamin B12 was blank from 02/26/21 - 02/28/21 with no reason for the omissions. Review of Resident #2's March 2021 MAR revealed there was no entry on the MAR for Lorazepam 0.5mg to be administered. Review of Resident #2's April 2021 MAR revealed: -There was a handwritten entry for Colace 100mg ½ tablet twice daily scheduled for 8:00am and 8:00pm. -Colace 100mg ½ tablet was documented as administered twice daily from 04/01/21 - 04/14/21 except for 2 occasions. -Documentation for Colace was blank on 04/02/21 at 8:00pm and 04/11/21 at 8:00am with no reason for the omissions. -There was a handwritten entry for Trazadone 50mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Trazodone was blank on 04/02/21 with no reason for the omissions. -There was a handwritten entry for Mirtazapine 30mg 1 tablet every night at bedtime scheduled for 8:00pm. -Documentation for Mirtazapine was blank on 04/02/21 at 8:00pm with no reason for the omission. -There was no entry on the MAR for Lorazepam 0.5mg to be administered.	C 342		

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C 342	Continued From page 48 Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 11:40am revealed: -The MAs were supposed to initial the MARs after they observed Resident #2 take her medications. -Resident #2 did not refuse medications. -She checked the MARs daily and if there were "holes" on the MARs, she would notify the MAs so they could fill in the blanks on the MARs. -She had not noticed any omissions on the MARs for Resident #2 for February 2021 - April 2021. Interview with the Administrator on 04/15/21 at 11:42am revealed: -A former staff person worked on the weekend of 02/27/21 and 02/28/21 and must have forgotten to document administration of Resident #2's medications on the MAR. -The MAs were supposed to document on the MARs immediately after administered medications to a resident. -She had not audited the MARs so she had not noticed the omissions on Resident #2's MARs. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. 3. Review of Resident #1's current FL-2 dated 10/28/20 revealed diagnoses included dementia, coronary artery disease, peripheral artery disease, chronic obstructive pulmonary disease, chronic pain, colitis, and acute kidney injury. Review of Resident #1's current FL-2 dated 10/28/20 revealed: -There was an order for Rosuvastatin Calcium 5mg; take one tablet at bedtime. (Rosuvastatin Calcium is used to lower bad cholesterol and raise good cholesterol.) -There was an order for Aspirin EC 325mg; take	C 342		

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C 342	Continued From page 49 one tablet a day. (Aspirin may be used for prevention of heart disease.) -There was an order for Acetaminophen 325mg; take one tablet every 8 hours. (Acetaminophen is used for pain.) -There was an order for Anoro Ellipta 62.5-25mcg inhaler; inhale one puff daily. (Anoro Ellipta is used to control and prevent wheezing and shortness of breath caused by chronic obstructive pulmonary disease.) Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for Rosuvastatin Calcium 5mg 1 tablet at bedtime scheduled for 8:00pm. -Documentation for Rosuvastatin Calcium was blank on 02/12/21 with no reason for the omission. Review of Resident #1's March 2021 MAR revealed: -There was an entry for Aspirin EC 325mg 1 tablet every day scheduled for 8:00am. -Documentation for Aspirin was blank on 03/21/21 with no reason for omission. -There was an entry for Rosuvastatin Calcium 5mg 1 tablet at bedtime scheduled for 8:00pm. -Documentation for Rosuvastatin Calcium was blank on 03/01/21 and 03/02/21 with no reason for omissions. Review of Resident #1's April 2021 MAR revealed: -There was an entry for Acetaminophen 325mg 1 tablet every 8 hours. -Documentation for Acetaminophen was blank on 04/02/21 at 5:00pm and 04/11/21 at 8:00am with no reason for omissions. -There was an entry for Anoro Ellipta 62.5-25mcg inhale one puff every day scheduled for 8:00am.	C 342		

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C 342	Continued From page 50 -Documentation for Anoro Ellipta was blank on 04/11/21 with no reason for the omission. Interview with the Administrator on 04/15/21 at 11:42am revealed: -The MAs were supposed to document on the MARs immediately after administered medications to a resident. -She had not audited the MARs so she had not noticed the omissions on the MARs for Resident #1. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.	C 342			
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt, disposition, and administration of controlled substances for 2 of 3 residents sampled (#1, #3) including a resident receiving medication for moderate to severe pain (#1); and a resident receiving a medication for diarrhea and an appetite stimulant (#3).	C 367			

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C 367	Continued From page 51 1. Review of Resident #1's current FL-2 dated 10/28/20 revealed: -Diagnoses included dementia, coronary artery disease, peripheral artery disease, chronic obstructive pulmonary disease, chronic pain, colitis, and acute kidney injury. -There was an order for Tramadol 50mg 1 tablet twice a day as needed for pain. (Tramadol is a controlled substance used to treat moderate to severe pain.) Observation of Resident #1's medications on hand on 04/15/21 at 12:23pm revealed: -There was a bubble card of Tramadol 50mg tablets with 49 of 60 tablets remaining. -There was a pharmacy printed label attached to the Tramadol bubble card which documented the medication was filled on 03/29/21. Review of Resident #1's February 2021 medication administration record (MAR) revealed: -There was an entry for Tramadol 50mg twice a day as needed for pain. -There was a total of 9 Tramadol 50mg tablets documented as administered from 02/18/21 - 02/26/21. Review of Resident #1's controlled substance (CS) logs revealed there was no CS log for the 9 Tramadol 50mg tablets documented as administered on the MAR from 02/18/21 - 02/26/21. Review of Resident #1's March 2021 MAR revealed: -There was an entry for Tramadol 50mg twice a day as needed for pain. -There was a total of 26 Tramadol 50mg tablets documented as administered from 03/04/21 - 03/29/21.	C 367		

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C 367	Continued From page 52 Review of Resident #1's CS logs revealed there was no CS log for the 26 Tramadol 50 mg tablets documented as administered on the MAR from 03/04/21 - 03/29/21. Review of Resident #1's April 2021 MAR revealed: -There was an entry for Tramadol 50mg twice a day as needed for pain. -There was a total of 8 Tramadol 50mg tablets documented as administered from 04/05/21 - 04/15/21. Review of Resident #1's CS log for Tramadol 50mg revealed: -Facility staff had completed a CS log which documented the supply of Tramadol 50mg was dispensed on 03/29/21 with 60 tablets. -The first dose administered from the supply was 03/31/21 at 2:00pm. -There were 10 doses of Tramadol 50mg documented as administered from 03/31/21 - 04/15/21. Review of second CS log for Resident #1's Tramadol 50mg revealed there were 10 Tramadol 50mg tablets documented as administered on the CS log and MAR from 04/05/21-04/15/21. The missing CS logs for Resident #1 were requested multiple times on 04/15/21 but not provided by the end of the survey. Interview with the Administrator on 04/15/21 at 5:40pm revealed: -She could not locate Resident #1's CS logs for February 2021 and March 2021. -She had meetings several times a month with all medication aides (MAs) to review MARs and CS	C 367		

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C 367	Continued From page 53 log documentation. -She expected staff to maintain the CS logs in the CS log binder. -She could not explain where Resident #1's CS logs were for February 2021 and March 2021. 2. Review of Resident #3's current FL-2 dated 07/23/20 revealed diagnoses included dementia, generalized weakness, chronic kidney disease stage III, hyperparathyroidism, coronary artery disease, hypokalemia, and atrial fibrillation - new onset. Review of Resident #3's after visit summary and hospital discharge summary dated 07/23/20 revealed there was an order for Dronabinol 2.5mg twice a day 30 minutes before a meal. (Dronabinol is a controlled substance used to stimulate appetite.) Review of Resident #3's physician's order dated 11/23/20 revealed an order for Lomotil 2.5mg 3 times a day as needed for diarrhea. (Lomotil is a controlled substance used to treat diarrhea.) Review of Resident #3's February 2021 medication administration record (MAR) revealed: -There was a handwritten entry for Dronabinol 2.5mg 1 capsule twice a day 30 minutes before meals scheduled for 7:30am and 4:30pm. -Documentation for Dronabinol was blank on 02/27/21 and 02/28/21 with no reason for the omissions. -Dronabinol was documented as administered twice daily from 02/01/21 - 02/26/21. -There was an entry for Lomotil 1 tablet 3 times a day as needed for diarrhea. -No Lomotil was documented as administered. Review of Resident #3's March 2021 MAR	C 367		

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C 367	Continued From page 54 revealed: -There was a handwritten entry for Dronabinol 2.5mg 1 capsule twice a day 30 minutes before meals scheduled for 7:30am and 4:30pm. -Dronabinol was documented as administered twice daily from 03/01/21 - 03/31/21. -There was no entry for Lomotil so none was documented as administered. Review of Resident #3's April 2021 MAR revealed: -There was a handwritten entry for Dronabinol 2.5mg 1 capsule twice a day 30 minutes before meals scheduled for 7:30am and 4:30pm. -Dronabinol was documented as administered twice daily from 04/01/21 - 04/14/21 except for 3 occasions. -There was no entry for Lomotil so none was documented as administered. Review of Resident #3's controlled substance (CS) logs revealed there was no CS logs for Dronabinol or Lomotil. Observation of Resident #3's medications on hand on 04/15/21 at 11:20am revealed: -There was a bottle of Dronabinol 2.5mg capsules dispensed on 03/05/21 with 10 of 60 capsules remaining. -There was a bottle of Dronabinol 2.5mg capsules dispensed on 04/01/21 with 60 of 60 capsules remaining. -There was one bubble card of Lomotil dispensed on 11/23/20 with 90 of 90 tablets remaining. Interview with a medication aide / personal care aide (MA/PCA) on 04/15/21 at 12:25pm revealed: -She was not documenting on a CS log for Resident #2's Lomotil or Dronabinol because she did not know they were controlled substances.	C 367			

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C 367	Continued From page 55 -The resident had not taken any Lomotil to her knowledge. Interview with the Administrator on 04/15/21 at 12:25pm revealed: -There were no CS logs for Resident #3's Lomotil or Dronabinol because she did not know they were controlled substances. -There should be CS logs for all controlled substances. -She would start CS logs for those medications today, 04/15/21. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	C 367			
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	C 375			

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C 375	Continued From page 56 current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side 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 interviews and record reviews, the facility failed to have medication reviews completed on-site and at least quarterly and on-site as required for 3 of 3 residents sampled (#1, #2, #3) resulting in medication related problems for all 3 residents. The findings are: 1. Review of Resident #2's current FL-2 dated 02/14/21 revealed diagnoses included dementia without behavioral disturbance, altered mental status, hypernatremia, and urinary tract infection without hematuria. Review of Resident #2's medication reviews revealed: -The resident's most current medication review was dated 09/02/19. -The pharmacist noted the resident was compliant with medications and the pharmacy needed to update the MAR to include the changed orders and new orders. -There were no other medication reviews in the	C 375			

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C 375	Continued From page 57 record dated after 09/02/19. Interview with the Administrator on 04/14/21 at 3:24pm revealed: -There should be more medication reviews for Resident #2. -She did not know why they were not in the record. -She would check with the consultant pharmacist. Review of Resident #2's medication reviews faxed to the facility from the pharmacy on 04/14/21 revealed: -There were 6 medication reviews faxed to the facility for Resident #2 that were not being maintained on file in the facility. -Resident #2's medication reviews were dated 10/11/19, 01/09/20, 04/22/20, 07/24/20, 10/30/20, and 01/29/21. -For all 6 medication reviews, the pharmacist noted medications were in order and the FL-2 was current and updated. -There were no recommendations for any of the medication reviews for Resident #2. -The pharmacist did not document any issue with clarification of orders, medication administration, or accuracy of the medication administration records (MARs). Review of Resident #2's medication orders, MARs, and medications on hand revealed: -Medication related problems were identified during the survey that were not identified in the resident's medication reviews. -Medication orders for Trazodone (for sleep), Colace (for constipation), Miralax (a laxative), and Lorazepam (for anxiety/agitation) were not clarified. -Resident #2's Tylenol (pain) was not administered daily as ordered for arthritis pain.	C 375			

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C 375	Continued From page 58 -There were multiple omissions with no reasons for the blanks on the MARs for Resident #2's medications. Refer to interview with the Administrator on 04/14/21 at 3:24pm. Refer to telephone interview with the consultant pharmacist on 04/15/21 at 3:58pm. 2. Review of Resident #3's current FL-2 dated 07/23/20 revealed diagnoses included dementia, generalized weakness, chronic kidney disease stage III, hyperparathyroidism, coronary artery disease, hypokalemia, and atrial fibrillation - new onset. Review of Resident #3's medication reviews revealed: -The resident's most current medication review was dated 01/09/20. -The pharmacist noted the resident was compliant with medications and the pharmacy needed to update the MAR to include the changed orders and new orders. -There were no other medication reviews in the record dated after 01/09/20. Interview with the Administrator on 04/14/21 at 3:24pm revealed: -There should be more medication reviews for Resident #3. -She did not know why they were not in the record. -She would check with the consultant pharmacist. Review of Resident #3's medication reviews faxed to the facility on 04/14/21 revealed: -There were 4 medication reviews faxed to the facility for Resident #3 that were not being	C 375		

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C 375	Continued From page 59 maintained on file in the facility. -Resident #3's medication reviews were dated 04/22/20, 07/24/20, 10/30/20, and 01/29/21. -For all 4 medication reviews, the pharmacist noted medications were in order and the FL-2 was current and updated. -There were not recommendations for any of the medication reviews for Resident #3. -The pharmacist did not document any issue with clarification of orders, medication administration, controlled substance logs, or accuracy of the medication administration records (MARs). Review of Resident #3's medication orders, MARs, and medications on hand revealed: -Medication related problems were identified during the survey that were not identified in the resident's medication reviews. -Resident #3's Timolol eye drops continued to be administered after the order was discontinued in February 2020 instead of changing to Cosopt eye drops as ordered. (Timolol and Cosopt are used to treat glaucoma.) -The residents Vitamin D 50,00 units was administered every 2 weeks instead of weekly for an undetermined amount of time when the order changed in November 2020. -Resident #3 was being administered expired Xalatan eye drops (for glaucoma). -Resident #3 had no controlled substance logs for two controlled medications ordered for the resident. -Apixaban (a blood thinner) was not documented as administered twice daily in March 2021 and April 2021 due to a transcription error on the MARs. -There were multiple omissions with no reasons for the blanks on the MARs for Resident #3's medications.	C 375		

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C 375	Continued From page 60 Refer to interview with the Administrator on 04/14/21 at 3:24pm. Refer to telephone interview with the consultant pharmacist on 04/15/21 at 3:58pm. 3. Review of Resident #1's current FL-2 dated 10/28/20 revealed diagnoses included dementia, coronary artery disease, peripheral artery disease, chronic obstructive pulmonary disease, chronic pain, colitis, and acute kidney injury. Review of Resident #1's medication reviews revealed: -The resident's most current medication review was dated 10/11/19. -The pharmacist noted to keep the prn (as needed) medications separate from the regular maintenance medications. -There were no other medication reviews in the record dated after 10/11/19. Interview with the Administrator on 04/14/21 at 3:24pm revealed: -There should be more medication reviews for Resident #1. -She did not know why they were not in the record. -She would check with the consultant pharmacist. Review of Resident #1's medication reviews faxed to the facility from the pharmacy on 04/14/21 revealed: -There were 5 medication reviews faxed to the facility for Resident #2 that were not being maintained on file in the facility. -Resident #1's medication reviews were dated 01/09/20, 04/22/20, 07/24/20, 10/30/20, and 01/29/21. -For all 5 medication reviews, the pharmacist	C 375			

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C 375	Continued From page 61 noted medications were in order and the FL-2 was current and updated. -There were no recommendations for any of the medication reviews for Resident #1. -The pharmacist did not document any issues controlled substance logs, medication administration, or accuracy of the medication administration records (MARs). Review of Resident #1's medication orders, MARs, and medications on hand revealed: -Medication related problems were identified during the survey that were not identified in the resident's medication reviews. -Resident #1 did not receive Metoprolol Tartrate as ordered in accordance with blood pressure parameters. -Resident #1 had missing controlled substance logs for Tramadol. -There were multiple omissions with no reasons for the blanks on the MARs for Resident #1's medications. Refer to interview with the Administrator on 04/14/21 at 3:24pm. Refer to telephone interview with the consultant pharmacist on 04/15/21 at 3:58pm. Interview with the Administrator on 04/14/21 at 3:24pm revealed: -A consultant pharmacist with the facility's contracted pharmacy usually did the medication reviews. -The consultant pharmacist usually came to the facility to do the medication reviews but he did not always leave a copy of the medication reviews the same day he came. -Sometimes the consultant pharmacist would email the medication reviews back to her later	C 375		

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C 375	Continued From page 62 (did not specify a time frame). -She called the consultant pharmacist today, 04/14/21, about the medication reviews not in the residents' records and he would fax them today, 04/14/21. Telephone interview with the consultant pharmacist on 04/15/21 at 3:58pm revealed: -He did not do on-site medication reviews at the facility in April 2020, July 2020, or October 2020 due to the COVID-19 pandemic. -He thought he started going back on-site to the facility for the January 2021 medication reviews but he was not sure. -When he did the medication reviews off-site, he would access the list of medications and orders in the pharmacy's computer system and review them. -He did not compare orders to the MARs documented by the MAs or check medications on hand. -When on-site, he would check the resident's records to make sure FL-2s were updated and allergy information was documented. -He would look at the MARs for refusals and he would check the prn (as needed) medications to see if any were expired. -He thought most of the orders were in the pharmacy computer system so he did not check the residents' records for additional orders. -He was generally checking the orders that were e-scribed (electronically sent) to the pharmacy by the providers. -He did not check controlled substances or the logs during the medication reviews. -He had not identified any concerns with medication orders, MAR documentation, medications on hand, or controlled substances during the medication reviews in January 2021.	C 375		

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C 453	Continued From page 63	C 453		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that	C 453		

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C 453	Continued From page 64 monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure bedrail restraints were used only after a written physician order; after a team assessment and care planning process; and that alternatives were tried prior to the restraint that would provide safety to the resident for 1 of 1 residents (#2) with full bedrails being used as restraints. The findings are: Review of Resident #2's current FL-2 dated 02/14/21 revealed: -Diagnoses included dementia without behavioral disturbance, altered mental status, hypernatremia, and urinary tract infection without hematuria. -The resident was constantly disoriented and semi-ambulatory. -The resident was incontinent of bowel and bladder. -The resident required personal care assistance by staff with bathing, dressing, and feeding. Review of Resident #2's Resident Register revealed: -The resident was admitted to the facility on 09/25/18. -The resident required assistance for dressing, bathing, nail care, getting in/out of bed, toileting,	C 453		

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NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
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C 453	Continued From page 65 hair/grooming, mouth care, and scheduling appointments. -The resident had significant memory loss and must be redirected. Review of Resident #2's previous FL-2 dated 09/09/19 revealed: -There was an order for side rails for safety. -The resident was "very busy and not safe in bed". Review of Resident #2's primary care provider (PCP) visit note dated 01/06/20 revealed: -This was a follow-up visit and the resident was drowsy and had gait instability. -The PCP noted the resident needed bedrails until ambulatory. Review of Resident #2's current assessment and care plan dated 10/26/20 revealed: -The resident was ambulatory with aide or device (type of device not noted). -The resident had no problems with the strength or range of motion of her upper extremities. -The resident was always disoriented, forgetful, and needed reminders. -The resident required supervision by staff for eating, ambulation, and transferring. -The resident required extensive assistance by staff for toileting, bathing, dressing, and grooming. -There was no documentation regarding the use of bedrails on the care plan. Observation of Resident #2 on 04/14/21 at 9:30am revealed: -The resident was sitting on the couch in the living room. -The resident replied "yeah" when asked how she was doing.	C 453			

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C 453	Continued From page 66 Observation of Resident #2's room on 04/14/21 at 9:45am revealed: -The resident was not in her room. -There were bilateral full bedrails on the resident's bed. -The bedrail against the wall was pulled halfway up. -The other bedrail was in the down position. Observation of Resident #2 on 04/14/21 at 11:08am revealed: -A medication aide / personal care aide (MA/PCA) assisted Resident #2 with transferring from a sitting position in a chair in the dining room to a standing position. -The MA/PCA held Resident #2's hand and guided the resident as the resident walked to the bathroom with no assistive device. -The MA/PCA stayed in the bathroom with the resident to assist with toileting. Observation of Resident #2 on 04/14/21 at 5:37pm revealed: -A PCA physically assisted Resident #2 with transferring from a seated position on the couch to a standing position. -The PCA held Resident #2's hands and guided the resident with walking to the dining room. Interview with the Administrator on 04/14/21 at 4:34pm revealed: -Resident #2 had bedrails because she would move around and roll out of bed. -She tried putting a mattress on the floor but the resident would still roll out of bed. Interview with a MA/PCA on 04/14/21 at 3:07pm revealed: -Resident #2 could bear weight and walk with	C 453		

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C 453	Continued From page 67 assistance. -The resident moved around in bed and could sit up on her own. -Staff pulled up the bedrail when the resident was in bed because the resident moved around so much and the bedrail kept her from falling out of bed. -She had not observed the resident try to get out of bed over the bedrail. Interview with a second MA/PCA on 04/14/21 at 5:55pm revealed: -Resident #2 had full bedrails on her bed and she pulled up the bedrail opposite the wall each night when the resident was put to bed. -She pulled up the bedrail so the resident would not roll off the bed and onto the floor. -The resident could roll herself from side to side while in bed and could roll out of the bed. -She had never found the resident on the floor. Interview with a PCA on 04/14/21 at 5:55pm revealed: -Resident #2 had bedrails on both sides of her bed, one was against the wall so she did not have to pull that one up. -She pulled the other bedrail up when the resident was put to bed at night. -Resident #2 could roll herself from side to side while in bed. -She was not sure if the resident could sit up by herself in bed. -She pulled the bedrail up so the resident would not roll out of the bed. -The resident usually slept all night. Review of Resident #2's physician's orders, progress notes, and assessments revealed: -There was no order for the bedrails to be used as restraints to include monitoring and releasing	C 453			

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C 453	Continued From page 68 of the restraint. -There was no assessment and care planning process for use of the restraint. -There was no signed consent for use of a restraint. Interview with the Administrator on 04/15/21 at 5:00pm revealed: -She got the order for Resident #2's bedrails because she was afraid the resident would fall out of bed. -She first tried lowering the bed to the floor but the resident still rolled out of bed. -She then put the mattress on the floor and the resident still rolled off the mattress. -The resident was constantly moving while in bed so she thought the bedrails were for the resident's safety. -The resident could not put the bedrails up or down by herself. -She did not think about the bedrails being a restraint so she did not get a restraint order. -She did not do an assessment and care planning process using a team approach for the use of the bedrails. -She did not get a consent from the family because she did not think it was a restraint. -It had been at least 6 months or more since the resident rolled out of bed and that was when a PCA walked in the room and saw the resident and caught her before she fell off the bed. Telephone interview with Resident #2's PCP on 04/15/21 at 4:31pm revealed: -The bedrails were ordered to keep the resident from falling out of bed. -The resident could physically roll herself out of bed. -The resident had some falls but she thought it had been 6 months or longer since she had a fall.	C 453			

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C 453	Continued From page 69 -She had not been contacted by the facility to sign any restraint orders for the bedrails. Attempted telephone interview with Resident #2's power of attorney (POA) on 04/15/21 at 4:14pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.	C 453			
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to building service equipment, medication administration, and adult care home medication aides training and competency evaluation requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees Fahrenheit (F) as evidenced by hot water temperatures higher than 116 degrees F for 6 of 6 fixtures. [Refer to Tag C105 10A NCAC 13G .0317(d) Building Service Requirements	C 912			

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C 912	Continued From page 70 (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents sampled (#1, #2, #3) including medications for glaucoma and Vitamin D deficiency (#3); medications for arthritis pain (#2); and medication for high blood pressure (#1). [Refer to Tag C330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).] 3. Based on interviews and record reviews, the facility failed to ensure 1 of 3 staff sampled (A) who administered medications had completed the medication administration clinical skills validation checklist prior to administering medications and had completed the state-approved 5-hour and 10-hour or 15-hour medication aide training courses as required. [Refer to Tag C935 G.S. 131D-4.5B(b) Adult Care Home Medication Aides Training and Competency Evaluation Requirements (Type B Violation).]	C 912		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the	C935		

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C935	Continued From page 71 Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 staff sampled (A) who administered medications had completed the medication administration clinical skills validation checklist prior to administering medications and had completed the state-approved 5-hour and 10-hour or 15-hour medication aide training courses as required.	C935		

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C935	Continued From page 72 The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented for Staff A. -There was a job description for medication aide / personal care aide (MA/PCA) in Staff A's record. -There was no medication administration clinical skills validation checklist for Staff A. -There was no documentation of Staff A completing the state-approved 5-hour and 10-hour or 15-hour medication aide training courses. -Staff A had passed the written medication aide exam on 11/21/19. Interview with the Administrator on 04/15/21 at 6:03pm revealed Staff A was hired full-time on 03/15/21 and started working full-time on 03/29/21, including administering medications. Interview with Staff A on 04/15/21 at 6:05pm revealed: -She started as "prn" (as needed) staff at the facility in October 2020 or November 2020. -She worked every other weekend at night and sometimes second shift (3:00pm - 11:00pm) when she was a prn staff person. -She started working full time in March 2021 (did not know date). -She administered medications when she worked prn and full-time. -A nurse had not checked her off and observed her administer medications at the facility. -She thought she took a 10-hour medication course when she worked at another facility, but she could not recall the date and she did not have the certificate. Review of residents' January 2021 - April 2021	C935			

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C935	Continued From page 73 medication administration records (MARs) revealed: -Staff A documented she administered medications on 3 of 31 days from 01/01/21 - 01/31/21. -Staff A documented she administered medications on 8 of 28 days from 02/01/21 - 02/28/21. -Staff A documented she administered medications on 25 of 31 days from 03/01/21 - 03/31/21. -Staff A documented she administered medications on 10 of 14 days from 04/01/21 - 04/14/21. -Staff A made error related to omissions on the MARs for multiple medications for Residents #1, #2, and #3. -Staff A did not identify medication labels and MARs did not match for multiple medications including Resident #3's Apixaban (a blood thinner) which was administered twice daily but not documented as administered on the March and April 2021 MARs. -Staff A administered expired eye drops to Resident #3. -Staff A administered Dronabinol (a controlled substance) and did not identify there was no controlled substance log for the medication. -Staff A failed to check Resident #1's blood pressure to determine if a blood pressure medication should be held based on parameters ordered by the physician. A second interview with the Administrator on 04/15/21 at 6:06pm revealed: -She was responsible for personnel records, including making sure the MAs were trained and met the requirements to administer medications. -She was aware the medication administration clinical skills validation checklist was required to	C935			

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C935	Continued From page 74 be done by a registered nurse (RN) prior to staff administering medications. -Staff A did not have a medication administration clinical skills validation checklist or the 5-hour, 10-hour, or 15-hour training courses. -She "overlooked it" and the checklist and training courses should have been completed prior to Staff A administering medications to the residents. _____ The facility failed to ensure 1 of 3 medication aides (MAs) sampled met the qualifications to administer medications to the 5 residents residing in the facility. Staff A had not been competency validated by a registered nurse with the medication aide clinical skills validation checklist and she had not completed the state-approved 5-hour and 10-hour or 15-hour medication aide training courses prior to administering medications. Staff A had made medication errors related to inaccurate documentation on the MARs; failing to compare the MARs and medication labels and identifying discrepancies; failing to document the administration of a controlled substance (CS) on a CS log; and failing to administer medications as ordered. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/15/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 30, 2021.	C935		