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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on December 17-19, 2019.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled Medication Aides (Staff A), who administered insulin and	D 164		

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obtained finger stick blood sugars for residents, completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

Review of Staff A's, medication aide, personnel record revealed:
-There was a hire date of 11/04/18.
-The Medication Clinical Skills Validation checklist was completed and dated 09/04/19.
-There was no documentation Staff A had completed training on the care of diabetic residents.

Review of a resident's September 2019 electronic Medication Administration Record (eMAR) revealed Staff A documented the administration of sliding scale insulin to a resident on 09/30/19.

Review of a resident's October 2019 eMAR revealed Staff A documented the administration of sliding scale insulin to a resident on 10/01/19, 10/03/19, 10/05/19, 10/06/19, 10/11/19, 10/17/19, 10/18/19, 10/23/19, 10/24/19, 10/29/19 and 10/30/19.

Review of a resident's November 2019 eMAR revealed:
- Staff A Staff A documented the administration of sliding scale insulin to a resident on 11/04/19, 11/05/19, 11/10/19, 11/11/19, 11/16/19 11/17/19, 11/23/19 and 11/24/19.

Review of a resident's December 2019 eMAR revealed Staff A documented the administration of sliding scale insulin to a resident on 12/05/19, 12/10/19 and 12/11/19.

Interview with Staff A on 12/18/19 at 2:20pm

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revealed:
-She had been mentoring under the second shift medication aide in September 2019.
-The facility's contracted registered nurse (RN) completed the Medication Clinical Skills Validation checklist with her on 09/04/19.
-She had been passing medications on second shift since September 2019 to the residents.
-She had been administering sliding scale and scheduled insulin to the residents since September 2019.
-She thought the RN covered diabetic care training during the Medication Clinical Skills Validation.
-She did not remember a separate training.
-She did not have a certificate indicating she had completed a course on the care of the diabetic resident.
-"The Administrator keeps all our training certificates in our personnel file."

Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 3:20pm revealed:
-The former RCC worked with the Administrator to ensure staff received the appropriate training for their position.
-She knew MAs should have training on the care of diabetic residents before administering insulin injections.
-She did not know if Staff A had received the training in the care of diabetic residents.
-She had not been directed by the Administrator as to the process for identifying and providing training for the staff.
-The RCC did not know why there was no documentation Staff A had completed training on the care of the diabetic resident in her personnel record.

Interview with the facility's contracted RN on

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D 164	Continued From page 3 12/19/19 at 10:17am revealed: -She provided training to the staff at the facility. -The former RCC would contact her and schedule required training. -She would send a copy of the certificate of completion to the Administrator or RCC as they were responsible for maintaining staff training records. -She did not keep a record of the classes she provided or the attendees. -She thought Staff A had all the necessary training to administer medications.	D 164		
D 218	10A NCAC 13F .0605 (g) Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (g) A supervisor shall meet the following qualifications: (1) be 21 years or older; (2) be a high school graduate or certified under the G.E.D. program, or have passed an alternative examination established by the Department; (3) meet the general health requirements according to Rule .0406 of this Section; (4) have at least six months of experience in performing or supervising the performance of duties to be supervised during a period of three years prior to the effective date of this Rule or the date of hire, whichever is later, or be a licensed health professional or a licensed nursing home administrator; (5) meet the same minimum training and competency requirements of the aides being supervised; and (6) earn at least 12 hours a year of continuing	D 218		

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D 218	Continued From page 4 education credits related to the care of aged and disabled persons in accordance with procedures established by the Department of Health and Human Services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 sampled staff (Staff C), who supervised Personal Care Aides, earned at least 12 hours a year of continuing education credits related to the care of aged and disabled persons. The findings are: Review of Staff C's, medication aide (MA)/Supervisor, personnel record revealed: -Staff C was hired on 03/01/14. -She had completed 4 hours of continuing education training on the aged person in 2016. -There was no documentation of continuing education training related to the care of aged and disabled persons in 2017, 2018 or 2019. Interview with Staff C on 12/18/19 at 3:20pm revealed: -She had been hired as the Resident Care Coordinator (RCC) on 12/16/19. -She knew she had completed continuing education courses (CEUs) related to dementia and the aging person, but did not remember the last course she had completed. -The former RCC would inform the staff when they were required to have additional training for compliance. -She did not know the CEU requirements were required annually for staff to be in compliance for their position.	D 218		

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D 218	Continued From page 5 -She did not know it had been several years since she had training on the care of the aged. Interview with the RCC from the sister community on 12/19/19 at 9:05am revealed: -She was training the current RCC in her new role. -The Administrator was responsible for personnel records. -The Administrator kept a handwritten sheet indicating the dates each staff person needed training. -The Administrator informed the former RCC when staff needed training. -The former RCC scheduled training classes with the contracted facility Registered nurse (RN). -She would post a sign up sheet with the names of the staff who must attend. -The RCC would submit the certificates of completion to the Administrator to be filed in the personnel records. -She was unaware of any reason that information would be missing. -She did not know where the former RCC kept the roster of staff attending training.	D 218		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews the facility failed to provide supervision to meet the needs of 1 of 5 sampled residents (Resident #2) who had three falls in less than 30 days.

The findings are:

Based on interviews and record reviews the facility did not have a fall management policy or procedure.

Review of Resident #2's current FL2 dated 10/24/19 revealed:
-Diagnoses included dementia, muscle weakness and anxiety,
-Level of care was a Special Care Unit.
-Orientation was constantly disoriented.
-Ambulatory status was semi ambulatory by using a wheelchair.
-Resident #2 was incontinent of bladder and bowel.

Review of Resident #2's Resident Register revealed an admission date of 10/24/19.

Review of Resident #2's care plan dated 11/30/19 revealed:
-There was documentation Resident #2 became agitated when his family visited.
-Resident #2 tried to stand, staff reminded him to sit down so he did not fall.
-Resident #2 tried to get out of his wheelchair without assistance often.

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D 270	Continued From page 7 -Resident #2 was totally dependent on staff for toileting, ambulation, bathing, dressing and grooming, extensive assistance for eating and transfers. -There was no documentation related to supervision needs. Review of Resident #2's New Patient Encounter form dated 10/24/19 and electronically signed by the prescribing Nurse Practitioner (NP) revealed: -Resident #2's mental status had recently declined after a surgery. -Resident #2 had generalized weakness that had worsened in the recent months, and he was in a wheelchair. -There was an order for physical therapy (PT). -Resident #2 was home bound and required 24-hour supervision and required 1+ assist to leave the facility due to his altered mental status and increase risk for falls. -Resident #2 had mobility limitations. -Resident #2 had an order for a new wheelchair. Review of Resident #2's incident report dated 11/21/19 at 7:06am revealed: -Resident #2 was found on the floor in his room between the bed and his wheelchair. -Resident #2 complained of back and neck pain. -First aide was not administered. -No injury was documented as present. -The facility staff called 911 for transport to the Emergency Room (ER). -The physician and the guardian were notified at 8:00am. -There was documentation Resident #2 returned to the facility on 11/21/19 with no new orders. -There was no documentation of interventions or increased supervision put in place to reduce falls for Resident #2.	D 270		

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Review of Resident #2's hospital ER note dated 11/21/19 revealed:
-Diagnoses included fall, strain of neck muscles.
-Documentation Resident #2 was found between the bed and nightstand.
-Emergency Medical Services (EMS) were called and applied a C-collar for transport to the ER.
-A cervical spine X-ray was obtained and read as negative.
-Resident #2 returned to the facility on 11/21/19.

Review of Resident #2's NP visit note dated 11/21/19 revealed:
-Resident #2 was being seen for a follow-up from a fall.
-Resident #2 had fallen in his room prior to the NP visit and was sent out to the ER for evaluation.
-The ER diagnoses were neck pain and fall.
-The ER completed an X-Ray the of cervical spine which were negative.
-Tylenol or Motrin were recommended for pain.
-The plan was documented as "Fall precautions per the facility policy."
-Follow-up with the NP in 1-2 months or as needed.
-The visit note was electronically signed by the NP.

Review of Resident #2's incident report dated 11/22/19 at 2:10pm revealed:
-Resident #2 was trying to get out of his wheelchair. Resident #2 "was being watched and as soon as the aide turned around [Resident #2] jumped onto the floor hitting his head on the right."
-The facility staff applied pressure to Resident #2's head until EMS arrived.
-The facility staff called 911 for transport to the ER.

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-The guardian was notified at 2:59pm.
-There was no documentation the physician was notified.
-There was documentation Resident #2 returned to the facility on 11/23/19.
-There was no documentation of interventions or increased supervision put in place to reduce falls or to increase supervision for Resident #2.

Review of Resident #2's hospital ER notes dated 11/22/19 revealed:
-Diagnoses included fall, laceration to forehead, head injury and Urinary Tract Infection (UTI).
-Documentation Resident #2 had a witnessed fall, Resident #2 had stood up from his wheelchair, falling forward hitting his head.
-There was documentation Resident #2 had a laceration to his right forehead.
-A CT of the head / spine was completed and laboratory studies performed.
-A urinalysis was obtained revealing Resident #2 had a UTI.
-Resident #2 had 9 sutures placed to his right forehead.
-Resident #2 returned to the facility on 11/23/19 with an order for antibiotic for the UTI.

Review of Resident #2's record revealed there were no NP visit notes for a follow up after the fall on 11/22/19.

Review of Resident #2's incident report dated 12/08/19 at 1:00pm revealed:
-A staff person was assisting Resident #2 with "ADLs" (activities of daily living) and Resident #2 fell hitting his head and re-opening the wound to his head that had sutures.
-The facility staff applied pressure to Resident #2 head until EMS arrived.
-The facility staff called 911 for transport to the

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ER.
-There was no documentation the physician or the guardian were notified.
-There was no documentation of interventions or increased supervision put in place to reduce falls or to increase supervision for Resident #2.

Review of Resident #2 hospital ER notes dated 12/08/19 revealed:
-The diagnosis was a fall.
-Resident #2 was attempting to get out of bed when a staff person walked by his room and saw him. She assisted Resident #2 to the floor. Resident #2 had a small laceration above the right eye. It appeared a few sutures may have "popped".
-"Reported fall. This appears to be his 3rd fall in the past month."
-A CT of the head and spine were performed.
-Blood cultures were obtained and waiting results.
-Returned to the facility on 12/08/19 with "Fall precautions".

Review of Resident #2's NP visit note dated 12/12/19 revealed:
-Resident #2 was being seen for a recent fall and ER visit.
-Resident #2 had fallen "sometime between 11/21/19 and 11/22/19" [Resident #2] was sent to the ER and had sutures placed.
-Resident #2 fell again on 12/08/19 was sent to the ER for evaluation, he had a CT of head and spine.
-Resident #2's previous placed sutures were intact on 12/08/19 visit to the ER.
-Resident #2's sutures were in place to the lacerations on the right forehead.
-The sutures were "well approximated with no drainage. No surrounding edema or erythema".
-There were orders for "Fall precautions per

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facility policy."
-There was an order for home health to remove the sutures.

Interview with a medication aide (MA) on 12/18/19 at 10:08am revealed:
-The facility did not have a fall policy.
-If a resident fell and hit their head they were to be sent to the ER for evaluation, if she was unsure if they hit their head or had an injury, she would send the resident to the ER.
-At one time they used a 15-minute check book for residents who had fallen, but they did not use it now.
-"I do the best I can to monitor the residents."
-All the residents were brought to the common area so staff could walk by and "keep an eye on them."
-She was never told to monitor Resident #2 more closely or to increase supervision after the falls.
-The RCC was responsible for informing staff when a resident needed increased supervision.
-She told the personal care aides (PCA) to "keep an eye on him (Resident #2)".
-The MAs document in a shift report book daily on all shifts when a resident fell or was sent out to the ER.
-The MAs were responsible for completing incident reports when a resident had fallen.

Interview with a PCA on 12/18/19 at 11:15am revealed:
-She did not know if the facility had a fall policy.
-All residents in a wheelchair were brought to the common area before meals and after meals so staff could "walk by are see them".
-Resident were placed together in the common area where staff could "can keep an eye on them".
-The MAs told the PCAs when a resident fell to

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"monitor them more".
-She completed 30-minute check on all residents, but she did not document, and no one ever told her to increase supervision for Resident #2.
-Resident #2 was always placed in the common area due to his falls.
-Resident #2 would try to stand up on his own but he required assistance with everything.
-Resident #2 was total care.
-She had never completed 15-minute checks on Resident #2 after the falls, or been told to increase supervision.

Interview with a second PCA on 12/18/19 at 11:30am revealed:
-She did not know if the facility had a fall policy or an increase in supervision policy.
-She monitored the residents every 2 hours and provided toileting.
-All residents were to be brought to the common area daily to be monitored more.
-Staff were constantly walking by the area or sometimes sitting in the area completing their documentation.
-She knew Resident #2 had fallen and was a high fall risk.
-She knew there was a 15-minute check book for documenting residents who required more frequent checks, but she had only used it once for another resident.
-She was never told to provide increased supervision for Resident #2 after the first fall, the second fall or the third fall.
-The MAs told the PCAs to monitor the resident more closely after they fell but they did not document.
-"Monitor more closely would be to walk by the common area more, or to sit in the common area while documenting the daily ADL log."
-She has never been instructed to increase

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D 270	Continued From page 13 supervision for Resident #2. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 12:00pm revealed: -She was new to the RCC position and her first day was 12/16/19. -The facility did not have a fall policy. -She could not recall any interventions put in place after Resident #2 had fallen three times in less than one month. -She did not know if Resident #2 was assessed for environmental issues, safety issues, improper shoe fit, toileting more often, medication reviewed or if the staff provided more frequent checks. -She was unsure if the former RCC had completed any interventions or increased supervision for Resident #2 after any of the falls. -She had never completed any interventions for Resident #2 after the falls. -She never told the staff to provide more supervision to Resident #2 because he was a high fall risk. -She knew all residents were placed in the common area daily for more frequent monitoring. Telephone interview with the NP for Resident #2 on 12/17/19 at 11:00am revealed: -The facility staff made her aware of the three falls for Resident #2. -She thought the facility staff were completing more frequent checks and following the facility fall policy for Resident #2. -She discussed options for Resident #2 after each fall with the former RCC. -The options included PT and a fall matt, but she was told by the former RCC Resident #2 always fell trying to get out of his wheelchair. -She had ordered PT on admission to the facility for Resident #2 and again on 12/12/19. -She did not know the staff had not increased	D 270		

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D 270	Continued From page 14 supervision for Resident #2 after each fall. Telephone interview with the contracted physical therapy office clinician on 12/19/19 at 10:45am revealed Resident #2 had PT ordered upon admission on 10/28/19 and had reached his maximum potential meeting his goals on 11/22/19, PT was discontinued, and they had received no new order from the facility for restarting PT or for an evaluation to treat Resident #2 for PT. Telephone interview with Resident #2's guardian on 12/19/19 at 8:05 revealed: -She had just started guardianship for Resident #2 and had not visited the facility or seen Resident #2. -The facility staff made her aware of the three falls for Resident #2. -She relied on the facility staff to provide care and supervision for Resident #2. -She knew Resident #2 would try to stand and get out of his wheelchair without assistance. -The facility had not contacted her for any interventions for increased supervision for Resident #2. -She was not aware the facility did not have a fall policy. -The NP tried to manage Resident #2's medications and reduce medications which caused sedation. -When the family visited Resident #2 it was reported Resident #2 would become agitated. -Resident #2 had a cushion in his wheelchair and the family thought the cushion was causing the falls. -She did not know the facility staff had not increased supervision or provided any interventions to reduce falls for Resident #2.	D 270		

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Review of the facility supervision policy revealed:
-All employees were trained in supervision policies and procedures.
-Staff were required to be in the facility at all times.
-Staff must be present with all meals.
-Staff should know the whereabouts of each resident.
-Do not leave the building unattended.

Interview with the RCC on 12/19/19 at 12:35pm revealed:
-The facility staff had completed a 15-minute check for Resident #2 after the second fall.
-She contacted the former RCC to question her where the documentation form was for Resident #2's 15-minute checks.
-She had found the documentation for Resident #2's 15-minute checks on 12/19/19.
-The facility's Fall risk form was to be used for increased supervision by providing 15-minute checks and documenting the checks after each fall.
-She was unsure why the Fall risk form was not completed for Resident #2 after the fall on 11/21/19 or on 12/08/19.

Review of Resident #2 facility 15-minute fall risk visual check form revelaed:
-The form was initiated on 11/23/19 at 6:00am and stopped on 11/24/19 at 11:45pm.
-There were documentation 15 minutes checks were completed for Resident #2 except on 11/24/19 from 4:00pm to 9:45pm.
-There was documentation at bottom of the form "Resident is to be visually seen every 30 minutes around the clock. This is to be documented for 48 hours after a fall."

Telephone interview with the Administrator on

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D 270	Continued From page 16 12/17/19 at 9:00am revealed she was currently out of the country and the RCC would answer all questions. _____ The facility failed to provide supervision to Resident #2 who had three falls in less than 30 days, each fall requiring ER visits with multiple CT scans performed to rule out head or neck injury, laboratory studies resulting in a positive UTI requiring antibiotics, and a head laceration with 9 sutures to Resident #2's forehead. This failure resulted in substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED January 18, 2019.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 273		

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D 273	Continued From page 17 Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 5 residents (Resident #5 and Resident #1) related to wound care treatment orders and new skin breakdown. The findings are: 1. Review of Resident #5's current FL2 dated 11/04/19 revealed: -Diagnoses included dementia and Parkinson's disease. -Recommended level of care was a Special Care Unit. -Resident #5 was incontinent of bowel and bladder. -Personal care assistance was total care. a. Review of Resident #5's facility form "Concerns from the Facility" dated 11/04/19 revealed: -The form was sent with the Resident #5 on 11/04/19 to the physician's office for orders. -The facility staff documented Resident #5 had a blister on the left heel and needed Home Health (HH). Review of Resident #5's physician's visit note dated 11/04/19 revealed: -Instructions included keep pressure off the left heel, with leg elevation to avoid pressure to the heel. -Resident #5 was to elevate the left heel daily. -Staff were to apply bunny boots to Resident #5's feet daily. -There was an order for wound care to the left heel and a surgical wound consult. -There was documentation Resident #5 required a 2+ staff assist with transfers.	D 273		

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D 273	Continued From page 18 Review of Resident #5's signed physician's order dated 11/04/19 revealed: -An order for HH to evaluate the left heel three times weekly and apply telfa dressing and wrap with kerlix. -An order to evaluate and check heel wound daily. -An order referral for the wound clinic. Review of Resident #5's HH note dated 11/05/19 revealed: -The HH nurse would see Resident #5 weekly and as needed for wound care. -Resident #5 had 1+ pitting edema to the left lower leg. -Resident #5 "grimaces when moving the left leg". -Documentation Resident #5 sat in the wheelchair most of the day. -Wound measurements were obtained to the left heel 3cm X 2cm, no drainage was noted but when the dressing was removed a slight odor was noted. -The HH nurse applied a dry kerlix to the left heel ulcer and the bunny boots to both feet. -The HH nurse documented Resident #5 needed a follow up appointment with the wound clinic weekly per the physician's order. -The HH documented she spoke to the Resident Care Coordinator (RCC) about the wound clinic orders. -The HH nurse was not aware the physician's order was for HH 3 times weekly for wound care. Review of Resident #5's HH note dated 11/10/19 revealed: -Resident #5 had 3+ pitting edema to left foot. -Measurement of the left heel ulcer length was 2.5cm X 1.5cm and the depth was 0.1cm, wound bed eschar-dry tough black brown, no odor was noted.	D 273		

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D 273	Continued From page 19 -Wound care was documented as wrapped with foam kerlix, facility staff were to complete the dressing daily when HH did not see Resident #5. Review of Resident #5's wound specialist physician's order dated 11/27/19 revealed daily wound cleaning of the left heel ulcer with sterile saline, pat dry, apply santyl (a debridement ointment) ointment to ulcer and wrap with sterile gauze dressing. Review of Resident #5's HH note dated 11/29/19 revealed: -There was documentation Resident #5 had no edema to left leg. -The left heel ulcer measured length 2.4cm X 2cm. -The ulcer was cleaned with normal saline, santyl ointment applied, non stick dressing applied then secured with kerlix and paper tape, bunny boots applied to both feet. -Facility staff were to complete the dressing changes daily for Resident #5 on the days HH were not in the facility. -Resident #5 was being followed at the wound clinic. -The HH nurse provided education to the facility staff on wound care and medication management. -"Caregivers appears to be following medication regiment." Review of Resident #5's HH note dated 12/06/19 revealed: -Ulcer to left heel was documented as eschar-dry tough black/ brown 100%. -The ulcer edges were peeling and flesh color, no signs of infection. -The left heel ulcer measured length 1.0cm X 0.5cm, depth 0.1cm.	D 273		

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-Wound care was documented as washed with water and soap, cleaned with normal saline, santyl ointment applied, telfa and wrapped with kerlix and secured with tape.
-Facility staff were to complete the dressing changes daily for Resident #5 on the days HH was not in the facility.
-Resident #5 was being followed at the wound clinic.

Review of Resident #5's HH note dated 12/10/19 revealed:
-Ulcer to left heel measured length 0.9cm X 0.6cm.
-The left heel wound was cleaned with soap and water, normal saline, santyl ointment applied, non stick dressing, kerlix wrapped and secured with tape.
-Facility staff were to complete the dressing changes daily for Resident #5 on the days HH was not in the facility.
-Resident #5 was being followed at the wound clinic.
-There was documentation the family member was present.

Telephone interview with a representative from the facility's contract pharmacy on 12/18/19 at 9:15am revealed:
-Resident #5 used an outside pharmacy for his medications.
-They received an order on 12/03/19 for santyl ointment apply to ulcer and wrap with secure gauze change every day.
-They were responsible for placing new orders on the electronic Medication Administration Record (eMAR) system.
-The pharmacy placed the order for the santyl ointment on the December 2019 eMAR.
-The facility staff were responsible for accepting

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the new order prior to administering the medication.
-If the facility staff did not accept the medication order it will not generate for them to administer.

Review of Resident #5's eMAR for December 2019 revealed:
-There was an entry for santyl ointment to ulcer and wrap with secure gauze change every day scheduled for 8:00am.
-There was no documentation the santyl ointment had been administered to the ulcer daily in December 2019.

Interview with a medication aide (MA) on 12/18/19 at 9:30am revealed:
-She did not know Resident #5's order for the santyl ointment dressing was on the December 2019 eMAR.
-She never completed the santyl dressing for Resident #5.
-HH was responsible for wound care for Resident #5 and she thought the HH nurse was responsible for the daily dressings.
-She had never contacted the physician for follow-up regarding the santyl not being administered daily to Resident #5.
-She was not aware MAs could not apply the debridement santyl ointment daily as ordered.

Interview with a second MA on 12/18/19 at 10:05am revealed:
-She knew Resident #5 had an ulcer to his left heel and HH was seeing him for dressing changes once a week.
-She was not aware the order on the December eMAR was for santyl ointment daily to Resident #5 ulcer on his left heel.
-She had never changed the dressing to Resident #5's left heel or applied the santyl ointment.

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-She had never contacted the physician for follow-up regarding the order for daily santyl dressing for Resident #5.

Telephone interview with the Home Health nurse on 12/18/19 at 10:25am revealed:
-Resident #5's date of service started on 11/05/19 for a left heel ulcer.
-Her skilled nurse visits were once weekly and as needed.
-She was not aware the physician had ordered HH visits 3 times weekly.
-She knew the order for the santyl ointment dressing was to be changed daily.
-Santyl was a debridement ointment used to remove eschar (dead skin tissue) for wounds while promoting new growth of skin tissue.
-She relied on the facility staff to change Resident #5's santyl dressing daily when she was not in the facility.
-Resident #5's santyl ointment was in the medication cart and she left supplies weekly in Resident #5's room for the dressing changes.
-"If the santyl ointment was not applied as ordered the ulcer would not heal properly, or could possible cause infection to the ulcer.
-She was not aware the MAs were not able to apply the debridement ointment santyl to Resident #5's left heel daily until 12/18/19.
-The facility staff had never made her aware they could not complete the daily santyl dressing for Resident #5's.
-She had never contacted the wound clinic's physician for follow up regarding the santyl ointment daily orders for Resident #5.

Observation of medications on hand for Resident #5 on 12/18/19 at 9:11am revealed a partial opened tube of santyl ointment 30 grams.

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D 273	Continued From page 23 Observation of Resident #5's dressing supplies located in his room on 12/18/19 at 9:22am revealed there were several rolls of kerlix gauge and tape in Resident #5 nightstand drawer. Interview with the current Resident Care Coordinator (RCC) on 12/18/19 at 10:45am revealed: -Resident #5 had a wound clinic appointment this afternoon on 12/18/19. -She knew Resident #5 was being seen by HH for wound care to his left heel. -She was unsure how often HH was seeing Resident #5. -Resident #5 was being followed by the wound specialist for a left heel ulcer. -She was not aware of the daily santyl dressing order for Resident #5. -She had never contacted the wound specialist or the NP in regard to the daily santyl ointment dressing changes for Resident #5 not being completed. -She did not know santyl was a debridement ointment for debridement of ulcers. -She did not know the santyl ointment was on the eMAR for December 2019 scheduled daily at 8:00am. -She did not know the MAs could not administer santyl debridement ointment. -She relied on the HH nurse to follow up with new orders for dressing changes and to contact the physician in regards to the ulcer dressing and condition of the ulcer. -"The HH nurse should know the MAs were not qualified to use the santyl." Interview with an RCC from a sister facility on 12/18/19 at 11:00am revealed: -She was training the current RCC in her new role.	D 273		

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-She knew the MAs could not apply the debridement ointment santyl to Resident #5's ulcer daily.
-The HH nurse should know the MAs cannot apply the santyl ointment daily to Resident #5's left heel ulcer.
-The HH nurse was responsible for wound care and wound care orders for Resident #5.
-The HH nurse should have never assumed the MAs were completing the santyl daily dressings when the MAs were not documenting completing the wound care on the eMAR.
-The former RCC was responsible for communicating with the physician when an order cannot be completed by the MAs.
-The former RCC should have contacted the wound clinic for other alternative medications they could have used.

Telephone interview with Resident #5's responsible party on 12/18/19 at 5:30pm revealed:
-She was in the facility daily.
-She knew Resident #5 had an ulcer to his left heel and HH was following his wound care.
-She had seen Resident #5's ulcer to his left heel on 11/27/19 at the wound specialist's office.
-"The heel looked bad it was black and nasty."
-She knew on 11/27/19 Resident #5's left heel dressing was to be completed daily.
-She thought the facility staff were applying Resident #5's dressing changes daily when the HH nurse was not in the facility.
-When she visited Resident #5 most of the time he was in the common area in his wheelchair and his socks and bunny boots were on.
-She had gone with Resident #5 to the follow-up wound specialist appointment on 12/18/19.
-The physician had changed the wound care orders and requested a follow-up visit in one

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month.
-She thought Resident #5's left heel ulcer was getting better.

Attempted telephone interview with the wound care specialist on 12/18/19 at 4:25pm, on 12/19/19 at 9:05am, on 12/19/19 at 10:42am and on 12/19/19 at 12:45pm was unsuccessful.

Telephone interview with Resident #5's facility Nurse Practitioner on 12/18/19 at 2:53pm revealed:
-She saw Resident #5 in the facility 2 times for facility concerns.
-Resident #5 was being followed by another physician as well.
-The facility never contacted her regarding Resident #5's wound care dressing order for santyl ointment daily.
-"That is not possible to do santyl ointment in an Assisted Living."
-"If the facility would have reached out to me, I would have changed the order or contacted the prescribing physician."

Refer to telephone interview with the Administrator on 12/17/19 at 9:00am.

b. Review of the HH note dated 12/10/19 for Resident #5 revealed:
-Two new pressure ulcers were identified as Stage 2 located on right upper buttocks, measured length 1.5cm width 1.0 and a Stage 1 located on the right lower buttocks measured length 3.0cm width 1.5cm.
-The left heel wound was cleaned with soap and water, normal saline, santyl ointment applied, non sick dressing, kerlix wrapped and secured with tape.
-Duoderm was applied to the new pressure ulcers

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located on the right upper buttock.
-There was documentation the family member was present.
-There was no documentation of notification to Resident #5's physician for the 2 new pressure ulcers.
Interview with a medication aide (MA) on 12/18/19 at 9:30am revealed:
-She did not know Resident #5 had 2 additional pressure ulcers to his right upper and lower buttock region.
-HH had never informed her of the 2 new pressure ulcers.

Interview with a second MA on 12/18/19 at 10:05am revealed:
-She did not know Resident #5 had 2 additional pressure ulcers to his right upper and lower buttock region.
-HH had never informed her of the 2 new pressure ulcers.

Telephone interview with the HH nurse on 12/18/19 at 10:25am revealed:
-Resident #5's date of service started 11/05/19 for a left heel ulcer.
-Her skilled nurse visits were once weekly and as needed.
-The family was present on 12/10/19 during her wound care visit for Resident #5.
-The family member had told her Resident #5 had 2 additional pressure ulcers to the buttock region.
-She had treated the 2 new pressure ulcers on 12/10/19.
-She had not contacted the physician for additional orders for the 2 new pressure ulcers.

Review of Resident #5's facility progress notes for the HH agency to complete documentation for each visit revealed:

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-There was no documentation of a HH nurse visit dated 12/10/19.
-There was documentation of a HH nurse visit dated 12/19/19, nurse saw Resident #5 for wound care to left heel, and right upper buttocks.
-There was no documentation the physician was notified of the right upper buttock pressure ulcer.

Interview with the current Resident Care Coordinator (RCC) on 12/18/19 at 10:45am revealed:
-She knew Resident #5 was being seen by HH for wound care to his left heel.
-She did not know Resident #5 had 2 additional ulcers to this right buttocks or that HH was treated the ulcers.
-She relied on the HH nurse to inform the facility staff of new wounds to the residents when they were completing wound care.
-The HH agency were to document in the resident's record when they completed wound care or see residents in the facility.

Telephone interview with Resident #5's responsible party on 12/18/19 at 5:30pm revealed:
-She was in the facility daily.
-She had told the HH nurse on 12/10/19 about the 2 additional wound areas to Resident #5's buttocks.
-Resident #5 sat in the wheelchair most of the day and she had concerns of skin breakdown.
-She had gone with Resident #5 to the follow-up wound specialist appointment on 12/18/19.
-The wound specialist physician was not aware of the 2 areas on Resident #5 buttocks until she informed the physician on 12/18/19 when she accompanied Resident #5 to the office visit.

Attempted telephone interview with the wound

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care specialist on 12/18/19 at 4:25pm, on 12/19/19 at 9:05am, on 12/19/19 at 10:42am and on 12/19/19 at 12:45pm was unsuccessful.

Telephone interview with Resident #5's facility Nurse Practitioner on 12/18/19 at 2:53pm revealed:
-She had seen Resident #5 in the facility 2 times for facility concerns.
-Resident #5 was being seen by another physician as well.
-She was not aware of the 2 ulcers to Resident #5's right buttock region.
-The facility staff should contact the primary physician with and new skin breakdown for Resident #5.

Refer to telephone interview with the Administrator on 12/17/19 at 9:00am.

2. Review of Resident #1's current FL2 dated 12/12/19 revealed:
-Diagnoses included dementia, anemia and Type 2 diabetes.
-Resident #1 was incontinent of bowel and bladder
-Personal care assistance was total care.
-Resident #1 was not able to make her needs known due to her advanced stage of dementia.
-The recommended level of care was a Special Care Unit.

a. Review of Resident #1's physician assessment during hospital admission dated 11/20/19 revealed Resident #1 was admitted to the hospital with a left hip decubitus ulcer with eschar formation and surrounding cellulitis.

Review of the hospital FL2 dated 12/09/19 revealed:

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-Diagnoses included dementia, anemia and Type 2 diabetes.
-Resident #1 was incontinent of bowel and bladder
-Level of personal care assistance was total care.
-The resident was not able to make her needs known due to her advanced stage of dementia.
-An active problem on discharge was the left hip wound.
-The wound care consult included "paint (the left hip area) with betadine, pad with foam, and change every other day, or as needed".

Interview with the Hospice Registered nurse (RN) on 12/17/19 at 12:00pm revealed:
-Resident #1 was a new client for her.
-She had visited Resident #1 once before on 12/10/19.
-She had not performed a skin assessment of Resident #1 at that time.
-She was not notified by the facility staff Resident #1 had any areas of skin breakdown.
-She did not know of any wound orders received by Hospice for Resident #1.
-She was at the facility for Resident #1's routine visit on 12/17/19.

Observation of Resident #1's skin assessment by the Hospice RN on 12/17/19 at 12:20pm revealed:
-There was a left hip wound with black eschar and the surrounding tissue was reddened.
-There was no dressing covering the wound.

Interview with the first shift personal care assistant (PCA)/medication aide (MA) on 12/17/19 at 12:05pm revealed:
-Resident #1 had been admitted to the facility from the hospital on 12/09/19.
-There was a wound dressing on the left hip when

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she was admitted.
-She had never seen the dressing changed.
-She was not aware of any orders to change the dressing.
-The dressing fell off last Sunday.

Interview with Resident #1's primary care physician (PCP) on 12/18/19 at 4:30pm revealed:
-She assessed Resident #1 upon admission on 12/10/19.
-She was only aware of the left hip wound.
-Hospice was the primary care provider and as such they would be following the wound care.
-She would have referred Resident #1 for a wound consult based on the discharge summary from the hospital.

Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 12:00pm revealed:
-Resident #1 had been discharged from the hospital to the facility on 12/09/19.
-She former RCC had processed Resident #1's admission to the facility.
-Resident #1 was under the primary care of Hospice.
-She did not know of any wound care orders for Resident #1.
-She had not reviewed the hospital discharge orders for Resident #1.
-She did not know of the wound care consult orders on the hospital discharge summary.

Telephone interview with the Hospice Preceptor RN on 12/17/19 at 12:45pm revealed:
-There were no wound orders for Resident #1 post hospital discharge.
-The Hospice RN should conduct a complete assessment every resident post hospital discharge.
-The facility should have presented the skin

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assessment that was completed upon admission to the Hospice nurse.
-With Resident #1 presenting with 3 covered areas (the left hip, left heel and sacrum) upon assessment, the facility should have requested Hospice to provide wound care.
-The discharge summary with the wound consult orders should have been forwarded to Hospice.

Refer to telephone interview with the Administrator on 12/17/19 at 9:00am.

b. Review of Resident #1's physician assessment during the hospital admission, dated 11/20/19, revealed Resident #1 also presented with a left heel pressure sore.

Review of the hospital FL2 dated 12/09/19 revealed:
-Active problems on discharge included a left heel pressure sore.
-Continue with supportive care and padding.
-Pad with foam and change every 3 days and as needed.
-Off load heels (remove pressure from heels).

Review of Resident #1's skin assessment on 12/09/19 revealed:
-The MA conducted a skin assessment on 12/09/19 upon Resident #1's admission to the facility.
-There was a handwritten note at the bottom of the assessment - "heel and left foot wound covering".

Interview with the Hospice Registered nurse (RN) on 12/17/19 at 12:00pm revealed:
-She did not know of any skin breakdown on Resident #1's left heel.
-She had not received any wound care orders for

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Resident #1's left heel.
-She saw the blue padded booties on Resident #1's dresser but did not know why they were there.

Observation of Resident #1's skin assessment by the Hospice RN on 12/17/19 at 12:20pm revealed:
-There was a left heel wound measuring approximately 2 x 3 centimeters.
-The area had a yellow crusting and the surrounding skin was reddened.
-There was no dressing covering the wound.

Observation on 12/17/19 at 12:50pm revealed 2 large blue padded booties on Resident #1's dresser.

Interview with the Resident Care Coordinator(RCC) on 12/18/19 at 12:00pm revealed:
-She did not know Resident #1 had a left heel wound.
-She did not know of the wound care consult orders on the hospital discharge summary.
-She knew the blue booties were in Resident #1's room but she had not seen any orders to apply them.
-Hospice was the primary care provider for Resident #1.

Interview with the first shift personal care assistant (PCA)/medication aide (MA) on 12/17/19 at 12:30pm revealed:
-The blue padded booties were sent from the hospital with Resident #1 on admission to the facility.
- She did not know why the booties were sent with Resident #1 and they had been on the dresser since admission.

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-There was a wound covering on Resident #1's left heel on admission.
-The wound covering fell off "over the weekend".
-She did not know of any orders for wound care or "off loading" the heels for Resident #1.

Telephone interview with the Hospice Preceptor RN on 12/17/19 at 12:45pm revealed:
-There were no wound orders for Resident #1 post hospital discharge.
-The Hospice RN should conduct a complete assessment every resident post hospital discharge.
-The facility should have presented the skin assessment that was completed upon admission to the Hospice nurse.
-With Resident #1 presenting with 3 covered areas (the left hip, left heel and sacrum) upon assessment, the facility should have requested Hospice to provide wound care.
-The discharge summary with the wound consult orders should have been forwarded to Hospice.

Refer to telephone interview with the Administrator on 12/17/19 at 9:00am.

c. Review of the hospital FL2 dated 12/09/19 revealed:
-Active problems on discharge included a sacral wound (no dimensions).
-The wound care consult included pad the sacral area with an aquacel foam and change every day and as needed.
-An order to turn the resident every 2 hours.

Interview with the Hospice Registered nurse (RN) on 12/17/19 at 12:00pm revealed:
-She did not know of any skin breakdown on Resident #1's sacrum.
-She had not received any wound care orders for

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D 273	Continued From page 34 Resident #1's sacral area. Observation of Resident #1's skin assessment by Hospice RN on 12/17/19 at 12:20pm revealed: -There was an open area on the sacrum less than 1 centimeter in diameter. -The surrounding skin was reddened. -There was no dressing covering the wound. Interview with the first shift personal care assistant (PCA)/medication aide (MA) on 12/17/19 at 12:30pm revealed: -There was a wound covering on Resident #1's sacrum on admission to the facility from the hospital. -The wound covering fell off on Sunday (12/15/19). -She did not know of any orders for wound care for the sacral area.. Review of Resident #1's skin assessment on 12/09/19 revealed: -The MA conducted a skin assessment on admission for Resident #1. -There was a handwritten note at the bottom of the assessment -"patch on the buttocks". Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 12:00pm revealed: -She did not know Resident #1 had an open area on her sacrum. -She did not know of the wound care consult orders on the hospital discharge summary for the sacral area. Telephone interview with the Hospice Preceptor RN on 12/17/19 at 12:45pm revealed: -There were no wound orders for Resident #1 post hospital discharge. -The Hospice RN should conduct a complete	D 273		

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assessment every resident post hospital discharge.
-The facility should have presented the skin assessment that was completed upon admission to the Hospice nurse.
-With Resident #1 presenting with 3 covered areas (the left hip, left heel and sacrum) upon assessment, the facility should have requested Hospice to provide wound care.
-The discharge summary with the wound consult orders should have been forwarded to Hospice.

Refer to telephone interview with the Administrator on 12/17/19 at 9:00am.

d. Observation during initial tour on 12/17/19 at 11:10am revealed:
-Resident #1 was sitting in a wheelchair in the common area with arms folded across her chest.
-On the right forearm there was a dry dressing approximately 4 inches wide.
-There was dried bloody drainage on the edges of the dressing.

Interview with first shift medication aide (MA) on 12/17/19 at 11:20am revealed:
-She did not know when Resident #1 sustained an injury to her right forearm.
-Resident #1 had a skin tear and she had been covering it with a dry dressing until the physician assessed.
-The physician should be in the facility tomorrow (12/18/19).

Interview with the second shift MA on 12/17/19 at 3:00pm revealed
-Resident #1 could be resistant to care and agitated with transfers.
-Resident #1's skin was very fragile.
-The skin tear to the right forearm happened

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D 273	Continued From page 36 Friday night (12/13/19). -The personal care aide (PCA) was transferring her from the wheelchair to the bed, and Resident #1 pulled her arm away. -She documented the incident in the progress notes and reported to the Resident Care Coordinator (RCC). -She was treating the area with an antibiotic cream and wrapping it in a dry dressing. -The staff notified the physician's of the resident's non-emergency issues when the physicians come to the facility. Review of the facility Special Care shift notes dated 12/13/19 revealed: -The MA on 3rd shift documented Resident #1 had a skin tear to the right arm. -Resident #1 was up all night "yelling and tearing her dry brief off". Interview with the third shift MA on 12/18/19 at 8:45am revealed: -Resident #1 sustained a skin tear to her right forearm on 12/13/19, second shift. -She worked third shift and the RCC was not in the building. -She entered the information on the Special Care shift report. -She did not contact the physician on her shift since it was not an emergency. Interview with the Hospice Registered nurse (RN) on 12/17/19 at 12:00pm revealed: -Resident #1 was a new client on her caseload. -She had visited Resident #1 once before on 12/10/17. -She was at the facility for a routine visit for Resident #1. -She did not know Resident #1 had a skin tear on her right forearm until she arrived.	D 273		

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D 273	Continued From page 37 -The staff told her the skin tear happened Sunday, 12/15/19. -She had not evaluated the skin tear at this time. Observation of Resident #1's skin assessment by Hospice RN on 12/17/19 at 12:20pm revealed: -The right lateral forearm had a skin tear which measured 9 x 4.5 x 0.1 centimeters. -The epidermis layer of the skin was removed with a small amount of serous exudate. Interview with the Hospice RN Preceptor on 12/17/19 at 12:45pm revealed: -Hospice resumed care post hospital discharge on 12/09/19 at the present facility. -She was training the current RN assigned to provide care to Resident #1. -Hospice protocols clearly state falls, skin breakdown, skin tears, any change in condition, should be reported immediately to Hospice. -The Hospice triage team was available by telephone 24/7. -The triage team will send a nurse to the facility to assess the situation and prescribe treatment. -The facility should not have waited from 12/13/19-12/17/19 to inform Hospice Resident #1 had a skin tear on the right forearm. -The facility did not have staff trained to complete assessments of this nature. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 12:00pm revealed: -She did not know Resident #1 had a skin tear to the right forearm. -She did not know when it occurred. -The MA on the incoming shift should read the shift notes and report to the RCC if necessary. -She did not generally read the shift notes. -She was not informed by the MAs Resident #1 had a skin tear.	D 273		

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D 273	Continued From page 38 Telephone interview with the Hospice Preceptor RN on 12/17/19 at 12:45pm revealed: -There were no wound orders for Resident #1 post hospital discharge. -The Hospice RN should conduct a complete assessment every resident post hospital discharge. -The facility should have presented the skin assessment that was completed upon admission to the Hospice nurse. -With Resident #1 presenting with 3 covered areas (the left hip, left heel and sacrum) upon assessment, the facility should have requested Hospice to provide wound care. -The discharge summary with the wound consult orders should have been forwarded to Hospice. Review of Resident #1's record revealed there were no new orders for treatment had been sent to the facility staff for the treatment of Resident #1's right forearm skin tear as of 12/19/19. Refer to telephone interview with the Administrator on 12/17/19 at 9:00am. _____ Telephone interview with the Administrator on 12/17/19 at 9:00am revealed she was currently out of the country and the RCC would answer all questions for the survey team. _____ The facility failed to assure physician notification for Resident #5 related to Santyl a debridement ointment dressing changes ordered daily and could not be administered by the facility staff; no notification to the wound care physician specialist of 2 new pressure ulcers a Stage 1 and a Stage 2 confirmed and documented by the HH nurse. Hospice was not notified of the wound care	D 273		

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D 273	Continued From page 39 orders post hospital discharge for the left hip, left heel and sacral area, and Hospice was not notified for 4 days of a large skin tear on the right forearm (Resident #1). This failure placed residents at substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED January 18, 2019.	D 273		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to implement an activity program that promoted the active involvement of the residents. The findings are: Observation of the December 2019 activities calendar posted in the main hallway on 12/17/19	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026066	A. BUILDING: _____ B. WING _____	R 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR SPECIAL CARE UNIT	3017 DUNN ROAD FAYETTEVILLE, NC 28301

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D 315	Continued From page 40 at 10:00am revealed: -Activities included for December 2019 were "Daily Chronicles", movies, exercise, Happy Hour and Bingo once a week, a Pastor from a local church twice a week, crafts twice a week. -These activities were repeated each week at the same time. -There were no activities for the residents scheduled on the weekends. Observation on 12/17/19 between 8:30am-12:30pm and 2:30pm-4:00pm revealed: -The activity for 9:00am was Daily Chronicles". -The residents who were non ambulatory in wheelchairs were positioned in front of the television in the common area a morning news program was presented. -There was no staff interaction to engage the residents in the content of the viewing. -The residents were positioned in front of the television in the common area after lunch watching a movie. -The non ambulatory residents were positioned in front of the television in the common area after meals until the next meal. -Ambulatory residents walked the halls, napped in their rooms or periodically sat in the common area. Observation on 12/18/19 between 8:30am and 11:30am revealed: -The activity for 9:00am was Daily Chronicles". -The residents who were non ambulatory in wheelchairs were positioned in front of the television in the common area and a morning news program was presented. -There was no staff interaction to engage the residents in the content of the viewing. -The activity for 11:00am was Christmas Carols. -There was no organized singing of Christmas	D 315		

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D 315	Continued From page 41 Carols. Observation on 12/18/19 at 10:00am of a locked room titled "Activity Room" revealed: -There was a desk, tables, a counter top and a few chairs in the room. -There were multiple boxes and plastic bins on the floor and tables with items tossed haphazardly inside. -There were multiple items strewn across the desk and floor. -What could have been art and craft supplies were scattered around the room. -There were items which appeared to be unrelated to activities stored in the room. Interview with the Activity Director on 12/18/19 at 12:40pm revealed: -She had been hired as the Activity Director in July of 2019. -She was not certified as an Activity Director. -She was responsible for creating and posting the activity calendar. -She did not submit the calendar to anyone for review before posting. -She also directed the activities. -Daily Chronicles was the title for current events. -She left newspapers around the common area and put the morning news program on the television in the common area for the residents to be aware of current events. -She did not do any activities today because she was so busy. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 3:45pm revealed: -The staff assist the Activity Director with activities with the residents. -The staff had sing alongs and danced with the residents.	D 315		

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D 315	Continued From page 42 -The AD has\d been busy this week with the Administrator on vacation. Interview with the RCC from the sister community on at revelaed: -Activities with a Special Care population should be engaging. -The residents need to be stimulated. -The Activity Director has been busy with the Administrator on vacation. -The staff should be assisting her with activities for the residents. Based on observations, interviews and record reviews it was determined the residents were not interviewable.	D 315		
D 352	10A NCAC 13F .1003(a) Medication Labels 10A NCAC 13F .1003 Medication Labels (a) Prescription legend medications shall have a legible label with the following information: (1) the name of the resident for whom the medication is prescribed; (2) the most recent date of issuance; (3) the name of the prescriber; (4) the name and concentration of the medication, quantity dispensed, and prescription serial number; (5) directions for use stated and not abbreviated; (6) a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed; (7) the expiration date, unless dispensed in a single unit or unit dose package that already has an expiration date; (8) auxiliary statements as required of the medication; (9) the name, address, telephone number of the	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 352	Continued From page 43 dispensing pharmacy; and (10) the name or initials of the dispensing pharmacist. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure insulin pens and vials were properly labeled for 3 of 5 sampled residents (Residents #6, #7,and #8). The findings are: 1. Review of Resident #6's current FL2 dated 07/05/19 revealed: -Diagnoses included Type 2 diabetes. -There was an order for Humalog 100units Kwikpen (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale 3 times daily before meals. Observation of Resident #6's medications on hand on 12/17/19 at 10:40am revealed: -In the top drawer of the medication cart there was a Humalog Kwikpen labeled with Resident #6's name. -There was no label regarding the opened date of the pen. Review of Resident #6's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog KwikPen inject as directed per sliding scale three times daily to be administered at 6:30am, 12:30pm and 5:30pm. -Humalog was administered 45 out of 57 possible opportunities. -There was an entry for fingerstick blood sugar (FSBS) readings three times daily.	D 352		

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D 352	Continued From page 44 -FSBS ranged from 75-292. Interview with the first shift medication aide (MA) on 12/17/19 at 8:35am revealed: -The Humalog Kwik Pen belonged to Resident #6. -She had been using the pen to administer insulin to Resident #6 as needed. -The Humalog insulin pen was to be discarded 28 days after opening. -She had not opened this pen, and did not know the date it was opened. -She had not noticed the open date was not on the pen. Interview with the second shift MA on 12/17/19 at 3:30pm revealed: -The Humalog Kwik Pen belonged to Resident #6. -She had been using the pen to administer insulin to Resident #6 as needed. -She did not open this insulin pen, and did not know the date it had been opened. -She had not noticed the open date was not on the pen. Telephone interview with the facility's contracted pharmacist on 12/18/19 at 10:00am revealed: -The facility was on a monthly cycle fill for their medications. -Insulin pens and vials did not come in the monthly cycle fill batch. -The facility staff contacted the pharmacist and requested a refill for insulin pens and vials as needed. -One Humalog KwikPen was filled for Resident #6 on 11/07/19. -The manufacturer's expiration date for the Humalog KwikPen was 28 days. -Twenty eight days after opening the pen it should	D 352		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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be discarded and a refill pen requested.
-After the expiration date has passed the insulin was not as effective, and the resident's blood sugar could become erratic.
-The best practice with an insulin pen or vial which did not have an open date was to replace the insulin pen or vial with a new one.

Refer to interview with the first shift medication aide(MA) on 12/17/19 at 8:35am.

Refer to interview with the second shift MA on 12/17/19 at 3:30pm.

Refer to interview with the third shift MA on 12/18/19 at 9:35am.

Refer to interview with the Resident Care Coordinator (RCC) on 12/18/19 at 11:51.

Refer to interview with the primary care physician (PCP) on 12/18/19 at 4:30pm.

2. Review of Resident #7's current FL2 dated 08/15/19 revealed:
-Diagnoses included Type 2 diabetes mellitus.
-There was an order for Lantus Solostar 100units, administer 12 units every morning (a slow acting insulin used to lower elevated blood sugar levels)
.

There was a subsequent physician's order dated 11/10/19 for Lantus Solostar 100units administer 18 units every morning.

Observation of Resident #7's medications on hand on 12/17/19 at 10:45am revealed:
-In the top drawer of the medication cart there was a Lantus Solostar pen labeled with Resident #7's name.

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D 352	Continued From page 46 -There was no label regarding the opened date of the pen. Review of Resident #7's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus Solostar 100units administer 18 units every morning at 8:00am. -Lantus Solostar was administered 16 out of 16 possible opportunities. Interview with the first shift medication aide (MA) on 12/17/19 at 8:35am revealed: -The Lantus Solostar pen belonged to Resident #7. -She had been using the pen to administer insulin to Resident #7 every morning at 8:00am. -She had not opened this pen, and did not know the date it was opened. -She had not noticed the open date was not on the pen. Telephone interview with the facility's contracted pharmacist on 12/18/19 at 10:00am revealed: -One Lantus Solostar pen was filled for Resident #7 on 12/02/19. -The manufacturer's expiration date for the Lantus Solostar pen was 17 days. -Seventeen days after opening the pen it should be discarded and a refill pen requested. -After the expiration date has passed the insulin was not as effective, and the resident's blood sugar could become erratic. -The best practice with an insulin pen or vial which did not have an open date was to replace the insulin pen or vial with a new one. Refer to interview with the first shift medication aide(MA) on 12/17/19 at 8:35am.	D 352		

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D 352	Continued From page 47 Refer to interview with the second shift MA on 12/17/19 at 3:30pm. Refer to interview with the third shift MA on 12/18/19 at 9:35am. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/19 at 11:51. Refer to interview with the primary care physician (PCP) on 12/18/19 at 4:30pm. 3. Review of Resident #8's current FL2 dated 07/26/19 revealed: -Diagnoses included Type 2 diabetes mellitus, insulin dependent. -There was an order for Novolog Flexpen, administer as directed per sliding scale three times daily before meals (a rapid acting insulin used to lower elevated blood sugar levels). Observation of Resident #8's medications on hand on 12/17/19 at 10:55am revealed: -In the top drawer of the medication cart there was Novolog Flexpen labeled with Resident #8's name. -There was no label regarding the opened date of the pen. Review of Resident #8's December 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flexpen administer as directed per sliding scale three times daily before meals, at 8:00am, 12:00pm and 4:00pm. -Novolog Flexpen was administered 55 out of 57 possible opportunities. -There was an entry for fingerstick blood sugar readings three times daily before meals at	D 352		

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D 352	Continued From page 48 8:00am, 12:00pm and 4:00pm. -Fingerstick blood sugar readings ranged from 136-300. Telephone interview with the facility's contracted pharmacist on 12/18/19 at 10:00am revealed: -Resident #8's medications were "Profile Only", which meant they were entered into the computer but not provided by their pharmacy. -Resident #8 received his medications from another pharmacy. -Novolog Flexpen 100units administer as directed per sliding scale three times daily before meals was on Resident #8's profile. Interview with the first shift medication aide (MA) on 12/17/19 at 8:35pm revealed: -The Novolog Flexpen belonged to Resident #8. -She had been using the pen to administer insulin to Resident #8 as needed. -The Novolog insulin pen was to be discarded 28 days after opening. -She had not opened this pen, and did not know the date it was opened. -She had not noticed the open date was not on the pen. Interview with the second shift MA on 12/17/19 at 3:15pm revealed: -The Novolog Flexpen belonged to Resident #8. -She had been using the pen to administer insulin to Resident #8 as needed. -She did not open this insulin pen, and did not know the date it had been opened. -She had not noticed the open date was not on the pen. Refer to interview with the first shift medication aide (MA) on 12/17/19 at 8:35am.	D 352		

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D 352	Continued From page 49 Refer to interview with the second shift MA on 12/17/19 at 3:30pm. Refer to interview with the third shift MA on 12/18/19 at 9:35am. Refer to interview with the Resident Care Coordinator (RCC) on 12/18/19 at 11:51am. Refer to interview with the primary care physician (PCP) on 12/18/19 at 4:30pm. _____ Interview with the first shift medication aide (MA) on 12/17/19 at 8:35am revealed: -It was the responsibility of the MA to label the insulin pens and vials with the date they were opened. -She identified pre-labeled stickers that were to be affixed to the pens and insulin vials with a space for the open date. Interview with the second shift MA on 12/17/19 at 3:30pm revealed: -It was the responsibility of the MAs to label the insulin pens, vials, creams and inhalers with the date they were opened. -There were labels on the medication cart to place on these items with a space for the open date. Interview with the third shift MA on 12/18/19 at 9:35am revealed: -The former RCC was supposed to train her on the correct process for cart audits and the frequency. -The RCC never trained her. -She had never completed a cart audit. -She did not administer insulin on her shift, so she never opened an insulin pen or vial.	D 352		

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D 352	Continued From page 50 Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 11:51am revealed: -The MAs were responsible for their medication carts. -The MAs were to order medications if needed, remove expired medications from the cart and label insulin pens, vials, creams and inhalers with an open date or expiration date. -The former RCC was completing cart audits as well as the third shift MAs. -She had not completed a cart audit and did not know how often cart audits had been completed in the past. -She did not have documentation as to when the last medication cart audit was or what the policy for cart audits was. Interview with the primary care physician (PCP) on 12/18/19 at 4:45pm revealed: -It was her expectation residents' insulin pens and vials were to be dated upon opening. -It was her expectation the facility would follow manufacturer's guidelines for expiration dates of all medications, especially insulin. -She assumed insulin past the expiration date increasing lost the effectiveness of controlling blood sugar, but she would defer to a pharmacist for more accurate information. -She would review the residents' blood sugar levels as one indicator of the effectiveness of the insulin.	D 352		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments	D 358		

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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observation, interviews and record reviews, the facility failed to administer medications as ordered by a physician for 2 of 5 sampled residents (Resident #3) administered glipizide (an antidiabetic medication) without an order and Resident #5 not administered Flomax 0.4mg (used to improve urination flow in men) for 12 consecutive days.

The finding are:

1. Review of Resident #3's current FL2 dated 07/18/19 revealed:
-Diagnoses included dementia and diabetes.
-Current level of care was for a Special Care Unit.
-Medications included glipizide (used to treat diabetes) 10mg daily.

Review of Resident #3's physician's orders revealed:
-An order dated 08/30/19 to check Finger Stick Blood Sugars (FSBS) daily.
-Another order dated 09/18/19 discontinue glipizide 10mg and start Januvia (used to treat diabetes) 50mg daily.

Review of Resident #3's hospital discharge summary dated 12/18/19 revealed:
-Resident #3's was diagnosis was syncope.
-Resident #3 was in the dining room and her face had fallen into her plate.

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-There was documentation Resident #3 had swelling on the right side of her head.
-Resident #3's FSBS was documented as 115 upon arrival but dropped to 48 during the emergency room (ER) visit.
-Resident #3 was administered dextrose solution intravenously (IV) as well as IV fluids.
-Resident #3 had a chest X-ray, an electro-cardiograph, a urinalysis and laboratory studies performed all results were negative.
-Resident #3 was discharged back to the facility on 12/18/19.

Review of Resident #3's electronic Medication Administration Record (eMAR) for September 2019 revealed:
-There was an entry for Glipizide 10mg daily scheduled for 8:00am and "DC'ed" (discontinued) was documented on 09/18/19.
-There was an entry for Januvia 50mg daily scheduled for 8:00am with documentation the medication had been administered 09/19/19 through 09/30/19.
-There was documentation the FSBS was 61 on 09/26/19 and the FSBS was 55 on 09/30/19.

Review of Resident #3's eMAR for October 2019 revealed:
-There was an entry for Januvia 50mg daily scheduled for 8:00am with documentation the medication had been administered 10/01/19 through 10/31/19.
-There was documentation FSBS ranged from 188-63.
-There was documentation the FSBS was 68 on 10/15/19, FSBS was 63 on 10/16/19, FSBS was 66 on 10/21/19, FSBS was 63 on 10/27/19, and the FSBS was 68 on 10/29/19.

Review of Resident #3's eMAR for November

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D 358	Continued From page 53 2019 revealed: -There was an entry for Januvia 50mg daily scheduled for 8:00am with documentation the medication had been administered 11/01/19 through 11/30/19. -There was documentation FSBS ranged from 138-58. -There was documentation the FSBS was 69 on 11/01/19, FSBS was 58 on 11/02/19, FSBS was 69 on 11/15/19, FSBS was 64 on 11/16/19, FSBS was 63 on 11/22/19, FSBS was 62 on 11/24/19, FSBS was 69 on 11/27/19, and the FSBS was 65 on 11/28/19. Review of Resident #3's eMAR for December 2019 revealed: -There was an entry for Januvia 50mg daily scheduled for 8:00am with documentation the medication had been administered 12/01/19 through 12/18/19. -There was an entry for glipizide 10mg daily scheduled at 8:00am with documentation the medication had been administered on 12/14/19 through 12/18/19. -"DC' d" was documented on 12/19/19 for the glipizide 10mg. -There was documentation FSBS ranged from 82-54. -There was documentation the FSBS was 63 on 12/03/19, FSBS was 67 on 12/07/19, FSBS was 55 on 12/11/19, FSBS was 67 on 12/12/19, FSBS was 65 on 12/13/19, FSBS 60 was on 12/17/19 and the FSBS was 54 on 12/18/19. Review of Resident #3's record revealed a pharmacy generated re-fill form listing glipizide 10mg and dispensing 30 tables with 11 refills to the facility with documentation on the bottom of the form "office copy not for dispensing, for information purpose only."	D 358		

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D 358	Continued From page 54 Telephone interview with the contracted pharmacist on 12/19/19 at 9:45am revealed: -Resident #3 had a current active re-fill dated 12/13/19 for glipizide 10mg. -The pharmacy had dispensed a 30-day supply of glipizide 10mg to the facility for Resident #4 on 12/13/19. -The last time Resident #3 had the glipizide 10mg dispensed was on 08/14/19 for a 30-day supply. -She could not tell if the re-fill form came from the physician's office or if pharmacy had faxed the form to the physician's office for confirmation. -The form was not signed by the physician. -The pharmacy assumed the refill form was e-signed by the physician. Observation of medication on hand for Resident #3 on 12/18/19 at 11:28am revealed there were 25 glipizide 10mg available for administration. Observation of Resident #3 on 12/17/18 between 12:25pm and 12:50pm during the lunch meal revealed: -Resident #3 walked into the dining room with hands-on assist by a personal care aide. -Resident #3 was drowsy and not eating. -The facility staff encouraged Resident #3 to eat as the staff walked around the dining room area. -Resident #3 dropped her head on to the table and into her food plate. -Staff responded by lifting Resident #3's head up and trying to arouse her verbally. -The MA immediately obtained a FSBS on Resident #3 with a result of 60. -The MA called Emergency Medical Services (EMS) for transport to the hospital for Resident #3. -The dietary staff fed Resident #3 several bites of food, which she did eat prior to the EMS arrival.	D 358		

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D 358	Continued From page 55 Interview with the medication aide (MA) on 12/17/19 at 12:55pm revealed: -Resident #3 usually fed herself and she ambulated in the facility on her own. -Resident #3 appeared groggy on 12/17/19 and the MA thought it was due to her not sleeping during the night of 12/16/19. -She had taken Resident #3's FSBS at lunch and the result was 60. -She had told the staff to try to get Resident #3 to eat and drink juice while she called 911 for transport to the Emergency Room (ER) for an evaluation. Telephone interview with the prescribing Nurse Practitioner at 10:00am on 12/19/19 revealed: -Resident #3 was not on glipizide 10mg, she had changed the order to Januvia 50mg daily in September 2019. -She was aware Resident #3 had low FSBS and did not want 2 antidiabetic medications administered to Resident 4. -The staff had contacted her regarding Resident #3 FSBS 60 on 12/17/19. -She was aware the facility had sent Resident #3 out to be evaluated on 12/17/19. -She did not know the facility staff had administered the glipizide 10mg to Resident #3 on 12/14/19, 12/15/19, 12/16/19, 12/17/19 and on 12/18/19. -The complications of administering 2 antidiabetic medications could lead to a lower blood sugar for Resident #3. -She was unsure if the pharmacy faxed the re-fill to her office, but Resident #3 had been off the glipizide for several months. -The facility had contacted her on 12/18/19 and she had discontinued the glipizide 10mg for Resident #3.	D 358		

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D 358	Continued From page 56 Second interview with the MA on 12/18/19 at 9:20am revealed: -She administered the glipizide 10mg to Resident #3 on 12/14/19, 12/17/19 and on 12/18/19. -The glipizide 10mg "popped" up on the eMAR system to administer to Resident #3 at 8:00am. -She had never seen the re-fill form for the glipizide 10mg for Resident #3. -The re-fill form was not an order because "a doctor has not signed" the form. -The pharmacy was responsible for putting the medication in the computer system, but a facility staff must except the order prior the MAs administering the medication to the residents. -She was unsure how the medication glipizide 10mg got placed on the eMAR system to administer. -The Resident Care Coordinator (RCC) had contacted Resident #3's NP on 12/18/19 to discontinue the glipizide 10mg daily. Review of a subsequent physician's order dated 12/18/19 for Resident #3 revealed discontinue glipizide, change FSBS to two times daily, if FSBS 61-80 give ½ cup of orange juice, if FSBS less than 60 give 1 cup of orange juice and recheck FSBS in 15 minutes after given the juice and call the provider. If resident has a low FSBS and is unresponsive call EMS and the provider. Follow up with the NP at next visit to the facility. Interview with the current RCC on 12/18/19 at 10:15am revealed: -The pharmacy was responsible for entering medications on the eMAR system, and the RCC was responsible for accepting the medication prior to the MAs administering the medication. -She had never seen the refill form for Resident #3's glipizide 10mg.	D 358		

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-She had never excepted Resident #3's glipizide 10mg in the eMAR system.
-She did not know the MAs had administered the glipizide 10mg to Resident #3 on 12/14/19 through 12/18/19.
-The re-fill form was not an order because it was not signed.
-She knew Resident #3 had gone to the ER on 12/17/19 for an evaluation and a low FSBS.
-The facility did not have a hypoglycemic policy or procedure to follow, the physician usually wrote an order for what the MAs would use for a high or low blood sugar.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Telephone interview with the Administrator on 12/17/19 at 9:00am revealed she was currently out of the country and the RCC could answer all questions.

2. Review of Resident #5's current FL2 dated 11/04/19 revealed:
-Diagnoses included dementia and Parkinson's disease.
-Level of care was Special Care Unit.
-Medication ordered included Flomax 0.4mg daily.

Review of Resident #5's physician visit note dated 08/29/19 revealed a diagnosis of benign prostatic hypertrophy.

Review of Resident #5's eMAR for November 2019 revealed:
-There was an entry for Flomax 0.4mg daily scheduled for 8:00am.
-There was documentation Flomax 0.4mg was

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not administered as ordered on 11/01/19, 11/02/19, 11/03/19, 11/06/19,11/10/19, 11/20/19, 11/21/19, 11/22/19, 11/23/19, 11/24/19, 11/25/19, 11/26/19, and on 11/28/19, reason documented "awaiting pharmacy delivery".

Observation of medications on hand for Resident #5 on 12/17/18 at 3:50pm revealed there were 13 Flomax 0.4mg tablets available for administering.

Interview with a medication aide (MA) on 12/18/19 at 12:18pm revealed:
-The flomax 0.4mg was not available to administer to Resident #5 in November 2019 due to "his pharmacy did not send any."
-Resident #5 used an outside pharmacy and "it is hard to get in touch with them."
-"I do not have access to Resident #5's pharmacy.
-She told the former RCC the flomax was not available for administration for Resident #5 multiple times.
-She did not know if the former Resident Care Coordinator (RCC) had notified Resident #5's physician.
-Resident #5's family handles his medications, "I think she could not get in touch with the pharmacy either."
-The RCC was responsible for contacting the physician and the pharmacy.

Telephone interview with Resident #5's Nurse Practitioner on 12/18/19 at 11:40am revealed:
-Resident #5 was prescribed flomax 0.4mg due to his history of (BPH) enlarged prostate.
-The NP saw Resident #5 twice in the facility, but Resident #5 was also seen by another primary care physician (PCP).
-She was not made aware the flomax 0.4mg was available to administer as ordered for Resident #5

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in November 2019.
-If flomax was not administered as ordered the complications could result in urinary retention.
-She was available for notification for the residents in the facility.

Attempted telephone interview with Resident #5's PCP on 12/17/19 at 2:41 and on 12/18/19 at 9:05am was unsuccessful.

Telephone interview with a representative with the facility's contracted pharmacy on 12/18/19 at 9:00am revealed:
-Resident #5 did not use their pharmacy.
-They had filled a 30-day supply on flomax 0.4mg of 12/02/19 per requested by the former RCC.
-The former RCC had faxed an order to the pharmacy for flomax 0.4mg on 12/02/19 for Resident #5.
-Flomax was used as a muscle relaxer for an enlarged prostate making it easier for men to urinate, if not administered as ordered the complications could result in making it hard to urinate.

Telephone interview with Resident #5's responsible party on 12/18/19 at 5:30pm revealed:
-She was in the facility daily.
-Resident #5 used an outside pharmacy but the facility handled all the medication transactions.
-The outside pharmacy always filled the prescriptions with either a 60- or 90-day stock.
-The facility staff never reached out to her concerning a prescription or re-fill for Resident #5's flomax.
-She was not aware the flomax 0.4mg was not available for administration in November 2019 as ordered by the physician.
-If the facility staff had informed her Resident #5

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D 358	Continued From page 60 did not have the Flomax she would have picked up another prescription. -Resident #5 required the flomax daily due to his bladder not emptying correctly. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 3:53pm revealed: -She did not know Resident #5 was not administered the flomax 0.4mg as ordered daily in November 2019. -She knew Resident #5 used an outside pharmacy for all his prescriptions, and it was hard to get in touch with them. -The facility did have back up pharmacy that should had been used when the flomax was missed after the third consecutive dose. -She was unsure if the physician was made aware the flomax 0.4mg was not available for administered in November 2019. Telephone interview with the Administrator on 12/17/19 at 9:00am revealed she was currently out of the country and the RCC would answer all questions. _____ The facility failed to administer medications as ordered for Resident #3 related to administering glipizide without an order for 5 consecutive days resulting in hypoglycemia (low blood sugar) requiring an ER visit and treatment with IV glucose, and Resident #5 missed 12 consecutive days of Flomax resulting in possible inability to urinate. This failure placed the residents at substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/18/19 for this violation.	D 358		

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D 358	Continued From page 61 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED January 18, 2019.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure medications were administered in accordance with infection control measures to prevent the development and transmission of disease or infection for 1 of 5 sampled residents (Resident #9) with documentation of administration of outdated and expired insulin. The findings are: Review of Resident #9's current FL2 dated 07/01/19 revealed: -Diagnoses included Diabetes Mellitus Type 2. -There was an order for Humalog 100units KwikPen administer as directed per sliding scale (a rapid acting insulin used to regulate blood sugar). Review of a subsequent physician's order dated 08/27/19 revealed an order for a Novolog Flexpen 100units to be administered as directed per	D 371		

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D 371	Continued From page 62 sliding scale instructions, three times daily after meals. Observation of medications on hand on 12/17/19 at 10:55am revealed: -There was a Novolog Flexpen with Resident #9's name on the pharmacy label. -There was a date opened sticker on the Novolog Flexpen with a handwritten date of 09/12/19 (which would expire 10/10/19). Review of Resident #9's October 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog Flexpen to be administered per sliding scale three times daily after meals at 8:00am, 11:00am and 4:00pm. -Novolog was documented as administered 40 out of 60 possible opportunities. -There was an entry for fingerstick blood sugar (FSBS) readings three times daily. -FSBS ranged from 247-102. Review of Resident #9's November 2019 eMAR revealed: -There was an entry for Novolog Flexpen to be administered per sliding scale three times daily after meals at 8:00am, 11:00am and 4:00pm. -Novolog was documented as administered 25 out of 89 possible opportunities from 11/01/19 through 11/30/19. -There was an entry for fingerstick blood sugar(FSBS) readings three times daily. -FSBS ranged from 249-106. Review of Resident #9's December 2019 eMAR revealed: -There was an entry for Novolog Flexpen to be administered per sliding scale three times daily after meals at 8:00am, 11:00am and 4:00pm.	D 371		

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-Novolog was documented as administered 9 out of 50 opportunities from 12/01/19 through 12/17/19.
-There was an entry for fingerstick blood sugar(FSBS) readings three times daily.
-FSBS ranged from 248-94.

Interview with the first shift medication aide (MA) on 12/17/19 at 8:50am revealed:
-She had been administering Resident #9's Novolog insulin from the Flexpen dated 09/12/19.
-There were no other Novolog insulin pens for Resident #9.
-The pharmacy would send one insulin pen or vial when staff requested a refill.
-There were times Resident #9 did not need the sliding scale insulin based on her fingerstick blood sugars.
-She did not know why she had not observed the opened date for Resident #9's Novolog Flexpen.
-She knew Novolog Flexpens were to be discarded after 28 days.
-Resident #9's Novolog pen should have been discarded on 10/10/19.

Interview with the second shift MA on 12/17/19 at 3:30pm revealed:
-She had been administering Resident #9's Novolog insulin from the Flexpen dated 09/12/19.
-There were no other Novolog pens for Resident #9.
-The pharmacy would send one insulin pen or vial when staff requested a refill.
-She did not notice the open date on the Novolog Flexpen.
-The MAs do not do cart audits but were responsible for the medications on their medication cart.
-She should have discarded Resident #9's Novolog Flexpen after 28 days and ordered a

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D 371	Continued From page 64 new one from the pharmacy. Interview with the third shift MA on 12/18/19 at 9:35am revealed: -The former Resident Care Coordinator (RCC) was supposed to train her on the correct process for cart audits and the frequency. -The RCC never trained her. -She had never completed a cart audit. -She did not administer insulin on her shift, so she never opened an insulin pen or vial. Telephone interview with the contracted pharmacist on 12/18/19 at 10:00am revealed: -The facility was on a monthly cycle fill for their medications. -Insulin pens and vials did not come in the monthly cycle fill batch. -The facility staff contacted the pharmacist and requested a refill for insulin pens and vials as needed. -One Novolog Flexpen was filled for Resident #9 on 08/27/19. -The manufacturer's expiration date for the Novolog Flexpen was 28 days. -Twenty eight days after opening the pen it should be discarded and a refill pen requested. -The refill date for Resident #9's Novolog Flexpen was 09/24/19. -After the expiration date had passed the insulin was not as effective, and the resident's blood sugar could become erratic. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 11:51am revealed: -The MAs were responsible for their medication carts. -The MAs were to order medications if needed, remove expired medications from the cart and label insulin pens, vials, creams and inhalers with	D 371		

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D 371	Continued From page 65 an open date or expiration date. -The former RCC was completing cart audits as well as the third shift MAs. -She had not completed a cart audit and did not know how often cart audits had been completed in the past. -She did not know Resident #9 had a Novolog Flexpen, expiration date 09/24/19, on the medication cart and used for her sliding scale parameters. -No documentation regarding completed cart audits was provided. -No written policy regarding cart audits was provided. Telephone interview with the primary care physician (PCP) on 12/18/19 at 4:30pm revealed: -Novolog insulin was effective for 28 days after opening. -When insulin was out of date the effectiveness was compromised. -This could cause a resident's blood sugars to be higher than normal. -This could place a diabetic resident in danger of the side effects of hyperglycemia (blurred vision, fatigue, restlessness). -It was her expectation the MAs would date the insulin pens and vials when opened and discard when the expiration date was reached. Based on observations and record review it was determined Resident #9 was not interviewable.	D 371		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training	D 468		

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D 468	Continued From page 66 The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff assigned to work in a special care unit (SCU) had completed 6 hours of orientation during the first week of employment and 20 hours of training within six months of employment for 1 of 4 sampled staff (Staff A). The findings are:	D 468		

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D 468	Continued From page 67 1. Review of Staff A's, personal care aide (PCA) and medication aide (MA) personnel file revealed: -Staff A was hired on 11/04/18. -There was no documentation of 6 hours of SCU training during the first week of employment in her personnel record. -There was no documentation of 20 hours of SCU training within the first six months of employment in her personnel record. Interview on with Staff A on 12/18/19 at 2:20pm revealed: -She was hired as a PCA/MA in November of 2018 and worked second shift. -She was not aware of how many hours of training she had completed. -She knew she had completed a lot of training on the computer when she was first hired. -The Administrator kept the personnel record and she should have a record of her training. -She did not have any certificates showing that she had completed any training to work on a SCU. Interview with the Resident Care Coordinator (RCC) on 12/18/19 at 3:20pm revealed: -The Administrator was responsible for the personnel records. -The Administrator informed the former RCC when staff needed training. -There was online dementia training provided during orientation for the staff. -The certificates for the training should be in the personnel record of the staff. -The certificates may be online. A request for the certificates of completion with the continuing education hours (CEU) hours for each course Staff A had completed during	D 468		

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D 468	Continued From page 68 orientation and beyond was not provided.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' 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 and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to supervision, health care and medication administration. The findings are: 1. Based on observations, interviews and record reviews the facility failed to provide supervision to meet the needs of 1 of 5 sampled residents (Resident #2) who had three falls in less than 30 days. [Refer to tag 270,10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to assure physician notification for 2 of 5 residents (Resident #5 and Resident #1) related to wound care treatment orders and new skin breakdown. [Refer to tag	D912		

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D912	Continued From page 69 273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]. 3. Based on observation, interviews and record reviews, the facility failed to administer medications as ordered by a physician for 2 of 5 sampled residents (Resident #3) administered glipizide (an antidiabetic medication) without an order and Resident #5 not administered Flomax 0.4mg (used to improve urination flow in men) for 12 consecutive days. [Refer to tag 358, 10A NCAC 13F .1004 Medication Administration (Type A2 Violation)].	D912		
D935	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 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.	D935		

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D935	Continued From page 70 (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: Based on interviews and record reviews, the facility failed to assure 2 of 3 sampled medication aides (Staff A and C) completed the 5, 10 or 15-hour state approved medication aide training, and 1 of 3 medication aides (Staff A) had successfully passed the state written Medication Aide examination within 60 days after successful completion of the Clinical Skills Validation evaluation. The findings are: 1. Review of Staff A's, medication aide, personnel	D935		

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D935	Continued From page 71 record revealed: -Staff A was hired on 11/04/18. -Staff A completed the Medication Clinical Skills Validation checklist on 09/04/19. -Staff A completed the 5 hour state approved medication training on 09/09/19. -There was no documentation Staff A had completed the 10 hour state approved medication training. -The Medication Clinical Skills Validation checklist was completed on 09/04/19. -There was no documentation Staff A had successfully passed the written medication aide examination. Review of the residents' electronic Medication Administration Records (eMARs) for September 2019 through December 2019 revealed Staff A had documented the administration of medications. Interview with the current Resident Care Coordinator (RCC) on 12/18/19 at 3:20pm revealed: -She was recently hired as the RCC on 12/16/19. -She had been the medication aide (MA) Supervisor. -She knew the former RCC had removed Staff A from the medication cart last week until she passed the Medication Aide Examination -She knew Staff A had taken the Medication Aide Examination on 12/16/19. -The RCC did not know if Staff A had passed the medication test on 12/16/19. -She was responsible for the staffing schedule at this time and she was scheduling Staff A as a personal care aide (PCA) until the Administrator approved her as a MA. -The Administrator was responsible for tracking the training required for the staff.	D935		

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D935	Continued From page 72 -The Administrator would let the former RCC know when staff needed training and the RCC would schedule the training with the facility contracted Registered Nurse (RN) -She did not know why Staff A had continued to pass medications without passing the Medication Aide Examination within 60 days. Interview with Staff A on 12/18/19 at 2:20pm revealed: -She had been passing medications on second shift since she completed the Medication Clinical Skills Validation checklist (09/04/19) until last Wednesday (12/11/19). -The facility's contracted RN had provided training regarding the administration of medications. -She did not know if that was the 5, 10 or 15 hour state approved medication training. -The Administrator kept the training certificates in the employee's personnel file. -"Whatever I have completed you should have in that personnel file." -She was scheduled to take the Medication Aide Examination in November, but did not remember the date. -She "did not make the exam" for reasons she did not explain. -She was re-scheduled to take the Medication Aide Examination on 12/16/19. -Staff A did not pass the Medication Aide Examination on 12/16/19. -She had been passing medications on second shift until last Wednesday (12/11/19). -She did not know she was past the 60 days since the Medication Clinical Skills Validation check off. -She did not know she had to pass the Medication Aide Examination, before the 60 days were completed, to continue passing medications to the residents until last week.	D935		

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D935	Continued From page 73 -The former RCC informed Staff A (on 12/11/19) she would not be able to pass medications until she took the Medication Aide Examination and passed. -She was scheduled to work as a PCA until she could reschedule the medication administration test. The staffing schedule requested on 12/18/19 and 12/19/19 was not provided. Interview with the facility's contracted RN on 12/19/19 at 10:17am revealed: -She provided training to the staff at the facility. -The former RCC would contact her and schedule whatever training was needed for staff compliance. -She would schedule the training at her earliest convenience. -She would send a copy of the certificate of completion to the Administrator or RCC. -They were responsible for maintaining staff training records. -She did not keep a record of the classes she provided or the attendees. "I guess I should start doing that." -She thought Staff A had all the necessary training to administer medications. Interview with the RCC from the sister facility on 12/19/19 at 10:40am revealed: -She was training the current RCC in her new role. -The procedure for medication aide training at both facilities was as follows: -The Administrator kept a schedule of the training needed for each staff person and their position. -The Administrator informed the RCC when the staff needed the required training. -The RCC would contact the RN who would	D935		

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D935	Continued From page 74 schedule the training at her earliest convenience. -The RN would administer the 5 hour class to the MAs before they would pass medications, and the 10 hour class shortly after that. -The training certificates of completion would be given to the Administrator who would file them in the personnel record of the staff. -Medication aides were trained by shadowing with current MAs. -When the RCC determined their training was sufficient, she would schedule the Medication Clinical Skills Validation check off with the RN. -The Medication Aide Examination had to be scheduled and passed by the MA if she was to continue administering medications after 60 days from the skills check off. -It was the responsibility of the MAs to schedule the date of the Medication Aide Examination and provide the documentation the test had been passed to the Administrator. -MAs were not allowed to continue passing medications if they did not pass the Medication Aide Examination within 60 days of the Medication Clinical Skills Validation check off. -It was the responsibility of the Administrator and the RCC to ensure the staff were in compliance with their training requirements. 2. Review of Staff C's, medication aide/supervisor, personnel record revealed: -Staff C was hired on 03/01/14. -Staff C completed the Medication Clinical Skills Validation checklist on 03/04/14. -Staff C completed the 5 hour medication training on 03/17/14 -Staff C passed the written Medication Aide Examination on 07/08/14 -There was no documentation Staff C had completed the 10 hour state approved medication training.	D935		

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D935	Continued From page 75 Review of the facility electronic Medication Administration Records (eMARs) for September 2019 through December 2019 revealed Staff C had documented the administration of medications. Interview with Staff C on 12/19/19 at 9:15am revealed: -She had been employed as a MA at the facility since 03/01/14. -She thought she had completed the 15 hour state approved medication training, but she was not sure. -All the certificates of completion for training should be in her personnel file. Interview with the facility's contracted Registered nurse (RN) on 12/19/19 at 10:17am revealed: -She did not have any recollection of training provided in 2014. -She thought all the MAs were up to date with their training and continuing education credits (CEUs). -She relied on the Administrator and the RCC to let her know when staff needed training.	D935		