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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a complaint investigation via desk review August 6-7, 2020, and August 10-14, 2020, and COVID-19 focused Infection Control survey with an onsite visit on August 10, 2020 and a telephone exit on August 14, 2020. | D 000 | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure a physician ordered laboratory test was implemented for 1 of 5 sampled residents (#1).<br><br>The findings are:<br><br>Review of Resident #1's current FL-2 dated revealed:<br>-Diagnoses included syncope and collapse, sleep apnea, lymphedema, bilateral lower extremities, | D 276 | | |

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cocaine use, hypertension, and debility.
-There were no orders for laboratory test.

Review of Resident #1's subsequent physician orders revealed there was an order dated 06/23/20 for repeat liver enzymes in one month.

Review of Resident #1's laboratory tests revealed there were no laboratory results for July 2020.

Attempted interviews with Resident #1 on 08/13/20 at 4:17 pm and 08/14/20 at 8:21 am were unsuccessful.

Interview with Resident #1's Primary Care Provider (PCP) on 08/12/20 at 3:45 pm and 08/13/20 at 8:57 am revealed:
-There were no liver enzymes drawn for Resident #1 in July 2020.
-She did order liver enzymes to be drawn in July 2020 for Resident #1.
-She gave lab orders to the Resident Care Coordinator (RCC).
-The RCC completed a requisition form for the labs and she signed it when she visited the facility.
-She or the RCC logged onto the laboratory company website and enters the order as part of the process used to orders laboratory tests.
-She ordered liver enzymes for Resident #1 to determine what was causing Resident #1's bilateral lower extremity edema.
-She did not know if it was due to Resident #1's kidneys, heart or liver, so she ordered liver enzymes to rule out or rule in Resident #1's liver.

Interview with a Medication Aide (MA) on 08/13/20 at 10:35 am revealed:
-The MAs did not process laboratory orders.
-The RCC handled all laboratory orders.

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| D 276 | Continued From page 2<br><br>Interview with the RCC on 08/14/20 at 11:16 am revealed:<br>-Resident #1's PCP told her what laboratory test she wanted to order, and she completed a requisition form for the laboratory test.<br>-She then placed the laboratory test for residents in a book that was kept in her office.<br>-The phlebotomist for the laboratory company came to the facility every Wednesday to complete laboratory blood draws.<br>-The phlebotomist looked at the book in her office to determine who needed laboratory blood tests.<br>-When Resident #1's physician wrote orders for laboratory tests to be drawn for the following month, she usually wrote it down on her calendar.<br>-She did not write down the liver enzymes laboratory test for Resident #1 on her calendar and the labs were not completed for him in July 2020.<br>-She was responsible for ensuring laboratory tests were completed for residents at the facility.<br><br>Interview with the Administrator on 08/14/20 at 12:17 pm revealed:<br>-She expected the RCC to have residents' laboratory tests drawn and completed as ordered.<br>-She did not know Resident #1 had liver enzymes ordered for July 2020.<br>-The RCC was responsible for ensuring laboratory tests were completed for the residents. | D 276 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. | D 338 | | |

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| D 338 | Continued From page 3<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to rapidly taking action to isolate a resident who might be infected to reduce risk of transmission and infection.<br><br>The findings are:<br><br>Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease (COVID-19) in long term care (LTC) facilities revealed:<br>-Facilities should identify a space within the facility to dedicated to monitor and care for residents with COVID-19.<br>-Facilities should have a plan for how residents will be handled i.e. transfer to a single room.<br>-Facilities should not place a resident with a confirmed positive COVID-19 test with a new admission.<br>-Facilities should have a plan for how roommates, other residents who may have been exposed to an individual with COVID-19 were handled.<br><br>Review of the notification from the North Carolina Department of Public Health dated 7/21/20 and 07/22/20 revealed:<br>-Two of thirty-nine residents residing in the facility had tested positive for COVID-19. | D 338 | | |

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| D 338 | Continued From page 4<br>-No staff working for the facility had tested positive for COVID-19.<br>-The date of first symptom onset was documented as 07/26/20.<br><br>Review of the North Carolina Department of Health and Human Services list of COVID-19 Ongoing Outbreaks in Congregate Living Settings dated 08/14/20 revealed:<br>-There were two staff cases who were positive for COVID-19.<br>-There were fourteen resident cases who were positive for COVID-19.<br><br>Review of the facility's Policy and Procedure for Infection Control revealed:<br>-There were instructions for hand washing, and the use of gloves.<br>-There was no other information included in the facility's infection control policy and procedures.<br><br>Review of a draft of the facility's COVID-19 policy and procedure revealed:<br>-The document was not dated.<br>-There were statements regarding visitation and persons the facility had contacted regarding COVID-19.<br>-There was a procedure documented for screening of staff.<br>-The remainder of the document was formatted in a question and answer format.<br>-The questions addressed preventative measures, if a resident or staff showed symptoms of COVID-19, if there was a positive diagnosis of COVID-19, precautions, what residents and staff were doing to stay safe, if residents were allowed to leave their rooms, outings and transportation, managing and answering resident and staff questions, conducting tours, and accepting move-ins. | D 338 | | |

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| D 338 | Continued From page 5<br>-There were eight attachments to the document which included signage for social distancing, use of PPE CDC sign "How to Protect Yourself and Others" and hand washing, the screening tool for staff and visitors, and the form for documenting resident temperatures and symptoms.<br>-There was a statement indicating residents were isolated if they were showing symptoms of COVID-19.<br>-There was a statement indicating the facility continued to act in full compliance with the CDC, local and state health authorities and followed CDC guidance for confirmed cases in healthcare setting.<br>-There was another statement that the facility would direct residents with suspected COVID-19 to self-isolate in their rooms to protect others in the community.<br><br>Telephone interview with Local Health Department (LHD) Registered Nurse (RN) on 08/06/20 at 8:53 am revealed:<br>-She spoke with the Administrator of the facility on several occasions.<br>-A site assessment was performed last week (07/27/20 to 07/31/20) by a RN for the facility where staff from the LHD visit the facility.<br>-She told the Administrator that she had to group the positive residents together.<br>-She told the Administrator all residents who tested positive needed to be grouped together.<br>-All residents who tested negative but who were exposed to COVID-19 needed to be grouped together.<br>-All residents who tested negative for COVID-19 needed to be grouped together.<br>-The Administrator then told her she was planning to move residents, but the layout of the building did not allow placement of residents on one wing based on their COVID-19 results. | D 338 | | |

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| D 338 | Continued From page 6<br><br>Review of COVID-19 test results dated 08/05/20 revealed:<br>-The results for the set of roommates on the 100 hallway were one resident was negative for COVID-19 and one resident had inconclusive test results for COVID-19.<br>-The results for the other two sets of roommates who resided on the 300 hallway were one resident was negative for COVID-19 and one resident was positive for COVID-19.<br><br>Review of COVID-19 test results dated 08/06/20 revealed there was a positive COVID-19 test result for the roommate who previously had an inconclusive test result on the 100 hallway.<br><br>Review of COVID-19 test results dated 08/11/20 revealed:<br>-The set of roommates who resided on the 100 hallway both tested negative for COVID-19.<br>-There was one set of roommates who resided on the 300 hallway who had negative test results for COVID-19.<br>-The remaining set of roommates who resided at the end of the 300 hallway had a reversal in their results.<br>-The resident who had previously tested negative for COVID-19 now had a positive test result and his roommate had a negative test result.<br><br>Telephone interview with the Administrator on 08/07/20 at 4:14 pm revealed:<br>-She initiated testing for COVID-19 once the first resident showed symptoms about two weeks ago in July 2020.<br>-She thought one of the residents contracted COVID-19 in the local hospital and then he returned to the facility with symptoms of COVID-19. | D 338 | | |

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-The resident who had visited the local hospital was not tested at the local hospital.
-All the residents were tested, and the facility went from two COVID-19 positive cases to fourteen COVID-19 cases.

Observation of the facility on 08/10/20 from 2:45 pm to 3:51 pm revealed:
-All residents were isolated to their rooms on the 100, 200 and 300 hallways.
-There was one room on the 100 hallway where one resident who tested negative for COVID-19 and one resident who tested positive for COVID-19 resided together.
-The residents on the 100 hallway had facemasks available for use but were not wearing the facemasks in their rooms.
-The residents had hand sanitizer available in their rooms.
-Staff entered other residents' rooms who had tested positive for COVID-19 with full PPE which included a gown, gloves, facemask, face shield, and shoe covers.
-There were two rooms on the 300 hallway where one resident who tested negative for COVID-19 and one resident who tested positive for COVID-19 resided together.
-One of the rooms was at the end of the 300 hallway near the exit door, and these residents wore their facemasks while they laid in bed.
-Both sets of roommates on the 300 hallway had facemasks available to use.

Interview with one set of residents who resided in the same room on the 100 hallway on 08/10/20 at 3:23 pm revealed:
-Both had individual bottles of hand sanitizer on their nightstands.
-They ate meals in their rooms.
-Staff wore facemasks, and gowns when coming

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into the room.
-They did not know how long they had been roommates.
-Neither reported symptoms of COVID-19 and staff checked their temperatures three times a day.
-Both were tested for COVID-19 two weeks ago.
-They wore their facemasks when they left the room to go to use the bathroom.
-The Administrator had told them about the virus about a month ago but neither could remember the specific things they were told about the virus.

Interview with the Resident Care Coordinator (RCC) on 08/10/20 at 2:55 pm revealed:
-She had prepared a list of residents had tested positive for COVID-19 and negative for COVID-19 for staff to use.
-There was one set of residents who were roommates that resided on the 100 hallway and one roommate had an inconclusive COVID-19 test result.

Interview with the Administrator on 08/10/20 at 3:30 pm revealed:
-There were 14 residents who tested positive for COVID-19 and one of the residents was sent to the hospital due to increased symptoms of COVID-19.
-Now the facility had 13 residents who tested positive for COVID-19 within the facility.
-The set of roommates at the end of the 300 hallway were kept together because the resident who had tested negative for COVID-19 began having symptoms the date after the test results.
-The resident's symptoms included vomiting and diarrhea so she made the decision not to move him away from his roommate who had tested positive for COVID-19.
-The other set of residents who were roommates

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on the 300 hallway were kept together after one of the roommates tested positive for COVID-19, because there was no place to move the roommate who tested negative for COVID-19.
-The residents who were roommates on the 100 hallway were kept together because one resident tested inconclusive for COVID-19.

Telephone interview with a Personal Care Aide on 08/13/20 at 1:23 pm revealed:
-The facility had the first resident case of COVID-19 in July 2020
-She had noted there were residents who tested negative sharing a room with a resident who tested positive for COVID-19.
-There was a piece of paper with the residents listed and their COVID-19 test results.
-The RCC also told staff which residents had tested positive for COVID-19.
-She wore a gown, gloves, facemask and a face shield when she entered these resident rooms.
-The Administrator was responsible for resident room placement.

Telephone interview with a Medication Aide on 08/13/20 at 3:46 pm revealed:
-She knew there were residents who tested negative sharing a room with a resident who tested positive for COVID-19.
-She had not discussed her concerns with the Administrator, but with other staff.
-She was told by other staff that it was the Administrator's discretion for resident room placement and that the Administrator did not want to move resident's belongings around the facility.
-She wore a facemask, gloves, gown, and a face shield when she entered resident rooms with a resident who tested negative and a resident who tested positive.
-She changed and discarded her gloves after first

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administering medications to the resident who tested negative for COVID-19, but she treated both residents as though they had tested positive for COVID-19.

Telephone interview with the Administrator on 08/11/20 at 11:19 am revealed:
-Staff cared for all residents by using universal precautions.
-She received faxed literature about COVID-19 from the county beginning in March 2020.
-She did receive documents about COVID-19 from the state of NC but it was hard to keep up with the changing information.
-She notified the LHD when the facility had a resident who tested positive for COVID-19.
-Two people came to the facility from the LHD and did a "walk through" of the facility for an hour and a half.
-The LHD staff gave the facility PPE and made recommendations to make a cleaning schedule, add items to the surveillance form, how to reuse gowns, and recommended residents who tested negative for COVID-19 should not share a room with a resident who tested positive for COVID-19.
-She gave staff a class on wearing and removing PPE in July after the first case.
-She did not move residents who had tested negative for COVID-19 but were exposed to COVID-19 due to their roommate's positive test results because these residents had already been exposed.
-She did not have a place to move these residents to within the facility.
-She did not want to move them in with another negative person because of their exposure to COVID-19.
-There were only two sets of residents who were roommates with a resident who tested positive.
-The residents who were roommates on the 100

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hallway had test results that were negative and inconclusive for COVID-19.
-By not moving the residents who were negative but exposed to COVID-19, she thought they were containing the virus.
-The LHD told her to place all the residents who tested positive for COVID-19 on the same hallway, but she thought moving the residents clothing and belongings would put other residents at risk for contracting COVID-19.
-She had to take responsibility for not moving the residents who were negative but exposed to COVID-19.

Telephone interview with the Administrator on 08/12/20 at 10:55 am and 4:15 pm revealed:
-All the residents were retested on 08/11/20.
-The test results for the 08/11/20 COVID-19 test revealed there were 5 residents who were positive for COVID-19.
-The residents who were roommates at the end of the 300 hallways were tested on 08/11/20.
-The resident in this room who was positive on 08/05/20 was now hospitalized because he had difficulty breathing and his roommate who had previously tested negative for COVID-19, tested positive for COVID-19.

Telephone interview with the RCC on 08/14/20 at 11:16 am revealed:
-She knew there were residents who tested negative in the same room as a resident who tested positive for COVID-19.
-Residents were quarantined to their rooms once the first resident case of COVID-19 occurred in July 2020.
-As of 08/14/20, there were eight residents who tested positive for COVID-19 on 08/12/20.
-She was not involved with residents who tested negative for COVID-19 remaining in the room

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with a resident who tested positive for COVID-19.
-However, if the Administrator had moved all residents who tested positive for COVID-19 onto the same hallway there would have been other residents who tested negative for COVID-19 on the hallway.
-The majority of the 14 residents who tested positive on 08/05/20 did not have roommates.
-The residents who were roommates with a resident who tested positive were told to use hand sanitizer, wear their facemasks, don't share things, and their beds were six feet apart.
-She and staff constantly reminded all residents of these restrictions.
-Residents were told they had to have two negative test results to be removed from quarantine.
-The LHD did tell us to separate the residents based on COVID-19 results in July 2020 but it was not feasible.
-The reason it was not feasible was because they would have to pull out all the residents' belongings and then try to sanitize the room adequately and hope no remnants of the virus remained in the room.
-There were also concerns because some of the residents did not get along with other residents and there would have been difficulty moving these residents into another room.
-There were three residents who tested positive for COVID-19 admitted to the local hospital.
-One of these hospitalized residents resided in the room at the end of the 300 hallway and he tested positive for COVID-19 at the hospital but tested negative for COVID-19 at the facility on 08/11/20.
-His roommate now tested positive for COVID-19 on 08/11/20.
-She, the owner, and the Administrator were all responsible for quarantining residents in the

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| D 338 | Continued From page 13<br>same room where they already resided.<br><br>Telephone interview with the Administrator on 08/14/20 at 12:17 pm revealed she was responsible for making the decision to keep residents who tested negative for COVID-19 in the same room with residents who tested positive for COVID-19.<br><br>_____<br>The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC), local health department, and North Carolina Department of Health and Human Services (NC DHHS) for Infection prevention and transmission during the COVID-19 pandemic in which one resident residing in the facility was diagnosed with COVID-19 after residing with another resident who tested positive for COVID-19 for two weeks. The facility's failure to isolate residents who tested positive for COVID-19 placed the residents who tested negative for COVID-19 at increased risk for transmission and infection from COVID-19, resulting in substantial risk of serious physical harm, neglect and constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/20 for this violation.<br><br>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2020. | D 338 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration | D 358 | | |

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| D 358 | Continued From page 14<br>(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on telephone interviews and record reviews, the facility failed to administer medication as ordered for 1 of 5 sampled residents (#5) related to the dose of a fast-acting insulin.<br><br>The findings are:<br><br>Review of Resident #5's current FL-2 dated 04/30/20 revealed:<br>-Diagnoses included Alzheimer's disease, major depressive disorder, cardiomyopathy, pacemaker, and gastroesophageal reflux disease (GERD).<br>-There was an order for Humalog (a fast-acting insulin) inject 10 units at midday and 8 units at the evening meal.<br>-There was an order for fingerstick blood sugar (FSBS) check four times daily before meals and at bedtime.<br><br>Review of Resident #5's six-month physician orders signed on 06/07/20 revealed:<br>-There was an order for Humalog inject 10 units at midday and 8 units at the evening meal.<br>-There was an order for FSBS check four times daily before meals and at bedtime.<br><br>Review of Resident #5's 01/14/20 A1C (a | D 358 | | |

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measurement indicating diabetes management) lab result revealed an A1C value of 6.6%. (The reference range for the lab that conducted Resident #5's test was 4.8%-5.6%.)

Review of Resident #5's electronic medication administration record (eMAR) for June 2020 revealed:
-There was an entry for Humalog inject 10 units at midday and 8 units at the evening meal scheduled for administration at 11:45am and 5:15pm.
-There were spaces to document the medication aide's (MA) initials, the site of the injection, and the blood sugar result.
-There was documentation Humalog had been administered 52 of 60 opportunities.
-There was documentation Humalog had not been administered 4 of 60 opportunities in accordance with hold parameters.
-There was documentation of the MA's initials, but no injection site or blood sugar result for 4 of 60 opportunities.
-There were two entries documenting the 5:15pm blood sugar result as "10."

Review of Resident #5's eMAR for July 2020 revealed:
-There was an entry for Humalog inject 10 units at midday and 8 units at the evening meal scheduled for administration at 11:45am and 5:15pm.
-There were spaces to document the MA's initials, the site of the injection, and the blood sugar result.
-There was documentation Humalog had been administered 60 of 62 opportunities.
-There was documentation Humalog had not been administered 2 of 62 opportunities in accordance with hold parameters.

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-There was one entry documenting the 11:45pm blood sugar result as "5."
-There were two entries documenting the 5:15pm blood sugar result as "5."
-There were eight entries documenting the 5:15pm blood sugar result as "10."

Review of Resident #5's eMAR for 08/01/20-08/10/20 revealed:
-There was an entry for Humalog inject 10 units at midday and 8 units at the evening meal scheduled for administration at 11:45am and 5:15pm.
-There was an entry for FSBS check four times daily before meals and at bedtime scheduled at 7:30am, 11:30am, 5:00pm, and 8:00pm.
-There was documentation Humalog had been administered 17 of 18 opportunities.
-There were four entries documenting the 8:15pm blood sugar result as "10."
-There was documentation Resident #5's FSBS result at 7:30am on 08/10/20 was 149.

Telephone interview with a MA on 08/13/20 at 1:44pm revealed:
-She manually entered the numbers in the eMAR; there was not an amount to click on in the system.
-She did not know why she documented 5 or 10 in the blood sugar result space.
-She was sure she administered the right amount of insulin on the dates in question.
-She normally paid attention when she was documenting in the eMAR.
-Sometimes the computer confused her.

Telephone interview with a MA on 08/13/20 at 2:33pm revealed if a MA documented "10" in the blood sugar result space, it may have been an error or it may have been the number of units of

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| D 358 | Continued From page 17<br>insulin administered.<br><br>Telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm revealed:<br>-She was responsible for auditing the eMARS.<br>-The audit consisted of reviewing exception notes, missed medication, and expired orders.<br>-She normally audited the eMARs weekly but had not been able to do so lately because another concern became the priority.<br>-She audited Resident #5's eMAR on 08/13/20; the previous review had been 2-3 weeks ago.<br>-The MAs were supposed to document the administration of Humalog and the injection site.<br>-She did not know why the MAs were documenting administering 5 units of Humalog to Resident #5.<br>-She was "almost sure" the MAs were administering 8 units of Humalog to Resident #5 at 5:15pm.<br><br>Telephone interview with the Administrator on 08/14/20 at 3:03pm revealed:<br>-The RCC was responsible for auditing the eMARS.<br>-The RCC audited the eMARs "quite often," especially to make sure the eMAR was accurate before the primary care provider (PCP) met with the residents.<br>-She did not know the specifics of how the RCC conducted the eMAR audits.<br>-She did not know the last time Resident #5's eMAR had been audited.<br>-The eMAR audits had been set aside recently due to another priority.<br>-The MAs were supposed to document the blood sugar results, the amount of Humalog administered, and the injection site.<br>-Either the documentation was an error or | D 358 | | |

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| D 358 | Continued From page 18<br>Resident #5 had received the wrong amount of Humalog.<br><br>Attempted interview with Resident #5 on 08/10/20 at 3:26pm was unsuccessful.<br><br>Attempted telephone interview with a third MA on 08/13/20 at 4:47pm was unsuccessful.<br><br>Attempted telephone interview with Resident #5's PCP on 08/14/20 at 8:53am was unsuccessful. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). | D 367 | | |

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This Rule is not met as evidenced by:
Based on telephone interviews and record reviews, the facility failed to ensure the accuracy of the electronic medication administration record (eMAR) for 1 of 5 sampled residents (#5) related to documenting the results of fingerstick blood sugar (FSBS) checks and the administration of medications used to treat Alzheimer's disease, blood clots, pain, diabetes, high cholesterol, mineral deficiency, and poor digestive symptoms.

Review of Resident #5's current FL-2 dated 04/30/20 revealed diagnoses included Alzheimer's disease, major depressive disorder, cardiomyopathy, pacemaker, and gastroesophageal reflux disease (GERD).

a. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for Humalog (a fast-acting insulin) inject 10 units at midday and 8 units at the evening meal.

Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for Humalog inject 10 units at midday and 8 units at the evening meal.

Review of Resident #5's electronic medication administration record (eMAR) for June 2020 revealed:
-There was an entry for Humalog inject 10 units at midday and 8 units at the evening meal scheduled for administration at 11:45am and

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5:15pm.
-There was an entry on 06/06/20 documenting the medication aide's (MA) initials, but not an injection site.
-There were three entries from 06/11/20-06/12/20 documenting the MA's initials, but not an injection site or the results of the blood sugar check.
-There were exception notes indicating the entries on 06/06/20 and from 06/11/20-06/12/20 were delayed entries.

Review of Resident #5's eMAR for August 2020 revealed:
-There was an entry for Humalog inject 10 units at midday and 8 units at the evening meal scheduled for administration at 11:45am and 5:15pm.
-There was no documentation indicating Humalog 8 units scheduled at 5:15pm was administered on 08/05/20.
-There were no exception notes dated 08/05/20 related to the 5:15pm Humalog administration.

Telephone interview with a MA on 08/13/20 at 1:44pm revealed she did not remember entering the exception notes in Resident #5's record related to delayed entry and she did not know what those entries meant.

Telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm revealed:
-She entered the exception notes related to the administration of Humalog on Resident #5's June 2020 eMAR.
-She entered "delayed entry" to document the initials of the MA who had been responsible for administrating Resident #5's medication on 06/06/20 and from 06/11/20-06/12/20.
-When "delayed entry" was used, only the MA's

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initials would be documented; information related to the injection site or the blood sugar result would not be documented.
-The lack of documentation related to the Humalog administration on 08/05/20 was either an error or the result of poor internet connection.
-Some areas of the facility had poor internet connection and medication administration would not be saved in the eMAR.

Telephone interview with the Administrator on 08/14/20 at 3:03pm revealed:
-"Delayed entry" meant the internet connection was poor and the administration was documented at a later time.
-There were times the internet connection was poor, the MAs would get knocked offline, and medication administration would not be saved in the eMAR.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.

b. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for metformin (used to treat diabetes) 500mg take one tablet twice a day with meals.

Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for metformin 500mg take one tablet twice a day with meals.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:
-There was an entry for metformin 500mg take

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one tablet twice a day with meals scheduled for administration at 8:00am and 5:30pm.
-There was no documentation metformin 500mg was administered at 5:30pm on 08/05/20.

Telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:33pm revealed the lack of documentation related to the metformin administration on 08/05/20 was either an error or the result of poor internet connection; some areas of the facility had poor internet connection.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.

c. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for atorvastatin (used to treat high cholesterol) 10mg take one tablet at bedtime.

Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for atorvastatin 10mg take one tablet at bedtime.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:
-There was an entry for atorvastatin 10mg take one tablet at bedtime scheduled for administration at 8:00pm.
-There was no documentation atorvastatin was administered at 8:00pm from 08/07/20-08/08/20.

Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was

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unsuccessful.

Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.

d. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for donepezil (used to treat Alzheimer's disease) 10mg take one tablet at bedtime.

Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for donepezil 10mg take one tablet at bedtime.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:
-There was an entry for donepezil 10mg take one tablet at bedtime scheduled for administration at 8:00pm.
-There was no documentation donepezil 10mg was administered at 8:00pm from 08/07/20-08/08/20.

Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.

Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

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| D 367 | Continued From page 24<br><br>Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.<br><br>e. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for Eliquis (used to prevent blood clots) 5mg take one tablet twice a day.<br><br>Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for Eliquis 5mg take one tablet twice a day.<br><br>Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:<br>-There was an entry for Eliquis 5mg take one tablet twice a day scheduled for administration at 8:00am and 8:00pm.<br>-There was no documentation Eliquis 5mg was administered at 8:00pm from 08/07/20-08/08/20.<br><br>Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.<br><br>Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.<br><br>Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.<br><br>Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.<br><br>f. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for Florastor (a probiotic supplement) 250mg take one capsule twice a day. | D 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL035031 | A. BUILDING: _____ B. WING _____ | C 08/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SOUTHERN LIVING FOR SENIORS OF LOUISBURG, N | 361 LEONARD ROAD LOUISBURG, NC 27549 |

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Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for Florastor 250mg take one capsule twice a day.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:
-There was an entry for Florastor (a probiotic supplement) 250mg take one capsule twice a day scheduled for administration at 8:00am and 8:00pm.
-There was no documentation Florastor was administered at 8:00pm from 08/07/20-08/08/20.

Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.

Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.

g. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for magnesium (a mineral supplement) 64mg take one tablet twice a day.

Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for magnesium 64mg take one tablet twice a day.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020

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|---|---|---|---|---|
| D 367 | Continued From page 26 | D 367 | | |

revealed:
-There was an entry for magnesium 64mg take one tablet twice a day scheduled for administration at 8:00am and 8:00pm.
-There was no documentation magnesium 64mg was administered at 8:00pm from 08/07/20-08/08/20.

Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.

Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.

Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.

Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.

h. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for memantine (used to treat Alzheimer's disease) 10mg take one tablet twice a day.
Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for memantine (used to treat Alzheimer's disease) 10mg take one tablet twice a day.

Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:
-There was an entry for memantine 10mg take one tablet twice a day scheduled for administration at 8:00am and 8:00pm.
-There was no documentation memantine 10mg was administered at 8:00pm from 08/07/20-08/08/20.

| 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 367 | Continued From page 27<br>Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.<br><br>Refer to telephone interview with a third MA on 08/12/20 at 2:05pm.<br><br>Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.<br><br>Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.<br><br>i. Review of Resident #5's current FL-2 dated 04/30/20 revealed there was an order for fingerstick blood sugar (FSBS) check four times daily before meals and at bedtime.<br><br>Review of Resident #5's six-month physician orders signed on 06/07/20 revealed there was an order for FSBS check four times daily before meals and at bedtime.<br><br>Review of Resident #5's electronic medication administration record (eMAR) for August 2020 revealed:<br>-There was an entry for FSBS check four times daily before meals and at bedtime scheduled at 7:30am, 11:30am, 5:00pm, and 8:00pm.<br>-There was no documentation the FSBS check was performed at 8:00pm from 08/07/20-08/08/20.<br><br>Attempted telephone interview with a second medication aide (MA) on 08/13/20 at 4:47pm was unsuccessful.<br><br>Refer to telephone interview with a third MA on 08/12/20 at 2:05pm. | D 367 | | |

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| D 367 | Continued From page 28<br>Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:43pm.<br><br>Refer to telephone interview with the Administrator on 08/14/20 at 3:03pm.<br><br>_____<br>Telephone interview with a third medication aide (MA) on 08/12/20 at 2:05pm revealed:<br>-She was responsible for administering Resident #5's evening medication on 08/08/20.<br>-There were areas in the facility that had poor internet connection and sometimes the medication administration would not be saved in the electronic medication administration record (eMAR).<br>-She had forgotten to talk with the Resident Care Coordinator (RCC) about the medication administration not being saved in the eMAR on 08/08/20.<br>-The RCC was responsible for reviewing the eMARs for blank spaces.<br>-She did not know how often the RCC reviewed the eMARs for blank spaces.<br><br>Telephone interview with the Resident Care Coordinator (RCC) on 08/14/20 at 2:33pm revealed:<br>-She was responsible for reviewing the electronic medication administration records (eMARs) for blank spaces.<br>-She normally reviewed the eMARs weekly but had not been able to lately because another concern had taken priority.<br>-She reviewed Resident #5's eMAR on 08/13/20; the review before that had been 2-3 weeks ago.<br>-She attributed the blanks on the eMARs to unreliable internet connection.<br>-Medications would not be documented as administered if the system was not connected to the internet. | D 367 | | |

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| D 367 | Continued From page 29<br>-The MAs were unable to modify their entries in the eMAR.<br>-She was able to modify the eMAR entries.<br><br>Telephone interview with the Administrator on 08/14/20 at 3:03pm revealed:<br>-The Resident Care Coordinator (RCC) was responsible for the accuracy of the eMARs.<br>-The RCC was responsible for reviewing the eMARs for blank spaces.<br>-The RCC reviewed the eMARs "quite often," especially to make sure the eMAR was accurate before the primary care provider (PCP) met with the residents.<br>-She did not know the specifics of how the RCC conducted the eMAR reviews.<br>-She did not know the last time Resident #5's eMAR had been reviewed.<br>-The eMAR reviews had been set aside recently due to another priority.<br>-There were blanks on the eMAR because of poor internet connection in some parts of the facility or because the MAs forgot to document the administration of a medication. | D 367 | | |
| D914 | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to residents rights.<br><br>The findings are: | D914 | | |

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| D914 | Continued From page 30<br><br>Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to rapidly taking action to isolate a resident who might be infected to reduce risk of transmission and infection.<br>[Refer to Tag D0338, 10A NCAC .0909 Resident Rights (Type A2 Violation)] | D914 | | |