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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 16, 2022 - February 18, 2022.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards as evidenced by oxygen canisters being stored in a unsecured manner on the floor in residents' rooms and in the oxygen storage room and on a resident's rollator without stands or storage racks or an oxygen storage bag to prevent tipping or falling from the resident's rollator. The findings are: Observation of a resident's room #203 on 02/16/22 at 9:15am revealed: -There were three unsecured oxygen canisters lined up next to each other against the wall of the resident's room. -There were two large oxygen canisters without a stand, or a storage rack stored on the floor. -There was one small oxygen canister without a stand, or a storage rack stored on the floor.	D 079		

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Observation of the oxygen storage room next to the facility's main dining room on 02/16/22 at 10:12am revealed:
-The door to the oxygen storage room was not locked.
-There was 1 large oxygen canister and 1 small oxygen without a stand or a storage rack stored on the floor to the right upon entrance into the oxygen storage room.
-The label on the 1 large oxygen canister read danger may cause or intensify fire; oxidizer. Contained gas under pressure; may explode if heated.
-There were 2 large oxygen canisters stored on the floor in an unsecured manner directly in front of shelving unit with resident incontinent supplies.

Observation of the facility's main hallway on 02/16/22 at 10:00am revealed a resident was ambulating in the hallway with a rollator with an oxygen canister stored on the padded seat of the rollator.

Refer to interview with the Resident Care Coordinator on 02/18/22 at 9:57am.

Refer to interview with the Administrator on 02/16/22 at 10:16am.

Refer to second interview with the Administrator on 02/16/22 at 11:30am.

3. Observation of a resident room #127 on 02/16/22 at 10:00am revealed two small oxygen canisters (approximately a foot tall) sitting unsecured on the floor behind a chair.

Interview with a resident residing in room #127 on 02/18/22 at 10:30am revealed:
-She was on 2 liters continuous oxygen.

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-She used a concentrator when she was in her room.
-She liked to have at least two small oxygen canisters on hand in her room to use when she left her room.

Observation of the storage area where oxygen canisters were stored on 02/18/22 at 12:10pm revealed there were racks and mobile carts available to secure the oxygen canisters.

Refer to the interview with the Resident Care Coordinator on 02/28/22 at 9:57am.

Refer to the interview with the Administrator on 02/16/22 at 10:16am.

Refer to the second interview with the Administrator on 02/16/22 at 11:30am.

4. Observation of a resident room #128 on 02/16/22 at 10:05am revealed an unsecured oxygen canister (approximately 2 feet tall) laying across the resident's rollator. (A rollator is a walker with two or four wheels).

Observation of the resident that resided in room #128 on 02/18/22 at 10:15am revealed she was walking down the hall with an unsecured oxygen canister laying across her rollator.

Interview with the resident that resided in room #128 on 02/18/22 at 10:15am revealed:
-She was on 2 liters continuous oxygen.
-She used a concentrator when she was in her room.
-It was convenient to lay the oxygen canister across her rollator when she was walking outside of her room.

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D 079	Continued From page 3 Observation of the storage area where oxygen canisters were stored on 02/18/22 at 12:10pm revealed there were racks and mobile carts available to secure the oxygen canisters. Refer to the interview with the Resident Care Coordinator on 02/28/22 at 9:57am. Refer to the interview with the Administrator on 02/16/22 at 10:16am. Refer to the second interview with the Administrator on 02/16/22 at 11:30am. _____ Interview with the Resident Care Coordinator on 02/18/22 at 9:57am revealed: -All oxygen canisters should be stored in a secured manner which meant in a rack, in a stand, or in a portable oxygen bag. -It was important to store oxygen securely because the oxygen canister could easily tip over and shot into the wall. Interview with the Administrator on 02/16/22 at 10:16am revealed: -All oxygen canisters should be secured upright in a rack or a stand to prevent them from tipping over. -He was not aware that were unsecured oxygen canisters in residents' rooms and in the oxygen storage room. -All staff were responsible to monitor the oxygen canisters to ensure they were stored securely because all staff were going in and out of the oxygen storage room to obtain resident's incontinent supplies. -It was important to store oxygen canisters securely to prevent "mishaps." -If an oxygen canisters fell the oxygen canister could explode and fly like a projectile.	D 079		

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D 079	Continued From page 4 Second interview with the Administrator on 02/16/22 at 11:30am revealed: -He was not aware a resident was ambulating with the oxygen canister resting flat on the rollator's padded seat. -The oxygen canister should be secured upright in a padded oxygen bag to prevent it from falling from the rollator. -He would contact the facility's durable medical equipment company to obtain a padded portable oxygen storage bag today, 02/16/22.	D 079		
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 Based on observations, record reviews, and interviews, the facility failed to ensure physician notification and follow-up with health care providers for 4 of 5 (#1,#3,#4,#5) sampled residents related to a resident who was ordered to follow-up with a surgeon 2 weeks after a hospitalization related to recurrent small bowel obstructions (obstruction in the small or large intestine, causing difficulty in passing digested material normally through the bowel) (#4); residents who had orders to notify their primary care providers (PCP) for blood sugars over 400 (#3,#5); a resident that had multiple medication refusals that were not reported to her PCP after 3 refusals (#5); a resident who was supposed to have a follow-up appointment with her PCP	D 273		

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related to a 3-month follow-up appointment (#1).

The findings are:

Review of the facility's Health Care Referral and Follow-Up policy dated 06/2020 revealed:
-It was the facility's responsibility to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident record.
-Documentation in the resident's records will include contacts with the physician, other support licensed service providers, family, responsible parties, and guardians, where there are illnesses, incidents, accidents, and routine care or follow-up as needed.
-Hospital discharges follow-up care and medication reconciliation.
-Labs, vitals, parameters, falls, and any other routine or acute health care needs of the resident.
-Facility staff will follow the provider's orders for vital signs outside of parameters.
-Facility staff would immediately notify the provider of any vital signs below or above parameters timely by telephone and fax.
-The facility staff would document notification to the provider in the progress notes and document any physician verbal orders given by the provider.

1. Review of Resident #4's current FL-2 dated 09/03/21 revealed:
-Diagnoses included transient ischemic attack, nonintentional weight loss, chronic kidney disease, chronic headaches, spinal stenosis, gastroesophageal reflux disease (GERD), and hypertension.
-She was intermittently disoriented.

Review of Resident #4's care plan dated 02/02/22

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revealed:
-The resident was forgetful and needed reminders.
-She required limited assistance with toileting and her bowels was normal.

Review of Resident #4's progress note dated 10/13/21 revealed:
-Resident #4 was sent to the hospital on 10/13/21 at 10:48am for a change in condition.
-She was taken to the hospital by her power of attorney (POA).

Review of Resident #4's hospital After Visit Summary dated 10/14/21 revealed:
-Resident #4 was admitted to the hospital on 10/13/21 for a small bowel obstruction.
-The resident was discharged back to the facility on 10/14/21.
-The resident was scheduled to follow up with her gastroenterologist (GI) (a physician that treats general diseases of the stomach and intestines) on 11/11/21.
-The resident was scheduled to have an upper gastrointestinal endoscopy (EGD) with biopsy on 10/27/21.

Review of Resident #4's progress note dated 10/14/21 revealed:
-She returned to the facility on 10/14/21 from the hospital at 10:35pm.
-Her follow-up appointment was added to the calendar follow-up on 10/27/21.

Review of Resident #4's hospital After Visit Summary dated 10/27/21 revealed:
-Resident #4 had an EGD with a biopsy completed on 10/27/21.
-Resident #4 was diagnosed with gastritis (the lining of the stomach weakened and damaged),

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esophagitis (inflammation of the esophagus), gastroparesis (a condition in which food takes longer than normal to empty from the stomach).
-She was scheduled to follow up with her GI provider on 12/02/21.

Review of Resident #4's progress note dated 11/14/21 revealed:
-Resident #4 was sent to the hospital on 11/14/21 at 2:30am.
-She was sent to the hospital for a change in condition.
-She was transported to the hospital by her POA.

Review of Resident #4's hospital After Visit Summary dated 11/17/21 revealed:
-Resident #4 was admitted to the hospital on 11/14/21 for a small obstruction with adhesions.
-The resident presented to the emergency room (ER) for evaluation of abdominal pain, diarrhea, and nausea.
-The resident had a computerized tomography (CT) scan of her abdomen which revealed a small bowel obstruction with adhesions.
-She was discharged from the hospital on 11/17/21.
-She had a follow-up appointment with her GI provider scheduled for 12/02/21.
-The facility was supposed to receive a call from Resident #4's primary care provider (PCP) for a follow-up appointment.

Review of Resident #4's progress note dated 11/17/21 revealed:
-Resident #4 returned to the facility from the hospital on 11/17/21 at 2:57pm.
-Her follow-up appointment was added to the calendar follow-up on 12/02/21.

Review of Resident #4's progress note dated

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12/22/21 revealed:
-Resident #4 was sent to the hospital on 12/22/21 at 8:45pm.
-She was sent to the hospital for complaints of pain in her abdomen and vomiting.
-She was transported to the hospital by her POA.

Review of Resident #4's hospital After Visit Summary dated 12/25/21 revealed:
-Resident #4 was admitted to the hospital with a complaint of abdominal pain and nausea.
-She was diagnosed with high-grade small bowel obstruction.
-She had a nasogastric tube (NG) (a tube passed through the nose and down through the nasopharynx and esophagus into the stomach) placed by her GI provider.
-After the placement of her NG tube, her small bowel obstruction resolved overnight.
-She was discharged back to the facility on 12/25/21.
-She needed to follow up with a surgeon for recurrent small bowel obstructions with adhesions in the abdomen as soon as possible in 2 weeks, someone will call you with a follow-up appointment.
-Resident #4 needed to follow up with her PCP as soon as possible for a visit in 4 days, someone will call you with an appointment.

Review of Resident #4's progress note dated 12/25/21 revealed:
-Resident #4 returned to the facility from the hospital on 12/25/21 at 5:00pm.
-There was no documentation that the resident's follow-up appointments with her PCP and surgeon were scheduled and added to the calendar.Telephone interview with Resident #4's primary care provider (PCP) on 02/18/22 at 8:46am revealed:

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D 273	Continued From page 9 -The first time she saw Resident #4 was in August 2021. -She followed up with Resident #4 in October 2021 to discuss lab work. -Her last visit with Resident #4 was on 01/25/22 for her annual check-up. -Resident #4's POA notified her that Resident #4 had recurrent small bowel obstruction that required hospitalizations from October 2021-December 2021. -She was not notified by the facility that Resident #4 was hospitalized for small bowel obstruction on 10/14/21 and 11/17/21. -She did not receive Resident #4's hospital After Visit Summaries from her hospitalizations on 10/14/21 and 11/17/21. -She received a faxed note from the facility in December 2021 that Resident #4 was sent to the hospital for abdominal pain. -She expected to be notified the same day by facility staff that Resident #4 returned from the hospital. -She expected to be notified of Resident #4's discharges from the hospital so she would know if the resident had any medication changes. -She was not aware that Resident #4 was supposed to have a follow-up visit with her after her hospitalization on 11/17/21 and 12/25/21. -If she was aware her Discharge Manager would have been able to schedule an appointment within 7 days after the resident was discharged from the hospital. -She was not aware that Resident #4 was supposed to follow up with a surgeon for recurrent small bowel obstructions until 01/25/22. Interview with the medical office assistance for GI physician on 02/17/22 at 9:43am revealed: -Resident #4 last saw the GI physician in the hospital on 01/18/22 for her colonoscopy.	D 273		

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-The resident saw the GI physician on a post hospital visit in the office on 12/02/21.
-The resident was a no call/no show to her appointment on 11/11/21.
-There was no documentation of Resdient #4 going to this appointment in the progress notes as noted above.
-The GI physician was unavailabe.

Review of Resident #4's After Visit Summary dated 01/18/22 revealed:
-Resident #4 had a colonoscopy with biopsy.
-Her GI provider performed the colonoscopy.
-Resident #4 was diagnosed with diverticulosis (a condition that develops when small pouches form in the wall of the large intestine).

Review of Resident #4's progress note dated 02/02/22 revealed:
-Resident #4 was sent to the hospital on 02/02/22 at 6:00pm.
-She was sent to the hospital because she had abdominal pain.
-Resident #4's family member transported her to the hospital.

Review of Resident #4 ER provider note dated 02/02/22 revealed:
-Resident #4 arrived at the hospital due to complaints of constipation.
-She became unresponsive while in the ER and cardiopulmonary resuscitation (CPR) was initiated.
-CPR was administered for 45 minutes and she was given 5 rounds of epinephrine (a medication to make the heartbeat faster and increase breathing rate).
-A time of death was ultimately called but she regained a pulse after an additional 10 minutes.
-The ER provider tried to get a CAT scan of

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Resident #4's abdomen and pelvis but it was rock hard and likely the source of her code.
-Resident #4 was diagnosed with pneumatosis intestinalis (gas cysts in the bowel wall), bowel ischemia (a condition in which inflammation and injury of the large intestines result from inadequate blood supply), pneumoperitoneum (air or gas in the abdominal cavity), and bowel perforation (a hole in the bowels that caused the contents in the bowel to leak into the abdomen).
-The ER provider discussed Resident #4's diagnoses with general surgery.
-Resident #4's pupils were fixed and dilated and she was non-operative.
-Resident #4 was placed on comfort measures (medical treatment of a dying person here the natural dying process is permitted to occur while assuring maximum comfort) only.
-Resident #4 died in the hospital on 02/02/22 at 9:50pm.

Telephone interview with a medical assistant at Resident #4's surgical provider's office on 02/17/22 at 9:17am revealed:
-She received a call on 01/31/22 from Resident #4's family member to find out if an appointment was made for the resident.
-There was no documentation that anyone called before 01/31/22 to schedule an appointment for Resident #4.
-She scheduled an appointment for Resident #4 on 02/09/22.

Interview with Resident #4's POA on 02/17/22 at 5:43pm revealed:
-He was not aware that Resident #4's hospital After Visit Summary on 12/25/21 ordered Resident #4 to follow-up with a surgeon.
-He was not aware that Resident #4 was supposed to follow up with her PCP after her

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hospitalization on 11/17/21 and 12/25/21.
-Resident #4 saw a different surgeon that her GI provider scheduled the second week of January 2022.
-He did not remember the exact date of the appointment.
-The surgeon that saw Resident #4 the second week of January 2022 refused to consider the resident as a surgical candidate.
-Resident #4's GI provider scheduled an appointment with the surgeon that Resident #4 was supposed to follow up within 2 weeks of her hospital discharge on 12/25/21.
-Resident #4's appointment was scheduled for 02/09/22.
-He knew that Resident #4 needed surgery to repair scar tissue in her intestines.
-Resident #4 had complained of loose stools around 01/31/22.
-When Resident #4 had complained to him that she had loose stools, he knew that was an onset of an SBO.
-On 02/02/22, he received a call from Resident #4 late in the afternoon that she needed to go to the hospital for constipation.
-The resident always called him when she needed to go to the hospital because she wanted him to transport her to the ER.
-When he arrived at the facility on 02/02/22, Resident #4 was waiting at the facility door.
-The resident would wait in her room until he arrived and then have staff help her outside to his vehicle.
-When Resident #4 got into his vehicle she was in severe pain and she slurred her words.
-The went into cardiac arrest shortly after she arrived at the hospital.
-He was notified that Resident #4's lower intestines were twisted and died which caused lactic acid to build up in her system.

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-He decided after he spoke with the ER provider and surgeon about her prognosis to make Resident #4 comfort measures only.
-The resident died around 9:00pm on 02/02/22.

Interview with the Resident Care Coordinator (RCC) on 02/17/22 at 9:55am revealed:
-Resident #4 always called her POA if she needed to go to the hospital.
-Resident #4 would notify the medication aides (MA) or the RCC after she called her POA.
-Resident #4 went to the hospital frequently for problems with her bowels and diarrhea.
-The resident always communicated with the personal care aides (PCA) and MA's if she had loose stools or constipation.
-The resident did not have any complaints of loose stools or constipation around 02/02/22.
-She was responsible to schedule residents' follow-up appointments when they returned from the hospital.
-She would receive the resident's hospital After Visit Summary when the resident returned from the hospital.
-She would schedule any follow-up appointments by the next business day.
-She worked with the facility transporter to schedule the resident's appointments.
-If she was unable to schedule an appointment for the resident within the timeframe documented on the hospital After Visit Summary, she would contact the resident's PCP to notify them of the delay.
-Once she scheduled the follow-up appointment, she would document the appointment in her appointment book.
-She received Resident #4's hospital After Visit Summary on 12/27/21.
-Resident #4 returned on 12/25/21 which was a Saturday so she received the hospital After Visit

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Summary on 12/27/21 when she returned to work.
-She did not see that Resident #4 required a follow-up appointment with a surgeon as soon as possible for a visit in 2 weeks.
-She did not schedule a follow-up appointment with Resident #4's PCP on 11/17/21 or 12/27/21.
-She did not schedule a follow-up appoint with Resident 4's GI physician on 11/11/21.
-She must have overlooked it.
-She was concerned that she did not schedule the appointment, because it may have saved Resident #4's life.
-She was not aware that the surgeon's office received a call on 01/31/22 and an appointment was scheduled on 02/09/22.

Interview with the Administrator on 02/17/22 at 10:24am revealed:
-The RCC was primarily responsible to schedule the resident's follow-up appointments when the resident returned from the hospital.
-If a resident returned from the hospital on the weekend, he expected the RCC to schedule any follow-up appointments by the next business day.
-He was not aware that the RCC did not schedule a follow-up appointment for Resident #4 with a surgeon following her 12/25/21 hospitalization.
-He was not aware that an appointment was made with the surgeon's office on 01/31/22 and an appointment was scheduled on 02/09/22.
-He was concerned that the RCC did not schedule the follow-up appointment.

Attempted interview with Resident #4's GI physician on 02/17/22 at 9:43am and 02/18/22 at 8:20am was unsuccessful.

2. Review of Resident #5's current FL-2 dated 09/23/21 revealed diagnoses included end stage

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renal disease, anemia in chronic kidney disease, type 2 diabetes, hereditary and idiopathic neuropathy, and obesity.

Review of the facility's medication administration policy dated July 2020 revealed:
-The medication refusal form was required documentation each time a medication was refused by a resident.
-Communities are required to contact the primary care provider (PCP) when a resident had refused any prescribed medication three consecutive times.
-The PCP notification should be sent via fax and documented in the resident chart.
-Immediate PCP notification with documentation was recommended for each missed dose of the following medications: antibiotics; thyroid medications, anticoagulants, all insulins (rapid acting, regular, and long acting); oral anti-diabetics; cardiovascular; psychotropics; dialysis medications (Phosphorous Binders); and chemotherapeutic agents.
-Under the medication cart audits section, it outlined to ensure PCP notification was documented for greater than 3 occurrences of missed or refused medications, and documentation of notification was completed.

a. Review of Resident #5's primary care provider (PCP) order dated 09/20/21 revealed an order for fingerstick blood sugars (FSBS) before meals at bedtime.

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain a FSBS four times a day before meals and at bedtime scheduled at 7:00am, 11:00am, 4:00pm, and 8:00pm.

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-It was documented Resident #5 refused her FSBS on 12/18/21 at 7:00am, 11:00am, and 8:00pm and on 12/19/21 at 7:00am.
-It was documented Resident #5 refused her FSBS on 12/27/21 at 4:00pm and 8:00pm, and on 12/28/21 at 11:00am.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry to finger stick blood sugar (FSBS) four times a day before meals and at bedtime scheduled at 7:00am, 11:00am, 4:00pm, and 8:00pm.
-It was documented Resident #5 refused her FSBS on 01/15/22 at 11:30am, on 01/17/22 at 11:30am, and on 01/18/22 at 4:30pm.

Review of Resident #5's medical record revealed there was no documentation of PCP notifications due to Resident #5's refusals of her FSBS on 12/18/21-12/19/21, on 01/15/22, and on 01/17/22, and on 01/18/22.

b. Review of Resident #5's primary care provider (PCP) order dated 09/17/21 revealed Sevelamer Carbonate tablet 800mg take 2 tablets (1600mg) twice a day with snacks (Sevelamer Carbonate is medication used to lower phosphate levels for residents who are on dialysis due to severe kidney disease).

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to administer Sevelamer Carbonate 800mg 2 tablets (1600mg) twice a day with snacks scheduled at 2:00pm and 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/03/21 at 7:00pm, on 12/04/21 at 2:00pm, and on 12/05/21

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at 2:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/06/21 at 7:00pm, on 12/07/21 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/10/21 at 7:00pm, on 12/11/21 at 7:00pm, and on 12/12/21 at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/13/21 at 7:00pm, on 12/14/21 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/17/21 at 7:00pm, on 12/18/21 at 2:00pm, on 12/19/21 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/27/21 at 7:00pm, on 12/28/21 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 12/29/21 at 7:00pm, on 12/30/21 at 2:00pm and at 7:00pm.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry to administer Sevelamer Carbonate 800mg 2 tablets (1600mg) twice a day with snacks scheduled at 2:00pm and 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 01/07/22 at 7:00pm, on 01/08/22 at 7:00pm, and on 01/09/22 at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 01/14/22 at 7:00pm, on 01/15/22 at 2:00pm and at 7:00pm, on 01/16/22 at 7:00pm, on 01/17/22 at 2:00pm and at 7:00pm, on 01/18/22 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 01/19/22 at 7:00pm, on 01/20/22 at 2:00pm and at 7:00pm,

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on 01/21/22 at 2:00pm and at 7:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 01/22/22 at 2:00pm and at 7:00pm, on 01/23/22 at 2:00pm and at 7:00pm.

Review of Resident #5's medical record revealed:
-There was no documentation of a PCP notification due to Resident #5's refusals of Sevelamer Carbonate on 12/03/21-12/07/21, on 12/10/21-12/14/21, on 12/17/21-12/19/21, and on 12/27/21-12/30/21.
-There was no documentation of a PCP notification due to Resident #5's refusals of Sevelamer Carbonate on 01/07/22-01/09/22, and on 01/14/22-01/23/22.

Review of Resident #5's electronic medication administration record from 02/01/22-02/16/22 revealed:
-There was an entry to administer Sevelamer Carbonate 800mg 2 tablets (1600mg) three times a day with meals scheduled at 8:00am, 11:00am, and 4:00pm.
-It was documented Resident #5 refused Sevelamer Carbonate 1600mg on 02/05/22 at 11:00am and at 4:00pm, on 02/06/22 at 11:00am and at 4:00pm.

Review of Resident #5's medical record revealed there was no documentation of a PCP notification due to Resident #5's refusals of Sevelamer Carbonate from 02/05/22-02/06/22.

c. Review of Resident #5's primary care provider order (PCP) dated 11/09/21 revealed Humalog U-100 Insulin (Insulin Lispro) four times a day inject 3 units in addition to sliding scale subcutaneously before meals and at bedtime per sliding scale: less than 70=0 units; 149=0 units;

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150-199=1 unit; 200-249=2 units; 250-299=3 units; 300-349=4 units; 350-399=5 units; over 400=Call MD.

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to obtain a finger stick blood sugar (FSBS) four times a day before meals and at bedtime scheduled at 7:00am, 11:00am, 4:00pm, and 8:00pm.
-It was documented Resident #5's FSBS result on 12/05/21 at 8:00pm was 473.
-It was documented Resident #5's FSBS result on 12/18/21 at 4:00pm was 405.
-It was documented Resident #5's FSBS result on 12/19/21 at 8:00pm was 472.
-It was documented Resident #5's FSBS result on 12/24/21 at 4:00pm was 408.

Review of Resident's medical record revealed there was no PCP notifications on 12/05/21 at 8:00pm, on 12/18/21 at 4:00pm, on 12/19/21 at 8:00pm, and on 12/24/21 at 4:00pm.

Interview with a MA on 02/17/22 at 1:07pm revealed:
-If a resident refused a medication three times the RCC would be notified by the MA.
-The MA would also complete a PCP notification to fax and a phone call would be completed to follow-up on the fax.
-The phone call to follow-up on the faxed PCP notification would occur the next business day.

Interview with the Licensed Health Professional Support nurse on 02/18/22 at 9:21am revealed:
-The MAs were responsible to document all resident refusals of medications/FSBS on the resident's eMAR.

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-When a resident refused medications or FSBS, the MA or the RCC should complete a communication note and call the resident's PCP.
-There should be a documentation trail to outline the facility's communication with the resident's PCP which documented the refusals from the resident.
-It was important to keep the resident's PCP update on the resident's refusals of medications or FSBS to obtain medical interventions/orders from the PCP.
-The MAs were expected to follow the facility's medication administration policy which outlined staff should ensure PCP notification was documented for greater than 3 occurrences of refused medications.
-The medication aides (MAs) should have followed Resident #5's PCP order to notify the PCP with all FSBS results over 400mg/dl.
-It was important for staff to follow the PCP's order to call with all FSBS results >400, so medical interventions/orders could be provided to address Resident #5's high FSBS results.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-The MAs were responsible to document all resident refusals of medications/FSBS within the resident's eMAR.
-The MAs should also discuss the medications or FSBS with the resident to make another attempt to administer the ordered medications or to obtain the FSBS.
-The MAs were responsible to communicate the medication refusals or FSBS refusals after 3 occurrences with the resident's PCP by phone or fax.
-She was not aware of all of Resident #5's medication refusals or FSBS refusals.
-She was not aware Resident #5's PCP was not

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notified of her FSBS results greater than 400 on 12/05/21, on 12/18/21, on 12/19/21, and on 12/24/21.
-The MAs were expected to call Resident #5's PCP with all FSBS results greater than 400 as soon as they obtained the FSBS result.
-The MAs were expected to call first then they were responsible to complete a PCP communication note.
-She had concerns Resident #5's PCP was not notified as ordered.
-Resident #5 could experience symptoms of hyperglycemia (a high blood sugar) which could cause confusion and result in falls.

Interview with the Administrator on 02/17/22 at 1:30pm revealed:
-The resident had a right to refuse medications or FSBS.
-The MA was responsible to document all resident refusals within the resident's eMAR.
-The PCP should be notified of medication refusals or FSBS refusals if there was a pattern of resident refusals after a certain number expanding over days, no additional details provided.
-He was not sure after how many medication refusals the staff would notify the RCC.
-He expected the medication aides to notify the RCC of the medication refusals or the FSBS refusals and the RCC would notify the resident's PCP.
-The RCC would notify the resident's PCP by fax or a phone call within a matter of days.
-If there was no response from the resident's PCP, the RCC would be responsible to follow up with the resident's PCP the next business day.

Second interview with the Administrator on 02/18/22 at 11:07am revealed:

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-He was not aware Resident #5's PCP was not notified of her FSBS results greater than 400 on 12/05/21, on 12/18/21, on 12/19/21, and on 12/24/21.
-He expected staff to notify Resident #5's PCP as ordered for all FSBS results greater than 400 immediately after her FSBS result was obtained.
-If there was no PCP notification made, there could be "medical consequences" for Resident #5, no additional details provided.

Attempted telephone interview with Resident #5's PCP on 02/18/22 at 8:30am was unsuccessful.

Attempted telephone interview with Resident #5's Endocrinologist on 02/18/22 at 8:35am was unsuccessful.

Attempted telephone interview with Resident #5's Nephrologist on 02/18/22 at 8:48am was unsuccessful.

3. Review of Resident #1's current FL-2 dated 01/24/22 revealed;
-Diagnoses include multiple sclerosis, essential hypertension, lower extremity weakness, and overactive bladder.
-The resident was non-ambulatory and used a wheelchair for mobility.

Review of a physician's visit summary report dated 11/08/21 revealed Resident #1 was scheduled for a follow-up visit with her local primary care provider (PCP) for 02/08/22 for depression, anxiety, hypertension, and multiple sclerosis.

Telephone interview with Resident #1's PCP's nurse on 02/16/22 at 4:38pm revealed Resident #1 had an appointment with the PCP on 02/08/22

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but she was a "no show" for the appointment.

Interview with Resident #1 on 02/18/22 at 11:00am revealed she was not aware she had an appointment with her PCP on 02/08/22.

Interview with the Resident Care Coordinator (RCC) on 02/17/22 at 3:45pm revealed:
-Resident #1 had an appointment with her PCP on 02/08/22.
-Resident #1 required 2-person assistance for transfers and had to be transported in a wheelchair when going to outside appointments.
-The facility's van was not equipped to transport a resident in a wheelchair.
-The facility contracted with a transportation company to provide transportation for Resident #1 for her appointments.
-Resident #1 was not taken to her appointment with the PCP on 02/08/22 because she did not have enough money in her account at that time to pay for the cost of the transportation service.
-She did not think about exploring other transportation resources for Resident #1.
-It was important for Resident #1 to get to her appointment with her PCP because of her healthcare needs.

Interview with the Administrator on 02/18/22 at 10:31 revealed:
-Resident #1 was not taken to her appointment on 02/08/22 because transportation was not available because the facility's van could not accommodate a resident in a wheelchair.
-The facility contracted with an outside transportation company when Resident #1 had to be taken to an appointment.
-He had communicated with Resident #1's POA/son that there was not enough money in her account to pay for the transportation service from

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the facility to her PCP's appointment on 02/08/22.
-He did not think about exploring alternative transportation resources that may have been more cost effective for Resident #1.
-He was not aware it was the facility's responsibility to ensure transportation to a resident's appointment at no additional cost to the resident.
-It was important that residents were taken to their PCP appointments to ensure their healthcare needs were being met.

4. Review of Resident #3's current FL-2 dated 01/06/22 revealed:
-Diagnoses of diabetes mellitus type 2 without complications, nausea, lower back pain, and chronic obstructive pulmonary disease.
-There was an order for Lispro (a medication used to control high blood sugar) sliding scale insulin (SSI): for fingerstick blood sugar (FSBS) 61-150= 0 units, 151-200= 3 units, 201-250= 5 units, 251-300= 8 units, 301-350=10 units, 351-400= 12 units, greater than 400= 15 units and recheck in 30 minutes if no improvement notify the provider.
-There was an order to check FSBS before meals and at bedtime.

Review of Resident #3's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Lispro SSI: FSBS 61-150 = 0 units, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 =10 units, 351-400 = 12 units, greater than 400 = 15 units and recheck in 30 minutes if no improvement notify the provider.
-FSBS reading from 12/11/21 at 7:00am was 407; there was no documentation that Resident #3's FSBS was rechecked in 30 minutes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 25 -There was no documentation the primary care provider (PCP) was notified. Review of Resident #3's February 2022 eMAR revealed: -There was an entry for Lispro SSI: FSBS 61-150 = 0 units, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 =10 units, 351-400 = 12 units, greater than 400 = 15 units and recheck in 30 minutes if no improvement notify the provider. -FSBS reading from 02/01/22 at 7:00am was 413; there was no documentation that Resident #3's FSBS was rechecked in 30 minutes. -There was no documentation the PCP was notified. Review of Resident #3's progress notes from 12/11/21 to 02/01/22 revealed: -There was no documentation that his FSBS was rechecked in 30 minutes on 12/11/21 and 02/01/22. -There was no documentation that his PCP was notified of his FSBS over 400 on 12/11/21 and 02/01/22. Interview with the Resident Care Coordinator(RCC) 02/18/22 at 11:33am revealed: -The medication aides (MA) were supposed to follow Resident #3's physician order for Lispro SSI: FSBS 61-150 = 0 units, 151-200 = 3 units, 201-250 = 5 units, 251-300 = 8 units, 301-350 =10 units, 351-400 = 12 units, greater than 400 = 15 units and recheck in 30 minutes if no improvement notify the provider. -The MAs were expected to recheck Resident #3's FSBS in 30 minutes if he had a blood sugar over 400. -The MAs were supposed to document the FSBS on Resident #3's progress note.	D 273		

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D 273	Continued From page 26 -The MAs were supposed to notify the PCP if Resident #3's FSBS was still over 400 in 30 minutes. -She did not know that Resident #3 had an FSBS of 407 on 12/11/21 and an FSBS of 413 on 02/01/22. -She was not aware that there was no documentation in Resident #3's progress notes that his FSBS was rechecked in 30 minutes on 12/11/21 and 02/01/22. -She was not aware that there was no documentation in Resident #3's progress note that his PCP was notified of his FSBS over 400. Attempted interview with Resident #4's PCP on 02/18/22 at 7:30am was unsuccessful. _____ The facility failed to ensure referral and follow-up for 4 of 5 residents (#1, #3, #4, #5) including a resident who was not scheduled for a follow-up appointment after a recent hospitalization on 11/11/21, 11/17/21, 12/25/21, and 12/27/21 for complaints of abdominal pain with a surgeon, primary care physician, and GI phyisican for recurrent small bowel obstruction in a timely manner and eventually died from complications (#4); a resident who had diabetes, severe kidney disease and was on dialysis, whose primary care provider (PCP) was not notified of multiple blood sugar levels greater than 400 ranging from 405 to 473, refusals of fingerstick blood sugars (FSBS), and multiple refusals of a medication used to treat a high phosphorus level (#5) greater than 3 occurrences per the facility's established policy.This failure resulted in physical harm, neglect and death to the residents and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/22 for	D 273		

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D 273	Continued From page 27 this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 20, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement orders for 2 out of 5 sampled residents including orders for fluid restrictions (#2) and orders for blood pressure monitoring (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 02/03/22 revealed diagnoses included diabetes mellitus type 2, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, and weakness. Review of Resident #2's primary care provider visit (PCP) note dated 11/18/21 revealed an order to restrict fluids to 1500ml daily for treatment of her chronic congestive heart failure. Review of Resident #2's PCP note dated	D 276		

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12/09/21 revealed an order to restrict fluids to 2000ml a day for treatment of her chronic congestive heart failure.

Interview with the Resident Care Coordinator (RCC) on 02/17/22 at 1:58pm revealed she had no documentation that the ordered fluid restrictions on 11/18/21 and 12/09/21 were implemented for Resident #2.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:
-When fluid restriction was ordered for Resident #2, there was a purpose for the order.
-All PCP orders should be implemented by staff facility or there should be PCP notification if unable to implement.
-There were concerns for the resident by not implementing both orders for the fluid restrictions 1500ml and 2000ml.
-The concerns were a worsening of congestive heart failure or hospitalization.
-She was not aware the orders for fluid restrictions were not implemented and the facility had not requested her to provide a training session on implementing fluid restrictions.

Second interview with the RCC on 02/18/22 at 9:57am revealed Resident #2's PCP orders dated 11/18/21 and 12/09/21 for fluid restriction were not implemented by the facility because she overlooked the orders; it was her "mess up."

Interview with the Administrator on 02/18/22 at 11:07am revealed:
-He was not aware the orders for Resident #2's fluid restrictions dated 11/18/21 and 12/09/21 were not implemented.
-He expected Resident #2's orders for fluid

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restrictions to be implemented by staff.

Refer to the interview with the Administrator on 02/18/22 at 11:07am.

Attempted a telephone interview with Resident #2's PCP on 02/18/22 at 8:26am was unsuccessful.

2. Review of Resident #5's current FL-2 dated 09/23/21 revealed diagnoses included end stage renal disease, anemia in chronic kidney disease, type 2 diabetes, hereditary and idiopathic neuropathy, and obesity.

Review of Resident #5's primary care provider (PCP) visit note dated 09/23/21 revealed an order to monitor blood pressure daily; notify the PCP if BP was elevated above the parameters after administering the medication as ordered.

Review of Resident #5's PCP visit note dated 12/09/21 revealed:
-There was an order to continue Metoprolol Tartrate 25mg 1 tablet with food twice a day on Tuesdays, Thursdays, Saturdays, and Sundays (Metoprolol is a medication used to treat high blood pressure, chest pain, and heart failure).
-There was an order to monitor blood pressures twice a day before administering blood pressure medications and to recheck the blood pressure 1 hour after the administrating the blood pressure medication and to notify the PCP if the blood pressure was greater than 160/90; hold medication if blood pressure is 100/60 or less before taking medication.

Review of Resident #5's December 2021 electronic medication administration record (eMAR) revealed:

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-There was an entry to obtain monthly vitals (temperature, pulse, respirations, blood pressure, and weight) once a day on the 4th of the month scheduled at 3:00pm.
-It was documented Resident #5 was unavailable on 12/04/21 at 3:00pm for her monthly vitals.
-There was an entry for Metoprolol Tartrate 25mg twice a day on Sunday, Tuesday, Thursday, and Saturday; hold Monday, Wednesday, and Friday.
-There was no documentation Resident #5's blood pressure readings before or 1 hour after the administration of Metoprolol Tartrate 25mg from 12/01/21-12/31/21.

Review of Resident #5's January 2022 eMAR revealed:
-There was an entry to obtain monthly vitals (temperature, pulse, respirations, blood pressure, and weight) once a day on the 4th of the month scheduled at 3:00pm.
-On 01/04/22 at 3:00pm, it was documented Resident #5's blood pressure was 148/82.
-There was an entry for Metoprolol Tartrate 25mg twice a day on Sunday, Tuesday, Thursday, and Saturday; hold Monday, Wednesday, and Friday.
-There was no documentation Resident #5's blood pressure readings before or 1 hour after the administration of Metoprolol Tartrate 25mg from 01/01/22-01/31/22.

Review of Resident #5's eMAR from 02/01/22-02/16/22 revealed:
-There was an entry to obtain monthly vitals (temperature, pulse, respirations, blood pressure, and weight) once a day on the 4th of the month scheduled at 3:00pm.
-On 02/04/22 at 3:00pm, it was documented Resident #5's temperature was 98.4 degrees Fahrenheit, her pulse was 82, her respirations were 18, her blood pressure was 136/86, and her

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weight was 193 pounds.
-There was an entry for Metoprolol Tartrate 25mg twice a day on Sunday, Tuesday, Thursday, and Saturday; hold Monday, Wednesday, and Friday.
-There was no documentation Resident #5's blood pressure was monitored before or 1 hour after the administration of Metoprolol Tartrate 25mg from 02/01/22-02/16/22.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:
-She was not aware the staff was not monitoring Resident #5's before or 1 hour after the administration of Metoprolol Tartrate per the PCP's order dated 12/09/21.
-There were concerns related to the facility not monitoring Resident #5's blood pressure before and after the administration of Metoprolol Tartrate.
-If the resident's blood pressure reading was lower than the parameter 100/60 and Metoprolol Tartrate was administered this could cause the resident to experience hypotension (hypotension is a low blood pressure).
-Hypotension could cause fainting/dizziness which could result in a fall or the resident could go to sleep and be hard to arouse.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed Resident #2's PCP orders dated 09/23/21 and 12/09/21 were not implemented by the facility because she overlooked the orders to monitor Resident #5's blood pressure.

Interview with the Administrator on 02/18/22 at 11:07am revealed:
-He was not aware the order to monitor Resident #5's blood pressure before and after the

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D 276	Continued From page 32 administration of Metoprolol Tartrate was not implemented. -He expected Resident #5's orders for blood pressure monitoring to be implemented by staff. -He had concerns that the facility did not implement the PCP's orders to monitor Resident #5's blood pressure. -His concerns included this could cause "medical consequences" for Resident #5. Refer to the interview with the Administrator on 02/18/22 at 11:07am. Attempted a telephone interview with Resident #5's PCP on 02/18/22 at 8:30am was unsuccessful. _____ Interview with the Administrator on 02/18/22 at 11:07am revealed: -He expected the RCC to process all residents' paperwork which included PCP visit notes, specialty provider visits notes, hospital discharge paperwork, etc. the same day. -All PCP orders should be implemented by staff, if the staff was unable to implement, the staff should notify the PCP. -It was important for all PCP orders to be implemented because it was an order from the resident's PCP.	D 276		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation	D 321		

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to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to provide transportation for 1 of 5 sampled residents (#1) resulting in a missed follow-up appointment with her primary care provider (PCP).

The findings are:

Review of Resident #1's current FL-2 dated 01/24/22 revealed:
-Diagnoses include multiple sclerosis, essential hypertension, lower extremity weakness, and overactive bladder.
-She was non-ambulatory and used a wheelchair for mobility.

Review of a physician's visit summary report dated 11/08/21 revealed Resident #1 was scheduled for a follow-up visit with her (PCP) on 02/08/22 for depression, anxiety, hypertension, and multiple sclerosis.

Telephone interview with the nurse at Resident #1's PCP's office on 02/16/22 at 4:38pm revealed Resident #1 had an appointment with the PCP on 02/08/22 but she was a "no show" for the appointment.

Interview with Resident #1 on 02/18/22 at

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D 321	Continued From page 34 11:00am revealed she was not aware she had an appointment with her PCP on 02/08/22 or that there was a transportation issue with this appointment. Interview with the Resident Care Coordinator (RCC) on 02/17/22 at 3:45pm revealed: -Resident #1 required 2-person assistance with transfers and used a wheelchair when transported to appointments. -The facility's van was not equipped to transport a resident in a wheelchair. -The facility contracted with an outside transportation company to provide transportation for Resident #1 when she had appointments. -Resident #1 was not taken to her appointment with the PCP on 02/08/22 because she did not have enough money in her account at that time to pay for the cost of an outside transportation service. -She did not think about exploring other transportation resources for Resident #1. -She was not aware the facility was responsible for ensuring the provision of transportation to the resident without charging an additional fee. Interview with the Administrator on 02/18/22 at 10:31 revealed: -Resident #1 was not taken to her appointment on 02/08/22 because the facility's van could not accommodate a resident in a wheelchair. -The facility scheduled transportation with an outside transportation company when Resident#1 had to be taken to an appointment. -He had communicated with Resident #1's power of attorney (POA) prior to 02/08/22 that there was not enough money in her account to pay for the transportation service. -He did not think about exploring alternative resources such as county medical transportation	D 321		

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D 321	Continued From page 35 that may have been more cost effective for Resident #1. -He was not aware that he was responsible for ensuring the provision of transportation to the resident at no additional cost.	D 321		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#6) observed during the medication pass including errors with medications for diabetes, an antihypertensive, an iron supplement, a vitamin, and a lipid-regulating medication and for 1 of 5 residents sampled for record review including a five-day delay in initiating an antibiotic for treatment of a urinary tract infection (#2). The findings are: Review of the facility's medication administration policy dated July 2020 revealed: -It was the standard of the facility to ensure medication orders are processed and	D 358		

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implemented based on physician/provider orders.
-Medication cart audits are completed to ensure medications are in the community and are available for administration.
-Medication cart audits are completed on Wednesday and the audits are scanned to the F Drive on Fridays.
-Medication cart audits required the following steps: 1-print all the physician's orders; 2-assign each medication aide on each shift a designated number of rooms to complete the cart audit within 24 hours; 3-remove any expired medications; 4-check for restocking of medications; 5-ensure all "held per MD order" exceptions had a corresponding physician's order; 6-check meds-on-hand for all "resident refused" medications to ensure the medication was available; 7-ensure MD notification was documented for greater than 3 occurrences of missed or refused medications, and documentation of notification was complete; and 8-ensure all as needed medications administered have documentation of follow-up/effectiveness.

1. The medication error rate was 19% as evidenced by the observation of 6 errors out of 31 opportunities during the 8:00am medication pass on 02/17/22.

Review of Resident #6's current FL-2 dated 10/07/21 revealed diagnoses included dementia and diabetes mellitus type 2.

a. Review of Resident #6's primary care provider (PCP) order report dated 10/07/21 revealed there was an order for Metformin 500 mg take 1 tablet twice daily (Metformin is a medication used to regulate blood glucose).

Review of Resident #6's February 2022 electronic

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medication administration record (eMAR) revealed there was an entry for Metformin 500mg 1 tablet twice a day scheduled for 9:00am and 9:00pm.

Observation of the 8:00am medication pass on 02/17/22 revealed the medication aide (MA) administered Resident #6 Metformin 1000mg at 8:05am.

Interview with the medication aide (MA) on 02/17/22 at 1:07pm revealed she was not aware she administered 1000mg of Metformin which did not match the PCP's order dated 10/07/21.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:
-If a resident received a higher than ordered dose of an anti-diabetic medication the resident could experience the symptoms of hypoglycemia (Hypoglycemia is also known as a low blood sugar).
-The resident could become lightheaded, experience shakiness, confusion, anxiety, and experience heart palpitations.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6' s medication orders dated 10/07/21.
-The current order for Resident #6's Metformin was 500mg twice a day.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

Refer to interview with the MA on 02/17/22 at 1:07pm.

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Refer to interview with the LHPS nurse on 02/18/22 at 9:21am.

Refer to interview with the RCC on 02/18/22 at 9:57am.

Refer to interview with the Administrator on 02/17/22 at 1:30pm.

Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am.

Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am.

b. Review of Resident #6's primary care provider (PCP) order report dated 10/07/21 revealed there was an order for Glimepiride 4 mg take 1.5 tablets (6mg) with the first meal of the day (Glimepiride is a medication used to regulate blood glucose).

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was no entry for Glimepiride 6mg.

Observation of the 8:00am medication pass on 02/07/22 revealed the medication aide (MA) administered Resident #6 Glimepiride 4mg at 8:05am.

Interview with the MA on 02/17/22 at 1:07pm revealed she was not aware when she administered 4mg of Glimepiride it did not match the PCP's order dated 10/07/21.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:

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-If a resident received a lower than ordered dose of an anti-diabetic medication the resident could experience the symptoms of hyperglycemia (Hyperglycemia is also known as a high blood sugar).
-The resident could experience weakness, confusion, and nausea/vomiting.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6's medication orders dated 10/07/21.
-The current order for Resident #6's Glimepiride was 6mg with the first meal of the day.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

Refer to interview with the MA on 02/17/22 at 1:07pm.

Refer to interview with the LHPS nurse on 02/18/22 at 9:21am.

Refer to interview with the RCC on 02/18/22 at 9:57am.

Refer to interview with the Administrator on 02/17/22 at 1:30pm.

Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am.

Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am.

c. Review of Resident #6's primary care provider (PCP) order report dated 10/07/21 revealed there was an order for Diltiazem HCL 360mg take 1

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capsule every day (Diltiazem is used to treat high blood pressure and chest pain).

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was an entry for Diltiazem HCL capsule, extended release 360mg take 1 capsule every day scheduled for 9:00am.

Observation of the 8:00am medication pass on 02/07/22 revealed the medication aide (MA) administered Resident #6 Diltiazem HCL 240mg at 8:05am.

Interview with the MA on 02/17/22 at 1:07pm revealed she was not aware when she administered 240mg of Diltiazem it did not match the entry on the MAR.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:
-If a resident received a lower than ordered dose of an anti-hypertension medication the resident could experience the symptoms of hypertension (hypertension is also known as a high blood pressure).
-The resident could experience headaches, an irregular heart rate, or confusion which could result in a resident fall.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6's medication orders dated 10/07/21.
-She did not have the order for Resident #6's Diltiazem 240mg administered on 02/17/22.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

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D 358	Continued From page 41 Refer to interview with the MA on 02/17/22 at 1:07pm. Refer to interview with the LHPS nurse on 02/18/22 at 9:21am. Refer to interview with the RCC on 02/18/22 at 9:57am. Refer to interview with the Administrator on 02/17/22 at 1:30pm. Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am. d. Review of Resident #6's primary care provider (PCP) report dated 10/07/21 revealed there was no order for Ferrous Sulfate (Ferrous Sulfate is a medication used to treat and prevent iron deficiency anemia). Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was no entry for Ferrous Sulfate. Observation of the 8:00am medication pass on 02/07/22 revealed the medication aide (MA) administered Resident #6 Ferrous Sulfate 325mg at 8:05am. Interview with the MA on 02/17/22 at 1:07pm revealed -She was not aware when she administered Ferrous Sulfate 325mg there was not a PCP order.	D 358		

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-She was not aware there was not an entry on Resident #6's eMAR to document the administration of Ferrous Sulfate 325mg.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6's medication orders dated 10/07/21.
-She did not have the current order for Resident #6's Ferrous Sulfate 325mg.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

Refer to interview with the MA on 02/17/22 at 1:07pm.

Refer to interview with the LHPS nurse on 02/18/22 at 9:21am.

Refer to interview with the RCC on 02/18/22 at 9:57am.

Refer to interview with the Administrator on 02/17/22 at 1:30pm.

Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am.

Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am.

e. Review of Resident #6's primary care provider (PCP) order report dated 10/07/21 revealed there was no order for Gemfibrozil (Gemfibrozil is a medication used to lower high cholesterol and triglyceride levels in the blood).

Review of Resident #6's February 2022 electronic

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medication administration record (eMAR) revealed there was no entry for Gemfibrozil.

Observation of the 8:00am medication pass on 02/07/22 revealed the medication aide (MA) administered Resident #6 Gemfibrozil 600mg at 8:05am.

Interview with the MA on 02/17/22 at 1:07pm revealed:
-She was not aware when she administered Gemfibrozil 600mg there was not a PCP order.
-She was not aware there was not an entry on Resident #6's eMAR to document the administration of 600mg of Gemfibrozil.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6's medication orders dated 10/07/21.
-She did not have the current order for Resident #6's Gemfibrozil 600mg.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

Refer to interview with the MA on 02/17/22 at 1:07pm.

Refer to interview with the LHPS nurse on 02/18/22 at 9:21am.

Refer to interview with the RCC on 02/18/22 at 9:57am.

Refer to interview with the Administrator on 02/17/22 at 1:30pm.

Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am.

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Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am.

f. Review of Resident #6's primary care provider (PCP) order report dated 10/07/21 revealed there was no order for Folic Acid (Folic Acid is a medication used to treat anemia).

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed there was no entry for Folic Acid.

Observation of the 8:00am medication pass on 02/07/22 revealed the medication aide (MA) administered Resident #6 Folic Acid 1mg at 8:05am.

Interview with the MA on 02/17/22 at 1:07pm revealed:
-She was not aware when she administered Folic 1mg there was not a PCP order.
-She was not aware there was not an entry on Resident #6's eMAR to document the administration of 1mg of Folic Acid.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-Yesterday, 02/17/22, she could only locate Resident #6's medication orders dated 10/07/21.
-She did not have the current order for Resident #6's Folic Acid 1mg.
-She had requested clarification from Resident #6's PCP while she was onsite on yesterday, 02/17/22.

Refer to interview with the MA on 02/17/22 at 1:07pm.

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D 358	Continued From page 45 Refer to interview with the LHPS nurse on 02/18/22 at 9:21am. Refer to interview with the RCC on 02/18/22 at 9:57am. Refer to interview with the Administrator on 02/17/22 at 1:30pm. Refer to interview with Resident #6's PCP on 02/18/22 at 9:03am. Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at 11:55am. _____ Interview with the MA on 02/17/22 at 1:07pm revealed: -She was the MA administering medications to residents on 02/17/22 during the 8:00am medication pass. -Before the administration of medications to a resident she would verify the 5 medication rights. -The 5 rights were the right resident, the right medication, the right dose, the right route, and the right time. -It was part of her process to verify the PCP's order with the medication prior to administration. -She used the scanner present on the medication cart to scan the medications' barcodes. -By scanning the medications, an alert would appear on the computer screen, for example, if it was not the right dose or right medication. -All new medication orders were sent to the facility's contracted pharmacy by the RCC. -There should be a notification on the eMAR if there was a new medication order, the notification appeared as an "icon" when there was a pending approval. -The RCC was the only staff member that could	D 358		

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approve a new medication on the eMAR system.
-Resident #6's medications were not ordered/received through the facility's main pharmacy.
-She was not sure how the process worked through Resident #6's pharmacy.

Interview with the RCC on 02/18/22 at 9:57am revealed:
-When a new medication order was received at the facility, the order came to her.
-It was her responsibility to fax the new medication order to the pharmacy.
-She let the MA know the resident had a new medication order.
-Once the new medication was received at the facility, she approved the medication on the eMAR.
-She was the only staff at the facility that could approve a new medication on the eMAR.
-If a new medication order was received in the evening time or on the weekends, the MAs called or texted her with the new medication order.
-She could approve a new medication order remotely when verifying the correct order was on the resident's eMAR.
-There was a daily medication cart audit schedule posted with the medication room in the facility.
-The schedule included the first shift (7:00am-3:00pm) MA, the second shift (3:00pm-11:00pm) MA, and the third shift (11:00pm-7:00am) MA.
-Each MA was assigned three medication cart audits per shift; the residents' rooms were listed per shift on the schedule.
-She printed out the current PCP orders and would provide them to the MA for completion of the medication cart audit.
-The MA was responsible to check each medication that was ordered was in the

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medication cart.
-The MAs would sign, and date the resident's PCP orders and would document if there no discrepancies or if discrepancies were identified.
-She could not recall the last time a medication audit had been done, it was not done last week.
-The medication orders should be verified by the MAs prior to administration.
-Her concerns from the medication errors were the resident could be become confused which could increase their chance of falls or a resident death could occur.

Interview with the Administrator on 02/17/22 at 1:30pm revealed:
-For a new medication order, the RCC was responsible to fax the medication order to the pharmacy.
-The RCC was responsible to verify the correct mediation which included the right dosage was transcribed onto the resident's eMAR prior to her approval.
-The facility's process to ensure the residents' medications were administered as ordered was a check and balance system between the RCC and the LHPS nurse and medication cart audits.
-The LHPS nurse was at the facility once per week but he was not sure the number of records that were audited or how often.
-The medication cart audits were part of the RCC's process to verify the right medications were in the cart.
-He was not sure how often the medication cart audits were completed or if there were deficiencies found during the medication cart audit were documented by staff.
-He expected record and medication cart audits to be completed a couple times per month by the RCC but not every resident.
-He was aware the RCC and the LHPS nurse

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were constantly reviewing the records of "high acuity" residents.
-He expected the residents' medications to be administered as ordered which included the 5 medication rights.
-The medication errors should have been caught prior to the administration of Resident #6's medications during the 8:00am medication pass.
-There were serious concerns Resident #6's medications were administered and there were no PCP orders, or the dosage was incorrect and did not match the PCP's orders at the facility.
-The medication errors could cause potential harm to the resident's health.

Interview with Resident #6's primary care provider on 02/18/22 at 9:03am revealed:
-She expected Resident #6's medications to be administered as ordered.
-She expected the facility to complete medication cart audits monthly for all residents at the facility to ensure the medications were administered as ordered.
-She was not sure why the facility did not have medication orders or the medication orders with the correct dosages onsite or where the disconnect existed.
-While she was onsite on 02/17/22, she received a request from the RCC to clarify Resident #6's orders for Ferrous Sulfate, Folic Acid, Gemfibrozil, Diltiazem, Glimepiride, and Metformin, but not prior to 02/17/22.
-She has not had any problems with the facility, this was all new to her.
-There was no response provided about the concerns for Resident #6's identified medication errors.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/18/22 at

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11:55am revealed:
-He had concerns with the observed medication errors related to the administration of Metformin, Glimepiride, and Diltiazem to Resident #6.
-The concerns with medication errors were the resident was administered subtherapeutic and over-therapeutic medication doses which could result in a resident hospitalization or resident death.

2. Review of Resident #2's current FL-2 dated 02/03/22 revealed diagnoses included gastritis, gastroesophageal reflux disease, diabetes mellitus type 2, hypertension, atrial fibrillation, chronic obstructive pulmonary disease, anemia, hyperlipidemia, weakness, and right eye vision loss.

Review of Resident #2's lab final report dated 01/08/22 revealed:
-The collection date and time was 01/06/22 at 3:38pm.
-The specimen for a urinalysis was received at the lab on 01/08/22 at 9:29am.
-The urinalysis was positive for leukocytes with a result of 15 (leukocytes are white cells and when detected in urine can indicate an infection).

Review of Resident #2's primary care provider (PCP)'s order dated 01/06/22 revealed to start Bactrim DS 1 tablet every 12 hours for 5 days (Bactrim is a medication used to treat or prevent infections).

Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Bactrim 800-160mg take 1 tablet every 12 hours for 5 days scheduled for 9:00am and 9:00pm.

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-It was documented Resident #2's Bactrim 800-160mg was administered from 02/11/22 to 02/15/22 at 9:00am and 9:00pm.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 02/18/22 at 11:00am revealed:
-Resident #2's PCP's order dated 01/06/22 to start Bactrim DS 1 tablet every 12 hours for 5 days was received at the pharmacy on 01/09/22.
-Resident #2's Bactrim DS 1 tablet was dispensed to the facility on 01/10/22 at 8:15pm.
-Resident #2's Bactrim DS arrived at the facility on 01/10/22 at 10:24pm.

Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/22 at 9:21am revealed:
-She was not aware of the 5-day delay in starting Resident #2's ordered antibiotic.
-An antibiotic should be started the next day after the PCP's order was received.
-If the facility had issues with obtaining the resident's antibiotic from the main contracted pharmacy the facility should have used their emergency pharmacy.
-Resident #2's kidneys were not working at a 100% and a delay in starting her antibiotic for treatment of a urinary tract infection, could have caused her to become delirious, experience a loss of appetite, dehydration, the resident could have gotten worse and required a hospitalization.

Interview with the Resident Care Coordinator (RCC) on 02/18/22 at 9:57am revealed:
-She was aware of the 5-day delay in starting Resident #2's ordered Bactrim DS.
-There was a delay because the pharmacy would not the fill prescription because the PCP that wrote the order for Bactrim DS was not listed as a

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Medicaid provider.
-There were concerns that Resident #2 had a 5-day delay, "that was a big problem." provided).
-She should have followed closer with the facility's contracted pharmacy and Resident #2's PCP.

Interview with the Administrator on 02/18/22 at 11:07am revealed:
-An order for an antibiotic should be implemented immediately or as soon as the medication was received at the facility.
-He was not aware Resident #2 had a 5-day delay in the initiation of her ordered Bactrim for treatment of her urinary tract infection.
-The delay was not "good" for the resident, no additional details provided.
-There was no reason there should be a 5-day delay.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Attempted telephone interview with Resident #2's PCP on 02/18/22 at 8:26am was unsuccessful.

_____

The facility failed to administer medications as ordered for 2 of 6 sampled residents (#2 and #6) which included a 19% medication error rate which resulted in medication administration errors for 2 medications for diabetes and 1 antihypertensive medication which resulted in Resident #2 receiving over-therapeutic and subtherapeutic doses of three medications including an antihypertensive medication which increased the resident's risk for headaches, an irregular heart rate, confusion, or a fall, and medications used to control blood glucose levels which increased the resident's risk to become lightheaded, experience shakiness, confusion, anxiety, heart palpitations,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL077010	A. BUILDING: _____ B. WING _____	R 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMLET HOUSE	632 FREEMAN MILL ROAD HAMLET, NC 28345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 52 weakness, nausea, hospitalization, or death and a 5-day delay initiating an antibiotic for a resident with a urinary tract infection (#2). The facility's failure was detrimental to the health and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 02/17/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 4, 2022. _____	D 358		
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, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#6) observed during the medication pass including	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 53 errors with medications for diabetes, an antihypertensive, an iron supplement, a vitamin, and a lipid-regulating medication and for 1 of 5 residents sampled for record review including a five-day delay in initiating an antibiotic for treatment of a urinary tract infection (#2). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure physician notification and follow-up with health care providers for 4 of 5 (#1,#3,#4,#5) sampled residents related to a resident who was ordered to follow-up with a surgeon 2 weeks after a hospitalization related to recurrent small bowel obstructions (obstruction in the small or large intestine, causing difficulty in passing digested material normally through the bowel) (#4);	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D914	Continued From page 54 residents who had orders to notify their primary care providers (PCP) for blood sugars over 400 (#3,#5); a resident that had multiple medication refusals that were not reported to her PCP after 3 refusals (#5); a resident who was supposed to have a follow-up appointment with her PCP related to a 3-month follow-up appointment (#1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).]	D914		