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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/23/22 through 03/24/22.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to provide supervision for 3 of 5 residents (#1, #2, and #3) related to two residents who had multiple falls resulting in injuries including fractures (#1, #2) and a resident with two unwitnessed falls (#3) . The findings are: Review of the facility's Fall Prevention Policy on 03/24/22 revealed the facility did not have a Fall Prevention Policy. Review of the resident rounds policy dated 12/14/12 revealed: -Rounds are scheduled every two hours on all residents in the facility. -Residents who are classified as wanderers are rounded on every one hour. -Rounds are done for the protection and safety of all residents. -If there was a resident that staff thinks needs to	D 270		

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be checked on more frequently "please do so."

1. Review of Resident #2's current FL-2 dated 07/1/21 revealed:
-Diagnoses included atrial fibrillation (irregular heartbeat), hypertension, anemia, anxiety, and memory loss.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #2's care plan dated 07/01/21 revealed:
-The resident required limited assistance for ambulation and transfer.
-The resident required extensive assistance for toileting, bathing, dressing and grooming.

Observation of Resident #2 on 03/24/22 at 3:46pm revealed she was in a wheelchair at the nursing station.

a. Review of Resident #2's incident and accident report dated 10/27/21 at 10:15am revealed:
-Resident #2 was found in the bathroom on the floor.
-Resident reported she was walking in her room and fell when was unable to get up.
-Resident stated that she scooted to the bathroom and pulled the call light.
-No injuries noted.
-There was no documentation of fall interventions put in place after the fall.

b. Review of Resident #2's incident and accident report dated 12/16/21 at 1:55pm revealed:
-Resident #2 was found behind her room door.
-Resident stated that she hit her head.
-No injury noted initially, until resident attempted to ambulate and complained of right hip pain.
-EMS was called and the resident was

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transported to a local ER.

Review of Resident #2's progress note dated 12/16/21 at 2:00pm revealed:
-Resident had an unwitnessed fall and an incident and accident report were completed.
-She was sent to the hospital for evaluation.

Review of Resident #2's hospital discharge summary dated 12/22/21 revealed:
-She was hospitalized from 12/16/21 to 12/22/21.
-She had a discharge diagnosis of a fall with a pelvic fracture.
-She was discharged to the facility with home health for physical therapy (PT) services.

Review of Resident #2's progress notes dated 12/22/21 at 8:45pm revealed:
-She returned to the facility from the hospital earlier in the evening.
-Resident #2 was found by a personal care aide (PCA) on the floor in her room.
-The PCA informed the medication aide (MA) to go to the resident's room because of a fall.
-Resident reported she felt dizzy and hit her head.
-She was sent to the ER.
-There was no documentation of fall interventions put in place for the resident.

Review of Resident #2's Incident and Accident reports facility file revealed there was no incident and accident report dated 12/22/21.

c. Review of Resident #2's incident and accident report dated 12/28/21 at 7:06pm revealed:
-She was found on the floor in her room during medication pass.
-The resident stated she was trying to get out of bed and hit her head.
-EMS was called but the resident and power of

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attorney (POA) refused to have resident sent to the local ER for evaluation.
-Staff was to monitor the resident throughout the night.

d. Review of Resident #2's incident and accident report dated 12/31/21 at 2:00pm revealed:
-She was found sitting in her wheelchair with a 2 to 3 inch wound on her right calf.
-Resident reported she fell in the bathroom and hit her leg on the toilet.
-She stated that she pulled herself off the floor and back into her wheelchair.
-The fall was unwitnessed.
-EMS was called and resident was sent to the hospital for evaluation.

Review of Resident #2's progress note dated 12/31/21 at 2:00pm revealed:
-Resident had an unwitnessed fall in the bathroom.
-She had a 2-to-3-inch wound on her right calf.
-She was sent to the local ER for evaluation.

Review of Resident #2's hospital ER discharge summary dated 12/31/21 revealed discharge diagnosis for ER visit was fall with open wound of leg; the wound required sutures.

e. Review of Resident #2's incident and accident report dated 01/25/22 at 5:30pm revealed:
-The resident was found on the floor in her room between the nightstand and bed.
-She stated she was putting herself to bed.
-There were no injuries noted.
-There was no documentation of fall interventions put in place for the resident.

Review of Resident #2's progress note dated 01/25/22 at 5:30pm revealed:

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D 270	Continued From page 4 -The resident was found on the floor in her room with no injuries noted. -There was no documentation of fall interventions put in place for the resident. f. Review of Resident #2's incident and accident report dated 02/01/22 at 7:10pm revealed: -Resident was found sitting on her bedroom floor. -Resident #2 stated that she hit her head but did not complain of pain. -There were no signs of injury noted to her head, but the resident had a skin tear on her right lower leg. -The resident was monitored throughout the night. -There was no documentation of fall interventions put in place for the resident. Review of Resident #2's progress notes dated 02/01/22 at 7:15pm revealed resident was found on floor and there was a skin tear noted to right lower leg. g. Review of Resident #2's incident and accident report dated 02/04/22 at 3:40am revealed: -The resident was found sitting on the floor by her bed. -The resident stated that she fell getting out of the bed. -There were no injuries noted. -There was no documentation of fall interventions put in place for the resident. Review of Resident #2's progress note dated 02/04/22 at 3:40am revealed the resident was found on the bedroom floor and she stated that she was attempting to get out of bed. -There was no documentation of fall interventions put in place for the resident.	D 270		

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D 270	Continued From page 5 h. Review of Resident #2's incident and accident report stated 02/05/22 at 4:43am revealed: -The resident was found on the floor next to her bed on her back. -Her right arm was behind her head, twisted under her back. -Her right arm appeared to be broken. -EMS was called to the facility and was unable to obtain a blood pressure. -The resident was sent to a trauma center for evaluation. -There was no documentation of fall interventions put in place for the resident. Review of Resident #2's progress note dated 02/05/22 at 4:43am revealed the resident was found on floor bedside her bed, her right arm was possibly broken, and she was sent to the trauma center hospital. -There was no documentation of fall interventions put in place for the resident. Review of Resident #2's discharge summary dated 02/05/22 revealed her discharge diagnosis was humerus fracture post fall, her right arm was splinted with a sling, and she was to return to the facility. Review of Fall Prevention Interventions in place effective 01/20/22 for Resident #2 revealed: -Resident floor should be kept free of clutter, call light within reach and she should have on socks and shoes. -Encourage her to use the call light and allow staff to provide assistance. -Conduct routine rounds every two hours and in between to ensure stability. -Her wheelchair should be locked during transfers. -When the resident was awake; keep her at the	D 270		

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nurse's station and/or close by for more frequent monitoring.
-Respond promptly when the resident used her call light.
-Answer and/or respond to telephone calls that resident frequently makes to the nurse's station for needs.

Interview with a personal care aide (PCA) on 03/24/22 at 4:37pm revealed:
-She was expected to monitor residents by checking on them every 30 minutes or once an hour post fall.
-PCAs did not document their checks on residents but the MAs were responsible for documenting the checks that PCAs reported to them verbally.
-She made sure the call bell was in place, bed lowered, and her room was free from clutter.
-She participated in staff meetings prior to her shift to obtain updates on residents and referred to the Repeat Book for updates on resident changes and needs.

Interview with a MA on 03/24/22 at 4:50pm revealed:
-She and the PCAs checked on the resident as often as possible to ensure she had her call bell within reach and did not have any unmet needs.
-Resident #2 would try to get up on her own and would not always use her call bell.
-She would keep the resident near the nurse's station in order to monitor her more closely to prevent falls.
-Residents were monitored every two hours but after they had a fall, they were monitored every hour.

Interview with the Registered Nurse for Resident Supervision (RNRS) on 03/24/22 at 5:20pm

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revealed:
-Staff were expected to monitor resident who fell at least every hour.
-Updates were provided at each shift change and residents who had a fall were placed on increased monitoring.
-The facility staff used a Repeat Book that provided a written notification of falls and reminded staff to check on residents every hour; the Repeat Book was a notebook kept at the nurse's station.

Interview with the Administrator on 03/24/22 at 6:09pm revealed:
-She expected staff to provide supervision of residents to ensure they were safe.
-Residents were monitored every two hours but if they had a fall, they were monitored every hour.
-Staff were expected to refer to the Repeat Book for updated on residents with any significant changes and each shift provided an update to the oncoming shift.
-Staff were expected to increase monitoring from every two hours to every hour to prevent future incidents.

Attempted telephone interview with Resident #2's power of attorney (POA) on 03/24/22 at 4:21pm was unsuccessful.

Attempted telephone interview with Resident #2's primary care provider (PCP) on 03/24/22 at 3:00pm was unsuccessful.

Based on observations and record reviews, it was determined that Resident #2 was not interviewable.

2. Review of Resident #1's current FL-2 dated 03/22/22 revealed:

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-Diagnoses included memory loss, osteoarthritis and osteoporosis.
-She was semi-ambulatory.
-She was constantly disoriented.
-She was continent of bowel and bladder.

Review of Resident #1's current care plan dated 03/22/22 revealed:
-She required extensive assistance from staff for toileting, ambulating, grooming and transfer.
-She was totally dependent on staff for bathing and dressing.
-She required supervision from staff for eating.

Review of Resident #1's physician's order dated 10/12/21 revealed an order to continue fall precautions.

Observation of Resident #1 on 03/24/22 at 8:56am revealed she was sitting inside the nursing station and had a wound on her nose and scab on her top lip.

a. Review of an Accident/Incident report for Resident #1 date 12/10/22 revealed:
-She fell off the toilet attempting to stand up.
-The fall was unwitnessed.
-There was no injury noted.

Review of Resident #1's progress note dated 12/10/21 at 1:35pm revealed she slid off of the toilet while trying to get up without assistance.

Review of Resident #1's progress note dated 02/14/22 at 11pm revealed she had fallen on the floor and requested Tylenol for pain.

b. Review of an Accident/Incident report for Resident #1 dated 02/15/22 revealed:
-Resident #1 had an unwitnessed fall on

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02/14/22.
-There was no bleeding or bruising.
-Resident #1 complained of right hip pain.

Review of Resident #1's record revealed there was no Accident/Incident report for 02/15/22.

Review of Resident 1's Primary Care Provider (PCP) visit note dated 02/15/22 revealed:
-Resident #1 fell "a couple days ago" but no acute injury was noted at the time of the fall.
-She was complaining of right hip pain.
-There was no bruising or swelling over the right hip area, however she was unable to bear weight and had decreased range of motion.
-There was an x-ray done that suggested concern for hip fracture, but she was being sent the emergency room for a follow-up CT scan.

Review of Resident #1's Assisted Living Hospital Transfer form dated 02/15/22 revealed:
-She fell on 02/15/22.
-A portable x-ray showed a hip fracture.
-Resident #1's PCP and family requested a CT for severity.

Review of an email dated 03/24/22 sent from Resident #1's Power of Attorney (POA) to the Registered Nurse for Resident Supervision (RN/RS) revealed:
-The radiologist assistant informed her on 02/15/22 that her family member had a fracture in her pelvic region and did not require surgery.
-She agreed with the plan of care to return her family member to the facility with pain control medication and non-weight bearing status.

c. Review of an Accident/Incident report for Resident #1 dated 02/23/22 revealed:
-She was found on the floor of her bathroom and

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stated she had hit her head.
-She was making conversation that "did not make sense".
-She was sent to the ER for evaluation.

Review of Resident #1's discharge summary from the local ER dated 02/23/22 revealed she was seen for a fall with a head injury and released to follow-up with her PCP.

d. Review of an Accident/Incident report for Resident #1 dated 03/09/22 revealed:
-She was found on the floor of her bedroom between her recliner and her nightstand.
-She complained that her bottom was hurting, and she had "knot" on the back of her head on the right side.

Review of Resident #1's discharge summary from the local ER dated 03/09/22 revealed she was seen for a fall with a head injury and released to follow-up with her PCP.

e. Review of an Accident/Incident report for Resident #1 date 03/21/22 revealed she fell "headfirst from her wheelchair" while going down the hall to her room and sustained a rug burn to her forehead.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

Interview with Resident #1's POA on 03/24/22 at 2:55pm revealed:
-The fall on 02/14/22 resulted in a pelvic fracture and she was sent back to the facility on no weight bearing status and no surgery was indicated.
-She would expect the facility and hospice to put interventions in place to prevent falls from

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occurring.
-She had been a nurse and thought there should be fall risk assessments done on admission and after a fall to identify interventions.

Interview with a personal care aide (PCA) on 03/24/22 at 4:38pm revealed:
-Resident #1 usually fell at night.
-Resident #1 was monitored closely throughout the day by keeping her close to the nursing station.
-She was not aware of any other interventions put into place to prevent falls.

Interview with a medication aide (MA) on 03/24/22 at 5:44pm revealed:
-Staff began monitoring Resident #1 at the nursing station on 03/21/22.
-The back cushion was removed from Resident #1's wheelchair on 03/21/22 because they were concerned the cushion caused her to sit too far forward and may contribute to falls.
-Resident #1 was monitored every hour beginning on 03/21/22 but was monitored every two hours prior to that being put into place.
-She did not remember any intervention being put into place prior to 03/21/22.

Review of Resident #1's Fall Prevention Interventions sheet on 03/24/22 revealed:
-Effective 02/14/22 interventions included keeping floors free of clutter, call light within reach, socks and shoes on, encourage resident use call light and allow staff time to help, routine every 2 hour rounds and in between to ensure stability, Wheelchair locked during transfers and keep at the nurse's station/close by for more frequent monitoring.
-Post fall on 02/15/22; All previous interventions to include making sure all personal item within

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reach and encourage resident to be careful about reaching over due to risk for fall.
-Post fall on 02/23/22; All previous interventions to include increased rounds to prevent attempts to go to the bathroom alone and all personal need are met, staff staying close by during bathroom visits to minimize trine in bathroom alone and close by the nurse's station for close monitoring.
-Post fall on 03/09/22; Reminder to resident not to try to pick things off the floor without assistance, discussion with her family member about increased falls and decline in memory, hospice discussion and order to evaluate and admitted to hospital 03/10/22.
-Post fall on 03/21/22; Cushion removed from chair to allow o sit back further, hospital bed delivered on 03/22/22, all previous interventions and continue to have at the nurse's station or close to nurse's station.

Interview with the Registered Nurse for Resident Supervision (RNRS) on 03/24/22 at 11:10am revealed:
-Resident #1 was monitored every 2 hours per routine resident checks at minimum.
-There was no written policy for fall precautions.
-There was no written fall assessment of residents completed at the facility.
-Fall precautions meant that the resident was kept close to the nursing station and frequently toileted.
-There had been no documented interventions following Resident #1's falls.

Interview with Resident #1's Primary Care Provider (PCP) on 03/24/22 at 2:23pm revealed:
-She could not remember the details related to the injury from Resident #1's fall on 02/14/22 but thought the hip fracture was an old fracture.
-She expected the facility to increase supervision

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of residents following a fall.
-She had not written an order to increase supervision because increased observation did not require a physician's order.
3. Review of Resident #3's current FL-2 dated 02/08/22 revealed:
-Diagnoses included coronary artery disease, allergic rhinitis and hyperlipidemia.
-The resident was ambulatory.

Review of Resident #3's current assessment and care plan dated 02/08/22 revealed:
-The resident was independent with transferring and required staff supervision with ambulation.
-The resident had limited mobility and required a wheelchair and a walker as an assistive device.

Review of Resident #3's progress note dated 01/07/22 at 3:05pm revealed:
-The resident was found on the floor.
-There was no documentation of fall interventions put in place after the fall.

Review of an incident and accident report for Resident #3 dated 01/07/22 at 3:05pm revealed:
-The resident reported she slipped out of her wheelchair.
-The resident called the nurses station and reported that she needed help getting up from the floor.
-The resident reported that she was not in pain.

Review of Resident #3's progress note dated 01/23/22 at 5:10am revealed:
-The resident was found on the bathroom floor.
-The resident reported she became lightheaded/dizzy and that was how she fell.
-The resident had no injuries or complaints of pain and reported she was "fine".
-The resident's blood pressure was 197/101,

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heart rate was 71; the resident's blood pressure would be rechecked in one hour.
-There was a second entry, the resident's blood pressure was rechecked at 187/95 and heart rate was 66.
-There was no documentation of fall interventions put in place after the fall.

Review of an incident and accident report for Resident #3 dated 01/23/22 at 5:10am revealed:
-The resident was found on the bathroom floor by a personal care aide (PCA).
-The resident had no injuries or complaints of pain.
-The resident reported she became lightheaded/dizzy and that was how she fell.

Interview with a PCA on 03/24/22 at 5:00pm revealed:
-Resident #3 was independent and did not like for staff to do tasks for her.
-Resident #3 had one or two falls.
-Resident #3 mostly used a wheelchair for ambulation.
-After Resident #3 fell, she was advised by the medication aide (MA) to keep a check on the resident, meaning "look" in on the resident "periodically".
-All residents were routinely checked on every 2 hours.
-After Resident #3 fell she checked on the resident more often than every 2 hours, however, she was not instructed on a specific time to perform monitoring checks for Resident #3 after she fell.

Review of Resident #3's fall prevention interventions provided by the Registered Nurse for Resident Supervision (RNRS) on 03/24/22 revealed:

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D 270	Continued From page 15 -"On 01/23/22, resident fall interventions activated. Previous fall 01/07/22". -The resident's fall preventions included: floors kept free of clutter, call light within reach, socks and shoes on, encourage resident to use call light and allow us to help her, and routine every 2-hour rounds and in between to ensure stability. Interview with the RN/RS on 03/24/22 at 10:20am revealed: -Residents were routinely checked on by staff every 2 hours. -Facility staff did not usually discuss intervention needs with the residents primary care providers (PCPs) after a resident had a fall. -Facility supervisors could place residents on increased supervision without a PCP order. -Resident #3 did not have any previous history of falling and was falling due to the resident being anxious and sliding off her bed. -There had been no documented interventions following Resident #3's falls. -Resident #3 was not placed on increased supervision more than every 2 hours after her falls. Telephone interview with Resident #3's hospice nurse on 03/24/22 at 3:58pm revealed the resident had physical limitations which placed her at risk for falls. Telephone interview with Resident #3's PCP on 03/24/22 at 2:23pm revealed she expected the facility to increase supervision for residents following a fall. _____ The facility failed to provide supervision for 3 of 5 samples residents (#1 #2, and #3) which resulted in the resident sustaining 8 unwitnessed falls with 3 of the 8 unwitnessed falls resulting in ER	D 270		

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D 270	Continued From page 16 services with a pelvic fracture, humerus fracture and a wound on her right calf that required sutures (#2); and a resident that was disoriented with a total of 6 falls in 4 months; resulting in a hip fracture. This failure resulted in serious physical harm and constitutes a Type A1 violation. This failure resulted in serious physical harm and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 24, 2022 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 6, 2022.	D 270		
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 ensure medications were administered as ordered for 1 of 5 residents sampled (#3) related to a vasodilator medication. The findings are:	D 358		

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Review of Resident #3's current FL-2 dated 02/08/22 revealed:
-Diagnoses included coronary artery disease, allergic rhinitis and hyperlipidemia.
-There was an order for Nitroglycerin 0.6mg/hour (HR) patch apply each morning and remove at bedtime. (A Nitroglycerin patch is a vasodilator used to treat and prevent episodes of angina (chest pain).
-There was an order for Nitrostat 0.4mg sublingual dissolve one tablet under the tongue every 5 minutes for 3 doses as needed for chest pain. Call 911 if pain persists. (Nitrostat is used on an as needed basis to treat chest pain).
-There was an entry the resident may self-administer medications including the nitroglycerin patch and Nitrostat tablets.

Review of Resident #3's previous FL-2 dated 02/08/21 revealed:
-There was an order for Nitroglycerin 0.6mg/HR patch apply each morning and remove at bedtime.
-There was an order for Nitrostat 0.4mg sublingual dissolve one tablet under the tongue every 5 minutes for 3 doses as needed for chest pain. Call 911 if pain persists.
-The resident may self-administer medications including the nitroglycerin patch and Nitrostat tablets.

Interview with Resident #3 on 03/23/22 at 9:10am revealed she had heart problems and experienced "bad angina". (Angina is a type of chest pain caused by reduced blood flow to the heart).

Review of Resident #3's emergency room (ER) visit note dated 02/16/22 revealed:
-Resident #3 was evaluated in the ER with a chief

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complaint of shortness of breath and chest pain.
-The resident's final diagnosis was anginal pain.
-The resident was discharged back to the facility.

Review of Resident #3's primary care provider (PCP) visit note dated 02/22/22 revealed:
-The resident was seen for a follow up visit for chest pain.
-The resident had been seen by the PCP during the last thirty days; two acute encounters involving chest pain and a fall.
-The resident was also being seen for a follow up for a recent ER visit related to chest pain. The facility reported 3 doses of NTG tablets were administered after which 911 was called.
-The resident since had been placed on hospice care.
-In the assessment section of the visit note there was an entry: chest pain due to myocardial ischemia. (Myocardial ischemia is a condition that occurs when blood flow to the heart is reduced, preventing the heart muscle from receiving enough oxygen, reducing the ability of the heart to pump blood which could result in blockages of the heart's arteries (coronary arteries), abnormal heart rhythms and could lead to a heart attack).

Review of Resident #3's January 2022 eMAR revealed:
-There was an entry for Nitroglycerin 0.6mg/HR patch apply each morning and remove at bedtime with a scheduled administration time at 8:00am and remove at 8:00pm.
-Nitroglycerin 0.6mg/HR patch was documented as self-administered/not recorded for applying and removing the patch from 01/01/22 - 01/05/22 at 8:00am and 8:00pm.
-Nitroglycerin 0.6mg/HR patch was documented as not applied on 01/06/22 and 01/07/22 at 8:00am with a reason as refill requested and

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waiting on refill.
-Nitroglycerin 0.6mg/HR patch was documented as applied each morning and removed at bedtime by facility staff from 01/08/22 - 01/31/22 at 8:00am and 8:00pm.
-There was an entry for Nitrostat 0.4mg sublingual dissolve one tablet under the tongue every 5 minutes for 3 doses as needed for chest pain. Call 911 if pain persists.
-There was documentation Nitrostat 0.4mg was administered two times on 01/20/22, one time on 01/21/22, two times on 01/27/22, 01/28/22 and 01/30/22.

Observation of Resident #3's medications on hand on 03/24/22 at 4:02pm revealed there was a supply of Nitroglycerin 0.6mg/HR patches dispensed on 03/02/22 with 13 of 30 patches remaining.

Review of Resident #3's pharmacy dispensing record revealed:
-The dispensing date range was from 01/01/22 - 03/24/22.
-Nitroglycerin 0.6mg/HR patches were dispensed on 01/05/22 as a new prescription with a quantity of 30 patches.
-Nitroglycerin 0.6mg/HR patches were dispensed on 01/31/22 and 03/02/22 as a refilled medication.

Review of Resident #3's pharmacy delivery sheets revealed:
-On 01/05/22, Nitroglycerin 0.6mg/HR was delivered to the facility however, there was a handwritten entry by a staff the medication was "not in bag".
-On 01/07/22 at 1:30pm, Nitroglycerin 0.6mg/HR was delivered to the facility with a handwritten entry the residents Nitroglycerin patches were on

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D 358	Continued From page 20 the "cart". Interview with a medication aide (MA) on 03/24/22 at 3:05pm revealed: -The MAs were responsible for reordering the resident's medications through the eMAR system by clicking on a refill tab. -The MAs were responsible for reordering residents' medications when the resident had 7 doses of daily medications remaining or 14 doses of a twice daily medication. -If no refills remained on the residents' medication, a fax request was sent to the contracted pharmacy and the pharmacy was responsible for notifying the residents' PCP that a refill for the medication was needed. Interview with the Registered Nurse for Resident Supervision (RNRS) on 03/24/22 at 10:20am revealed: -She thought there was a delay refilling Resident #3's Nitroglycerin patches in January 2022 because the pharmacy sent the resident's new prescription request to Resident #3's provider's office instead of the facility. -She was able to expedite requests with Resident #3's PCP when a new prescription was needed when no refills remained. -Resident #3 could have experienced increased blood pressure and increased chest pain when she did not receive the Nitroglycerin patches as ordered. Telephone interview Resident #3's PCP on 03/24/22 at 2:22pm revealed: -She was not aware of Resident #3's Nitroglycerin patch was not available to apply on 01/06/22 and 01/07/22. -If she had known Resident #3's Nitroglycerin patch was not available on 01/06/22 and 01/07/22	D 358		

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then she would have tried to expedite the refill request to avoid the resident from missing any doses.
-She expected the facility to ensure Resident #3's Nitroglycerin patches were available to administer as ordered.
-She had concerns if Resident #3 did not receive her Nitroglycerin patch daily as ordered because the resident would have experienced angina and rebound blood pressure issues.
-Missing doses of Nitroglycerin could cause outcome, the resident had an increased use of Nitrostat as needed for chest pain starting in January 2022 and required ER evaluation and treatment for unrelieved anginal pain in February 2022.
-She expected medications to be administered as ordered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/24/22 at 3:15pm revealed:
-Resident #3's Nitroglycerin 0.6mg/HR patch had not been dispensed since 10/26/20.
-In January 2022, the pharmacy received a request from the facility to refill Resident #3's patch again, however the pharmacy did not have a current prescription for the medication.
-The pharmacy sent a fax to Resident #3's PCP for the Nitroglycerin patch and a new prescription was received on 01/05/22.
-She was not sure how or where Resident #3 was receiving the Nitroglycerin 0.6mg/HR patches from November 2020 - 2021; it was possible the resident had received the medication from a different pharmacy or possibly the resident's family was bringing the medication into the facility for the resident.
-Resident #3's Nitroglycerin patches worked by widening and relaxing the blood vessels to

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increase oxygen to the heart.
-If Resident #3 was not receiving the Nitroglycerin 0.6mg/HR patches as ordered then the resident would have been at risk for stress on her heart muscle.

Telephone interview with Resident #3's family member on 03/24/22 at 5:10pm revealed Resident #3 did not receive any samples of the Nitroglycerin patches, had not used a secondary pharmacy and should have received the patches from the facility's contracted pharmacy.

Telephone interview with Resident #3's Hospice Nurse on 03/24/22 at 3:35pm revealed:
-Resident #3 had a lot of issues with angina.
-Resident #3 was prescribed a Nitroglycerin patch to control angina and untreated angina could result in a heart attack.

A second interview with the RNRS in 03/24/22 at 5:22pm revealed Resident #3 self-administered her Nitroglycerin patches during the month of December 2021 through the first of January 2022 however the resident was having trouble getting the patch placed and taking the patch off; staff started administering the patch for the resident in January 2022.

Interview with the Administrator on 03/24/22 at 6:10pm revealed she expected Resident #3 to receive all her medications as ordered by the resident's PCP.

_____

The facility failed to administer medications as ordered for 1 of 5 residents (#3) for a medication used to treat and prevent chest pain which could result in uncontrolled chest pain, rebound blood pressures, untreated angina which could result in a heart attack. This failure was detrimental to the

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D 358	Continued From page 23 health and safety of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/24/22 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 08, 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 as related to supervision and medication administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to provide supervision in accordance with the residents assessed needs for 3 of 5 residents (#1, #2, and #3) related to two residents who had multiple falls resulting in injuries including fractures (#1, #2) and a resident with two unwitnessed falls (#3). [Refer to Tag	D912		

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D912	Continued From page 24 270, 10A NCAC 13F .0901(b) Supervision (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents sampled (#3) related to a vasodilator medication. [Refer to tag 0358, 10A NCAC 13F .1004(a) medication adminstration (Type B Violation)].	D912		