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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 10/05/21 through 10/07/21.	D 000		
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, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#3, #4) related to vaginal bleeding not reported to the primary care provider (PCP) (#3) and failure to schedule an echocardiogram ordered by the resident's PCP for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) (#4). The findings are: 1. Review of Resident #4's current FL-2 dated 06/02/21 revealed: -Diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and atrial fibrillation (irregular heart rhythm). -The resident was semi-ambulatory and intermittently disoriented. Review of Resident #4's Resident Register dated 05/27/21 revealed the resident required assistance with scheduling appointments. Observation of Resident #4 on 10/06/21 at	D 273		

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D 273	Continued From page 1 4:30pm revealed: -The resident stopped to take breaths and intermittently coughed mid-sentence when trying to talk. -The resident sat in a tripod position (when one leans forward with shoulders rolled forward and hands on knees for support - generally indicates respiratory distress) when speaking. Interview with Resident #4 on 10/06/21 at 4:30pm revealed -He stated that he normally sat in tripod position to stay comfortable due to difficulty breathing. -He took pride in trying to stay as independent as possible. -He wore continuous oxygen because his biggest issue was shortness of breath due to his COPD. -He routinely used his rescue inhaler 2-3 times per day for his shortness of breath in addition to his other scheduled medications. -He sometimes had exacerbations and panic attacks when he could not breathe well. Review of Resident #4's progress note dated 06/21/21 revealed: -The resident was complaining of shortness of breath while on oxygen. -The resident was unable to eat dinner due to his symptoms. -The medication aide (MA) checked his vital signs that morning and would continue to monitor him. Review of a change of condition report for Resident #4 dated 06/21/21 revealed: -A change of condition was reported via fax to the resident's primary care provider (PCP) on 06/21/21 at 5:00pm. -The resident had been complaining of shortness of breath even while wearing his oxygen as ordered.	D 273		

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-The resident's vital signs and oxygen saturations were within normal limits.
-The resident's rescue inhaler that he used as needed was also not helping with the shortness of breath.

Review of a physician's order sheet for Resident #4 dated 06/24/21 revealed:
-The PCP sent orders in response to the change of condition reported to them on 06/21/21.
-There was an order for the facility to obtain an echocardiogram.
-There was a handwritten note at 9:56am that the Health and Wellness Director (HWD) called the resident's family member to set up an appointment with the PCP to have the orders completed.

Review of Resident #4's record revealed no documentation or results for the echocardiogram ordered on 06/24/21.

Review of Resident #4's progress note dated 06/27/21 revealed:
-The resident was complaining of being short of breath while on oxygen and he was unable to eat.
-The resident's vital signs were recorded and faxed to the PCP.

Review of Resident #4's progress note dated 07/05/21 revealed:
-The resident was short of breath while on oxygen.
-The resident's oxygen level was 98% (generally 95% or higher is desired) and the MA would continue to monitor him.

Review of Resident #4's progress note dated 07/22/21 revealed:
-The resident was in distress due to not having

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his oxygen on.
-The MA reapplied the oxygen and helped the resident administer his rescue inhaler.
-The resident calmed down and became stable after about 10 minutes.

Review of Resident #4's progress note dated 08/03/21 revealed:
-The resident was in respiratory distress because his oxygen was off.
-The resident's oxygen level was 83%.
-The MA reapplied the oxygen and assisted the resident to administer his rescue inhaler.
-After about 10 minutes, the resident was better, and his oxygen level came up to 98%.

Review of Resident #4's progress note dated 08/05/21 revealed:
-The resident yelled for help down the hall at 11:00am.
-The resident was leaned forward, breathing heavy, and complained of chest pain.
-The resident was wearing his oxygen and his oxygen levels were 93%.
-The resident was sent to the emergency room for evaluation via ambulance.

Review of Resident #4's progress note dated 08/06/21 revealed:
-The resident was hospitalized after being in the emergency room overnight.
-The resident had a chest x-ray that showed pleural effusion (a buildup of fluid in the tissues around the lungs) and had fluid around his heart.
-The hospital was trying to reduce the fluid around his heart and was treating him for a urinary tract infection.
-The hospital planned to perform a repeat chest x-ray, echocardiogram, and computed tomography scan (CT scan - scan to obtain

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detailed images of the body).
-The resident had abnormal cardiac enzymes that could have been due to the buildup of fluid around his lungs and heart, his CHF, or both.

Review of Resident #4's hospital discharge summary dated 08/09/21 revealed:
-The resident was hospitalized from 08/05/21-08/09/21 for heart failure.
-The resident was discharged back to the assisted living facility on 08/09/21 with a referral to hospice.
-The hospice nurse was to come see the resident at the assisted living facility within 48 hours.
-The resident's medications to assist with COPD were adjusted.

Interview with Resident #4's family member on 10/07/21 at 11:50am revealed:
-The facility had not made her aware that Resident #4 needed an echocardiogram.
-She was not sure why the resident's echocardiogram had not been performed as ordered.
-The orders might have been forgotten or overlooked.
-The resident was hospitalized on 08/05/21 for a COPD exacerbation and she thought the test had been done while he was a patient at the hospital.

Telephone interview with Resident #4's second family member on 10/07/21 at 12:06pm revealed:
-She was not aware that Resident #4 needed an echocardiogram.
-The resident had COPD exacerbations every couple of months that required him to see the doctor.
-The resident had been steadily declining in condition due to his COPD and had recently been admitted to hospice due to the decline.

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D 273	Continued From page 5 -She was the person that normally picked Resident #4 up and took him to his doctor appointments. -When she picked Resident #4 up for doctor appointments, the facility would give her a folder of paperwork to give to the doctor which she would bring back to the facility after the appointment with any new orders, results, or follow up appointments. -She expected the facility to follow up on Resident #4's orders and let her know to take him to any appointments he might need. -It seemed like the facility was having difficulty following up and keeping track of Resident #4's care and needs and they routinely did not have his folder of paperwork ready on his appointment days. -She routinely had to call the facility the day of appointments to remind them that she was coming, and the paperwork was oftentimes not ready upon her arrival. -She did not recall the resident having an appointment for an echocardiogram or chest x-ray. -It was possible that the order for an echocardiogram from 06/24/21 had been overlooked and forgotten about. -If she had been aware that the resident needed to follow up for an echocardiogram, she would have called the PCP to arrange for it to happen. Interview with the Health and Wellness Director on 10/07/21 at 2:10pm revealed: -She was unaware that Resident #4 had an echocardiogram ordered on 06/24/21. -She was unsure if Resident #4's echocardiogram had been completed; there was no documentation that it had been. -It was normally her or the Resident Care Coordinator's (RCC's) responsibility to process	D 273		

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and initiate any orders that were written by a resident's PCP.
-It was her responsibility to follow up and ensure Resident #4's orders were implemented and carried out as ordered.
-Resident #4's family member did take him to an appointment on 06/25/21, but she did not follow up to ensure the echocardiogram had been done.
-She performed chart audits every quarter to ensure orders were carried out as expected.
-She missed second quarter audits due to the facility not having an RCC in place from May 2021-September 2021, and it was her responsibility to implement orders for residents in the absence of the RCC.
-She last did chart audits in August 2021 but must have missed the order for Resident #4's echocardiogram.

Interview with the Administrator on 10/07/21 at 6:09pm revealed:
-She was not aware that Resident #4's order for an echocardiogram had not been implemented or completed.
-She expected the RCC or the HWD to notate, implement, and follow-up on orders for residents as written by the provider to ensure residents received the care they needed.
-Chart audits and orders should be implemented and checked thoroughly to ensure orders were being carried out as written.
-She expected the RCC or HWD to follow and implement orders as written because the residents' PCP or other provider wrote those orders for an important reason based on a resident's medical diagnosis.

Telephone interview with a receptionist at Resident #4's PCP's office on 10/07/21 at 10:40am revealed:

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-She was able to see where the resident's PCP ordered an echocardiogram on 06/24/21.
-She could not find where the echocardiogram had been done until the resident had been admitted to the hospital on 08/05/21.
-She was not sure why the echocardiogram had not been done on an outpatient basis on or around 06/24/21 as ordered.
-She would leave a message with the nurse for Resident #4's PCP to call back with more information.

Telephone interview with a nurse from Resident #4's PCP office on 10/07/21 at 11:06 revealed:
-She was unsure why the resident's echocardiogram had not been done as ordered on 06/24/21.
-She would have to do more research and place a note in the resident's chart to have the PCP call back to clarify why the tests had not been performed.

Telephone interview with a certified medical assistant (CMA) from Resident #4's PCP office on 10/08/21 at 12:00pm revealed:
-The resident had an echocardiogram ordered on 06/24/21 because he had CHF and was experiencing chest pain and shortness of breath on that day (06/24/21).
-She was not sure why the echocardiogram was not done but the resident's PCP could call later in the afternoon on that day to discuss further (10/08/21).

Telephone interview with Resident #4's PCP on 10/08/21 at 2:29pm revealed:
-Resident #4 had end stage COPD and heart disease.
-The resident had an echocardiogram ordered on 06/24/21 due to COPD exacerbation to evaluate if

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his heart was weaker than previously assessed and to see if there was any fluid in or around his heart.
-The echocardiogram would have helped him to understand why the resident would be having an exacerbation of COPD symptoms.
-The resident did not have the echocardiogram until he had been admitted to the hospital on 08/05/21 for COPD exacerbation.
-He was concerned that the echocardiogram had not been done on 06/24/21 because having the results from that test would have helped him treat the resident accordingly.
-If Resident #4 had the echocardiogram when ordered on 06/24/21, it might have prevented the resident from being hospitalized on 08/05/21, if he had been able to treat him accordingly.
-He expected the facility to follow-up with him and ensure orders for the resident were carried out in a timely manner.

2. Review of Resident #3's current FL-2 dated 02/25/21 revealed:
-Diagnoses included severe dementia, diabetes, hypertension and lacunar stroke (a stroke caused when a blood clot blocks or narrows an artery leading to the brain).
-She was constantly disoriented.

Review of the Resident Register revealed Resident #3 had an admission date of 03/01/21.

Observation of Resident #3 on 10/06/21 at 8:19am revealed:
-The resident was in a wheelchair at the dining room table for breakfast.
-Her head was on the table and there was a pillow on the left side of her wheelchair to prevent her from leaning too far to the left.
-The Resident Care Coordinator (RCC) provided

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her feeding assistance.
-She was lethargic and ate only 25% of her meal.

Review of Resident #3's electronic progress notes revealed:
-On 04/16/21 at 9:09pm, a personal care aide (PCA) reported to a medication aide (MA) the resident had started her menstrual cycle, the blood was not bright red or dark red.
-On 04/17/21 at 3:10pm, a MA documented the resident did not have vaginal bleeding; but had brown discharge in her brief.
-On 04/17/21 at 10:19pm, a MA documented that the resident had a brown discharge from her vaginal area.
-On 04/18/21 at 10:26pm, a MA documented that the resident had a brown discharge from her vaginal area.
-On 04/21/21 at 7:46pm, the Health and Wellness Director (HWD) contacted the previous assisted living facility to inquire if the resident had a history of vaginal bleeding or brown discharge; she was seen by a gynecologist and there was no infection or cause for the vaginal bleeding.
-Per staff at Resident #3's previous ALF, she had episodes of bleeding several times, the resident had a gynecology appointment that showed no infection or cause for the bleeding, and the examination was normal.
-On 04/21/21 at 7:46pm, the HWD documented that she would continue to monitor the resident for worsening of bleeding or additional symptoms.
-On 06/07/21 at 3:20pm, a MA contacted the resident's primary care provider (PCP) to report she had a strong odor of yeast and had been acting unusual the past few days.
-The PCP wrote an order for antibiotics on 06/08/21.
-On 06/19/21 at 9:33pm a MA documented that the resident started her menstrual cycle.

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-On 06/20/21 at 10:12pm, a MA documented that the resident still had her menstrual cycle and she was changed three times during the shift.
-On 06/22/21 at 6:50pm, a MA documented the resident had a light menstrual cycle.
-On 06/22/21 at 9:44pm, a MA documented the resident's vaginal bleeding was dark red and there were no other concerns.
-On 06/27/21 at 3:11pm, a MA documented the resident's menstrual cycle was dark red.
-On 07/08/21 at 9:35pm, a MA documented the resident was bleeding slightly from her vaginal area.
-On 07/09/21 at 6:17am, a MA documented the resident had a light amount of menstrual cycle and had an odor.
-On 07/09/21 at 3:25pm, a MA documented the resident's menstrual cycle was light, with an odor and had a change in behavior.
-On 07/09/21 at 10:32pm, a MA documented the resident was withdrawn and her appetite had decreased.
-On 07/10/21 at 2:35pm, a MA documented the resident was withdrawn and had light vaginal bleeding.
-On 07/11/21 at 3:22pm, a MA documented the resident had a little vaginal odor; no issues or concerns.
-On 07/12/21 at 6:40am, 3:10pm and 11:17pm three different MAs documented there were no concerns or issues during their shift.
-There was no documentation on Resident #3's electronic progress notes from 07/13/21 until 07/18/21 at 9:20pm.
-On 07/18/21 at 9:20pm, a MA documented the resident was sent to a local emergency room (ER) during the 7:00am-3:00pm shift.
-There was no documentation for the reason Resident #3 was sent to the ER.
-On 07/18/21 at 11:21pm, a MA documented she

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received a call from an ER physician at 10:15pm about the resident.
-The MA documented that the ER physician reported that her urine culture, MRI (magnetic resonance imaging), CT Scan (computed tomography scan) and blood work were negative.
-The MA documented that they ER physician asked how the resident was before being sent to the hospital; the MA informed the ER physician that Resident #3 was withdrawn, had a decreased appetite and was leaning more to the right than normal.
-There was no documentation that the facility had contacted the resident's PCP or family to report her vaginal bleeding or brown discharge.

Interview with a MA on 10/07/21 at 5:20pm revealed:
-Resident #3 was 68 years old and was admitted to the Special Care Unit (SCU) in the spring of 2021 from another facility.
-Resident #3 was independent when she was admitted; she walked, fed herself, and could communicate her needs verbally.
-The resident had vaginal bleeding that lasted 4-5 days in April 2021.
-She knew vaginal bleeding was not normal for a resident her age and when she asked Resident #3 about it, the resident only laughed.
-She could not remember when she asked Resident #3 about her vaginal bleeding.
-She documented the vaginal bleeding in Resident #3's electronic progress notes and reported the bleeding to the RCC.
-She did not report the bleeding to the facility's HWD because she assumed the HWD would read Resident #3's electronic progress notes and follow up on it.
-She continued to document the resident had vaginal bleeding and a brown discharge for

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approximately three months intermittently.
-She reported the vaginal bleeding and brown discharge to the resident's PCP in person when the PCP visited the resident, but she could not remember the date she reported it.
-She thought she faxed a notification about Resident #3's vaginal bleeding to the resident's PCP but was unsure if the PCP had received the notification or if there were any new orders regarding the notification.
-Resident #3 was admitted to the hospital for three days in July 2021 due to confusion and a fever.

Interview with a second medication aide (MA) on 10/05/21 at 12:00pm revealed:
-Resident #3 had a history of vaginal bleeding, an odor and brown discharge for several months.
-She had documented her observations in the electronic progress notes.
-She could not remember if she notified the RCC or the PCP of the vaginal bleeding, odor and discharge.
-She knew the HWD; who was a registered nurse (RN) reviewed progress notes each week.
-She could not remember why she had not contacted the resident's PCP to report the residents vaginal bleeding, odor and discharge.
-The MAs were expected to report significant changes to the PCP, RCC and the HWD.

Review of a discharge summary from a local hospital dated 07/21/21 revealed:
-On 07/18/21, a physician from the hospital called the facility nursing staff for more information regarding her history.
-The facility staff reported that the resident was more withdrawn, had difficulty walking, had intermittent vaginal bleeding and her last episode of vaginal bleeding occurred the previous week.

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D 273	Continued From page 13 -On 07/19/21 the resident had an ultrasound of her pelvis. -She had vaginal bleeding and history of a uterine mass. -There was an exophytic minimally complex cyst arising from the left ovary (exophytic is used to describe an abnormal growth that stick outs from the surface of a tissue). -The cyst increased in size from 4.0 centimeters (cm) on her previous exam (January 2021) to 5.7cm; an increase of 1.7cm. -This was abnormal in postmenopausal women and further evaluation was recommended to rule out neoplasm (a type of abnormal and excessive growth of tissue). -The physician recommended further evaluation due to the findings on the resident's previous pelvic ultrasound; especially since there was postmenopausal bleeding. Telephone interview with Resident #3's POA on 10/07/21 at 5:26pm revealed: -He was responsible for the resident's health and financial needs. -He attended most of her doctor appointments and communicated frequently with her PCP. -The HWD had contacted him on 06/06/21 to inform him that the resident's urine had a strong odor and that she possibly had a urinary tract infection and the resident's PCP would be contacted for recommendations. -He was not notified by the HWD until May 2021 or July 2021 that several staff had observed the resident with vaginal bleeding. Interview with the HWD on 10/06/21 at 8:58am revealed: -Resident #3 was admitted to the SCU from an assisted living facility. -When she was admitted she was able to walk,	D 273		

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talk and feed herself.
-Staff had informed her the resident had vaginal bleeding approximately one month after she was admitted.
-She was aware that the resident had a gynecologist appointment in January 2020, but she did not have any documentation of the visit.
-Resident #3's vaginal bleeding became heavier in June 2021 and she required more assistance with her activities of daily living.

Second interview with the HWD on 10/07/21 at 2:15pm revealed:
-The MAs and RCC were expected to document any changes or concerns in the resident's electronic progress notes.
-She and the RCC were responsible for reviewing progress notes.
-When a resident had a significant change the MAs and RCC were expected to report the change directly to her.
-She was responsible for reviewing each shift report daily.
-She should have notified the PCP to notify of the vaginal bleeding and brown discharge.

Interview with the Administrator on 10/07/21 at 6:03pm revealed:
-The MAs or RCC were expected to report any concerns or changes to the resident's PCP.
-The MAs were expected to document concerns or changes on the shift report.
-The RCC and the HWD were responsible for reviewing the shift report daily.
-She and the HWD met with Resident #3's family member at the facility in July 2021 to discuss the vaginal bleeding and brown discharge.
-The resident's PCP and family member should have been notified in April 2021 when staff first observed the vaginal bleeding and brown

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D 273	Continued From page 15 discharge. -She was not aware that the HWD knew about the vaginal bleeding approximately one month after the resident was admitted. -She expected the HWD to notify the resident's PCP immediately of the vaginal bleeding. Based on observations, record reviews and interviews it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's PCP on 10/07/21 at 4:22pm was unsuccessful. The facility failed to ensure referral and follow-up for 2 of 5 sampled residents (#3, #4) to include failure to notify the primary care provider (PCP) of Resident #3, who had a history of uterine cancer, brown discharge and did not receive treatment for approximately three months and scheduling an echocardiogram for a resident who had chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) (#4) and was hospitalized due to complications of COPD exacerbation and CHF (#4). The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/07/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 6, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care	D 276		

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#4, #5) regarding weekly vital signs (#4), and daily weights with parameters and fluid restrictions (#5).

The findings are:

1.. Review of Resident #4's current FL-2 dated 06/02/21 revealed:
-Diagnoses that included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and atrial fibrillation (irregular heart rhythm).
-The resident was semi-ambulatory and intermittently disoriented.

Observation of Resident #4 on 10/06/21 at 4:30pm revealed:
-The resident stopped to take breaths and intermittently coughed mid-sentence when trying to talk.
-The resident sat in a tripod position (when one leans forward with shoulders rolled forward and hands on knees for support - generally indicating respiratory distress) when speaking and stated

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D 276	Continued From page 17 that was how he normally sat to remain comfortable. Interview with Resident #4 on 10/06/21 at 4:30pm revealed: -He took pride in trying to stay as independent as possible. -He wore continuous oxygen because his biggest issue was shortness of breath due to his COPD. -He routinely used his rescue inhaler 2-3 times per day for his shortness of breath in additional to his other scheduled medications. -He sometimes had exacerbations and panic attacks when he couldn't breathe well. Review of Resident #4's change in condition form dated 06/27/21 revealed the resident complained of being short of breath and unable to eat despite wearing his ordered oxygen and using his rescue inhaler as needed. Review of Resident #4's progress note dated 06/27/21 revealed: -The resident was complaining of being short of breath while on oxygen and he was unable to eat. -The resident's vital signs were recorded and faxed to the PCP. Review of Resident #4's progress note dated 07/05/21 revealed: -The resident was short of breath while on oxygen. -The resident's oxygen level was 98% (generally 95% or higher is desired) and the MA would continue to monitor him. Review of Resident #4's progress note dated 07/22/21 revealed: -The resident was in distress due to not having his oxygen on.	D 276		

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D 276	Continued From page 18 -The MA reapplied the oxygen and helped the resident administer his rescue inhaler. -The resident calmed down and became stable after about 10 minutes. Review of Resident #4's progress note dated 08/03/21 revealed: -The resident was in respiratory distress because his oxygen was off. -The resident's oxygen level was 83%. -The MA reapplied the oxygen and assisted the resident to administer his rescue inhaler. -After about 10 minutes, the resident was better, and his oxygen level came up to 98%. Review of Resident #4's progress note dated 08/05/21 revealed: -The resident yelled for help down the hall at 11:00am. -The resident was leaned forward, breathing heavy, and complained of chest pain. -The resident was wearing his oxygen and his oxygen levels were 93%. -The resident was sent to the emergency room for evaluation via ambulance. Review of Resident #4's progress note dated 08/06/21 revealed: -The resident was hospitalized after being in the emergency room overnight. -The resident had a chest x-ray that showed pleural effusion (a buildup of fluid in the tissues around the lungs) and had fluid around his heart. -The hospital was trying to reduce the fluid around his heart and was treating him for a urinary tract infection. -The hospital planned to perform a repeat chest x-ray, echocardiogram, and computed tomography scan (CT scan - scan to obtain detailed images of the body).	D 276		

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-The resident had abnormal cardiac enzymes that could have been due to the buildup of fluid around his lungs and heart, his CHF, or both.

Review of Resident #4's hospital discharge summary dated 08/09/21 revealed:
-The resident was hospitalized from 08/05/21-08/09/21 for heart failure.
-The resident was discharged back to the assisted living facility on 08/09/21 with a referral to hospice.
-The hospice nurse was to come see the resident at the assisted living facility within 48 hours.
-The resident's medications to assist with COPD were adjusted.

Review of Resident #4's physician's orders dated 06/29/21 revealed an order to check the resident's vital signs with pulse oximeter (non-invasive way to measure the level of oxygen in the blood) every week with symptoms.

Review of Resident #4's June 2021 electronic medication administration records (eMAR) revealed no entry or documentation of weekly vital signs with pulse oximeter.

Review of Resident #4's July 2021 eMAR revealed no entry or documentation of weekly vital signs with pulse oximeter.

Review of Resident #4's August 2021 eMAR revealed no entry or documentation of weekly vital signs with pulse oximeter.

Review of Resident #4's September 2021 eMAR revealed no entry or documentation of weekly vital signs with pulse oximeter.

Review of Resident #4's October 2021 eMAR

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revealed no entry or documentation of weekly vital signs with pulse oximeter.

Interview with the Health and Wellness Director on 10/07/21 at 4:30pm revealed:
-Resident #4's weekly vital signs with oxygen saturation orders from 06/29/21 had never been implemented and she did not know why.
-The order must have been missed.

Interview with the Administrator on 10/07/21 at 6:09pm revealed:
-She was not aware that Resident #4's order for weekly vital signs with oxygen saturations had not been implemented.
-She expected staff to notate, implement, and follow-up on orders for residents as written by the provider.
-Chart audits and orders should be implemented and checked thoroughly to ensure orders were being carried out as written.
-She expected staff to follow-up and implement orders as written because the residents' Primary Care Provider (PCP) or other provider wrote those orders did so for an important reason based on a resident's medical diagnosis.

Telephone interview with Resident #4's PCP on 10/08/21 at 2:29pm revealed:
-Resident #4 had end stage COPD and heart disease.
-The resident had vital signs with oxygen saturation ordered each week to help him evaluate how the resident was doing.
-The resident had been admitted to the hospital on 08/05/21 for COPD exacerbation.
-He was concerned that the vital signs with oxygen saturation had not been done because having the results from those vital signs may have helped him treat and manage the resident's

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care accordingly or differently.
-He expected the facility to follow-up with him and ensure orders for the resident were carried out in a timely manner.

Based in observations, interviews, record reviews, the facility failed to obtain vital signs with oxygen saturation on Resident #4 weekly.

2. Review of Resident #5's current FL-2 dated 02/25/21 revealed diagnoses that included chronic kidney disease (CKD), chronic systolic congestive heart failure (CHF), and essential hypertension.

Interview with Resident #5 on 10/05/21 at 9:45am revealed:
-She had heart problems, but she was unsure of the details of her disease process or the medications she took.
-She had a history of swelling in her legs and feet and wore TED hose (compression stockings).
-She normally slept in her recliner because she had shortness of breath and it was more comfortable and easier to breath sitting up.

a. Review of Resident #5's current FL-2 dated 02/25/21 revealed an order to weigh the resident daily.

Review of discharge instructions from Resident #5's cardiology appointment on 04/26/21 revealed:
-There was an order to weight the resident daily.
-There were parameters to notify the resident's cardiologist for any weight gain of 3 or more pounds in a 24-hour period, or for a weight gain of 5 or more pounds in a 5-7 day period.

Review of Resident #5's August 2021 electronic

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D 276	Continued From page 22 medication administration record (eMAR) revealed: -There was an entry to weigh the resident once daily at 6:00am with parameters to notify the primary care provider (PCP) for +3 pounds in 24 hours or 5 pounds in 5-7 days. -There were no weights documented on 08/03/21, 08/07/21, 08/24/21, 08/29/21, and 08/30/21. -There was no documentation that the resident's cardiologist or primary care provider (PCP) were notified that the resident had missed 5 daily weights in August 2021. -The resident weighed 181.3 pounds on 08/15/21 and 185.4 pounds on 08/16/21 resulting in a 4.1-pound weight gain in a 24-hour period. -There was no documentation that the resident's cardiologist or PCP were notified of her weight gain on 08/16/21. -The resident weighed 181.3 pounds on 08/15/21 and 186.4 pounds on 08/20/21, resulting in a 5.1-pound weight gain in a 5-day period. -There was no documentation that the resident's cardiologist or PCP were notified of the resident's weight gain on 08/20/21. -The resident weighed 182.6 pounds on 08/23/21, had no weight documented on 08/24/21, and weighed 186.4 pounds on 08/25/21, resulting in a 3.8-pound weight gain in a 48-hour period with a missed weight on 08/24/21. -There was no documentation that the resident's cardiologist or PCP were notified of the resident's weight gain in the 48-hour period with a missed weight on 08/25/21. Review of Resident #5's September 2021 eMAR revealed: -There was an entry to weigh the resident once daily at 6:00am with parameters to notify the PCP for +3 pounds in 24 hours or 5 pounds in 5-7 days.	D 276		

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D 276	Continued From page 23 -There were no weights documented on 09/04/21, 09/11/21, 09/29/21, and 09/30/21. -There was no documentation that the resident's cardiologist or PCP were notified that the resident had missed 3 daily weights in September 2021. -The resident weighed 182.6 pounds on 09/26/21 and 185.6 pounds on 09/27/21, resulting in a 3-pound weight gain in a 24-hour period. -There was no documentation that the resident's cardiologist or PCP were notified of her weight gain on 09/27/21. Review of Resident #5's October 2021 eMAR revealed: -There was an entry to weigh the resident once daily at 6:00am with parameters to notify the PCP for +3 pounds in 24 hours or 5 pounds in 5-7 days. -The resident weighed 182.6 on 09/25/21 and 187.6 pounds of 10/1/21, resulting in a 5-pound weight gain over a 6-day period. -There was no documentation that the resident's cardiologist or PCP were notified of the resident's weight gain on 10/01/21. Interview with Resident #5 on 10/06/21 at 4:47pm revealed: -Someone usually came in to take her weight early every morning. -She was unsure if the staff ever forgot to obtain her weight or if she had fluctuations in her weight that would be concerning to her doctor. -She saw a cardiologist but did not feel like her appointments were often enough because of how uncomfortable she was being short of breath all the time. Interview with a medication aide (MA) on 10/07/21 at 5:20pm revealed: -MAs were responsible to obtain residents'	D 276		

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weights each day as ordered.
-MAs were responsible to evaluate residents' daily weights according to ordered parameters.
-MAs were responsible to document weight gains outside of parameters in a resident's eMAR.
-MAs were responsible to contact the resident's PCP to notify them of gains outside of ordered parameters.
-She did not recall Resident #5 having any weights outside of ordered parameters.

Interview with the Health and Wellness Director (HWD) on 10/07/21 at 2:10pm revealed:
-She was unaware that Resident #5 had missed any daily weights.
-The MAs were responsible to obtain Resident #5's weights each day and compare the current weight with previous weights per the ordered parameters to evaluate fluctuations.
-If Resident #5 had weight fluctuations outside of the ordered parameters, the MAs should have contacted the resident's cardiologist to notify them of the weight gain as ordered.
-The facility did not have any documentation of notification to Resident #5's cardiologist or PCP of the resident's weight gains outside of ordered parameters since June 2021.
-She was unsure why the facility had not notified Resident #5's providers of her weight fluctuations outside of ordered parameters in August, September, and October 2021.

Interview with the Administrator on 10/07/21 at 6:09pm revealed:
-It was the MA's responsibility to weigh residents daily as ordered and contact the PCP for any weights outside of ordered parameters.
-She was not aware that Resident #5 was missing daily weights or having weights outside of ordered parameters.

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-Resident #5 had congestive heart failure and a sudden increase in weight outside of ordered parameters could be detrimental to her health.
-There should have been more oversight from the HWD for Resident #5's daily weights with parameters so the facility did not miss contacting the resident's PCP.
-She expected staff to notate, implement, and follow-up on orders for residents as written by the provider.

Telephone interview with Resident #5's Nurse Practitioner at her cardiologist's office on 10/07/21 at 3:57pm revealed:
-Daily weights had been ordered for the resident due to her having heart failure which resulted in complications requiring hospitalizations in 2019 and 2020.
-Complications of heart failure could include fluid overload which would cause shortness of breath, edema, and exacerbation of symptoms.
-The resident was on high dose diuretics for renal health and monitoring her daily weights was important to avoid shortness of breath and swelling from fluid overload.
-She expected the facility to follow orders for Resident #5 as written for daily weights with parameters.
-She expected the facility to notify her of any missed daily weights or weight gains outside of parameters as ordered.
-She had not been notified of any missed weights for Resident #5.
-She had not been notified of any weight gains outside of parameters for Resident #5 since June 2021.
-She was concerned that the facility was not following through with Resident #5's orders resulting in missed weights and she should have been notified of any weight gains outside of

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D 276	Continued From page 26 parameters so she could evaluate the resident. Telephone interview with Resident #5's PCP on 10/07/21 at 4:23pm revealed: -Resident #5 had a diagnosis of heart failure and the facility should obtain her weight daily as ordered. -Monitoring the resident's weight daily for gains outside of parameters would monitor for fluid overload. -Fluid overload could lead to increased shortness of breath, chest pain, increased edema, and exacerbation of heart failure. -She expected to be notified of weight gains outside of parameters and was unaware that she had any missed daily weights or weight gains outside of parameters. b. Review of discharge instructions from Resident #5's cardiology appointment on 04/26/21 revealed an order to limit the resident's total fluid intake to 64 fluid ounces per day. Interview with Resident #5 on 10/06/21 at 4:47pm revealed: -She was not aware that her doctor wanted her to restrict her fluid intake. -The facility staff had never monitored how much she drank or told her to restrict her fluids. -She was able to drink as much as she wanted and had free access to fluids in her room. -She saw a cardiologist but did not feel like her appointments were often enough because of how uncomfortable she was being short of breath all the time. Interview with the Health and Wellness Director (HWD) on 10/07/21 at 2:10pm revealed: -The facility was not monitoring or restricting Residents #5's fluid intake.	D 276		

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D 276	Continued From page 27 -The facility's previous Resident Care Coordinator (RCC) must have missed the order to limit Resident #5's fluid intake to 64 fluid ounces per day. -The facility typically performed chart audits each quarter. -The last chart audit was done in August 2021 and the chart audits had not been done the previous quarter due to being without an RCC during that time period. -She did not go back to April during the August 2021 chart audit and did not realized the order had been missed. Interview with the Administrator on 10/07/21 at 6:09pm revealed: -She was not aware that Resident #5's order to limit her fluid intake had been missed and never implemented. -It was concerning that Resident #5's fluid intake order had been missed because Resident #5 had kidney and heart issues. -She expected staff to notate, implement, and follow-up on orders for residents as written by the provider. Telephone interview with Resident #5's Nurse Practitioner at her cardiologist's office on 10/07/21 at 3:57pm revealed: -Fluid restrictions had been ordered for the resident due to her having heart failure which resulted in complications requiring hospitalizations in 2019 and 2020. -Complications of heart failure could include fluid overload which would cause shortness of breath, edema, and exacerbation of symptoms. -The resident was on high dose diuretics for renal health and limiting her fluid was important to avoid shortness of breath and swelling from fluid overload.	D 276		

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D 276	Continued From page 28 -She expected the facility to follow orders for Resident #5 as written. -She was unaware that the facility was not limiting fluids for Resident #5. -She was concerned that the facility was not following through with Resident #5's orders and she should have been notified that the order was missed so she could evaluate the resident. Telephone interview with Resident #5's primary care provider (PCP) on 10/07/21 at 4:23pm revealed: -Resident #5 had a diagnosis of heart failure and the facility should limit her fluids as ordered by the cardiologist to prevent fluid overload. -She expected the facility to implement orders as written. -Fluid overload could lead to increased shortness of breath, chest pain, increased edema, and exacerbation of heart failure. _____ The facility failed to implement and follow-up on orders for a resident who experienced exacerbation of COPD symptoms and needed weekly vital signs for close monitoring of symptoms of COPD who subsequently ended up in the hospital 5-weeks later due to COPD exacerbation of symptoms (#4); and orders to restrict fluids to 64 fluid ounces per day and obtain daily weights with failure to report weight gains outside ordered parameters to the PCP to prevent exacerbation of heart failure and symptoms of fluid overload (#5). The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/07/21 for this violation.	D 276		

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D 276	Continued From page 29 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 22, 2021.	D 276		
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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policy for 2 of 3 residents (#6, #7) observed during the medication passes including errors using a liquid medication to rinse the mouth after the use of an inhaler medication (#6) and the administration of a blood thinner (#7); and for 2 of 5 sampled residents (#4, #5) for record review including errors in not administering an inhaler or a topical antibiotic (#4) and errors with a medication for osteoporosis as (#5). The findings are: Review of the facility's medication administration policy dated 12/2019 revealed: -Medication administration shall be provided in a safe and timely manner as prescribed by the resident's physician/healthcare provider.	D 358		

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D 358	Continued From page 30 -Medication administration shall be in accordance with the prescriber's orders. -The individual administering medications shall check the label three times to verify the right medication, right dosage, right time, and right method of administration before giving a medication. 1.The medication error rate was 5% as evidenced by the observation of 2 errors out of 34 opportunities during the 8:00am and 9:00am medication passes on 10/07/21. a.Review of Resident #6's current FL-2 dated 02/25/21 revealed: -Diagnoses included gastro-esophageal reflux disease and vitamin B deficiency. -There was an order for Miralax 17 grams (used for constipation) each day. Review of a provider's visit form dated 09/29/21 revealed: -The resident had a chest x-ray done that revealed improvement with small effusion still present (a buildup of fluid between the tissues that line the lungs and the chest). -The resident had hoarseness of voice. -There was an order for Spiriva Handihaler 18mcg (used to treat respiratory complications) once daily. Observation of a medication aide (MA) on 10/06/21 at from 7:40am to 7:55am revealed: -The MA prepped all of Resident #6's medications to be administered that morning to include his Miralax (17gm of powder mixed in 8 ounces of water) and a Spiriva inhaler. -The MA prepared the Miralax into a cup mixing it with 8 ounces of water. -The MA took the prepared medications to	D 358		

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Resident #6's bedside and used the resident's bedside table as a workstation.
-Resident #6 did not have any other drinks available to him in the room.
-The MA assisted Resident #6 with the administration of his Spiriva inhaler at 7:52am.
-Resident #6 stated out loud that he needed to rinse his mouth and picked up the Miralax taking a moderate sip of the mediation, swished it throughout his mouth, then spit it into an empty cup sitting on the bedside table.
-The MA did not stop Resident #6 from swishing his mouth with the Miralax solution and did not off him a separate drink to rinse his mouth with.
-The MA then administered Resident #6's pills allowing the resident to take the medication using his Miralax as the drink to swallow the pills with at 7:54am.
-The MA then encouraged the resident to finish consuming the Miralax at 7:55am.

Review of Resident #6's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax 17 grams once per day for constipation.
-The Miralax 17 grams was documented as administered on 10/07/21.
-There was an entry for Spiriva 18mcg, one capsule once per day for shortness of breath.
-The Spiriva 18mcg was documented as administered on 10/07/21.

Review of the manufacturer's administration instructions for Spiriva on 10/07/21 revealed the inhaler could cause dry mouth and irritation with use.

Interview with Resident #6 on 10/06/21 at 1:08pm revealed:

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D 358	Continued From page 32 -He had been diagnosed with COVID-19 in the fall of 2020 and that was why he needed to use the Spiriva inhaler. -He was taught to rinse after using the Spiriva inhaler by another MA when he started using the medication. -He did not realize the drink he used to rinse his mouth with had Miralax in it until the MA told him to drink the rest because it was his Miralax. -He sometimes had loose stools once per day and diarrhea once per week. -He did not think he had ever had a separate drink to rinse the Spiriva with aside from his Miralax. Interview with the MA on 10/06/21 at 12:16pm revealed: -She did not realize that the white line in the Miralax cap was the 17gm measurement to prepare the medication accurately. -She thought she was supposed to fill the whole cap up with the Miralax powder to prepare 17gm of Miralax for Resident #6. -She did not realize Resident #6 was going to rinse after using his Spiriva inhaler and that he needed a separate drink to do so. -She did not know that it was a recommendation to rinse after use of the Spiriva inhaler. -She normally allowed the resident to take all his medications using the prepared Miralax liquid drink and did not normally offer him a separate drink unless he requested it. Interview with a second MA on 10/07/21 at 5:20pm revealed: -MAs were responsible to administer medications to residents accurately as ordered. -MA were supposed to administer medications per the six rights meaning they would ensure they were administering the right medications to the	D 358		

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right resident at the right times in the right dose via the right route with the right documentation.
-MAs were trained to always have a resident rinse their mouth out after the administration of an inhaler.
-It was expected for MAs to offer residents a drink that did not have another medication in it to rinse the mouth out after using an inhaler to ensure medications did not get mixed and the resident received the full dose of all medications administered.
-MAs were trained to have residents rinse their mouths after using an inhaler to prevent medication build up in the mouth, dry mouth, and infection of the mouth.

Interview with the Health and Wellness Director (HWD) on 10/06/21 at 12:50am revealed:
-She expected staff to administer medications accurately and ask for help if they did not know how to administer a new medication.
-She had recently trained an MA to have the residents rinse after using a Spiriva inhaler, but she did not know if the MA that administered Resident #6's Spiriva inhaler that day, 10/07/21, knew to have the resident rinse his mouth.
-She would have expected the MA to stop Resident #6 from rinsing his mouth with his Miralax after using his Spiriva and instead offer him a separate drink of water to rinse with instead.
-It was important for Resident #6 to get his full accurate dose of Miralax and not mix medications.
-She expected the MAs to administer medications as trained and as ordered so they did not make mistakes.

Interview with the Administrator on 10/06/21 at 1:35pm revealed:

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D 358	Continued From page 34 -She expected staff to measure and administer mediations accurately. -She expected the MA to offer Resident #6 a separate drink to rinse his mouth after using his Spiriva. -She expected the MA to stop the resident from rinsing his mouth out with Miralax. -She expected the MA to measure and offer Resident #6 an accurate dose of Miralax as ordered. -She expected the MAs to administer medications as trained and as ordered so they did not make mistakes. -She expected staff to follow orders as written because the resident's PCP or other provider wrote those orders for an important reason based on the resident's medical diagnoses. Telephone interview with Resident #6's primary care provider (PCP) on 10/07/21 at 4:23pm revealed: -She was unaware the resident had used the Miralax to rinse his mouth after an inhaler. -She expected the facility to offer the resident a separate drink to rinse his mouth after using his inhaler. -It was important to rinse with a separate drink from the Miralax so that the medications did not get mixed and the resident received the full dose of both medications. -She ordered Miralax for the resident because he had issues with constipation from taking Tramadol (pain medication that can cause constipation). -She expected staff to administer the resident's Miralax accurately and as ordered. -Having too much or too little Miralax could cause the resident complications such as increased constipation or diarrhea. -She expected the resident to get an accurate	D 358		

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and full dose of Miralax as ordered.

b. Review of Resident #7's FL-2 addendum dated 08/12/21 revealed diagnoses that included hypertension, coronary artery disease, chronic kidney disease, and a history of stroke.

Review of a medication list from Resident #7's neurologist dated 08/05/21 revealed an order for Aspirin 81mg tablet enteric coated (TBEC- tablet enteric coated - delayed release tablet which protects the stomach lining and slowly releases a medication into the body).

Review of Resident #7's physician's orders dated 10/05/21 revealed an order for Aspirin 81mg delayed release (enteric coated).

Observation of a medication aide (MA) on 10/06/21 at 9:25am revealed:
-The MA gave Resident #7 an Aspirin 81mg chewable tablet at 9:25am.
-Resident #7 swallowed and did not chew the Aspirin 81mg chewable tablet at 9:25am.
-The MA documented Aspirin 81mg delayed release tablet was administered at 8:00am.

Review of Resident #7's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Aspirin 81mg delayed release, give one tablet in the morning at 8:00am.
-The medication was documented as administered as ordered daily 10/01/21-10/06/21.

Observation of Resident #7's medications on hand on 10/06/21 at 12:00pm revealed:
-The resident had Aspirin 81mg chewable tablets on hand dispensed on 09/27/21.
-There were 19 out of 28 Aspirin 81mg chewable

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tablets remaining in the pill packet.

Review of Resident #7's pharmacy delivery receipt dated 09/22/21 revealed there were 28 Aspirin 81mg chewable tablets were delivered to the facility.

Review of Resident #7's pharmacy delivery receipt dated 08/17/21 revealed there were 30 Aspirin 81mg chewable tablets delivered to the facility.

Interview with the MA on 10/06/21 at 12:25pm revealed:
-She did not realize that Resident #7's Aspirin 81mg chewable tablets did not match the order on his eMAR for 81mg delayed release tablets.
-She was expected to ensure the medications she administered matched the resident's order prior to administration.
-She was expected to administer medications as ordered no more than one hour before or one hour after the scheduled administration time per the facility's policy and the provider's expectations.

Interview with a second MA on 10/07/21 at 5:20pm revealed:
-MAs were responsible to administer medications to residents accurately as ordered.
-MA were supposed to administer medications per the six rights meaning they would ensure they were administering the right medications to the right resident at the right times in the right dose via the right route with the right documentation.

Interview with the Health and Wellness Director on 10/06/21 at 1:02pm revealed:
-She expected the MAs to catch the discrepancy of Resident #7's form of Aspirin upon

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administration because MAs should compare the medication card label being administered to the order on the eMAR prior to administering a medication to a resident.

Interview with the Health and Wellness Director on 10/07/21 at 9:03am and 4:30pm revealed:
-She expected MAs to administer medications as ordered and document on resident eMARs accurately.
-She expected the MAs to clarify a discrepancy in a form of medication with the pharmacy and notify her if there were any discrepancies so she could follow up on the issue.
-To her knowledge, Resident #7 had not had any upset stomach issues from getting the wrong form of Aspirin 81mg.

Interview with the Administrator on 10/06/21 at 1:35pm revealed:
-She expected MAs to administer medications as ordered and report any issues with medication administration and why a resident did not get a medication to the Resident Care Coordinator (RCC) or HWD.
-She expected the MAs to compare the medication being administered to a resident to the resident's order on the eMAR prior to administering the medication.
-She expected MAs to clarify with the pharmacy if a medication did not match the eMAR.
-She expected the MAs to administer medications no more than 1-hour before or after a medication was scheduled to be administered.

Interview with the Administrator on 10/07/21 at 6:08pm revealed:
-To her knowledge, Resident #7 had not had any issues with upset stomach from getting the wrong form of Aspirin 81mg.

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D 358	Continued From page 38 -She expected staff to notate, implement, and follow-up on orders for residents as written by the provider. -She expected staff to follow orders as written because the resident's PCP or other provider wrote those orders for an important reason based on the resident's medical diagnoses. Telephone interview with Resident #7's primary care provider (PCP) on 10/07/21 at 4:23pm revealed: -She was unaware the resident had been receiving chewable Aspirin instead of enteric coated/delayed release Aspirin as ordered. -She expected the facility to have on hand and administer medications accurately as ordered to all residents. 2. Review of Resident #4's current FL-2 dated 06/02/21 revealed: -Diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), atrial fibrillation (irregular heart rhythm), and old age. -The resident was semi-ambulatory and intermittently disoriented. a.Review of Resident #4's current FL-2 dated 06/02/21 revealed there was an order for Spiriva 18mcg, take one capsule each day. (Spiriva is a bronchodilator medication that is used to prevent bronchospasm's (sudden constriction of the branch walls in the lungs) caused by COPD and to reduce flare-ups of serious symptoms.) Review of Resident #4's June 2021 electronic medication administration records (eMAR) revealed no entry or documentation of administration of Spiriva.	D 358		

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D 358	Continued From page 39 Review of Resident #4's July 2021 eMAR revealed no entry or documentation of administration of Spiriva. Review of Resident #4's August 2021 eMAR revealed no entry or documentation of administration of Spiriva. Review of Resident #4's September 2021 eMAR revealed no entry or documentation of administration of Spiriva. Review of Resident #4's October 2021 eMAR revealed no entry or documentation of administration of Spiriva. Interview with the Health and Wellness Director (HWD) on 10/07/21 at 4:30pm revealed: -It was her responsibility to process and enter resident's medication orders into the eMAR. -Resident #4's Spiriva order from his FL-2 was never implemented upon admission. -Resident #4 did not have Spiriva available to him for administration and was not receiving the medication because the order had been missed. -She was unsure how the order had been missed. -She must have missed the order when performing quarterly audits. Interview with the Administrator on 10/07/21 at 6:08pm revealed: -She was unaware that Resident #4's order for Spiriva had not been implemented as ordered. -She expected the Resident Care Coordinator or HWD to notate, implement, and follow-up on orders for residents as written by the provider. -Record audits and orders should be implemented and checked thoroughly to ensure orders were being carried out as written. -She expected all staff to follow and implement	D 358		

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orders as written because the resident's primary care provider (PCP) or other provider wrote those orders for an important reason based on the resident's medical diagnoses.

Telephone interview with Resident #4's PCP on 10/08/21 at 2:29pm revealed:
-Resident #4 had end stage COPD and heart disease.
-The resident had Spiriva ordered to help treat and maintain his symptoms from COPD and prevent exacerbation.
-He was not aware the resident was not receiving his Spiriva as ordered after his admission to the facility on 06/02/21.
-He was concerned because the resident had experienced several exacerbations since his admission to the facility on 06/02/21 and he added additional medication to the resident's orders to prevent further exacerbations of COPD.
-He was concerned because the Resident #4 had been hospitalized from COPD exacerbation on 08/05/21.
-He expected the facility to ensure medications were administered to the resident as ordered and follow-up with him if an order did not get carried out as ordered so he could evaluate the resident.

b. Review of Resident #4's current FL-2 dated 06/02/21 revealed an order for Mupirocin 2% (used topically to treat skin infections) three times per day.

Review of Resident #4's previous addendum to FL-2 dated 05/28/21 revealed the resident had a laceration to the right arm and was to use topical antibiotics to the area.

Observation of Resident #4 on 10/06/21 at 4:30pm revealed the resident had multiple

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D 358	Continued From page 41 bruises and scratches to both arms bilaterally. Review of Resident #4's June 2021 electronic medication administration record (eMAR) revealed there was no entry or documentation of administration of Mupirocin 2%. Review of Resident #4's July 2021 eMAR revealed: -There was an entry for Mupirocin 2% to be applied to the affected area topically three times a day for infection. -The Mupirocin 2% was documented as administered three times daily from 07/01/21-07/22/21, and once on 07/23/21. -The Mupirocin 2% was discontinued on 07/23/21 at 9:01am. Review of Resident #4's August 2021 eMAR revealed there was no entry or documentation of administration of Mupirocin 2%. Review of Resident #4's September 2021 eMAR revealed there was no entry or documentation of administration of Mupirocin 2%. Review of Resident #4's October 2021 eMAR revealed there was no entry or documentation of administration of Mupirocin 2%. Review of Resident #4's resident record revealed no order to discontinue the Mupirocin 2%. Interview with a medication aide (MA) on 10/07/21 at 5:20pm revealed: -MAs were responsible to administer medications accurately to residents as ordered. -The Resident Care Coordinator (RCC) or Health and Wellness Director (HWD) were responsible to ensure accurate eMARs.	D 358		

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D 358	Continued From page 42 Interview with the Health and Wellness Director on 10/07/21 at 4:30pm revealed: -She did not know why the Mupirocin was not administered during June 2021. -There was no order to discontinue Resident #4's Mupirocin 2% on file. -Resident #4's Mupirocin 2% ointment was accidentally discontinued by an MA while she was on vacation and she was unaware until it was brought to her attention that day (10/07/21). -She was unsure why the Mupirocin had been discontinued as there was no documented order to discontinue to the medication. -She was unsure why the MA discontinued the medication but thought it was because the home health nurse documented Resident #4's left forearm skin tear was healed. Interview with the Administrator on 10/07/21 at 6:08pm revealed: -She was unaware that Resident #4's order for Mupirocin 2% had been discontinued without an order. -She expected MAs to administer medications as ordered and document on resident eMARs accurately when a resident did not receive a medication. -She expected the RCC or HWD to notate, implement, and follow-up on orders for residents as written by the provider. -Record audits and orders should be implemented and checked thoroughly to ensure orders were being carried out as written. -She expected all staff to follow and implement orders as written because the resident's PCP or other provider wrote those orders for an important reason based on the resident's medical diagnoses.	D 358		

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Telephone interview with Resident #4's PCP on 10/08/21 at 2:29pm revealed:
-He was not aware the resident was not receiving his Mupirocin as ordered.
-He expected the facility to follow-up with him and ensure medications were administered to the resident as ordered.

3. Review of Resident #5's current FL-2 dated 02/25/21 revealed:
-Diagnoses included wedge compression fracture of 1st lumbar vertebrae, age related osteoporosis, chronic kidney disease (CKD), chronic systolic congestive heart failure (CHF), and essential hypertension.
-There was an order for Miacalcin 200 unit/actuation (used to treat osteoporosis), give 1 spray in alternating nostrils each day.

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Miacalcin 200 unit/actuation, give 1 spray alternating nostrils one time a day for osteoporosis.
-The Miacalcin was documented as administered, except on 09/12/21-09/16/21 and 09/20/21-09/21/21, resulting in 7 missed doses of the medication in September 2021.
-There was no documentation why the resident missed 7 doses in September 2021.

Interview with Resident #5 on 10/05/21 at 9:45am revealed she was unsure of the details of her disease process or the medications she took.

Interview with a pharmacist at the facility's contracted pharmacy on 10/06/21 at 4:22pm revealed:
-The facility last requested a refill for Resident

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#5's Miacalcin on 09/11/21.
-Resident #5's Miacalcin was delivered to the facility on 09/14/21 at 1:41am.
-Two of Resident #5's missed doses of Miacalcin were due to the medication not being available at the facility.
-There was no reason Resident #5 missed the other 5 doses of Miacalcin on 09/14/21, 09/15/21, 09/16/21, 09/20/21, or 09/21/21.
-There was no correspondence or documentation that Resident #5's Miacalcin had been lost or damaged requiring a refill meaning the medication was available at the facility to be administered to the resident as ordered except on 09/12/21-09/13/21.

Interview with a medication aide (MA) on 10/07/21 at 5:20pm revealed:
-MAs were responsible to administer medications accurately to residents as ordered.
-MAs were to clarify issues with medications with the pharmacy or PCP and report it to the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD).

Interview with the HWD on 10/07/21 at 4:30pm revealed:
-She was not aware that Resident #5 had missed 5 doses of Miacalcin in September 2021 and she did not know why.
-She expected MAs to administer medications as ordered and document on resident eMARs accurately when a resident did not receive a medication.

Interview with the Administrator on 10/07/21 at 6:08pm revealed:
-She was not aware that Resident #5 had missed 5 doses of Miacalcin in September 2021.
-She expected MAs to administer medications as

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D 358	Continued From page 45 ordered and report any issues with medication administration and why a resident did not get a medication to the RCC or HWD. -Record audits and orders should be implemented and checked thoroughly to ensure orders were being carried out as written. -She expected staff to follow and implement orders as written because the resident's PCP or other provider wrote those orders for an important reason based on the resident's medical diagnoses. Telephone interview with Resident #5's primary care provider (PCP) on 10/07/21 at 4:23pm revealed: -She was unaware that Resident #5 had missed 5 doses of her Miacalcin in September 2021. -Resident #5 was prescribed Miacalcin to treat osteoporosis. -She expected the facility to administer all of Resident #5's medications as ordered. -She expected staff to notate, implement, and follow-up on orders for residents as written by the provider. Attempted telephone interview with Resident #5's family member on 10/06/21 at 4:30pm was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) were accurate for 1 of 5 sampled residents (#4) regarding medications documented as administered when the resident was out of the facility and a patient in the hospital.

The findings are:

Review of Resident #4's current FL-2 dated 06/02/21 revealed the resident had diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and atrial fibrillation (irregular heart rhythm).

Review of a physician's order for Resident #4 dated 07/21/21 revealed an order for Colace 100mg, given one capsule each day.

Review of Resident #4's physician orders dated 07/28/21 revealed:
-There was an order for Eliquis 2.5mg, given one

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tablet twice daily.
-There was an order for Ensure, given one can with meals.

Review of Resident #4's hospital discharge summary dated 08/09/21 revealed the resident was hospitalized from 08/05/21-08/09/21 for heart failure.

Review of Resident #4's August 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Eliquis 2.5mg, give one tablet twice daily for blood thinner at 9:00am and 9:00pm.
-Eliquis 2.5mg was documented as administered on 08/08/21 at 9:00pm..
-There was an entry for Colace 100mg, give one capsule each evening for constipation at 5:00pm.
-Colace 100mg was documented as administered on 08/07/21 and 08/08/21 at 5:00pm.
-There was an entry for Ensure, give 1 can by mouth with meals for weight loss at 8:00am, 12:00pm, and 5:00pm.
-Ensure was documented as administered on 08/07/21 and 08/08/21 at 5:00pm.

Interview with a medication aide (MA) on 10/07/21 at 5:20pm revealed:
-MAs were responsible to administer and document medications accurately to residents as ordered.
-When a resident was in the hospital, MAs were expected to document the resident's medications were not administered due to being out of the facility.
-It was impossible to have administered medications to Resident #4 while he was in the hospital and she was unsure why his medications had been documented as administered while he

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D 367	Continued From page 48 was in the hospital. Interview with the Health and Wellness Director (HWD) on 10/07/21 at 4:30pm revealed: -She was unaware that Resident #4's eMARs showed he received medications while he was in the hospital. -It would have been impossible to administer medications to Resident #4 while he was out of the facility. -She expected MAs to document on resident eMARs accurately and document holding medications while a resident was out of the facility as appropriate. Interview with the Administrator on 10/07/21 at 6:08pm revealed: -She expected MAs to administer medications as ordered and document why a resident did not get a medication as appropriate. -She expected MAs to document administration or holding of medications on resident eMARs accurately. -It was unacceptable for Resident #4 to have medications documented as administered on his eMAR while he was in the hospital because that was impossible. Telephone interview with Resident #4's PCP on 10/08/21 at 2:29pm revealed he expected the facility to accurately administer and document medications as ordered.	D 367		
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	D912		

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D912	Continued From page 49 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 2 of 5 sampled residents (#3, #4) related to vaginal bleeding not reported to the primary care provider (PCP) (#3) and failure to schedule an echocardiogram ordered by the resident's PCP for chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) (#4). [Refer to Tag C273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of physician's orders for 2 of 5 sampled residents (#4, #5) regarding weekly vital signs (#4), and daily weights with parameters and fluid restrictions (#5). [Refer to Tag C276 10A NCAC 13F .0902(c) (3-4) Health Care (Type B Violation).]	D912		