Received 04/29/19
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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092182	A. BUILDING: ______ B. WING ______	R 03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIVER HOUSE	4230 WENDELL BOULEVARD WENDELL, NC 27591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/12/19 - 03/14/19.	{D 000}	Response to stated deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged, or conclusions set forth, in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with state laws.	
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.	D 273		
	This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews the facility failed to assure a referral to home health for wound care for 1 of 3 sampled residents (#1), who had three pressure ulcers to the buttocks. The findings are: Review of Resident #1's current FL-2 dated 03/07/19 revealed there was a diagnoses of Type 2 diabetes mellitus without complications. Review of Resident #1's Resident Service Plan dated 12/18/18 revealed: -Her skin was normal with no skin care needs. -She was incontinent of bowel and bladder. -She required limited to extensive assistance from 2 staff members with bathing. -She required extensive assistance from 2 staff		Adult care homes should assure referral and follow-up to meet the routine and acute health needs of residents Resident #1 was discharged from home health services on 03/14/19, due to the areas treated being healed. Home health referrals will be placed on the 24-hour log with orders followed and reviewed via the "Bucket System". New referrals will be reviewed during Stand-up. The Executive Director and Care Manager will receive copies of Home Health Referrals for two months, to ensure follow-up has been completed, or more frequently if challenges are noted.	04/28/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela E Crimson ED — TITLE — (X6) DATE 04/28/19

Reviewed & accepted
05/13/19 S. Bowen, RN

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D 273	Continued From page 1 members with dressing and undressing. -She required extensive assistance from 2 staff members for transfers to and from the bed and chair, including lifting, balancing, and pivoting into bed. -She required limited assistance with transferring to and from the bedside commode or toilet. -She required extensive assistance with hygiene after toileting. Review of Resident #1's Primary Care Provider (PCP) note dated 01/15/19 revealed: -There were three dime sized stage 2 pressure ulcers (a wound where the skin breaks open, or forms an ulcer, usually tender and painful. The sore expands into deeper layers of the skin. It can look like a scrape (abrasion), blister, or a shallow crater in the skin) on Resident #1's right buttock with minimal amount of oozing, purulent discharge, and was tender to touch. -Resident #1 had diagnosis of diabetes mellitus with hyperglycemia, and obesity. -Resident #1 was wheelchair bound because of weakness and obesity. -Staff requested Resident #1 to be evaluated for buttock wounds that were discovered last week. -Home health (HH) for wound care to stage 2 decubitus on the buttocks was ordered. Review of Resident #1's PCP note dated 02/06/19 revealed: -The visit was for a hospital follow up visit. -There were three dime sized stage 2 pressure ulcers on Resident #1's right buttock with minimal amount of oozing, purulent discharge, and was tender to touch. Review of Resident #1's physician notes, care notes, and HH notes revealed: -Resident #1 had returned from the hospital on	D 273		

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D 273	Continued From page 2 02/06/19. -There was no documentation the referral for HH was implemented until 02/22/19. Review of Resident #1's home health (HH) certification and plan of care note dated 02/22/19 revealed: -The HH start of care was documented as 02/22/19. -Resident #1 was referred for stage 2 pressure ulcers to the right buttock. -Resident #1 would receive skilled nursing once a week for four weeks to provide wound care, dressing changes, and wound measurements to the stage 2 decubitus of the right and left buttocks. -There was no documentation referencing the order for wound care dated 01/15/19, or treatment being initiated prior to 02/22/19. Interview with Resident #1 on 03/12/19 at 11:25 am revealed: -She was incontinent of urine and wore incontinent pads and incontinent briefs. -HH saw her "last Monday" for a wound on her bottom. -She did not know when HH would see her again. Interview with a MA on 03/14/19 at 12:10 pm revealed: -Resident #1 did not have skin breakdown on her buttocks. -Resident #1 was not being treated by HH. Interview with a personal care aide (PCA) on 03/14/19 at 4:15 pm revealed: -Resident #1 had "sores on her bottom that would come and go". -She provided personal care for Resident #1. -One week ago Resident #1 had "one sore" on	D 273		

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D 273	Continued From page 3 her left buttock that was red in color and the skin was not broken. -She had seen HH with Resident #1 but did not remember when. Interview with the HH nurse on 03/14/19 at 4:30 pm revealed: -Resident #1 was admitted for HH wound care for stage 2 pressure ulcers to her buttocks on 02/22/19 for weekly visits for wound care and measurements. -Additional visits for Resident #1 were completed on 03/01/19, 03/07/19, and today (03/14/19). -Today (03/14/19) was the first time he had seen Resident #1 and did not know anything about the 01/15/19 HH referral. Observations on 03/14/19 at 4:35 pm revealed: -There was a white transparent substance on the right and left side of Resident #1's buttocks. -The normal skin color was dark, on both buttocks were scattered areas of pink skin that was not open. -There were three areas to the right buttock where the skin was open and the wounds were red. One area measured approximately 1cm x 0.5cm, a second area measured approximately 0.5cm x 0.5cm, a third area measured approximately 0.25cm x 0.25cm in diameter. -There was one area to the left inner buttock where the skin was open and red in color that measured 5.5 cm x 0.2 cm x 0.1 cm. -There were no dressings to the wounds. Interview with the Administrator on 03/14/19 between 6:20 pm and 6:38 pm revealed: -The HH provider told her today (03/14/19) that Resident #1 had been seen for the 01/15/19 HH order and the Resident had refused HH services. -The HH provider told her today (03/14/19) they	D 273		

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had returned to see Resident #1 after her refusal, but she was in the hospital when they returned.
-Resident #1 had refused HH a "few" times.
-She did not know when Resident #1 had refused HH services and would obtain that information from the HH provider.
-There was no documentation of when HH saw Resident #1 for the 01/15/19 HH order.
-There was no documentation of when Resident #1 refused HH for the 01/15/19 HH order.
-The facility had not notified Resident #1's PCP of her refusal for HH services.

Interview with a MA on 03/14/19 at 11:20 am revealed:
-When a resident refused services, the refusals were documented on a facility resident refusal form and submitted to the Memory Care Coordinator (MCC) or other supervisor for review.
-Resident refusals were also documented on a 24 hour report for first, second, and third shift to keep each shift informed of resident occurrences. The form was filed in a shift report book after third shift documented and passed to the oncoming shift.
-There were no documented refusals for Resident #1 in the resident refusal book.

Interview with the Memory Care Coordinator (MCC) on 03/14/19 at 12:35 pm revealed:
-Resident refusals were to be documented on a resident refusal form and the provider informed.
-She did not "believe" she had any refusal sheets for Resident #1 and would look.

Review of Resident #1's physician notes, care notes, HH notes, orders, and hospital records revealed:
-There was no documentation a HH referral was made per the 01/15/19 HH order.

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D 273	Continued From page 5 -There was no documentation Resident #1 had refused HH services. -There was no documentation Resident #1's PCP had been informed of Resident #1's refusal of HH services. -There was no documentation Resident #'1s PCP had been informed of a delay in initiating the HH referral initially ordered on 01/15/19. -There was no documentation the HH order dated 01/15/19 had been discontinued. -There were thirty-eight days from the time HH was ordered and the time HH first saw Resident #1. Seven of those days Resident #1 was hospitalized (from 01/29/19 to 02/05/19). -HH admitted Resident #1 for wound care to stage 2 pressure ulcers to the buttocks on 02/22/19. Interview with Resident #1's Primary Care Provider (PCP) on 03/14/19 at 5:15pm revealed: -He did not know Resident #1 did not have a HH referral for the 01/15/19 HH order for wound care to stage 2 pressure ulcers to the buttocks until today (03/14/19). -He expected the facility to contact HH for residents the same day HH was ordered. -He expected HH to see residents within 24 hours to 48 hours after ordering HH. -When residents were seen in the facility he would give verbal orders to the facility staff for the HH referral then include the plan for HH in his dictated notes that were transcribed at a later time. -Resident #1's body did not have the ability to self-heal because she was a diabetic and non-ambulatory. -A delay in HH for wound care for Resident #1 could have resulted in an increase in wound size and depth, increased risk for infection and sepsis, and delayed healing because she was a diabetic	D 273		

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D 273	Continued From page 6 which would have resulted in slower wound healing that would have required more in depth wound care. __________ The facility failed to assure Resident #1, who had a diagnosis of diabetes and was wheelchair dependent, was referred to home health for treatment of pressure ulcers to the buttocks. There were thirty-eight days from the time HH was ordered on 01/15/19 and the time HH first saw Resident #1 on 02/22/19. Resident #1 was hospitalized seven of those thirty-eight days from 01/29/19 to 02/05/19. The facility failed follow up with the resident's PCP and HH provider when home health services were not initiated for the 01/15/19 order. The facility's failure resulted in a delay in assessment and treatment which was detrimental to Resident #1's health and welfare and constitutes a Type B Violation. __________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/14/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2019.	D 273		
{D 276}	10A NCAC 13F .0902(c)(3-4) Health Care	{D 276}		
	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.			

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{D 276}	Continued From page 7 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure physician orders were implemented for 3 of 5 sampled residents (#1, #2, #4) by failing to administer continuous oxygen (#1); document and implement blood sugars as ordered for a newly diagnosed diabetic (#4); and perform blood sugars as ordered 30 minutes before breakfast for an insulin dependent diabetic (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 03/07/19 revealed: -Diagnoses included Type 2 diabetes mellitus without complications. -She required Oxygen (O2) 2 liters per minute (LPM) via nasal cannula (NC) continuously (cont). Review of Resident #1's hospital discharge summary dated 02/05/19 revealed: -She was hospitalized from 01/29/19 - 02/05/19 for diagnoses including congestive heart failure (CHF) and a pulmonary nodule thought to be pneumonia. -In a section titled other discharge instructions there was documentation for Resident #1 to wear oxygen at 2 LPM continuously.	{D 276}	Adult care homes should assure documentation of the following in the resident's record. Written procedures, treatments or orders from a physician or other licensed health professional and implementation of procedures treatments, or orders specified. An in-service for all care staff will be performed to ensure all staff are properly trained to change and refill O2 tanks. LHPS will be updated as indicated. Orders to check supply of oxygen have been added to the eMAR. Portable O2 will be checked every 2 hours while on portable O2 to ensure there is a sufficient amount to last between checks. The Executive Director or their designee will perform random O2 Checks 3x/week x 3 weeks, then 2 x/week for 2 weeks and 1x/week x 1 week to ensure compliance. First shift will check blood sugars ordered daily prior to breakfast to provide accurate reading. The Care manager will review weekly on Mondays to ensure completion.	04/28/19

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{D 276}	Continued From page 8 Review of Resident #1's Primary Care Provider (PCP) visit note dated 02/06/19 revealed Resident #1 was on O2 continuously for chronic obstructive pulmonary disease (COPD). Review of Resident #1's February 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for O2 at 2 LPM continuously. -There was documentation O2 was administered from 02/06/19 - 02/28/19 continuously on every shift. -There was documentation Resident #1 was hospitalized from 02/01/19 - 02/06/19. Review of Resident #1's March 2019 eMAR from 03/01/19 - 03/13/19 revealed: -There was an electronic entry for O2 at 2 LPM continuously. -There was documentation O2 was administered from 03/01/19 - 03/12/19 continuously on every shift. -There was documentation O2 was administered at 7:00 am - 3:00 pm and 3:00 pm - 11:00pm on 03/13/19. Interview with Resident #1 on 03/12/19 at 11:21 am revealed: -She was supposed to have O2 at 2 LPM at all times because of shortness of breath. -The O2 canister she was using was empty. -She knew the O2 canister was empty because she did not feel O2 coming from the NC. -She was shaky because she did not have O2. -When her O2 canister was empty she had to tell the medication aides (MA's) so they could change the canister. -The MA's and personal care aides (PCA's) normally checked her O2 canister every two	{D 276}		

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{D 276}	Continued From page 9 hours. -The PCA last checked her O2 canister about one hour ago. -She did not want to bother the PCA to change her O2 canister because she was providing care for another resident. Observations on 03/12/19 from 11:21 am - 11:35 am revealed: -Resident #1 was in the hallway going to her room in an electric wheelchair. -Resident #1 was wearing an O2 NC attached to a small portable O2 canister in the back pocket of her electric wheelchair. -Her speech was low and she paused in the middle of sentences. -There was an O2 regulator attached to the O2 canister and the needle in the O2 regulator gauge was in the red section below the 0 and rested on the words "refill". -Resident #1 found a PCA coming out of a resident's room and told her the O2 canister was empty. Interview with a PCA on 03/12/19 at 11:35 am revealed: -Resident #1 was not getting O2 from the canister because the on/off valve was not turned on. -She turned on the O2 valve on so the Resident #1 would receive O2 through the NC. -Resident #1's had an O2 concentrator in her room that was used to refill her portable O2 canisters. -To refill portable O2 canisters, she would place them on top of the O2 concentrator and attach it to a refill valve. Observations on 03/12/19 at 11:35 am revealed: -A PCA turned the portable O2 valve to see if it was off or on.	{D 276}		

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{D 276}	Continued From page 10 -The PCA demonstrated how Resident #1's O2 concentrator was used to refill portable O2 canisters. Observations on 03/14/19 at 4:20 pm to 4:22 pm revealed: -Resident #1 was in the activity room in her electric wheelchair wearing a NC with a portable O2 tank in the wheelchair back pocket. -Her speech was low and sentences short. -The O2 regulator gauge needle was in the red section past 0 resting on the words refill. Interview with Resident #1 on 03/14/19 at 4:23 pm revealed: -Her O2 canister was empty and she had not told staff because she was enjoying the activity. -She was going to return to her room to find someone to change her O2 canister. -She knew her O2 canister was empty because she did not feel O2 coming from the NC and she was "shaky". Interview with a PCA on 03/14/19 15 4:25 pm revealed: -She did not know Resident #1's portable O2 canister was empty. -She had not checked Resident #1's portable O2 canister since coming on shift because Resident #1 was in the activity room. -She normally checked Resident #1's portable O2 canister when she came on shift. Observations on 03/14/19 at 4:25 pm revealed: -A PCA turned the on and off valve of Resident #1's portable O2 canister. -The O2 regulator gauge stayed in the red section on the words "refill". -The PCA removed the portable O2 tank and placed it in an O2 concentrator in Resident #1's	{D 276}		

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{D 276}	Continued From page 11	{D 276}		

room and she replaced it with another O2 canister.

Interview with a MA on 03/14/19 at 4:28 pm revealed:
-She did not know Resident #1's portable O2 canister was empty.
-She had not checked Resident #1's portable O2 canister since coming on shift because Resident #1 was in the activity room.
-She normally checked Resident #1's portable O2 canister every two - three hours and reported the amount of O2 in the O2 canister to the next oncoming shift at shift change.

Telephone interview with Resident #1's PCP on 03/14/19 at 5:15 pm revealed:
-Resident #1 was on continuous O2 because of COPD.
-He expected staff to be aware of the amount of O2 remaining in Resident #1's O2 canister.
-He would revise the order for Resident #1's O2 to be checked every two hours to ensure the O2 canister did not run out of O2.

2. Review of Resident #4's current FL-2 dated 03/07/19 revealed diagnoses included aggressive behavior and vascular dementia with behavior.

Review of Resident #4's hospital discharge instructions dated 02/25/19 revealed:
-The resident was admitted to the hospital on 02/22/19 and discharged on 02/25/19.
-There was an order for Lantus insulin 20 units nightly. (Lantus is long-acting insulin used to lower blood sugar.)
-There was an order for Metformin 500mg twice a day with meals. (Metformin is used to lower blood sugar.)

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{D 276}	Continued From page 12 Review of Resident #4's verbal clarification physician's orders dated 02/26/19 revealed: -There was an order for Metformin 500mg 1 tablet twice daily. -There was an order to change Lantus insulin to Basaglar Insulin 20 units at bedtime (due to Lantus not covered by insurance). (Basaglar is long-acting insulin used to lower blood sugar.) -There was an order for blood sugar checks once a day at 7:00am on Monday, Wednesday, and Friday and 2:00pm on Tuesday, Thursday, Saturday, and Sunday; notify primary care provider if blood sugar is greater than (>) 400 or less than (<) 60. Review of Resident #4's primary care provider (PCP) visit note dated 02/26/19 revealed: -The resident was being seen for a hospital follow-up visit. -The resident was sent to the hospital on 02/22/19 after routine lab results showed a sudden increase in glucose read at 449, coupled with a random blood sugar following the lab result that read "High". -The resident previously had no diagnosis of diabetes mellitus and no treatment plan in place. -The resident reported no recollection of having a diagnosis of diabetes in the past. -The resident was hospitalized from 02/22/19 - 02/25/19 and prescribed new orders for Lantus and Metformin. -The PCP ordered blood sugar checks at 7:00am on Monday, Wednesday, and Friday and 2:00pm on Tuesday, Thursday, Saturday, and Sunday. Review of Resident #4's PCP visit note dated 03/07/19 revealed: -The resident was seen for a hemoglobin A1C review. (Hemoglobin A1C is a blood test used to tell the average blood sugar level over the last 2	{D 276}		

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	HAL092182	A. BUILDING: ______ B. WING ______	R 03/14/2019

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{D 276}	Continued From page 13 to 3 months. The higher the A1C level, the poorer the blood sugar control. The target hemoglobin A1C for diabetics is less than 7.) -The resident was recently diagnosed with diabetes mellitus type II in the hospital and the resident was currently receiving Basaglar 20 units at bedtime and Metformin 500mg twice a day. -The resident's hemoglobin A1C of 12.7 confirmed the diagnosis. -The PCP ordered Novolog 7 units 3 times a day before meals per blood sugar parameters. (Novolog is rapid-acting insulin used to lower blood sugar.) -The PCP ordered to change blood sugar checks to 3 times a day before meals and if blood sugar < 40: hold insulin, contact EMS, administer 10 ounces of juice; 41 - 60: hold insulin, administer 10 ounces of juice; 61 - 80: hold insulin, administer 5 ounces of juice; 81 - 149: hold insulin; and >450: contract provider for further instruction. -The resident was to follow-up in one month. Review of Resident #4's February 2019 electronic medication administration record (e-MAR) dated 02/25/19 - 02/28/19 revealed: -There was an entry to check blood sugar daily at 7:00am on Monday, Wednesday, and Friday but the scheduled time on the e-MAR was 1:00am. -The start date for the blood sugar checks was 02/27/19. -There was an "x" documented in the block for 02/27/19 and no blood sugar result. -There were staff initials in the block for 02/28/19 but no blood sugar result was documented. -There was no row specified on the e-MAR to document the blood sugar result, only a row for staff initials. -There was a second entry to check blood sugar daily at 2:00pm on Tuesday, Thursday, Saturday,	{D 276}		

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{D 276}	Continued From page 14 and Sunday but the scheduled time on the e-MAR was 1:00am. -The start date for the blood sugar checks was 02/27/19. -There was an "x" documented in the block for 02/27/19 and no blood sugar result. -There were staff initials in the block for 02/28/19 but no blood sugar result was documented. -There was no row specified on the e-MAR to document the blood sugar results, only a row for staff initials. Review of Resident #4's March 2019 e-MAR dated 03/01/19 - 03/14/19 revealed: -There was an entry to check blood sugar daily at 7:00am on Monday, Wednesday, and Friday but the scheduled time on the e-MAR was 1:00am instead of 7:00am and there was an "end date" of 03/08/19. -Blood sugars were initialed as checked at 1:00am on 03/01/19, 03/03/19 - 03/06/19 and 03/08/19 but no blood sugar results were documented. -There was no row on the e-MAR to document the blood sugar results, only a row for staff initials for this entry. -Blood sugar checks were not documented as completed on 03/02/19 or 03/07/19. -There was a second entry to check blood sugar daily at 2:00pm on Tuesday, Thursday, Saturday, and Sunday; notify prescriber if blood sugar was greater than 400 or less than 60. -The scheduled time on the e-MAR for this entry was 1:00am instead of 2:00pm as ordered and there was and "end date" of 03/08/19. -Blood sugars were initialed as checked at 1:00am on 03/01/19, and 03/03/19 - 03/06/19 but no blood sugar results were documented. -There was no row on the e-MAR to document the blood sugar results, only a row for staff	{D 276}		

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{D 276}	Continued From page 15	{D 276}		

initials.
-Blood sugar checks were not documented as completed on 03/02/19, 03/07/19, or 03/08/19.
-There was a third entry with a start date of 03/08/19 to check blood sugar daily at 7:00am on Monday, Wednesday, and Friday and it was scheduled for 7:00am with an "end date" of 03/11/19.
-A blood sugar was initialed as checked at 7:00am on 03/11/19 but there was no blood sugar result documented and no row specified to document the result.
-There was a fourth entry to check blood sugar daily at 2:00pm on Tuesday, Thursday, Saturday, and Sunday; notify prescriber if blood sugar was greater than 400 or less than 60.
-The scheduled time for this entry was "cont" for continuous, no time was specified, and there was an "end date" of 03/11/19.
-Blood sugars were initialed as checked for this entry on 03/09/19 and 03/10/19 but there were no blood sugar results noted and no row to document the results.
-There was a fifth entry with a start date of 03/12/19 to check blood sugar 3 times daily before meals scheduled to be checked at 7:00am, 11:30am, and 4:30pm.
-Blood sugars were initialed as checked from 03/13/19 at 7:00am through 7:00am on 03/14/19 but there were no blood sugar results documented on the e-MAR.

Interviews with Resident #4 on 03/12/19 at 11:40am and 03/14/19 at 12:34pm revealed:
-He went to the hospital about 2 to 3 weeks ago because his blood sugar was over 600.
-He had never been diabetic before going to the hospital.
-He thought staff had checked his blood sugar about every other day.

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{D 276}	Continued From page 16 -His blood sugar "runs alright". -He thought staff had checked his blood sugar late at night because he had trouble sleeping and he was usually awake when they checked it. -Staff checked his blood sugar that morning before breakfast and it was in the 100s. -He did not feel different when his blood sugar was high or low to his knowledge. -He thought he received insulin once a day but different staff did different things. Observation of Resident 4's glucometer on 03/14/19 at 9:20am and review of a handwritten list of blood sugar results in the memory of the glucometer provided by the facility on 03/14/19 revealed: -The date and time in the glucometer did not match the current date and time when the glucometer was turned on. -There were 15 readings for 12 days in the memory of the glucometer for February and March 2019. -The blood sugar readings ranged from 114 - "HI". (According to the manufacturer of the glucometer, a result of "HI" meant the blood sugar was > 600.) Telephone interview with a third shift medication aide (MA) on 03/14/19 at 11:30am revealed: -She checked Resident #4's blood sugar every Monday, Wednesday, and Friday at 1:00a for about 2 weeks. -She did not specify which dates. -The order for blood sugars would "pop up" on the e-MAR to be checked at 1:00am so that was when she checked it. -There was no area on the e-MAR to record the resident's blood sugars, which was unusual. -She wrote the blood sugar results on a piece of paper when she checked them but then threw the	{D 276}		

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{D 276}	Continued From page 17 paper away. -She documented some of the blood sugar results on the facility's 24 hour shift report. -She did not report to management that the blood sugars were scheduled on the e-MAR at 1:00am or that she was unable to record blood sugars in the e-MAR system. -She could not explain why she did not report it to management. Interview with the Memory Care Coordinator (MCC) on 03/14/19 at 10:55am revealed: -The facility switched to a new e-MAR system near the end of February 2019. -The pharmacy entered new orders into the e-MAR system which would send an alert for her to review and verify the orders. -When she verified orders, she could see the scheduled times and checked them as well. -She had seen some residents' medications were scheduled for 1:00am and changed those when she was checking orders in the system. -She verified orders for Resident #4 but did not recall seeing blood sugar checks scheduled at 1:00am. -She could have "overlooked" it. -The MAs had not notified her of the Resident #4's blood sugar checks being scheduled at 1:00am. -When she checked and verified Resident #4's blood sugar orders in the new e-MAR system, she did not realize there was a box that needed to be clicked in order to set up a row for the blood sugars to be documented. -The MAs had not reported to her that they were unable to enter Resident #4's blood sugar results into the e-MAR system. -She clicked on the box today, 03/14/19, so Resident #4's blood sugar results could now be recorded on the MAR.	{D 276}		

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{D 276}	Continued From page 18 -She would check the 24 hour shift reports to find any documented blood sugar results for Resident #4. Interviews with the Regional Clinical Director (RCD) on 03/14/19 at 11:00am and 11:12am revealed: -The new e-MAR system would not record blood sugar results if the box to record results was not checked off when the order was entered and verified. -She contacted the e-MAR support specialist via phone on 03/14/19 who reported if the box was not checked off, there would be no area on the e-MAR to record the blood sugar results. -She and the MCC clicked the box to record blood sugar results for Resident #4 today, 03/14/19. Interview with the Regional Clinical Director (RCD) on 03/14/19 at 3:08pm revealed: -The new e-MAR system defaulted some scheduled times to 1:00am. -The facility was responsible for entering the correct scheduled times on the e-MARs based on the facility's protocols. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/14/19 at 4:15pm revealed: -The pharmacy had an order on file for Resident #4 dated 02/26/19 for blood sugars to be checked daily at 7:00am on Monday, Wednesday, and Friday and at 2:00pm on the other days of the week. -The pharmacy usually entered new orders into the e-MAR system when they received the orders. -The facility chose scheduled default times that were set up initially in the electronic system.	{D 276}		

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{D 276}	Continued From page 19 -Once the pharmacy entered orders, facility staff had to review and approve the orders before the order became active on the e-MARs. -He did not know why Resident #4's blood sugar was initially scheduled for 1:00am unless that was the default time set by the facility. -The pharmacy had a new order dated 03/07/19 for Resident #4 to increase blood sugar checks to 3 times a day before meals. Telephone interview with Resident #4's primary care provider (PCP) on 03/14/19 at 5:30pm revealed: -Resident #4 was newly diagnosed with diabetes mellitus when the resident was hospitalized in February 2019. -He was not aware facility staff had checked the resident's blood sugar at 1:00am instead of 7:00am and 2:00pm as ordered in February 2019. -He expected the resident's blood sugar to be checked at 7:00am and 2:00pm according to the order at that time. -He saw the resident for a follow-up visit on 03/07/19 and the resident's hemoglobin A1C was 12.7 which was very high. -He added Novolog insulin and increased the blood sugar checks during that visit. -When he saw the resident at the facility on 03/07/19, he recalled seeing some blood sugar results documented but he could not recall where they were documented, possibly the e-MARs. -He thought the blood sugars he reviewed were consistently in the 200s and 300s. Review of 24 hour reports revealed: -Resident #4's blood sugar was over 500 at 3:00pm on 02/22/19; called emergency medical services (EMS). -Resident #4's blood sugar was 254 at 12:30am on third shift on 02/26/19.	{D 276}		

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{D 276}	Continued From page 20 -Resident #4's blood sugar was 213 at 12:12am on third shift on 02/28/19. -Resident #4's blood sugar was 288 at 1:00am on third shift on 03/01/19. -Resident #4's blood sugar was 218 at 12:30am on third shift on 03/02/19. -Resident #4's blood sugar was 259 at 1:00am on third shift on 03/03/19. -Resident #4's blood sugar was 205 (no time) on third shift on 03/04/19. -Resident #4's blood sugar was 205 (no time) on third shift on 03/05/19. -Resident #4's blood sugar was 131 at 2:00pm on 03/09/19. -Resident #4's blood sugar was 147 (no time) on first shift on 03/10/19. -Resident #4's blood sugar was 114 (no time) on third shift on 03/13/19. -Resident #4's blood sugar was 207 (no time) on second shift on 03/14/19. 3. Review of Resident #2's current FL-2 dated 05/01/2018 revealed: -Diagnoses included Alzheimer's disease, diabetes mellitus (unspecified) and diabetic neuropathy. -There was an order to check blood sugars 30 minutes before meals and at bedtime. Review of a Physician Order Report form for Resident #2 signed 03/07/19 revealed an order to check blood sugars 30 minutes before meals and at bedtime. Review of Resident #2's an electronic medication administration record (eMAR) dated January 2019 revealed: -There was an entry for blood sugar checks scheduled at 6:00am daily. -There was documentation of blood sugar results	{D 276}		

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{D 276}	Continued From page 21 at 6:00am daily from January 01, 2019 through January 31, 2019. Review of Resident #2's eMAR dated February 2019 revealed. -There was an entry for blood sugar checks scheduled for 6:00am daily. -There was documentation of blood sugar results at 6:00am daily from February 01, 2019 through February 28, 2019. Review of Resident #2's eMAR dated March 2019 revealed: -There was an entry for blood sugar checks to be done at 6:00am daily. -There was documentation of blood sugar results at 6:00am from March 01, 2019 through March 13 (date of survey), 2019. Interview with a medication aide (MA) on 03/14/19 revealed meals were served at 7:30am, 12:00pm and 5:00pm on both the Assisted Living (AL) "side" and in the Memory Care Unit (MCU). Interview with the Memory Care Coordinator (MCC) on 03/13/13 at 4:25pm revealed: -Breakfast was served on the MCU "around 8:00am." -The residents were eating breakfast at 8:12am this morning (03/14/19). Interview with the MCC on 03/14/19 at 12:10pm revealed: -The pharmacy assigned the eMAR times for all residents. -The facility had the ability to edit the eMAR times for all residents. -The blood sugar check eMAR times could be edited at the facility for Resident #2. -There was an eMAR provider system change at	{D 276}		

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{D 276}	Continued From page 22 the end of February 2019. -Resident #2's eMAR information was imported over into the new eMAR system. -Resident #2's blood sugar check eMAR times were "overlooked" during the eMAR change over. Telephone interview with Resident #2's primary care provider (PCP) on 03/14/19 at 5:10pm revealed: -He expected Resident #2's blood sugar to be checked 30 minutes before meals as ordered. -He was not aware that the breakfast blood sugar check was being done up to 2 hours before the meal. Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable. ______________________ The facility failed to assure continuous oxygen was administered to a resident with a diagnoses of chronic obstructive pulmonary disease, who displayed symptoms of shortness of breath by having to pause in between sentences; and document and implement blood sugars as ordered for a resident newly diagnosed with diabetes requiring hospitalization for a blood sugar over 600. The facility's failure placed Resident #1 at increased risk for shortness of breath and low oxygen levels in the blood due to running out of oxygen and failure to use continuously which 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 03/14/19 for this violation. CORRECTION DATE FOR THE TYPE B	{D 276}		

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{D 276}	Continued From page 23 VIOLATION SHALL NOT EXCEED APRIL 28, 2019.	{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: FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION. Based on these findings, the previously Unabated Type A2 Violation was abated. Non-compliance continues. TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7,	{D 358}	Adult care homes should assure the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: Orders by a licensed prescribing practitioner which are maintained in the residents record; and the facility's policies and procedures. An in-service for all staff responsible for medication administration was held on 4-22-19. Implementation of Do Not Crush medication orders were reviewed, as well as presence of a Do Not Crush list placed within the medication cart for reference. When standing orders for crush meds is implemented, a note is added to the MAR for all meds which are unable to be crushed by the person implementing the DNC standing order. Medication Pass Observations will be performed bi-weekly x 3 weeks and monthly thereafter by the LHPS nurse. Any concerns noted in the medication pass will be addressed with the staff member, with notification to the Executive Director or their designee the day the observation is made.	4-28-19

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{D 358}	Continued From page 24 #8) observed during the medication passes including errors with a medication for mood disorders and a vitamin supplement (#8), medications used to treat and prevent constipation (#6, #7), and a mild pain reliever (#7); and for 3 of 5 residents sampled (#1, #4, #5) for record review including errors with insulin (#1, #4), a blood pressure /heart medication (#1), a medication for acid reflux (#4), and an antibiotic for infection (#5). The findings are: 1. The medication error rate was 24% as evidenced by the observation of 6 errors out of 25 opportunities during the 8:00am/9:00am and 12:30pm medication passes on 03/13/19. a. Review of Resident #6's current FL-2 dated 03/07/19 revealed: -Diagnoses included dementia, bradycardia, syncope, and hypertension. -There was an order for Miralax take 17 grams mixed with 8 ounces of water daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the cap on the bottle has a marking for 17 grams that should be used to measure the dosage at the top of the white section of the cap.) Observation of the 8:00am medication pass on 03/13/19 revealed: -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17 g" imprinted near the top of the white section and an arrow pointing up to indicate the measurement for 17 grams was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder to the bottom edge of the "17 g" imprint	{D 358}		

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{D 358}	Continued From page 25 which was approximately 1/8th to 1/4th inch below the top of the white section marking 17 grams. -The MA did not measure the Miralax correctly and the full dosage was not mixed in the water. -The MA mixed the Miralax powder in water and gave it to the resident to take with her oral pills at 8:48am. -The resident drank about half of the water with Miralax and said "that's all". -The MA asked if the resident was sure and then took the cup with Miralax from the resident. -The MA did not explain to the resident that there was medication in the water and she needed to drink the water to get the medication. -The MA did not encourage the resident to drink the water with Miralax. -The MA went back to the medication cart and threw the remainder of the Miralax in the trash can. -The MA clicked on the electronic medication administration record (e-MAR) that all medications were administered, including the Miralax. Interviews with the MA on 03/13/19 at 8:50am and 12:10am revealed: -She usually measured the Miralax powder just below the imprint of "17 g". -She did not see the arrow pointing up that indicated 17 grams marking was at the top of the white section of the cap. -She did not administer medications on this hall but about twice a month. -When she worked on this hall, Resident #6 did not usually drink all of the water with Miralax. -She thought the resident knew there was medication in the water. -She had not notified the resident's primary care provider (PCP) that the resident did not usually	{D 358}		

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{D 358}	Continued From page 26 drink all of the Miralax. -She would document in the progress notes that the resident did not drink all of the Miralax. Review of Resident #6's March 2019 e-MAR revealed: -There was an entry for Miralax take 17 grams mixed with 8 ounces of water by mouth daily with a scheduled administration time of 8:00am. -Miralax was documented as administered daily from 03/01/19 - 03/13/19. -There was no documentation the resident had refused any Miralax. Interview with Resident #6 on 03/13/19 at 11:40am revealed: -She did not know there was medication in the water when she received her morning medications. -It tasted like plain water and sometimes she did not drink all of it. -She would "drink all I can". -She did not have any current issues with constipation. Interview with the Memory Care Coordinator (MCC) on 03/13/19 at 2:04pm revealed: -The MAs should encourage the residents to drink all of the water with Miralax. -If the resident's do not drink it all, it should be documented and the PCP should be notified. b. Review of Resident #7's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's disease, dementia, anoxic brain damage, cardiac murmur, hypertension, hyperlipidemia, benign prostatic hypertrophy, iron deficiency, and ruptured cardiac wall without hemorrhage. -There was an order for Sennosides - Docusate	{D 358}		

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{D 358}	Continued From page 27 Sodium 8.6/50mg take 1 tablet every 12 hours. (Sennosides - Docusate Sodium is a combination product that contains a stimulant laxative and a stool softener and it used to treat and prevent constipation.) Review of Resident #7's standing house orders dated 10/16/18 revealed all medications may be crushed (check do not crush list) and placed in applesauce/pudding unless otherwise noted. Review of Resident #7's March 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Sennosides-Docusate Sodium 8.6/50mg take 1 tablet every 12 hours with scheduled administration times of 9:00am and 9:00pm. -Sennosides-Docusate Sodium was documented as administered from 03/01/19 - 03/12/19 at 9:00am. -The 9:00pm dose on 03/12/19 was not administered due to "med not available". Observation of the 9:00 am medication pass in the memory care unit (MCU) on 03/13/19 revealed: -The medication aide (MA) was preparing morning medications for Resident #7. -The MA stated he was borrowing Sennosides-Docusate Sodium from another resident because Resident #7 was out of the medication. -There was a bubble card for another resident labeled with Docusate Sodium 100mg and the MA punched 1 capsule into the medication cup prepared for Resident #7. (Docusate Sodium is a stool softener and is not the same as Sennosides-Docusate Sodium.) -The MA took the cup into Resident #7's room	{D 358}		

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{D 358}	Continued From page 28 and began to set the resident up in bed to administer his medications. -The MA was prompted to step back to the medication cart in the hallway. -The MA was asked if the Docusate Sodium label for the other resident matched the order on Resident #7's e-MAR. -The MA did not answer but asked the Memory Care Coordinator (MCC) about Resident #7's Sennosides-Docusate Sodium being unavailable. -The MCC brought a new bubble card with Resident #7's Sennosides-Docusate Sodium to the MA from the back up medication supply that was dispensed on 03/11/19. -The MA then answered the question and said the other resident's Docusate Sodium was not the same as Resident #7's Sennosides-Docusate Sodium and discarded the Docusate Sodium. -The MA punched one Sennosides-Docusate Sodium 8.6/50mg tablet into the medication cup with Resident #7's other morning medication and crushed all of the tablets and mixed them in applesauce. -The MA asked the MCC for assistance in sitting up the resident from a lying position so the resident's medications could be administered. -The MA used a plastic spoon to feed a small spoonful of crushed medications to the resident at 9:12am. -The resident was fed a second small spoonful but the resident left about 1/3rd of the applesauce with crushed medications on the spoon. -The plastic cup also had some applesauce with crushed medications on the inside walls and bottom of the cup. -The MA put the spoon in the cup with the leftover applesauce and crushed medications and threw it away. -The MA did not try to get all of the crushed medications from the cup and spoon and	{D 358}		

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{D 358}	Continued From page 29 administer to the resident. -The resident did not receive the full dosage of the medications, including Sennosides-Docusate Sodium. Interview with the MA on 03/13/19 at 1:08pm revealed: -Resident #7's medications were usually in the medication cart. -If a medication needed refills, the MAs would fill out a form and give it to the MCC who would order the medication from the pharmacy. -If a medication was not available, they could borrow the same medication from another resident and repay that resident later. -He did not notice the Docusate Sodium he initially borrowed from another resident did not match the medication listed on Resident #7's e-MAR. -He usually crushed Resident #7's medications because the resident had swallowing problems. -He usually tried to scrape the sides and bottom of the cup to get all of the applesauce and crushed medications to administer to the resident. -He should have administered all of the applesauce with crushed medications to Resident #7 that morning on 03/13/19. -Resident #7 usually took all of the medication for the MA. Interviews with the MCC on 03/13/19 at 12:24pm and 2:04pm revealed: -The MAs were only supposed to borrow medications in an emergency situation. -The MAs should check with her before borrowing medications. -Resident #7's medications should have been available. -The medications were on an anniversary cycle fill	{D 358}		

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{D 358}	Continued From page 30 so if a medication was not available when there was a 5 day supply remaining, the MAs were supposed to notify the MCC. -The MA texted the MCC last night (03/12/19) and told her Resident #7 was out of Sennosides-Docusate Sodium. -The Sennosides-Docusate Sodium was in the back up supply of medication. -The MAs should always check the back up supply of medication if they could not locate a medication on the medication cart. -Resident #7 did not usually refuse his medications. -The MAs should scrape out as much of the applesauce with crushed medications as possible and feed it all to the resident. Interview with the Regional Clinical Director (RCD) on 03/13/19 at 12:25pm revealed: -The MAs could call and use the back-up pharmacy if medications were unavailable. -The MAs should check with the MCC before borrowing medications. c. Review of Resident #7's current FL-2 dated 03/07/19 revealed an order for Tylenol 325mg take 3 tablets 3 times daily. (Tylenol is a mild pain reliever and fever reducer.) Review of Resident #7's standing house orders dated 10/16/18 revealed all medications may be crushed (check do not crush list) and placed in applesauce/pudding unless otherwise noted. Review of Resident #7's March 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Tylenol 325mg take 3 tablets 3 times daily at 9:00am, 3:00pm, and 9:00pm.	{D 358}		

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{D 358}	Continued From page 31 -Tylenol was documented as administered 3 times daily from 03/01/19 - 03/12/19. Observation of the 9:00am medication pass in the memory care unit (MCU) on 03/13/19 revealed: -The medication aide (MA) punched 3 Tylenol 325mg tablets into the medication cup with Resident #7's other morning medication and crushed all of the tablets and mixed them in applesauce. -The MA asked the Memory Care Coordinator (MCC) for assistance in sitting up the resident from a lying position so the resident's medications could be administered. -The MA used a plastic spoon to feed a small spoonful of crushed medications to the resident at 9:12am. -The resident was fed a second small spoonful but the resident left about 1/3rd of the applesauce with crushed medications on the spoon. -The plastic cup also had some applesauce with crushed medications on the inside walls and bottom of the cup. -The MA put the spoon in the cup with the leftover applesauce and crushed medications and threw it away. -The MA did not try to get all of the crushed medications from the cup and spoon and administer to the resident. -The resident did not receive the full dosage of the medications, including Tylenol. Interview with the MA on 03/13/19 at 1:08pm revealed: -He usually crushed Resident #7's medications because the resident had swallowing problems. -He usually tried to scrape the sides and bottom of the cup to get all of the applesauce and crushed medications to administer to the resident.	{D 358}		

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{D 358}	Continued From page 32 -He should have administered all of the applesauce with crushed medications to Resident #7 that morning on 03/13/19. -Resident #7 usually took all of the medication for the MA. Interview with the MCC on 03/13/19 at 2:04pm revealed: -Resident #7's medications were crushed because he could not swallow them whole. -Resident #7 did not usually refuse his medications. -The MAs should scrape out as much of the applesauce with crushed medications as possible and feed it all to the resident. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. d. Review of Resident #7's current FL-2 dated 03/07/19 revealed an order for Miralax take 17 grams mixed with 8 ounces of water every day. (Miralax is a laxative used to treat and prevent constipation.) Observation of the 9:00am medication pass on 03/13/19 revealed: -The medication aide (MA) mixed 17 grams of Miralax in approximately 8 ounces of water for Resident #7. -The MA asked the Memory Care Coordinator (MCC) for assistance in sitting up the resident from a lying position so the resident's medications could be administered. -After the MA administered the resident's crushed oral medications at 9:12am, the MCC put the cup to the resident's mouth and turned it up while the resident took 3 small swallows of water with Miralax.	{D 358}		

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{D 358}	Continued From page 33 -The MCC asked the resident if he wanted any more water and the resident shook his head back and forth from left to right. -The MCC said "he's done" and handed the cup with water mixed with the Miralax powder to the MA at 9:13am. -There was approximately 75% of the water with Miralax remaining in the cup. -The MCC and MA did not encourage or explain to the resident that there was medication in the water and he needed to drink the water to get the medication. -The MCC and MA did not put the cup back to the resident's mouth to prompt the resident with dementia to drink the water with Miralax. -The MA went back to the medication cart and threw the remainder of the Miralax in the trash can. -The MA documented on the electronic medication administration record (e-MAR) that the resident did not drink all of the water with the Miralax. Interviews with the MA on 03/13/19 at 18pm revealed: -Resident #7 usually drank all of the Miralax. -The MA could not say why he did not encourage the resident to drink all of the Miralax that morning, 03/13/19. -The resident had regular bowel movement and currently had no problems with constipation. Interview with the MCC on 03/13/19 at 2:04pm revealed: -Resident #7 usually drank all of the water with Miralax. -The resident had dementia and staff had to hold the cup and assist the resident with drinking liquids. -She thought it would have helped if she had	{D 358}		

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{D 358}	Continued From page 34 explained to the resident he needed to drink the water because there was medication in it. -It would have helped if she had put the cup back to the resident's mouth so it would prompt him to drink more of the water with Miralax. Review of Resident #7's March 2019 e-MAR revealed: -There was an entry for Miralax take 17 grams mixed with 8 ounces of water by mouth every day with a scheduled administration time of 9:00am. -Miralax was documented as administered daily from 03/01/19 - 03/12/19. -On 03/13/19, the MA documented the resident did not take full glass of water with med. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. e. Review of Resident #8's current FL-2 dated 03/07/19 revealed: -Diagnoses included Alzheimer's dementia, generalized anxiety disease, insomnia, kidney stone, and dry eye syndrome. -There was an order for Depakote ER 250mg take 1 tablet twice daily. (Depakote ER is an extended release medication that may be used to treat mood disorders. Depakote is extended release and should not be crushed or chewed.) Review of Resident #8's standing house orders dated 10/16/18 revealed all medications may be crushed (check do not crush list) and placed in applesauce/pudding unless otherwise noted. Observation of the 9:00am medication pass on 03/13/19 revealed: -The medication aide (MA) prepared morning medications for Resident #8, including one	{D 358}		

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{D 358}	Continued From page 35 Depakote ER 250mg tablet. -The MA crushed all of Resident #7's oral pills, including Depakote ER, mixed them in applesauce and administered them to the resident at 9:21am. Observation of Resident #8's medications on hand on 03/13/19 revealed: -There was a supply of Depakote ER 250mg tablets dispensed on 02/21/19. -There was an auxiliary label with "Do NOT CHEW or CRUSH before swallowing" on the medication label. Review of Resident #8's March 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Depakote ER 250mg take 1 tablet twice daily with scheduled administration times of 9:00am and 9:00pm. -There was no information noted on the e-MAR to indicate the medication should not be crushed. Review of the facility's Do Not Crush (DNC) medication list revealed Depakote ER was included on the list as a medication that should not be crushed because it was an extended release tablet. Interview with the MA on 03/13/19 at 1:15pm revealed: -Resident #8's medications were usually crushed because the resident had swallowing problems. -He did not know Depakote ER should not be crushed. -Sometimes it was noted on the e-MAR or the medication label if a medication could not be crushed. -He did not see the sticker on the Depakote ER that it should not be crushed or chewed.	{D 358}		

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{D 358}	Continued From page 36	{D 358}		

-He did not know Depakote ER was included on the facility's DNC list.

Interview with the Memory Care Coordinator (MCC) on 03/13/19 at 2:04pm revealed:
-The MAs were supposed to refer to the DNC list before crushing medications.
-There should be a DNC list kept in each medication cart.
-Sometimes it was noted on the e-MAR and on the medication label that a medication should not be crushed.
-The Depakote ER should not have been crushed.

Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable.

f. Review of Resident #8's current FL-2 dated 03/07/19 revealed an order for Vitamin D3 1,000 units take 2 tablets (2,000 units) daily. (Vitamin D3 is a supplement used to treat Vitamin D deficiency.)

Review of Resident #8's previous physician's order dated 02/07/19 also revealed an order for Vitamin D3 1,000 units take 2 tablets daily.

Review of Resident #8's previous physician's order dated 02/07/19 also revealed an order for Vitamin D3 1,000 units take 2 tablets daily.

Observation of the morning medication pass on 03/13/19 revealed:
-The medication aide (MA) prepared and administered morning medications to Resident #8 at 9:21am.
-The MA did not administer Vitamin D3 to the resident.

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{D 358}	Continued From page 37 Review of Resident #8's March 2019 electronic medication administration record (e-MAR) revealed: -There was an entry for Vitamin D3 1,000 units take 2 tablets once a day with a scheduled administration time of 8:00am. -Vitamin D3 was documented as administered from 03/01/19 - 03/06/19. -There was documentation of a discontinue (D/C) date of 03/06/19 with an electronic entry that read "awaiting D/C verification". -No Vitamin D3 was documented as administered after 03/06/19. Interview with the MA on 03/13/19 at 1:15pm revealed: -Resident #8 had a supply of Vitamin D3 in the medication cart. -He did not administer the Vitamin D3 that morning on 03/13/19 because the Vitamin D3 did not "pop up" on the e-MAR to be administered. -He did not remember when he last administered Vitamin D3 to the resident. Observation of Resident #8's medications on hand on 03/13/19 at 1:15pm revealed: -There was a bubble card labeled 2 of 2 with a supply of Vitamin D3 1,000 units that held 30 tablets. -There were 15 of 30 tablets remaining in the bubble card. -The MAs had initialed and dated beside each of the 15 empty bubbles. -Staff initialed on the bubble card that 2 tablets were used on 03/01/19, 03/03/19, 03/05/19, 03/06/19, 03/08/19, 03/10/19, and 03/11/19. -Staff initialed on the bubble card that 1 tablet was used on 03/02/19. -No tablets were initialed as administered on	{D 358}		

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{D 358}	Continued From page 38 03/04/19, 03/07/19, 03/09/19, 03/12/19, and 03/13/19. Review of Resident #8's physician's orders revealed there was no order to discontinue the Vitamin D3. Interview with the Memory Care Coordinator (MCC) on 03/13/19 at 1:20pm revealed: -The resident was supposed to receive Vitamin D3. -She did not know why the order was suspended on the e-MAR. -She did not remember getting an order to discontinue it and she had not contacted the primary care provider (PCP) to verify it. -The facility had recently switched to a different e-MAR system and there may have been a problem when the Vitamin D3 was changed to the new system. -She had been working on checking the orders but had not had time to check all orders since they switched e-MAR systems. -The MAs should notify the MCC when there was a medication in the cart that was not listed on e-MAR. -She would contact Resident #8's PCP about the Vitamin D3. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/14/19 at 4:15pm revealed: -The pharmacy had orders on file for Vitamin D3 1,000 units 2 tablets daily dated 02/07/19 and 03/06/19. -The pharmacy did not have an order on file for Vitamin D3 to be discontinued. -The pharmacy usually entered new orders into the e-MAR system but the facility had to review and approved the orders for them to become	{D 358}		

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{D 358}	Continued From page 39 active orders in the e-MAR. -The facility could change and update orders in the e-MAR system. Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. A second interview with the MCC on 03/13/19 at 2:00pm revealed: -She contacted Resident #8's PCP about the Vitamin D3. -The PCP reported the resident should still be receiving Vitamin D3 and it had not been discontinued. Telephone interview with Resident #8's PCP on 03/14/19 at 5:30pm revealed: -He had never discontinued Resident #8's Vitamin D3. -The resident should still be receiving Vitamin D3. Review of a clarification verbal order dated 03/13/19 for Resident #8 revealed the PCP noted the resident should be taking Vitamin D3 take 2 tablets daily. 2. Review of Resident #4's current FL-2 dated 03/07/19 revealed: -Diagnoses included aggressive behavior and vascular dementia with behavior. -There was an order Basaglar insulin 20 units a bedtime. (Basaglar is a long-acting insulin used to lower blood sugar.) -There was an order for Metformin 500mg 1 tablet twice daily. (Metformin lowers blood sugar.) -There was an order to check blood sugars daily at 7:00am on Monday, Wednesday, and Friday. -There was an order to check blood sugars daily	{D 358}		

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{D 358}	Continued From page 40 at 2:00pm on Tuesday, Thursday, Saturday, and Sunday; notify prescriber if blood sugar is greater than (>) 400 or less than (<) 60. Review of Resident #4's primary care provider (PCP) visit note dated 03/07/19 revealed: -The resident was seen for a hemoglobin A1C review. (Hemoglobin A1C is a blood test used to tell the average blood sugar level over the last 2 to 3 months. The higher the A1C level, the poorer the blood sugar control. The target hemoglobin A1C for diabetics is less than 7.) -The resident was recently diagnosed with diabetes mellitus type II in the hospital and the resident was currently receiving Basaglar 20 units at bedtime and Metformin 500mg twice a day. -The resident's hemoglobin A1C of 12.7 confirmed the diagnosis. -The PCP ordered Novolog 7 units 3 times a day before meals per blood sugar parameters. (Novolog is rapid-acting insulin used to lower blood sugar.) -The PCP ordered to change blood sugar checks to 3 times a day before meals and if blood sugar < 40: hold insulin, contact EMS, administer 10 ounces of juice; 41 - 60: hold insulin, administer 10 ounces of juice; 61 - 80: hold insulin, administer 5 ounces of juice; 81 - 149: hold insulin; and >450: contract provider for further instruction. -The resident was to follow-up in one month. Review of Resident #4's March 2019 electronic medication administration record (e-MAR) dated 03/01/19 - 03/14/19 revealed: -There was an entry for Novolog insulin, inject 7 units 3 times daily before meals hold per parameters if blood sugar is less than 150. -Novolog was scheduled to be administered at 7:00am, 12:00pm, and 5:00pm.	{D 358}		

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{D 358}	Continued From page 41	{D 358}		

-The start dated noted was 03/13/19 but the first and only dose documented as administered was 03/14/19 at 7:00am.
-There were no blood sugars results documented on the e-MAR, only staff initials.

Observation of Resident #4's medications on hand on 03/14/19 at 9:50am revealed:
-There was one vial of Novolog insulin dispensed on 03/13/19.
-The sealed cap had been removed and the vial appeared nearly full of insulin.
-There was no open date documented.

Interview with the first shift MA on 03/14/19 at 9:50am revealed:
-She had opened and first used the vial of Novolog insulin for Resident #4 that morning on 03/14/19.
-She would document the open date on the vial as 03/14/19.
-There was no Novolog on hand prior to the vial dispensed on 03/13/19.

Observation of Resident 4's glucometer on 03/14/19 at 9:20am and review of a handwritten list of blood sugar results in the memory of the glucometer provided by the facility on 03/14/19 revealed:
-The date and time in the glucometer did not match the current date and time.
-There were 15 readings for 12 days in the memory of the glucometer for February and March 2019.
-The blood sugar results ranged from 114 - "HI". (According to the manufacturer of the glucometer, a result of "HI" meant the blood sugar was > 600.)

Interview with Resident #4 on 03/14/19 at 12:34pm revealed:

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{D 358}	Continued From page 42 -He went to the hospital about 2 to 3 weeks ago because his blood sugar was over 600. -He had never been diabetic before going to the hospital. -He thought staff had checked his blood sugar about every other day. -His blood sugar "runs alright". -He thought staff had checked his blood sugar late at night because he had trouble sleeping and he was usually awake when they checked it. -Staff checked his blood sugar that morning before breakfast and it was in the 100s. -He did not feel different when his blood sugar was high or low to his knowledge. -He thought he received insulin once a day but different staff did different things. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/14/19 at 4:15pm revealed: -The pharmacy did not receive orders for Resident #4's PCP visit dated 03/07/19 until 03/13/19 when it was received by fax from the facility. -The pharmacy dispensed one vial of Novolog insulin for Resident #4 on 03/13/19 and it was delivered to the facility around 12:00 noon on 03/13/19. Interview with the Regional Clinical Director (RCD) on 03/14/19 at 6:45pm revealed: -Resident #4's PCP visit note with orders for Novolog insulin dated 03/07/19 were received and printed by the facility on 03/07/19. -The orders dated 03/07/19 should have been faxed to the pharmacy by the facility when received on 03/07/19. -They could also request insulin be sent by the back up pharmacy. -She did not know why staff did not fax the orders to the pharmacy when received on 03/07/19.	{D 358}		

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{D 358}	Continued From page 43	{D 358}		

-The Memory Care Coordinator (MCC) or MAs would have been responsible for faxing the orders.

Interview with the MCC on 03/14/19 at 6:56pm revealed:
-She thought she called the pharmacy a few days ago about Resident #4's Novolog insulin to find out why it was not in the facility.
-She thought the pharmacy had not sent the Novolog insulin because they were waiting for parameters for the order.
-She did not document any contacts with the pharmacy regarding the Novolog and she did not know who she spoke with at the pharmacy.
-She faxed the PCP visit note with the orders dated 03/07/19 to the pharmacy yesterday, 03/13/19.
-She did not recall if the visit note with the order for Novolog was faxed prior to 03/13/19.

Telephone interview with Resident #4's primary care provider (PCP) on 03/14/19 at 5:30pm revealed:
-He saw the resident for a follow-up visit on 03/07/19 and the resident's hemoglobin A1C was 12.7 which was very high.
-He added Novolog insulin and increased the blood sugar checks during that visit.
-He usually sent orders electronically to the pharmacy and he recalled sending the orders to the pharmacy on 03/07/19.
-He did not know Resident #4 did not get the first dose of Novolog insulin until today, 03/14/19.
-He would have expected the resident to start receiving Novolog on 03/08/19 the day after it was ordered in order for it to arrive from the pharmacy.
-When he saw the resident at the facility on 03/07/19, he recalled seeing some blood sugars

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{D 358}	Continued From page 44 documented but he could not recall where they were documented, possibly the MARs. -He thought the blood sugars he reviewed were consistently in the 200s and 300s. -He was concerned about the delay in the resident starting Novolog insulin since the resident was a newly diagnosed diabetic and at risk for diabetic ketoacidosis. -He was also concerned because the resident's hemoglobin A1C was high which could cause long term diabetic side effects, like organ damage, for the resident if not lowered. b. Review of Resident #4's current FL-2 dated 03/07/19 revealed an order for Omeprazole 20mg 1 capsule at bedtime for 60 days. (Omeprazole is used to treat acid reflux.) Review of Resident #4's primary care provider (PCP) visit note dated 02/19/19 revealed: -The resident complained of having chest pains after eating. -The PCP ordered Omeprazole 20mg 1 capsule at bedtime for 60 days. Review of Resident #4's February 2019 electronic medication administration record (e-MAR) dated 02/01/19 - 02/24/19 revealed: -There was an entry for Omeprazole 20mg 1 capsule at bedtime for 60 days and it was scheduled for administration at 9:00pm. -Documentation for the administration of Omeprazole started on 02/20/19. -Omeprazole was documented as administered on 02/20/19 and 02/21/19. -Omeprazole was not documented as administered from 02/22/19 - 02/24/19 due to the resident being in the hospital. Review of Resident #4's second February 2019	{D 358}		

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{D 358}	Continued From page 45 e-MAR dated 02/25/19 - 02/28/19 revealed: -There was an entry for Omeprazole 20mg 1 capsule at bedtime for 60 days but was scheduled for administration at 1:00am. -There was an "x" documented for 02/25/19 - 02/26/19 with no indication Omeprazole was administered. -On 02/27/19, staff documented they did not administer Omeprazole on third shift with no reason noted. -Omeprazole was documented as administered at 1:00am on 02/28/19. Review of Resident #4's March 2019 e-MAR dated 03/01/19 - 03/14/19 revealed: -There was an entry for Omeprazole 20mg 1 capsule at bedtime for 60 days but it was scheduled for administration at 1:00am. -Omeprazole was documented as administered at 1:00am from 03/01/19 - 03/14/19. Interview with Resident #4 on 03/14/19 at 12:34pm revealed he thought he received medication for heartburn but he was not sure what time he got it. Interview with the Memory Care Coordinator (MCC) on 03/14/19 at 10:55am revealed: -The facility switched to a new e-MAR system near the end of February 2019. -The pharmacy entered new orders into the e-MAR system which would send an alert for her to review and verify the orders. -When she verified orders, she could see the scheduled times and checked them as well. -She had seen some residents' medications scheduled for 1:00am and changed those when she was checking orders in the system. -She verified orders for Resident #4 but did not recall seeing scheduled times of 1:00am.	{D 358}		

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{D 358}	Continued From page 46 -She could have "overlooked" it. -The MAs had not notified her of the resident's Omeprazole was scheduled and administered at 1:00am. Telephone interview with a third shift medication aide (MA) on 03/14/19 at 11:30am revealed: -Resident #4's Omeprazole was scheduled and administered at 1:00am. -She did not report to management that the Omeprazole was "popping up" on the e-MAR at 1:00am. Interview with the Regional Clinical Director (RCD) on 03/14/19 at 3:08pm revealed: -The new e-MAR system defaulted some scheduled times to 1:00am. -The facility was responsible for entering the correct scheduled times on the MARs based on the facility's protocols. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/14/19 at 4:15pm revealed: -The pharmacy usually entered new orders into the e-MAR system but the facility chose scheduled times that are set up in the system. -Once the pharmacy entered orders, facility staff had to review and approve the orders before the order became active on the e-MARs. -He did not know why Omeprazole was scheduled for 1:00am unless that was the default time set by the facility. Telephone interview with Resident #4's primary care provider (PCP) on 03/14/19 at 5:30pm revealed: -He did not know Resident #4 was receiving Omeprazole at 1:00am. -The resident should receive Omeprazole at	{D 358}		

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{D 358}	Continued From page 47 bedtime as ordered. 3. Review of Resident #1's current FL-2 dated 03/07/19 revealed diagnosis of Type 2 diabetes mellitus without complications. a. Review of Resident #1's physician's order sheet dated 01/08/19 revealed an order for Humalog insulin 9 units 3 times a day at 7:30 am, 12:30 pm, and 5:30 pm. Hold if fingerstick (FSBS) is less than (<) 150. (Humalog is rapid-acting insulin that lowers blood sugar.) Review of Resident #1's current FL-2 dated 03/07/19 revealed an order for Humalog insulin 9 units 3 times a day at 7:30 am, 12:30 pm, and 5:30 pm. Hold if FSBS < 150. Review of Resident #1's hospital discharge summary dated 02/05/19 revealed: -Resident #1 was admitted to the hospital from 01/29/19 to 02/05/19 for congestive heart failure (CHF) and pneumonia. -There was an electronic order for Humalog insulin 100 units/milliliter 3 times a day before meals. -There was a handwritten, telephone order dated 02/06/19 beside the Humalog insulin that read 9 units three times a day before meals. Hold if FSBS < 150. Review of Resident #1's January 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog insulin 9 units 3 times a day, hold if FSBS < 150. -The resident's FSBS was 121 on 01/08/19 at 6:30 am. -The resident's FSBS was 122 on 01/13/19 at 11:30 am. -The resident's FSBS was 112 on 01/14/19 at	{D 358}		

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{D 358}	Continued From page 48 6:30 am. -The resident's FSBS was 137 on 01/22/19 at 4:30 pm. -The resident's FSBS was 121 on 01/26/19 at 4:30 pm. -The resident's FSBS was 121 on 01/27/19 at 4:30 pm. -Humalog insulin was documented as administered on these 6 occasions when the FSBS was <150 instead of held as ordered. -The resident's FSBS ranged from 109 - 246 from 01/01/19 - 01/31/19 -The resident was in the hospital from 01/29/19 - 01/31/19. Review of Resident #1's February 2019 eMAR revealed: -There was an entry for Humalog insulin 9 units 3 times a day, hold if FSBS < 150. -The resident's FSBS was 109 on 02/06/19 at 4:30 pm. -The resident's FSBS was 117 on 02/15/19 at 6:30 am. -The resident's FSBS was 109 on 02/15/19 at 11:30 am. -The resident's FSBS was 115 02/19/19 at 4:30 am. -The resident's FSBS was 116 on 02/23/19 at 6:30 am. -The resident's FSBS was 147 on 02/23/19 at 4:40 am. -Humalog insulin was documented as administered on these 6 occasions when the FSBS was <150 instead of held as ordered. -The resident's FSBS ranged from 104 - 243 from 02/01/19 - 02/28/19. -The resident was in the hospital from 02/01/19 - 02/06/19. Interview with a medication aide (MA) on 03/14/19 at 11:00 am revealed:	{D 358}		

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{D 358}	Continued From page 49 -She would not administer insulin to Resident #1 if the FSBS was < 150. -If she had administered insulin to Resident #1 with a FSBS < 150 she would have told the Administrator and asked for "guidance". Interview with a second MA on 03/14/19 at 11:20 am revealed: -She would not administer insulin to Resident #1 if the FSBS was < 150. -If she had administered insulin to Resident #1 with a FSBS < 150 she would have informed the Memory Care Coordinator (MCC). Interview with a third MA on 03/14/19 at 12:10 pm revealed: -She would not administer insulin to Resident #1 if the FSBS was < 150. -If she had administered insulin to Resident #1 with a FSBS < 150 she would have informed the provider. -If staff initials on the eMAR were circled the insulin was not administered. -If staff initials on the eMAR were not circled the insulin was administered. Interview with the MCC on 03/14/19 at 12:35 pm revealed: -The previous Resident Care Coordinator (RCC) was supposed to have been checking residents' FSBSs and comparing them to the insulin that was administered as an audit process. She did not know how often. -There was currently no RCC, and for the past 2 weeks she had also been filling the RCC role. -If Resident #1's FSBS was < 150 she expected the MA's to hold the insulin per orders. -If Resident #1 was administered insulin when her FSBS was < 150 she expected the MA to notify her, the Administrator, or the Licensed Health	{D 358}		

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{D 358}	Continued From page 50 Professional Support (LHPS) nurse, and the provider for resident evaluation. -The MA's had been trained by the LHPS nurse on FSBSs, and preparing and administering insulin. Telephone interview with the Primary Care Provider (PCP) on 03/14/19 at 5:15 pm revealed: -He had not been notified of insulin being administered to Resident #1 when the FSBS was < 150. -He expected the insulin to be held If Resident #1's FSBS was < 150. -He expected the facility to notify him immediately after administration if insulin was administered to Resident #1 when the FSBS was < 150 so he could give additional orders. -If he was notified immediately after the insulin was administered he would give an order to recheck the FSBS in fifteen minutes. -If it had been greater than fifteen minutes from when the insulin was administered and he was notified, he expected the FSBS recheck to be done while he was on the phone so he could have immediate results then give additional orders depending on the FSBS result. -If Resident #1's blood sugar level dropped in the 40's, 50's, 60's or 70's range he expected staff to follow the orders for those parameters and monitor the resident every 30 minutes for a steady increase in blood sugars. Interview with the Administrator on 03/14/19 at 6:38 pm revealed: -She did not know Resident #1 had been administered insulin with a FSBS < 150. -She expected the insulin to be held per orders if Resident 1's FSBS was < 150 -She expected the provider to be notified "immediately", follow any orders received by the	{D 358}		

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{D 358}	Continued From page 51 provider, and document the error if insulin was administered to Resident #1 with a FSBS < 150. b. Review of Resident #1's hospital discharge summary dated 02/05/19 revealed: -There was an admission diagnosis of acute on chronic congestive heart failure (CHF), unspecified heart failure type. -There was a discharge diagnosis of CHF. -There was an electronic order for Metoprolol 12.5mg two times a day (Metoprolol is a medication used to treat CHF, high blood pressure, and chest pain). -There was a discharge date and time of 02/05/19 at 12:44 pm. -It was electronically signed by a cardiologist on 02/05/19 at 12:55 pm. Review of Resident #'1s February 2019 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Metoprolol 12.5 mg two times a day at 8:00 am and 8:00 pm. -There was an electronic origination date of 02/10/19 at 7:00 pm. -There was no documentation that Metoprolol was administered from 02/06/19 to 02/09/19 at 8:00 am and 8:00 pm, and on 02/10/19 at 8:00 am. -The first dose of Metoprolol was documented as administered on 02/10/19 at 8:00 pm. Interview with a medication aide (MA) on 03/14/19 at 12:10 pm revealed she did not know why Metoprolol was not administered to Resident #1 from 02/06/19 - 02/10/19. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/14/19 at 4:15pm revealed:	{D 358}		

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{D 358}	Continued From page 52 -The pharmacy received Resident #1's hospital discharge summary dated 02/05/19 via fax on 02/08/19 at 4:39pm. -The pharmacy dispensed a one month supply of Metoprolol on 02/08/19 and it was delivered to the facility on 02/09/19 at 12:30am. -The pharmacy usually entered the medication orders into the eMAR record system. -The facility staff had to verify the orders for them to become active on the e-MAR. Interview with the Memory Care Coordinator (MCC) on 03/14/19 at 12:35 pm revealed: -The order for Resident #1's Metoprolol 12.5mg two times a day was not entered on the eMAR by the pharmacy until 02/10/19. She did not know why. -She did not know why Metoprolol was not administered to Resident #1 from 02/06/19 - 02/10/19. -The hospital discharge instructions and orders were given to the Resident Care Coordinator (RCC) when residents returned to the facility and the RCC would review and fax them to the pharmacy. -When the RCC was not at the facility the MA's would review hospital discharge instructions and orders, and fax them to the pharmacy. -If orders were sent to the pharmacy before 5:00 pm the medications would arrive at the facility the same day. -If orders were sent to the pharmacy after 5:00 pm, the medications would arrive at the facility the following day. -She expected Resident #1's Metoprolol to have been at the facility on 02/07/19 at the latest. -She expected either the RCC or the MA to have followed up with the pharmacy regarding the status of the Metoprolol.	{D 358}		

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{D 358}	Continued From page 53	{D 358}		

Interview with the Resident #1's Primary Care Provider (PCP) on 03/14/19 at 5:15 pm revealed:
-He would have liked hospital discharge medications to have been filled "promptly" and "as soon as possible".
-He expected facility staff to look over new medications and prescription orders and fax to the pharmacy.
-If the resident was discharged before 5:00 pm he expected the medications to be sent to the facility the night of discharge for implementation the following day.
-He expected resident's medications to be available for administration within 24 hours - 48 hours of hospital discharge.
-Resident #1's Metoprolol dosage was a low dose to decrease heart rate and heart strain, and help control CHF.
-He was not concerned regarding missed dosages because the Metoprolol was ordered at a low dose.

Interview with the Administrator on 03/14/19 at 6:38 pm revealed:
-The RCC and MCC were responsible for clarifying and reconciling all medications before and after hospital discharge.
-She expected RCC and MCC to always make sure medications were available for administration for the residents by performing weekly medication cart audits.
-If a medication was not available for administration for a resident, she expected the care managers to notify the provider and obtain the medication immediately from the pharmacy, or contact the backup pharmacy.
-She did not know Resident #1 had missed doses of Metoprolol after hospital discharge.

4. Review of Resident #5's current FL-2 dated

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{D 358}	Continued From page 54 09/25/18 revealed: -Diagnoses included Alzheimer's disease. -Resident #5 was non-ambulatory, constantly disoriented and was incontinent of bowel and bladder. Review of a Physician Order Form for Resident #5 dated 02/22/19 revealed: -Resident #5 had been diagnosed with a urinary tract infection (UTI). -There was an order for Macrobid (an antibiotic) 100mg twice a day for 10 days; a total of 20 doses. Review of Resident #5's electronic medication administration (eMAR) record dated February 2019 revealed: -There was an electronic entry for Macrobid 100mg to be given at 8:00am and at 8:00pm. -There was documentation the first dose was administered at 8:00pm on 02/24/2019. -There was documentation the 8:00am and 8:00pm doses were administered 03/25/19 through 03/28/19. -There was documentation of administration of a total of 9 doses of Macrobid were administered in February 2019. Review of Resident #5's eMAR dated March 2019 revealed: -There was an electronic entry for Macrobid 100mg to be administered at 8:00am and at 8:00pm. -There was documentation the 8:00am and 8:00pm doses were administered 03/0 1/19 through 03/03/19. -The time boxes from 03/04/19 through 03/14/19 (last date printed on eMAR) were blocked so additional doses could not be recorded. -There was documentation of a total of 6 doses of	{D 358}		

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{D 358}	Continued From page 55	{D 358}		

Macrobid were administered in March 2019.

Interview with the Administrator on 03/14/19 at 3:10pm revealed:
-She did not know documentation indicated 5 doses of an ordered 20 doses of Macrobid had not been administered.
-There was an eMAR provider system change at the end of February 2019.
-Resident #5's eMAR information was imported over into the new eMAR system.
-Resident #5's total dose count was overlooked during the eMAR change over.
-Resident #5's primary care provider (PCP) would be notified of the missed doses.

Telephone interview with Resident#5's PCP on 03/14/19 at 5:10pm revealed:
-He would expect that an antibiotic would be administered as ordered.
-If doses were missed, a repeat urinalysis would be necessary to assure the infection had cleared.

The facility failed to administer medications as ordered for 3 of 6 residents observed during the medication passes resulting in a 24% medication error rate with 6 errors out of 25 opportunities. The medication aide (MA) borrowed the wrong medication from another resident and attempted to administer it to Resident #7. The MA did not administer all of Resident #7's medications that had been crushed and put in applesauce. Resident #1's insulin was not held as ordered on 13 occasions for blood sugars less than 150. There was a delay in starting Resident #1's medication after a hospitalization for an exacerbation of congestive heart failure. Resident #4's insulin and oral diabetic medication were not administered as ordered after the resident was hospitalized for a blood sugar

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{D 358}	Continued From page 56 greater than 600 and being newly diagnosed as a diabetic. Resident #5 missed at least 5 doses of an antibiotic for a urinary tract infection. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/13/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 28, 2019.	{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 assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration.	{D912}	Residents have the right to receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as related to health care and medication administration. In-services conducting resident's rights will be scheduled and completed by all employees	5-22-18

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{D912}	Continued From page 57 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure a referral to home health for wound care for 1 of 3 sampled residents (#1) who had three pressure ulcers to the buttocks. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure physician orders were implemented for 3 of 5 sampled residents (#1, #2, #4) by failing to administer continuous oxygen (#1); document and implement blood sugars as ordered for a newly diagnosed diabetic (#4); and perform blood sugars as ordered 30 minutes before breakfast for an insulin dependent diabetic (#2). [Refer to Tag D276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 6 residents (#6, #7, #8) observed during the medication passes including errors with a medication for mood disorders and a Vitamin D supplement (#8), medications used to treat and prevent constipation (#6, #7), and a mild pain reliever (#7); and for 3 of 5 residents sampled (#1, #4, #5) for record review including errors with insulin (#1, #4), a blood pressure/heart medication (#1), a medication for acid reflux (#4), and an antibiotic for infection (#5). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		

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D 273	Continued From page 5 -There was no documentation Resident #1 had refused HH services. -There was no documentation Resident #1's PCP had been informed of Resident #1's refusal of HH services. -There was no documentation Resident #1s PCP had been informed of a delay in initiating the HH referral initially ordered on 01/15/19. -There was no documentation the HH order dated 01/15/19 had been discontinued. -There were thirty-eight days from the time HH was ordered and the time HH first saw Resident #1. Seven of those days Resident #1 was hospitalized (from 01/29/19 to 02/05/19). -HH admitted Resident #1 for wound care to stage 2 pressure ulcers to the buttocks on 02/22/19. Interview with Resident #1's Primary Care Provider (PCP) on 03/14/19 at 5:15pm revealed: -He did not know Resident #1 did not have a HH referral for the 01/15/19 HH order for wound care to stage 2 pressure ulcers to the buttocks until today (03/14/19). -He expected the facility to contact HH for residents the same day HH was ordered. -He expected HH to see residents within 24 hours to 48 hours after ordering HH. -When residents were seen in the facility he would give verbal orders to the facility staff for the HH referral then include the plan for HH in his dictated notes that were transcribed at a later time. -Resident #1's body did not have the ability to self-heal because she was a diabetic and non-ambulatory. -A delay in HH for wound care for Resident #1 could have resulted in an increase in wound size and depth, increased risk for infection and sepsis, and delayed healing because she was a diabetic	D 273		