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	HAL010007	A. BUILDING: _____ B. WING _____	C 08/06/2019

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D 000	Initial Comments The Adult Care Licensure Section and Brunswick County Department of Social Services conducted and annual survey and complaint investigation on July 31, 2019 - August 2, 2019 and August 5 - 6, 2019. The Brunswick County Department of Social Services initiated a complaint investigation on July 19, 2019.	D 000	Responses to the cited 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 Law.	
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 14 of 15 shifts on third shift from July 1, 2019 through July	D 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Shalar-Mason Paula Shalar-Mason — TITLE: Executive Director — (X6) DATE: 09-29-2019 09-18-2019

Amended/revised POC per conversation with [redacted] RN-Licensure Consultant on 9/27/19. Revised POC submitted, signed by ED on 9/29/19-SK

Reviewed and accepted POCA dated 09/29/19 - HF, Licensure Consultant 9/30/19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paula Shuler-Mason

TITLE: Executive Director

(X5) DATE: 9-18-2019

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D 167	Continued From page 1 15, 2019. The findings are: Review of 14 of 15 staff personnel files revealed: -Staff D, G and N had documentation of CPR certification within the past 24 months. -Staff A, B, C, E, F, H, I, J, K, L, and M had no documentation of completing a course in CPR in the past 24 months. Review of the staffing schedule and the punch time detail reports for third shift 07/01/19 through 07/15/19 revealed: -Staff D, G, and N did not work on third shift from 07/01/19 through 07/15/19. -There were 14 of 15 night shifts where there was no CPR certified staff on the premises. Interview with medication aide/supervisor (MA/S) on 08/019 at 1:00pm revealed: -She was responsible for completing the staff schedule for the facility. -On first shift (7:00am-3:00pm) three MAs and four personal care aides (PCAs) would be scheduled. -On second shift (3:00pm-11:00pm) three MAs and four PCAs would be scheduled. -On third shift (11:00pm-07:00am) two MAs and three PCAs would be scheduled. -The staffing schedule was also dependent on the current resident census. -She was not aware of the current number of facility staff who had completed a course on CPR within the last 24 months. -The facility staff who were current with their CPR certification could be found in the Executive Director (ED)'s office. -She was not aware of the regulation requiring at least one staff on site per shift who had	D 167	10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation Schedule was immediately reviewed and revised to assure coverage of CPR certified personnel were on duty as of 8/5/2019 & ongoing. Personnel files were audited by the business office manager to assure adequate number of employees had a current CPR Certification to include the Heimlich maneuver. The Divisional Director of Business will provide continuous oversight and support in coordination with the Executive Director. Cardio Pulmonary Resuscitation class was completed on 8/13/19 to increase the number of certified CPR personnel on staff. The schedule is reviewed during daily stand up with the Executive Director to assure CPR certified personnel are designated on schedule.	09/20/2019 09/20/2019 09/20/2019 09/05/2019

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D 167	Continued From page 2 completed CPR training within the last 24 months. -If a resident required CPR intervention, the Good Samaritan Law would apply. -She was confident in the staff to know how to complete CPR without training. -She would now complete the staff scheduling with having at least one facility staff on site with current CPR per shift. -She had previously worked on shift due to a facility staff not having a current CPR training; however; her CPR certification had expired (no dates provided). -She was not sure if the other MA/S or the Director of Resident Care (DRC) were current with their CPR certification. Interview with the MCM on 08/05/19 at 1:40pm revealed she had not completed a CPR class in the last 24 months. Interview with the ED on 08/05/2019 at 1:12pm revealed: -She was aware of the rule requiring one person on each shift to be certified in CPR. -She approved the schedule after the MA/S completed it. -She was not sure which staff were CPR certified. -She was aware the two MA/S's CPR had expired. -She was aware the Memory Care Manager's (MCM) CPR had expired. -She thought the staff would perform CPR if a resident needed it even if they did not have a CPR certification. -The staff would call 911 if they needed help. -There was a CPR class scheduled for 07/31/19 but it got canceled. -Her expectation was to have someone on each shift with CPR certification.	D 167	CPR certification was added to the employee tracking tool and monitored by Business Office Manager upon hire. The scheduler (Med Tech/Supervisor) will ensure each shift has an associate that is certified in CPR and will notate this on the schedule with a heart. This will be monitored ongoing by the Director of Resident Care, Business Office Manager and the Executive Director. The Business Manager will schedule CPR classes in coordination with the Director of Resident Care and Executive Director to ensure certified personnel are on duty as requried in the event of an emergency requiring CPR.	09/20/2019 09/20/2019

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D 167	Continued From page 3 -She would have the staff switch shifts to get third shift covered with someone that was CPR certified. The facility failed to assure staff on duty for fourteen shifts had completed a course on CPR within the last 24 months. The facility's failure was detrimental to the health and safety of the residents in case of an emergency requiring cardio-pulmonary resuscitation of a resident, which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-21 on 08/05/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2019.	D 167		
D 212	10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required	D 212		

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D 212	Continued From page 4 aide duty. (For staffing chart, see Rule .0606 of this Section.) This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure a Supervisor of personal care aides (PCAs) was on duty and available for 19 of 24 shifts sampled for eight dates in May 2019 -August 2019. The findings are: Review of the facility's 2019 license revealed the facility had a capacity of 78 residents. Review of the Daily Census Report (DCR) dated 05/14/19 revealed the facility census was 74 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 05/14/19 revealed: -There were 2 Supervisor hours for second shift, a shortage of 6 Supervisor hours. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 05/22/19 revealed the facility census was 74 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 05/22/19 revealed:	D 212	10A NCAC 13F .0605 Staffing of Personal Care Aide Supervisors Employee files were audited to identify and assure the qualifications for Supervisors In Charge. Supervisors are identified for each shift and are designated on the schedule as the Supervisor for the identified shift/unit. Staff have been inserviced regarding schedule designation to ensure all staff are aware of who is in charge on each shift. Monitoring Compliance: Director of Resident Care in coordination with the scheduler will review the schedule daily and present at daily stand up for review by the Executive Director to assure compliance. Business Manager will review time records daily in coordination with the Executive Director.	09/20/2019 09/20/2019 09/20/2019 09/20/2019 09/20/2019

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D 212	Continued From page 5 -There was no Supervisor on second shift. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 06/13/19 revealed the facility census was 74 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 06/13/19 revealed: -There were 4.77 Supervisor hours for second shift, leaving the facility short 3.23 Supervisor hours. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 07/20/19 revealed the facility census was 69 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 07/20/19 revealed: -There were 2.75 Supervisor hours for second shift, leaving the facility short 5.25 Supervisor hours. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 07/21/19 revealed the facility census was 68 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 07/21/19 revealed:	D 212	DVPO reviewed 10A NCAC 13F .0605 requirements for Staffing of Personal Care Aide Supervisors with the Executive Director. 09/20/2019 Quality Assurance: Shift staff analysis reports are run weekly as a measure to assure compliance with staffing of personal care aide supervisors. DVPO reviews reports for compliance and follows up with Executive Director weekly. 09/20/2019 Note: The preceeding internal systems are utilized throughout daily operations to assure compliance in Staffing of Personal Care Aide Supervisors.	

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D 212	Continued From page 6 -There was not a Supervisor on first or second shift. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 07/22/19 revealed the facility census was 68 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 07/22/19 revealed: -There were Supervisor 7 hours for first shift, a shortage of 1 Supervisor hour. -There was not a Supervisor on second shift. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 08/03/19 revealed the facility census was 68 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 08/03/19 revealed: -There were 2 Supervisor hours for second shift, leaving the facility short 6 Supervisor hours. -There was not a Supervisor within the building or within 500 feet on third shift. Review of the DCR dated 08/04/19 revealed the facility census was 68 which required at least 8 Supervisor hours on first and second shifts and Supervisor hours in the building, or within 500 feet and immediately available on third shift. Review of the individual employee time card punch detail reports dated 08/04/19 revealed:	D 212		

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D 212	Continued From page 7 -There was not a Supervisor on first shift. -There was not a Supervisor on second shift. -There was not a Supervisor within the building or within 500 feet on third shift. Interview with the MA/Supervisor on 08/06/19 11:32am revealed: -She acknowledged the facility did not have a Supervisor on all shifts. -A Supervisor was recently hired for third shift and was starting on 08/06/19. -The staff schedule also known as the assignment sheets was completed on weekly basis (Wednesday to Wednesday). -The MA/Supervisor and the Executive Director (ED) would go over the staff scheduling before it was finalized. -A copy of the final schedule would be given to the ED. Interview with the Director of Resident Care (DRC) on 08/06/19 at 02:30pm revealed: -There was a MA/Supervisor assigned to complete the staff schedule for the entire facility. -The DRC reviewed the staffing schedule daily. -She was not aware if there was a Supervisor scheduled on every shift. Interview with the ED on 08/06/19 10:20am revealed: -She was aware of the daily staffing schedule for the facility. -She wasn't aware that she had to have a Supervisor on duty on second shift and a Supervisor on duty in the facility or within 500 feet of the facility during third shift. -Every weekend there was a Supervisor on duty from 10:00-02:00pm. -She acknowledged the MA/Supervisor who completed the staff schedule was not aware of	D 212		

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D 212	Continued From page 8 the required staffing ratios. -The Memory Care Manager (MCM) and the ED would look over the schedule before it was finalized. Interview with the ED on 08/06/19 at 4:45pm revealed she expected for staffing to be maintained in accordance with the rules and to meet the residents' needs.	D 212	10A NCAC 13F .0902(b) Health Care Resident chart audits were initiated immediately during survey and completed by 9/5/19 to assure health care referral and follow up needs were addressed. Any outstanding needs identified were addressed with the primary care provider and any additional order processed accordingly.	09/5/2019
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION The facility failed to assure the acute and chronic health care needs were met for 5 of 8 sampled residents (#1, #3, #4, #13, and #15) related to primary care provider (PCP) notification of pain and signs and symptoms of infection and not receiving antibiotics as orderedfor an axillary abscess (#4); notification of the PCP for a change in status (#13); missed and rescheduling of dental appointments and notification to the PCP and/or dental provider of ongoing facial swelling and oral pain after missed doses of an antibiotic	D 273	Health care referral and follow-up needs are monitored through the following processes as outlined in the plan of correction for 13F .0902(b), Tag 273 to assure compliance. -Communication logs are reviewed daily by the Care Mgrs and monitored by the ED at daily dept head meetings. -Shower sheets/body assessments are documented on resident bath days and reviewed by the Care Mgrs. ED monitors compliance during daily dept head meetings. -Appointment calendars are reviewed by the Care Mgr and appts coordinated with transport personnel daily. ED monitors daily during dept head meetings. -Medication administration compliance is reviewed daily by the Care Mgrs and monitored by the ED during daily dept head meetings -Order processing system files are reviewed by Care Mgrs daily and monitored by ED to assure -Daily reports including, but not limtied to incident reports are reviewed by Care Mgrs daily and monitored by the ED daily dept head The preceding processes are monitored by the ED with additional senior level oversight weekly. SVP will follow-up with weekly compliance calls and frequent on-site visits at least monthly to monitor progress and compliance.	09/5/2019 ongoing process 9/5/12019 ongoing

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D 273	Continued From page 9 ordered prior to the dental procedure (#15); coordination of care between the PCP and endocrinologist, scheduling of endocrinology and orthopedic consults as ordered, and notification of the endocrinologist and the PCP for finger stick blood sugars outside of the ordered parameters (#3);); and coordination of a referral for counseling services (#1). The findings are: 1. Review of Resident #4's FL-2 dated 01/17/19 revealed diagnoses of major depressive disorder, unspecified personality disorder, chronic pain with disc disease, hypotension, and unspecified somatization disorder. Interview with Resident #4 on 07/31/19 at 3:17pm revealed: -In May 2019, Resident #4 had a large abscess under her arm near her right breast that was painful, itchy, and hot to the touch. -The staff kept telling her it was nothing to be about. -The abscess under her arm "was bothering me for several weeks before I called the doctor". -The abscess was hurting so she contacted her primary care provider (PCP) to schedule an appointment and a friend took her to the appointment on 05/01/19. -The PCP was very concerned about the abscess and referred her to a surgeon that day. -The abscess "got a little better" after she saw the surgeon in May but started bothering her again "this month" (July 2019). -She showed multiple staff the area was red, itching, and swollen but they told her it was nothing to worry about. -There were a couple of times when "infection" drained from the abscess.	D 273	Health care and follow up needs are reviewed by utilizing reports, systems & tools at the daily stand-up meetings presented by the Memory Care Manager and Director of Resident Care to the Executive Director. Training provided to the ED, DRC & MCM on order processing system completed 8/15/19. Training provided to medication aides on the order processing system on 8/22/19. The Memory Care Manager and Director of Resident Care are responsible for processing orders. Monitored at daily meetings by the ED. Executive Director is responsible for following up to obtain a status report from the Memory Care Manager and Director of Resident Care daily on outstanding orders by reviewing the order processing files. Memory Care Manager (MCM) and Director of Resident Care (DRC) are running medication administration compliance reports each morning to review during daily meetings with the Executive Director. MCM and DRC are monitoring medication administration compliance to include but not limited to medications or orders with parameters to assure compliance. 24 hour communication log implemented 8/7/19 as a tool to report resident needs from shift to shift. MCM and DRC review the 24 hr report and address any outstanding items. MCM and DRC review daily activity reports to assure continuity of care.	09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019

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D 273	Continued From page 10 -One staff told her it was probably a mosquito bite. -The abscessed area progressively worsened. -She called her PCP and scheduled another visit and a friend took her to the appointment on 07/17/19. -On 07/17/19, "My doctor told me I needed to see the surgeon right away and he called and got me in that day". -The surgeon "cut the abscess and got the infection out." -She was prescribed an oral antibiotic. Review of Resident #4's electronic progress notes for April 2019 revealed: -There was an entry dated 04/29/19 describing a small bump under the resident's right arm. -A message was left for the PCP. -There was no further documentation about the area. Review of the PCP's "After Visit Summary" for Resident #4 dated 05/01/19 revealed: -Resident #4 was brought into the office by a friend to be seen for an abscess of the right axilla. -Resident #4 was prescribed an antibiotic for 10 days and referred to be seen by a surgeon that same day. Review of the surgeon's "After Visit Summary" for Resident #4 dated 05/01/19 revealed: -Resident #4 was seen for an abscess of the right axilla. -She was referred urgently by the PCP for consideration of incision and drainage. -She had instructions to apply a hot compress to the area, to clean with soap and water, to begin an oral antibiotic two times daily for ten days, and to return in 48 hours after taking the antibiotic to	D 273	MCM and DRC review shower sheets/body assessments to assure identfiied concerns are addressed accordingly as of 8/12/19. Training provided on the importance of medical appointments and notification of primary care provider on 8/22/19. Procedure established: The Executive Director must approve any changes or cancelation of appointments initiated due to scheduling conflicts. If any appointments are re-scheduled by the provider, then the chart will reflect the documentation. MCM and DRC are responsible for communicating Resident needs and expectations with the nurses' aides and medication aides to assure continuity of care. Divisional Director of Clinical Services or qualified desginee will conduct site visits at least weekly to monitor for health care referral and follow up. Health care referral and follow up needs will be monitored by the DRC and Executive Director for compliance. Continued ongoing compliance will be monitored through utilization of systems, tools and processed outlined on page 10. Additional chart audits to equal a total of 10% of the census will be conducted by qualified personnel at least monthly to assure compliance with health care referral and follow up. Audits will be reviewed with the Care Mgrs and ED by the qualified person who conducted the audit.	09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/5/2019 ongoing Ongoing

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D 273	Continued From page 11 assess the need for incision and drainage. Review of the surgeons "After Visit Summary" for Resident #4 dated 05/03/19 revealed: -Resident #4 had been using a hot compress on the abscess. -There was a small amount of bloody drainage, but the symptoms had improved. -Continued care instructions were given, including keeping the area clean, continuing with warm compresses, and taking the full course of antibiotics, which were "not seen on medication sheet as being started". Review of a "Results Report" for Resident #4 dated 05/06/19 revealed: -Resident #4's abscess was cultured by the PCP during the office visit on 05/01/19. -The culture results were positive for methicillin resistant Staphylococcus aureus (MRSA is a bacterial infection that is tough to treat due to it's resistance to commonly used antibiotics). Review of a "Physician's Note" for Resident #4 dated 05/06/19 revealed: -The note was faxed by the PCP to the facility on 05/06/19. -The PCP provided written notification of the abscess culture testing positive for MRSA. Review of an electronic progress note for Resident #4 dated 05/06/19 revealed the staff were notified by the physician of the positive MRSA culture and Resident #4 was reminded to wash her hands throughout the day. Review of the PCP's "After Visit Summary" for Resident #4 dated 07/17/19 revealed: -Resident #4 was seen on 07/17/19 for a "large carbuncle/abscess" in the right axilla area with	D 273	Refer to intense internal monitoring systems outlined on page 10 for an overview of processes and tools for monitoring compliance in health care referral and follow-up.	

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D 273	Continued From page 12 "failure to treat in an outpatient setting for several days". -Resident #4's abscess had grown and worsened. -Resident #4 had partial drainage from the abscess. -Resident #4 had a low-grade fever and chills. -After the resident called the PCP and described the symptoms of her abscess, she was started on antibiotics 3-4 days ago for a period of seven days. -The PCP now wanted the antibiotic continued for 10 days and recommended using bactericidal soap. -The PCP was concerned the abscess was still MRSA. -The PCP was concerned the area had not improved after taking a prescription of 10 days of antibiotic therapy in May 2019. -Resident #4 was referred to the surgeon. Review of the surgeon's "After Visit Summary" for Resident #4 dated 07/17/19 revealed: -Resident #4 was referred on 07/17/19 for an emergent visit for right axilla abscess. -Resident #4 had incision and drainage of the abscess. Review of Resident #4's electronic progress notes for July 2019 revealed: -The first entry related to Resident #4's abscess was dated 07/19/19 when there was an entry the resident went out to have a surgical procedure of having a boil lanced. -The wound was to be washed with antibacterial soap at each shower. -The staff was awaiting the delivery of an antibacterial soap. -The Director of Resident Care (DRC) spoke with the nurse and received instructions for after-care.	D 273		

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D 273	Continued From page 13 Interview with the DRC on 08/02/19 at 12:00pm revealed: -She had nothing to do with scheduling the PCP or the surgeon's appointments for the resident on 07/17/19. -Resident #4 "did that on her own". -Resident #4 and lots of other residents "schedule appointments and don't even tell us". A second interview with the DRC on 08/02/19 at 12:15pm revealed: -To her knowledge, Resident #4 had never tested positive for MRSA in the abscessed area under her arm. -If Resident #4 had a prior positive MRSA culture in the abscess under her arm, she would have considered it to be very important to seek medical care if the resident was subsequently symptomatic. A third interview with the DRC on 08/02/19 at 3:45pm revealed: -She was the staff who received care instructions from the surgeon's office after the resident had her abscess lanced. -She "had no idea" Resident #4 had a positive culture for MRSA in May 2019. -If she had known about the positive MRSA culture in the abscess, it would have been her expectation that any subsequent symptoms should have been referred out for medical care. -She did not know why the staff did not schedule an appointment for Resident #4 to see the PCP about the abscess but she guessed it was because the resident scheduled it herself. Interview with the Medication Aide/Supervisor on 08/05/19 at 10:30am revealed: -She saw Resident #4's abscess but it did not	D 273		

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D 273	Continued From page 14 look bad to her. -She did not know why the staff had not made a referral to the PCP to treat Resident #4's abscess. -She knew the abscess had previously tested positive for MRSA and the staff were notified to use the box of gloves placed outside Resident #4's door. Confidential staff interview revealed: -The staff "saw how bad her (Resident #4) abscess looked before she went to the doctor in July". -It was about 3 to 4 inches around and appeared to be filled with infection. -Resident #4 "definitely needed to see a doctor about getting it treated". -The staff did not report Resident #4's abscess because she thought the resident had already told a Supervisor. -It was every staff's responsibility to scheduled healthcare appointments. -She did not know why an appointment had not been scheduled for Resident #4. Confidential interview with a second staff revealed: -She remembered seeing Resident #4's abscess and it looked "pretty bad". -She did not know why a staff had not scheduled a healthcare appointment for the resident. Telephone interview with a representative of Resident #4's surgeon's office on 08/05/19 at 10:36pm revealed: -Resident #4 was referred to them by the PCP on 07/17/19 as an emergent visit. -Resident #4 was having fever and chills when she came into the surgeon's office on 07/17/19. -The PCP was concerned the abscess may still	D 273		

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D 273	Continued From page 15 be MRSA positive. -The surgeon's office lanced the abscess but did not culture it. -If Resident #4 was symptomatic of infection, she should have been scheduled to see the PCP as soon as the symptoms began, especially since the abscess previously tested positive for MRSA. Telephone interview with a representative of Resident #4's PCP's office on 08/06/19 at 10:35am revealed: -Resident #4 contacted their office on 07/11/19 and informed them of her symptoms regarding the abscess. -Resident #4 was given an appointment date of 07/17/19. -Due to the abscess previously testing positive for MRSA, the PCP faxed over a prescription to the facility for the resident to immediately begin an antibiotic for 7 days. A voicemail was also left at the facility with the instructions for the order. -The abscess was not cultured during this visit but was treated as though it were MRSA. -Resident #4 was immediately referred to the surgeon's office. -The resident should have been referred to their office when symptoms began. Interview with the Executive Director (ED) on 08/06/19 at 11:25am revealed: -She did not know why staff had not scheduled a healthcare appointment for Resident #4. -All staff were responsible for scheduling of healthcare appointments. -It was her expectation the resident should have been scheduled with her PCP when her symptoms started, especially if the abscess previously tested positive for MRSA.	D 273		

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D 273	Continued From page 16 2. Review of Resident #13's current FL-2 dated 10/11/18 revealed: -Diagnoses included Alzheimer's Disease, hypertension, diabetes mellitus type 2, hyperlipidemia, vitamin D deficiency, and anxiety. -The resident was intermittently disoriented, required assistance with bathing and personal care, reminders for feeding, and was continent of bowel and bladder. a. Confidential staff interview revealed: -Around May 2019, Resident #13 was stable with mobility and activities; Resident #13 would shower three times a week with stand by assistance from staff when showering, would sweep the floor, and work in the garden outside. -Around June 2019, Resident #13 began needing assistance with a walker for ambulation. -Around 07/04/19, Resident #13 became "total care;" it would take 3 staff to pick Resident #13 up out of the bed and put the resident into a wheelchair most of the time. -The staff did not know if Resident #13's primary care provider (PCP) was notified of the change in her condition. -If Resident #13's PCP was notified, it would be documented in the resident's progress notes. -The medication aides (MAs) were responsible for notifying the PCP of any resident concerns and change in conditions. -[MA's name] was told "many times" Resident #13 needed to go to the hospital because the resident was not using her legs and declined to do anything for herself and needed assistance with feeding. -[MA's name] said Resident #13 had been sent to the hospital in on 06/20/19, x-rays were taken, and the resident's labs were okay. -Resident #13 declined over approximately three weeks, around the beginning of July 2019.	D 273		

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D 273	Continued From page 17 -Resident #13 could not use her legs approximately 2 weeks before she went to the hospital on 07/24/19. -When staff would try to pick up Resident #13 for transfer, the resident's legs would "fold". -Resident #13 did not go to the hospital in July 2019 prior to 07/24/19. -Resident #13 had swelling to her lumbar and coccyx area in June 2019. -[MA's name] was told about Resident #13's swelling to her lumbar and coccyx area in June 2019 and the MA looked at the area. Interview with a MA on 08/02/19 at 10:00am revealed: -She had previously worked with Resident #13. -She would assist the PCAs with transferring Resident #13 from the bed to the chair. -She last assisted with Resident #13's transfers approximately two weeks ago. -At that time, Resident #13 could not move her legs or stand. -It was not normal that Resident #13 could not move her legs. -[MA's name] told Resident #13's PCP the resident could not walk or move her legs. -She did not know when the named MA told Resident #13's PCP. -Resident #13's change in condition was sudden. -"One day she was walking and the next day she was not." -Resident #13 began complaining of pain sometime in June 2019, approximately 1 month ago. -Resident #13's pain began in her hips; and she had x-rays. -Resident #13 began complaining of spine pain. -Resident #13 began to have to use a wheelchair. -Staff would get Resident #13 out of bed and into a wheelchair about 7:00am daily.	D 273		

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D 273	Continued From page 18 -Staff would put Resident #13 to bed about 12:00pm daily. -Staff would put Resident #13 back in the wheelchair about 2:45pm daily. -Staff would put Resident #13 back to bed about 7:00pm nightly. -Resident #13 could shift in the wheelchair "a little". -Resident #13 would be put to bed on her side and turned every 2 hours to prevent skin breakdown. -[MA's name] or the Memory Care Manager (MCM) would be responsible to notify the PCP's of decreased mobility and change in condition. Interview with a second MA on 08/02/19 at 4:25pm revealed: -She had provided personal care to Resident #13. -Resident #13 required total care and could not walk for about 1 week before being admitted to the hospital on 07/24/19. -Resident #13 advanced from a walker to a wheelchair. -Resident #13 could not move her legs, walk, stand, or transfer. -Resident #13 required 4 staff to transfer from the bed to the wheelchair and back to the bed. -Staff had tried using a gait belt for Resident #13, but the gait belt was more difficult for the resident because it caused the resident more pain. -It would take 1 person to sit up Resident #13 and another person to dress the resident. -Staff would have to position Resident #13 to sit on the side of the bed like she was "a mannequin". -She and staff had to pick up Resident #13 with their arms around the resident's waist when standing the resident up to transfer the resident to the wheelchair because the resident's legs would go limp.	D 273		

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D 273	Continued From page 19 -She remembered telling Resident #13's PCP over the phone and in person the resident could not stand or walk, and her legs would go limp. She did not remember the date. -She remembered Resident #13's PCP came to the facility and saw the resident in a wheelchair. She did not remember the date. Interview with the MCM on 08/02/19 at 3:10pm revealed: -In May 2019, Resident #13 was independent with verbal ques for dressing. -In May 2019, Resident #13 was independent with feeding. -In May 2019, Resident #13 was independent with ambulation, did not require verbal ques, and did not use an assistive device. -In May 2019, Resident #13 would help sweep the dining room and clean the dining room tables. -Resident #13 began complaining of low back pain in early June 2019 and advanced to a rolling walker in June 2019. -Resident #13's back pain progressed to both thigh and hip pain. -Resident #13 had previous x-rays of her hips and lower back (on 06/20/19) ordered by the resident's PCP. -When Resident #13 would try to walk with her walker the resident's legs would "give out" and cross over. -Resident #13's knees would buckle and one leg would lag behind the other leg when walking. -Resident #13 advanced to a wheelchair approximately 1 - 2 weeks after using the walker. -Resident #13 required 2 persons assist when she advanced to the wheelchair. -She or a MA had notified Resident #13's PCP about her change in condition by either fax or calling. -It would be documented in Resident #13's	D 273		

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D 273	Continued From page 20 progress notes when the resident's PCP was notified. Review of electronic documentation received from Resident #13's PCP's office dated 06/20/19 revealed: -The facility staff had called to report Resident #13 was in pain not relieved with Naproxen (Naproxen is an anti-inflammatory used to treat pain.) -Resident #13 was sent to the emergency department (ED). Review of Resident #13's hospital emergency department notes dated 06/20/19 revealed: -The resident was sent for evaluation of bilateral hip and leg pain that had been going on for 2 weeks. -The resident's hip pain was located on the front part of her thighs. -The resident was ambulatory with a walker. -The resident had good range of motion in all major joints. -The resident did not have tenderness to palpation or major deformities noted. -The resident was diagnosed with bilateral degenerative change in her hips, the left greater than the right. Review of Resident #13's accident/incident report dated 06/23/19 revealed: -The resident was walking with water in her hand and pushing her walker. -One side of her walker was closed. -The resident slipped in the water. -The resident was found on her bathroom floor with water beside her and one side of her walker was closed. -The fall was unwitnessed. -The resident did not have injuries.	D 273		

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D 273	Continued From page 21 -The resident did not exhibit or complain of pain. -The resident was not taken to the hospital for examination. -The resident was not seen by her PCP. Review of Resident #13's progress note dated 06/23/19 at 10:23pm revealed: -The resident was ambulating with a walker. -One side of the walker was closed. -The resident was carrying water in her other hand. -Water was found on the floor beside the resident. -The resident did not have signs of injuries. -There was no documentation the resident's PCP was notified. Interview with the MA/S who reported Resident #13's 06/23/19 fall to the MCM on 08/06/19 at 9:30am revealed: -Resident #13 was walking with her walker and carrying water when the water spilled, and the resident slipped in the water. -She found Resident #13 in her room sitting on the floor. -Resident #13 complained of back pain at the time of the fall. -Resident #13 did not show or tell the MA where her back pain was located. -The MA did not ask Resident #13 to show or tell her where her back pain was located because the resident always complained of "bad" back pain. -She did not tell Resident #13's PCP of the residents' complaints of back pain because the resident already had pain medication ordered prior to the fall. -She documented the PCP notification in Resident #13's progress notes. -The MA also faxed the PCP notification of finding Resident #13 on the floor.	D 273		

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D 273	Continued From page 22 -She filed the faxed notification to Resident #13's PCP in the resident's record. A second interview with a MA/S on 08/06/19 at 11:50am revealed: -She did not see Resident #13 fall on 06/23/19. -A personal care aide (PCA) witnessed Resident #13 fall on 06/23/19. -When she found Resident #13 on 06/23/19, the resident was at the door in her room sitting on her buttocks with her legs extended straight in front of her with her walker on her right side. -One side of Resident #13's walker was folded in and was standing. -There was water on the floor located on the left side of the resident. A third interview with the MA/S on 08/06/19 at 2:00pm revealed: -She had completed the 06/23/19 accident/incident report on Resident #13. -Resident #13 fell around 9:30pm in the SCU. -She had called Resident #13's PCP on 06/23/19 telling her the resident had fallen. -Resident 13's PCP requested to be faxed the notification of the resident's fall. -She had faxed Resident #13's PCP notification of the resident's fall. -The faxed notification should be in Resident #13's facility chart. Interview with the MCM on 08/06/19 at 9:10am revealed: -She thought Resident #13 sustained a fall around the middle of June 2019 but could not remember the exact date. -Resident #13 was walking with her walker and a cup of water in her hand when she spilled the water causing her to fall. -Resident #13 did not have redness, bruising, or	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 23 other injuries when she fell. -The MA reported Resident #13's fall to her when it occurred. -The fall Resident #13 sustained would be documented in her progress notes. Interview with the Executive Director (ED) on 08/06/19 at 10:20am revealed: -Resident #13 sustained a fall in the middle of June 2019. -Resident #13 was walking with her walker and carrying water. -Resident #13 spilled the water and "slid down". -Resident #13 did not sustain injuries with the fall. -Resident #13's PCP was notified of the residents fall. -She believed Resident #13's fall was witnessed by a staff. Review of Resident #13's PCP visit note dated 06/28/19 revealed: -The resident denied pain. -The resident was walking with a walker. -The resident had an abnormal gait. Review of Resident #13's PCP visit note dated 07/08/19 revealed: -The resident was complaining of back pain. -The resident was waiting a nuclear bone scan. -The resident had an abnormal gait. -The resident was walking with a walker. Review of electronic documentation received from Resident #13's PCP dated 07/11/19 revealed: -The MCM called to report Resident #13 was having difficulty walking with a walker, the resident could not bear weight on her legs, and her legs would get crossed up. -The MCM asked for an order for a wheelchair.	D 273		

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D 273	Continued From page 24 -Resident #13's PCP would see the resident on 07/15/19. Review of Resident #13's nuclear bone scan report dated 07/16/19 revealed: -There was an accumulation of dye at the thoracic (T) 10 and T-11 vertebra which could mean neoplasm, compression fracture, or other bone disease. -There was an accumulation of dye at the left front third and fourth ribs would was probably due to trauma. Review of Resident #13's progress note dated 07/18/19 at 6:44am revealed the resident was unwilling to help the PCAs assist her. Review of Resident #13's progress note dated 07/18/19 at 2:08pm revealed: -The resident complained of pain in her hip and spine. -The resident would not use her legs at all to move in the chair. -The resident required 3 - 4 staff for assistance with transfers out of the bed, dressing, and toileting. -There was no documentation the resident's PCP was informed of the residents' complaints of pain, not using her legs, and needed 3 - 4 staff for assistance. Review of Resident #13's physician communication revealed there was no documentation the PCP was informed on 0718/19 the resident complained of hip and spine pain and required 3 - 4 staff to assist in getting the resident in and out of bed, dressing, and toileting. Interview with a MA on 08/06/19 at 3:35pm revealed:	D 273		

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D 273	Continued From page 25 -She documented the progress note for Resident #13 dated 07/18/19 at 2:08pm -Resident #13's PCP was at the facility on 07/18/19 and was told about the resident needing 3 - 4 staff for transfers, dressing, and toileting. -She could not remember if Resident #13's PCP saw her on 07/18/19 or 07/19/19. -She did not document speaking to Resident #13's PCP regarding the residents need for assistance. Interview with the MCM on 08/02/19 at 4:00pm revealed: -In reviewing the 07/18/19 progress note, she thought Resident #13 was not able to help the PCAs. -If Resident #13 would try to turn herself she would yell in pain. -She could not remember if she helped with Resident 13's care on 07/18/19. -She expected Resident #13's PCP to have been notified of the 07/18/19 documentation in the resident's progress notes of requiring 3-4 staff assist and not being able to use her legs. -She was unable to locate in Resident #13's record where the provider was notified on 07/18/19 of the resident requiring 3 - 4 staff assist and the resident's inability to use her legs. -She expected Resident #13's PCP to have been notified on 07/18/19 of the resident's decline as documented in the 07/18/19 progress note. Review of Resident #13's progress note dated 07/20/19 at 4:38pm revealed: -The resident was not using her legs at all. -The resident required 4 staff to help her do anything "(toileting, laying down, etc..)". -The resident was complaining of pain in her spine and hips. -There was no documentation the resident's PCP	D 273		

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D 273	Continued From page 26 was informed of the resident's complaints of pain, not using her legs, and needed 4 staff for assistance. Review of Resident #13's physician notifications revealed there was no documentation the resident's PCP was informed on 07/20/18 the resident was not using her legs at all and required 4 staff to assist to the resident and had spine and hip pain. Interview with a MA on 08/06/19 at 3:35pm revealed: -She documented the progress note for Resident #13 on 07/20/19 at 4:38pm. -She " ...had to have spoken ..." with Resident #13's PCP because the PCP gave her an order for the resident to have a bone scan. -She did not remember dates she spoke with Resident #13's PCP regarding the residents 07/20/19 progress note. Interview with the MCM on 08/02/19 at 4:00pm revealed: -In reviewing Resident #13's 07/20/19 progress notes she knew some days it took more than 2 staff to get the resident up. She did not know for that specific day. -Resident #13's PCP was aware the resident was in pain and could not use her legs because he would make facility visits. -She could not locate in Resident #13's record where the resident's PCP was notified of the 07/20/19 documentation of the resident requiring 4 or more staff to assist the resident in daily routines and/or complaints of spine and hip pain. Telephone interview with a representative of Resident #13's PCP's office on 08/02/19 at 11:01am revealed there was no documentation of	D 273		

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D 273	Continued From page 27 notification on 07/20/19 of 4 or more staff to assist the resident in daily routines and/or complaints of spine and hip pain. Review of Resident #13's progress note dated 07/21/19 at 2:03pm revealed: -The resident was " ...still not using her legs ..." -The resident " ...still required 4 or more staff to assist her in her daily routines ..." -The resident complained of pain in her spine and legs. -The resident was eating less of her food. -The resident's PCP would see her when at the facility that week. -There was no documentation the resident's PCP was informed of the resident's complaints of pain, not using her legs, needed 4 or more staff to assist, eating less food, and her feet had been dragging the floor in her wheelchair. Review of Resident #13's physician notifications revealed there was no documentation the resident's PCP was informed on 07/21/19 the resident was still not using her legs and required 4 or more staff to assist in daily routines and complained of hip and spine pain. Interview with a MA on 08/06/19 at 3:35pm revealed: -She documented the progress note for Resident #13 on 07/21/19 at 2:03pm and 8:52pm. -Resident #13's PCP knew everything about the resident she had documented in the progress notes because they had spoken about the resident needing 3 -4 staff for assistance with daily routines, transfers, and the resident not walking. -She did not remember the date she spoke with Resident #13's PCP about the resident needing 3 - 4 staff with assistance with daily routines,	D 273		

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D 273	Continued From page 28 transfers, and the resident not walking. Interview with the MCM on 08/02/19 at 4:00pm revealed in reviewing Resident #13's 07/21/19 progress notes, she could not locate in the resident's record where the resident's PCP was notified of the resident not using her legs, and still requiring 4 or more staff to assist the resident. Telephone interview with a representative of Resident #13's PCP's office on 08/02/19 at 11:01am revealed there was no documentation of notification on 07/21/19. Review of Resident 13's progress note dated 07/23/19 at 9:54pm revealed: -The resident complained of back and spine pain. -The resident's PCP was aware of the resident's issues and the resident would be seen when the PCP came to the facility. -There was no documentation the resident's PCP was informed of the resident's complaints of pain on 07/23/19. Review of Resident #13's physician notifications revealed there was no documentation the resident's PCP was informed on 07/23/19 of her complaint of spine and back pain. Telephone interview with a representative of Resident #13's PCP's office on 08/02/19 at 11:01am revealed there was no documentation of notification on 07/23/19. Review of Resident #13's progress note dated 07/24/19 at 2:10pm revealed: -The resident was seen by her PCP for uncontrolled diabetes mellitus, skin breakdown, and severe vaginitis. -The resident was transported to the hospital ED	D 273		

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D 273	Continued From page 29 for evaluation. Review of Resident #13's PCP visit note dated 07/24/19 revealed: -Facility staff had requested evaluation for decline of the resident's functional status. -Staff reported a general decline. -The resident was no longer able to walk with a walker. -The resident was using a wheelchair. -The resident was in a wheelchair and unable to rise. -The resident required feeding assistance the week of the visit. -The resident's required care was beyond assisted living facility level of care. -The resident was transported to the ED for admission. Review of Resident #13's physicians order dated 07/24/19 revealed: -The resident had uncontrolled diabetes mellitus, skin breakdown, vaginitis, and new gait inability, abnormal bone scan of thoracic 10-11. -There was an order to send the resident to the ED. Review of Resident #13's hospital ED note dated 07/24/19 revealed: -The resident had back tenderness. -The resident could not move her lower extremities. -The resident had a compression fracture of T-10 that had burst. -The resident had a fracture of her lumbar 5 vertebra. -The resident had lower extremity paralysis. Review of Resident #13's hospitalist admission note dated 07/24/19 revealed:	D 273		

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D 273	Continued From page 30 -The resident could not feel or move her lower extremities. -The resident's back was tender to palpation with any movement of back. -She had no strength in her lower extremities, could not feel anything and missed legs when touching. -The resident was incontinent of urine, which was new. Review of Resident #13's neurosurgical consultation note dated 07/24/19 revealed: -The resident was reportedly walking with a walker 10 days ago. -The resident arrived at the ED with new onset bilateral lower extremity paralysis urinary incontinence, and difficulty with sensation. -The residents' bilateral lower extremities were flaccid. -The resident had no sensation in her bilateral lower extremities. -Diagnosis was a T-10 burst compression fracture with questionable etiology, chronic L-5 fracture. Review of Resident #13's hospital discharge summary dated 07/26/19 revealed: -Discharge diagnoses included paralysis, paraplegia, and closed unstable burst fracture of 10th thoracic vertebra. -The resident was evaluated by neurosurgery and was not a surgical candidate because surgery would not repair the neurological symptoms. -The resident was transferred to hospice because of dementia, frailty, and paraplegia. Telephone interview with Resident 13's family member on 08/01/19 at 7:11pm revealed: -The resident arrived at the emergency department on 07/24/19.	D 273		

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D 273	Continued From page 31 -The resident was paralyzed from her waist down when she arrived at the emergency department. -It was unknown if the resident had an injury. -On 07/05/19 the resident was ambulating with a walker. -On 07/12/19 the resident was in a wheelchair. -On 07/13/19 a visit was made to the facility, and the resident was in a wheelchair yelling of back pain with movement. Review of Resident #13's current care plan dated 07/15/19 revealed: -Resident #13 was non-ambulatory and required a wheelchair for mobility. -The resident had daily incontinence of bowel and bladder. -The resident was always disoriented. -The resident's speech and communication needs were normal. -The resident was totally dependent in ambulation, transferring, toileting, bathing, and grooming. -It was signed by the resident's PCP on 07/19/19. Resident #13's previous care plan was requested from the MCM but was not provided prior to survey exit. Telephone interview with a representative of Resident #13's PCP's office on 08/02/19 at 11:01am revealed: -On 07/11/19, the MCM called the PCP's office, reporting Resident #13 had a decrease in ambulation and could not bear weight. There was documentation the PCP would see the resident the following day. -There were no other notifications regarding Resident #13 to the PCP through 07/24/19. Telephone interview with Resident #13's PCP on	D 273		

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D 273	Continued From page 32 08/05/19 at 10:30am revealed: -She remembered Resident #13 requiring four staff assist when she saw the resident at the facility on 07/24/19. -It was difficult for her to say if Resident #13's transfers or fall contributed to the resident's thoracic 10 and lumbar 5 vertebral fractures. -She thought Resident #13's lumbar 5 fracture was old and chronic. -If a resident needed to be seen, the facility would contact her office by phone or fax, or her pager, which was available 24/7. -When she made facility visits, staff would make rounds with her and tell her what the resident's needs were, who she needed to see, or show her things such as resident's wounds. -She had not been informed of the documentation in Resident #13's progress notes dated 07/18/19 of the resident not using her legs to move in the chair and requiring 3 - 4 staff to assist the resident in transfers, dressing, and toileting; complaints of spine and hip pain; or communication the resident needed to be seen. -She relied on the facility to let her know when residents needed to be seen. -The facility did not tell her or leave a message that Resident #13 could not move her legs. -She expected the facility to have contacted her with any changes with Resident #13. Review of Resident #13's death certificate dated on 08/02/19 revealed: -The resident died while on hospice. -The cause of death was documented as complications of a thoracic compression fracture. -The manner of death was documented as an accident. -The date and time of injury was documented as unknown. -The description of the injury was documented as	D 273		

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D 273	Continued From page 33 the resident sustained a spinal injury at an unknown time. Attempted interview with a case manager from Resident #13's local hospital emergency department on 08/05/19 at 8:20am was unsuccessful. Attempted interview with Resident #13's neurologist on 08/05/19 at 2:30pm was unsuccessful. b. Review of Resident #13's progress note dated 07/18/19 at 2:08pm revealed: -The resident had skin break down on her buttocks. -The resident's PCP had been faxed regarding the skin breakdown. -The facility was awaiting the resident's PCP response. Interview with the MA who documented Resident #13's progress note dated 07/18/19 on 08/06/19 at 3:35pm revealed: -She documented the progress note for Resident #13 dated 07/18/19 at 2:08pm. -Resident #13 had a circular wound approximately the size of a 50-cent piece to her lower back/buttocks area. -The wound was red "like a scrape" and the middle of the wound was open. -The wound did not have drainage or foul odor. -She did not know when she noticed the wound. -Resident #13's PCP was at the facility on 07/18/19 and was told about the resident's wound. -She could not remember if Resident #13's PCP saw her on 07/18/19 or 07/19/19. -She did not document speaking to Resident #13's PCP regarding the wound.	D 273		

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D 273	Continued From page 34 Review of Resident #13's physician's order dated 07/18/19 revealed: -The facility had faxed notification to Resident #13's PCP that Resident #13 had skin breakdown on her buttocks. -An order for a barrier cream was requested from the facility. -An order for barrier cream to Resident #13's buttocks twice daily and as needed after incontinence care was given. -It was signed by the resident's PCP and dated 07/19/19. Review of Resident #13's progress note dated 07/21/19 at 8:52pm revealed: -The resident had a " ...sore on her bottom around where her undergarments elastic would be ..." -The resident had a " ...sore on the sacrum ..." -There was no documentation the resident's PCP was informed of the wound on her bottom or the sacrum. Interview with the MA who documented Resident #13's progress note dated 07/21/19 on 08/06/19 at 3:35pm revealed Resident #13's PCP knew everything about the resident she had documented in the progress notes. Review of Resident #13's physician notifications revealed there was no documentation the PCP was notified on 07/21/19 the resident had a sore where her undergarments would be and a sore on the sacrum. Review of Resident #13's progress note dated 07/24/19 at 2:01pm revealed: -The resident was seen by her PCP for uncontrolled diabetes mellitus, skin breakdown,	D 273		

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D 273	Continued From page 35 and severe vaginitis. -The resident was transported to the hospital emergency department for evaluation. Interview with the MA who documented Resident #13's progress note dated 07/24/19 on 08/06/19 at 3:35pm revealed: -She documented Resident #13's progress note dated 07/24/19 at 2:01pm. -The resident was sent to the hospital ED because of her blood sugars. -She did not remember if Resident #13 was seen by the PCP as a scheduled visit or if the PCP was called to see her. Review of Resident #13's PCP visit notes dated 07/24/19 revealed: -Staff had requested evaluation of diabetes mellitus and skin breakdown. -The resident had skin breakdown and moisture associated with dermatitis. -The wound was open with a slit like area midline skin crease of the resident's buttocks. -The midline of the wound was dark. -The resident was transferred to the ED. Review of Resident #13's physicians order dated 07/24/19 revealed: -The resident had uncontrolled diabetes mellitus and skin breakdown. -There was an order to send the resident to the emergency department (ED). Review of Resident #13's hospital ED notes dated 07/24/19 revealed: -The resident arrived at the ED with a skin ulcer to her sacrum. -There was documentation the resident had two small areas on her sacrum and buttocks. Wound measurements or descriptions were not	D 273		

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D 273	Continued From page 36 documented. Interview with Resident #13's family member on 08/01/19 at 7:11pm revealed: -A picture of Resident #13's wound was taken on 07/24/19 when the resident was transferred to the ED from the facility. -Resident #13's wound was to the coccyx area and was diagnosed as a stage 4 decubitus by the ED provider who treated the resident. -The family member did not know Resident #13 had a wound until the resident was at the ED on 07/24/19. Review of a picture of Resident #13's wound taken on 07/24/19 revealed: -The wound was located on Resident #13's sacrum/coccyx area. -The wound color was deep reddish purple to black and dark gray to black that extended down to the bottom of the wound. -There was no skin covering approximately 75% of the wound from mid top to the bottom and towards the sides. -Skin was attached to the top and upper sides of the wound and was dark gray to light black in color. -There was a white substance scattered around and over the wound. -The perimeter of the wound was light red to bright pink in color and extended down towards the residents' buttocks. Confidential staff interview revealed: -Resident #13 had a wound to her low back and buttocks area between her buttock folds at the coccyx area around 07/19/19. -Resident #13's wound to her low back, coccyx area, and buttocks was pink and dark purple in color, and swollen.	D 273		

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LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

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D 273	Continued From page 37 -A barrier cream was the only wound care performed to Resident #13's wound. Interview with the medication aide (MA) on 08/02/19 at 4:25pm revealed: -She had provided personal care to Resident #13. -Resident #13 was total care and could not walk for about 1 week before being admitted to the hospital on 07/24/19. -Resident #13 had a wound on her buttocks. -The wound was red to deep red in color, the skin was open in the middle of the wound. -The wound looked like a skin scrape and was about the size of a 50-cent piece. -The wound developed about 1 week before she was admitted to the hospital on 07/24/19. -Resident #13's PCP was notified of the wound. She could not remember the date. -The wound was cleaned with normal saline and covered with a barrier cream. Interview with a second MA on 08/02/19 at 10:00am revealed: -She last worked with Resident #13 about 2 weeks ago. -She would help the PCAs transfer Resident #13. -Staff would get Resident #13 out of bed and into a wheelchair about 7:00am daily. -Staff would put Resident #13 to bed about 12:00pm daily. -Staff would put Resident #13 back in the wheelchair about 2:45pm daily. -Staff would put Resident #13 back to bed about 7:00pm nightly. -Resident #13 could shift in the wheelchair "a little". -Resident #13 would be put to bed on her side and turned every 2 hours to prevent skin breakdown. -Resident #13's skin breakdown would be	D 273		

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D 273	Continued From page 38 documented in the residents progress notes and skin assessment sheets. -Skin assessments were done every six months for all residents by the Director of Resident Care (DRC) and MA's. -Skin assessments were done every bath by the PCAs. -Baths were given three times a week. - [MA's name] or the Memory Care Manager (MCM) would be responsible to notify the PCP of skin breakdown. -Resident #13 did not have any wounds before the resident began having pain around the middle of June 2019. -Resident #13 became less mobile after her pain started then developed a pressure ulcer. Interview with the MCM on 08/02/19 at 3:10pm revealed: -Around 07/04/19 Resident #13 became totally dependent upon staff for dressing and toileting and was incontinent of bowel and bladder. -Resident #13's decline " ...happened so fast, in a matter of 1 week". -The MA reported to her Resident #13 had developed a small sore on her coccyx about 1 week before she was transferred to the hospital. She never saw the wound. -She believed the wound was red, and skin not open. -A barrier cream was applied to Resident #13's wound, per orders. -The PCP would be notified of new wounds documentation would be completed on the skin assessment sheet. -Whoever discovered wounds would complete a skin assessment sheet and then inform her of the wound. Review of Resident #13's shower/skin	D 273		

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D 273	Continued From page 39 assessment sheets revealed: -On 07/09/19, 07/16/19, and 07/18/19, there was no documentation the resident had a wound. -There were no shower/skin assessments dated after 07/18/19. A second interview with the MCM on 08/02/19 at 4:00pm revealed: -Resident concerns were faxed to the PCP the moment concerns were noted. -Resident #13's PCP would also come to the facility routinely every 2 weeks and would be updated at those visits also. -She expected Resident #13's PCP to have been notified of resident concerns as they occurred. -She expected documentation of when Resident #13's PCP was notified of the resident's concerns. Review of Resident #13's current Care Plan dated 07/15/19 revealed there was a section for a skin assessment. The skin was marked as normal. The area for "pressure ulcers", "decubi", and "other" was blank. Telephone interview with a representative for Resident #13's PCP on 08/02/19 at 11:01am revealed: -On 07/18/19 the facility notified the PCP by fax the resident had skin breakdown on her buttocks. There was no description of the skin breakdown. The PCP sent orders. -On 07/22/19 the facility notified the resident's PCP the resident had a "spot that needed attention". The PCP ordered home health for wound care. -There was no other communication from the facility to the PCP regarding Resident #13's wounds from 07/18/19 - 07/24/19.	D 273		

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D 273	Continued From page 40 Review of Resident #13's physician order dated 07/22/19 revealed an order for home health nursing for wound care. Telephone interview with a home health nurse for Resident #13 on 08/05/19 at 10:51am revealed Resident #13 was transferred from the facility on 07/24/19 before a home health nurse visit could be made for wound care. Telephone interview with Resident #13's PCP on 08/05/19 at 10:30am revealed: -She was first informed of Resident #13's skin breakdown on 07/18/19 by the facility staff and barrier cream was ordered. -There was no communication from the facility staff Resident #13 needed to be seen on 07/18/19. -She first saw Resident #13's wound on 07/24/19. -The resident's wound had black skin breakdown on her coccyx and was "probably a stage 2 decubitus." (A stage 2 decubitus is a shallow crater wound with broken skin.) -When she made facility visits, staff would make rounds with her and tell her what the residents' needs were, who she needed to see, or show her things such as resident's wounds. -There was no communication from the facility staff the extent of Resident #13's wound. -She relied on the facility staff to let her know when residents needed to be seen. -If a resident needed to be seen, the facility staff would contact her office by phone or fax, or her pager which was available 24/7. Interview with the Executive Director (ED) no 08/05/19 at 11:10am revealed: -She was told in a stand-up meeting by the MCM Resident #13 had skin breakdown on her buttocks. She did not remember the date.	D 273		

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D 273	Continued From page 41 -She thought the wound was intact, she did not know the wound was open. -She expected Resident #13's PCP to be informed of the skin changes. -She expected communication with the PCP to be documented in the resident's progress notes. 3. Review of Resident #15's FL-2 dated 01/17/19 revealed diagnoses included anxiety, type 2 diabetes, acquired hypothyroidism, essential hypertension, and history of transient ischemic attacks. Interview with Resident #15 on 08/01/19 at 6:47am revealed: -She had a tooth ache and swelling in her face that started "about a month ago". -She had an abscessed area near the tooth that kept bursting and "spreading infection" inside her mouth. -Her tooth had been hurting for a while before a staff made an appointment with a local dental provider. -Her dental appointment was scheduled for 07/16/19. -On 07/16/19, she was informed by the Business Office Manager (BOM) there was no staff available to transport her to the dentist; the BOM did not tell her why there was no staff to take her to her appointment. -Her dental appointment was rescheduled for 07/25/19. -She remained in "terrible pain" from 07/16/19 through 07/25/19. -She saw a dental provider on 07/25/19 and received the diagnosis of a tooth abscess. -It was the recommendation of the dental provider she begin taking an antibiotic that day. -She was to begin the prescribed antibiotic on 07/25/19, to take four times daily for five days,	D 273		

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D 273	Continued From page 42 and then return to the office to have the tooth extracted "today" (08/01/19). -She was not administered her prescribed antibiotic from the staff until the day before yesterday (7/30/19). -She asked several staff about the antibiotic and was told it had not yet arrived from the pharmacy. -Resident #15 asked the BOM to call the dental provider to inquire if the tooth could still be extracted as scheduled. -Since she had not been administered her antibiotic as ordered, she was concerned the dentist would not pull her tooth. -The dental provider rescheduled the tooth extraction until 08/08/19 due to the resident not being given the antibiotics as ordered for five days prior to the extraction. A second interview with Resident #15 on 08/01/19 at 4:40pm revealed: -She had been telling staff members for about a month about her tooth pain. -She remembered telling several MAs, Personal Care Aides (PCA), the BOM, and the Executive Director (ED). Review of Resident #15's electronic progress notes for July 2019 revealed there was no documentation about the resident's tooth pain or scheduling a dental appointment. Review of Resident #15's medication orders dated 07/25/19 revealed an order for Penicillin 500mg four times a day for five days. (Penicillin is an antibiotic used to treat infection). Review of Resident #15's July 2019 electronic Medication Administration Records (eMAR) revealed the resident received the first dose of Penicillin at 9:00pm on 07/30/19.	D 273		

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D 273	Continued From page 43 Interview with a Medication Aide/Supervisor (MA/S) on 08/01/19 at 9:00am revealed: -She remembered Resident #15 had been having issues with her tooth "for a while". -She had seen swelling in Resident #15's face in July 2019. -She had not reported the swelling in Resident #15's face to the PCP. -She was not sure why the resident was not able to keep her dental appointment on 07/16/19. -Scheduled healthcare appointments should be documented in the "chart notes". -She did not realize the resident's dental appointment for the extraction had to be postponed due to the delay in her getting her antibiotic. Interview with the BOM on 08/01/19 at 3:45pm revealed: -He did not know if Resident #15 had a dental appointment scheduled earlier in the month of July. -If the appointment was rescheduled, he did not remember why. Review of the facility's Transport Log for the month of July 2019 revealed: -Resident #15's name was written in on 07/16/19 for an appointment with a local dental provider. -The appointment was not crossed out and there were no notations beside the appointment. Telephone interview with a representative from Resident #15's dental office on 08/01/19 at 4:05pm revealed: -The representative was unable to view rescheduled appointments in her electronic scheduling system. -When appointments were rescheduled, she just	D 273		

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D 273	Continued From page 44 moved the date of the appointment from the old date to the new date. -She was able to confirm Resident #15 was seen at their office on 07/25/19 and was scheduled for another appointment on 08/08/19. Telephone interview with Resident #15's Dentist on 08/01/19 at 4:33pm revealed: -Resident #15 was seen on 07/25/19 and had a significant tooth abscess. -On 07/25/19, the resident reported having pain and swelling for about three weeks. -She recommended Resident #15 begin an antibiotic that day (07/25/19) and complete at least five days of the antibiotic prior to having the tooth extracted. -The appointment scheduled for "today", 08/01/19, to extract the tooth, had to be rescheduled until next week due to the resident not getting her prescribed antibiotic in time to treat the infection. -Resident #15 "was sure to have ongoing pain and swelling if she did not begin the prescribed antibiotic last week". Observation of Resident #15 on 08/02/19 at 10:04am revealed she was lying in bed under a blanket and the right side of her face was swollen. Interview with Resident #15 on 08/02/19 at 10:05pm revealed: -She had been feeling "too bad to get out of bed". -Her face was swollen and felt hot to the touch. -Her head was "pounding in pain". -She was now getting her antibiotic as prescribed. -She was already taking pain medication prior to getting the tooth abscess but " ...it isn't touching the pain". -Her doctor could not prescribe her more pain	D 273		

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D 273	Continued From page 45 medication than what she was currently taking, " ...so she would have to tough it out until the tooth can be pulled". -She had stayed in bed and missed several meals, but no staff member had asked how she was doing or if they could do anything for her. -She knew the staff had a lot of responsibility, but she wished they were better about helping her to get her healthcare needs addressed. -She would be so happy when the tooth was pulled. Confidential staff interview revealed: -She knew Resident #15 had been having tooth pain and swelling for "quite a while"; the staff did not report the tooth pain and swelling to the PCP. -She did not know why Resident #15 was not taken to see the dentist earlier in the month. Confidential Interview with a second staff revealed: -It was the responsibility of all the medication aides to schedule healthcare appointments and she did not know why the resident (Resident #15) was not seen earlier in the month when she first started hurting. -Resident #15's face had been "pretty swollen for a while". Interview with the ED on 08/06/19 at 11:20am revealed: -She did not remember why Resident #15 was unable to get to her dental appointment on 07/16/19. -It was her expectation that all recommendations made by the dental provider on 07/25/19 should have been followed by staff so as not to delay the dental appointment that was scheduled on 08/01/19.	D 273		

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D 273	Continued From page 46 Interview with the Transporter on 08/06/19 at 2:15pm revealed if Resident #15 was not taken to a dental appointment on 07/16/19, the resident must have canceled the appointment herself. 4. Review of Resident #3's current, hospital generated FL-2 dated 02/13/19 revealed diagnoses included chronic kidney disease, congestive heart failure (CHF), coronary artery disease (CAD), bipolar disorder, and hypoglycemia. Review of Resident #3's previous, hospital generated FL-2 dated 01/14/19 revealed diagnoses included diabetes mellitus. Interview with Resident #3's former primary care provider (PCP) on 08/01/19 revealed: -She was Resident #3's PCP from November 2018-April 2019. -Resident #3 was a very "brittle diabetic"; her finger stick blood sugar (FSBS) would fluctuate from very low to high. -In November 2018, she ordered Resident #3 to be evaluated by endocrinology because nothing was working as far as insulin and the resident was non-compliant with her diet. -She wrote several orders for an endocrinology consult and asked staff at the facility about the scheduling of the endocrinology appointment "17 or 18 times." -"There was a delay in care" related to the endocrinology appointment. -The delay in care resulted in Resident #3 having multiple unnecessary emergency room (ER) visits for high and low FSBS, nausea, and decreased level of consciousness. Review of a primary care provider (PCP) visit note for Resident #3 dated 11/25/18 revealed:	D 273		

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D 273	Continued From page 47 -The resident's previous PCP was contacted (by the current PCP) and the PCP discovered the resident's diabetes had been difficult to manage for "quite some time." -The resident was followed by endocrinology but had not had an appointment recently. Her previous PCP recommended a follow up and she was likely "overdue." -There was an order to follow up with endocrinology. Review of Resident #3's former PCP progress notes revealed: -On 11/29/18 at 12:49pm, there was documentation the facility notified the PCP the resident's FSBS was 588; new orders were given. -On 12/04/18 at 12:48pm the facility staff notified the PCP the resident's FSBS was 413 before lunch. At 4:59pm, the facility called back to report the resident's FSBS was 425. -On 12/05/18 at 12:07pm, the facility staff notified the PCP the resident's FSBS was 575. -On 12/27/18 at 12:21pm, the facility staff notified the PCP the resident's FSBS was 322. -On 01/09/19 at 12:41pm, the facility staff notified the PCP the resident's FSBS was 510. "...her blood glucose varies greatly. I gave an order to send her to Endocrinology. I will ask the Care Manager if she went yet." At 12:55pm, staff called the PCP back to report the resident's FSBS was now 329. "I asked her if she knew if [resident's first name] had been to Endocrinology. She checked and did not see any note of that." -On 01/10/19 at 12:17pm, the facility staff notified the PCP the resident's FSBS was more than 500. The meter "read high." At 2:47pm, the PCP called the facility "...called back, left massage for Care Manager to inquire about Endocrine referral that was ordered in November." -On 01/17/19 at 12:08pm, the facility staff notified	D 273		

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D 273	Continued From page 48 the PCP the resident's FSBS was reading high on the glucometer. -On 01/18/19 at 6:16pm, the facility staff notified the PCP the resident's FSBS was 587. "This is the patient who is supposed to see the endocrinologist but the facility still has not scheduled the appointment..." -On 01/17/19 at 12:30pm, a [Medication Aide/ [Supervisor's (MA/S) name] notified the PCP the resident's FSBS was 403 at lunch time. The MA/S told the PCP the endocrinology consult had not been scheduled. The PCP "advised" the facility again Resident #3 needed to see the endocrinologist per previous orders. -On 01/22/19 at 12:10pm, the facility staff notified the PCP the resident's FSBS was 522. "Staff instructed to schedule Endocrinology consult ASAP (as soon as possible) per order written in November, however, they still have not done so." -On 01/24/19 at 12:25pm the facility notified the PCP the resident's FSBS was reading high on the glucometer. -On 02/12/19 at 12:11pm there was documentation the endocrinology office called the PCP's office to inform Resident #3 had an appointment scheduled with the endocrinologist on 02/14/19. At 5:20pm, there was documentation the facility notified the PCP's office Resident #3's was unresponsive and FSBS 54. The resident was sent out to the ER and admitted to the hospital. Review of an Emergency Department (ED) Encounter for Resident #3 dated 02/09/19 revealed: -Resident #3 arrived at the ED by emergency medical services (EMS) after an unwitnessed fall. -Resident #3 was initially unresponsive and her FSBS was 48. -The diagnosis was hypoglycemia.	D 273		

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D 273	Continued From page 49 -The resident was treated with glucagon and her FSBS improved. (Glucagon is used to treat low blood sugar). -The resident was discharged 02/09/19. Review of a hospital discharge summary for Resident #3 dated 02/14/19 revealed: -The resident was admitted on 02/11/19 and discharged on 02/14/19. -The resident had a witnessed fall and hit her head. -In route to the hospital, Resident #3's FSBS 35. -During evaluation in the ED, the resident had two episodes of being unresponsive, requiring dextrose administration with each episode. -Diagnoses included hypoglycemia, two spinal fractures: acute L2-L3 fracture, and subacute T12 compression fracture. -The resident had been seen in the ED the previous night for similar symptoms. -The resident should follow up with endocrinology within one week. Review of Resident #3's former PCP progress notes revealed: -On 02/15/19 at 4:55pm, the facility staff notified the PCP the resident's FSBS was 52 and the resident was given chocolate candy. -On 02/20/19 at 1:59pm, the facility staff notified the PCP the resident's FSBS was 318 at early morning. The resident was given sliding scale insulin (SSI). The resident's FSBS was now 70. The resident was given orange juice and was eating lunch. At 1:47pm: The resident did not attend her endocrinology appointment that was scheduled on 02/14/19. The facility had not re-scheduled the endocrinology appointment despite an order written 02/15/19 to do so. The facility was reminded by the PCP of the need to be seen by endocrinology ASAP.	D 273		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 50 Review of a second ED Encounter for Resident #3 dated 03/21/19 revealed: -The resident was evaluated and discharged on 03/21/19. -The diagnosis was documented as hyperglycemia. Review of Resident #3's former PCP progress notes received from the former PCP dated 03/16/19 at 9:18am revealed Resident #3 had an appointment scheduled with endocrinology on 04/11/19. Interview with Resident #3 on 08/02/19 at 8:46am revealed: -She could not remember the last time she went to the hospital for elevated FSBS. -She was supposed to go to the endocrinologist every three months, but the facility did not always get her there. A second interview with Resident #3 on 08/05/19 at 10:20am revealed: -She was supposed to go to the "diabetic doctor" every three months but had not gone every 3 months. -She had "trouble" seeing her endocrinologist in February 2019. -In February 2019, she was supposed to see the diabetic doctor and have labs drawn but the facility's van was broken, and she had no way to get there. -She did not know if there was ever any delay in the scheduling of her appointments with her endocrinologist. Interview with a MA/S on 08/01/19 at 9:00am revealed scheduled healthcare appointments should be documented in each resident's	D 273		

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D 273	Continued From page 51 progress notes. Telephone interview with a Registered Nurse (RN) at Resident #3's endocrinologist's office on 08/01/19 at 4:00pm revealed: -Resident #3 was a diabetic and was last seen in the endocrinology office on 04/11/19. -Resident #3's last hemoglobin (Hgb) A1C laboratory (lab) result was 10.1 on 04/11/19. (Hgb A1C is a blood lab test that measures the blood sugar for a 3 month time frame. According to the American Diabetes Association, the Hgb A1C goal recommendation for diabetics is less than 7). Interview with a medication aide/supervisor (MA/S) on 08/02/19 at 8:12am revealed as far as the MA/S knew, Resident #3 went to endocrinology appointments like she should; there had been no missed or delayed endocrinology appointments. Review of Resident #3's progress notes revealed there was no documentation of the resident going to any endocrinology appointments. Interview with the transporter on 08/06/19 at 8:15am revealed: -Resident #3 had not missed any medical appointments; "absolutely not." -She did not recall if Resident #3 had any delay in going to endocrinology appointments. Interview with the Executive Director (ED) on 08/06/19 at 11:25am revealed all staff were responsible for scheduling of healthcare appointments. A follow-up interview with the RN at Resident #3's endocrinologist's office on 08/06/19 at 11:35am revealed:	D 273		

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D 273	Continued From page 52 -Resident #3 was evaluated in the office on 11/07/18 and 04/11/19. -If Resident #3's PCP ordered an endocrinology consult in between the resident's November 2018 and April 2019 endocrinology appointments, the facility staff should have scheduled an appointment for the resident to be seen by the endocrinologist. -The failure of the facility to schedule the endocrinology appointment as ordered by the PCP placed the resident at risk for high and low blood sugar, decreased kidney function, increased cholesterol and triglycerides, and heart problems. -If the endocrinology appointment had been made, there was a potential to have decreased Resident #3's hospital visits from high and low blood sugar. Interview with the ED and DRC on 08/06/19 at 4:45pm revealed: -Resident #3 may have had a delay in scheduling appointments due to changes in her PCP. -Resident #3 saw the endocrinologist in November 2018, February 2019, and April 2019. Observation on 08/06/19 at 5:00pm revealed the DRC was looking through documentation related to Resident #3's endocrinology appointments but did not find documentation of the resident being evaluated by endocrinology in February 2019. Copies of Resident #3's appointments documented in the appointment/calendar book were requested on 08/01/19 at 4:20pm and on 08/06/19 at 8:15am; however, the documentation was not provided prior to survey exit. Attempted telephone interview with a second PCP (from April 2019-May 2019) for Resident	D 273		

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D 273	Continued From page 53 #3's on 08/05/19 at 9:23am was unsuccessful. Refer to the interview with the DRC and MA/S on 08/02/19 at 8:12am revealed: Refer to the interview with the Transporter on 08/06/19 at 8:15am. Refer to the interview with the ED and DRC on 08/06/19 at 4:45pm. b. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -Her hands hurt "so bad I want to scream." -She had a knot on her right hand that had been there for about 6 months to one year. -Her new primary care provider (PCP) ordered her a cream for the pain that helped and was going to try to get her hands checked by a "specialist", but she did not know when. Observation on 08/05/19 at 10:20am revealed Resident #3 had a dime sized hardened area on her right hand below her thumb. Review of a PCP order for Resident #3 dated 06/10/19 revealed an order for an orthopedic consult for "hand pain." Review of a second PCP order for Resident #3 dated 07/22/19 revealed an order for an orthopedic consult for "hand cramp." Interview with a medication aide/supervisor (MA/S) on 08/01/19 at 9:00am revealed scheduled healthcare appointments should be documented in each resident's progress notes. Interview with a medication aide (MA) on 08/02/19 at 11:00am revealed Resident #3	D 273		

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D 273	Continued From page 54 complained of hand pain at times and had as needed medication for her pain. Interview with a second MA on 08/05/19 at 10:03am revealed: -Resident #3 had not complained of pain to the MA. -The MA did not know if Resident #3 had been scheduled any specialty appointments. -Resident #3's appointments would be documented in her progress notes. Review of Resident #3's June 2019 - August 2019 progress notes revealed there was no documentation of any scheduled orthopedic appointments or the resident going to any orthopedic appointments. Interview with Resident #3's PCP on 08/05/19 at 12:23pm revealed: -She took over as Resident #3's PCP on 06/01/19. -She ordered orthopedic consults for Resident #3 on 06/10/19 and 07/22/19 for hand pain. -She wrote two different orders because if she could not find an order she just re-wrote the order. -The facility staff was responsible for scheduling the consult appointments. -She expected orders for appointments to be implemented for scheduling within one week of date written. Interview with the Executive Director (ED) on 08/06/19 at 10:20am revealed the facility staff was still working on gathering documentation related to Resident #3's orthopedic consult. Interview with the ED on 08/06/19 at 11:25am revealed all staff were responsible for scheduling	D 273		

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D 273	Continued From page 55 of healthcare appointments. Copies of Resident #3's appointments documented in the appointment/calendar book were requested from the ED on 08/01/19 at 4:20pm and from the transporter on 08/06/19 at 8:15m; however, the documentation was not provided prior to survey exit. Documentation of implementation of Resident #3's orthopedic consult orders dated 06/10/19 and 07/22/19 was not received prior to survey exit. Refer to the interview with the Director of Resident Care (DRC) and a MA/S on 08/02/19 at 8:12am revealed: Refer to the interview with the Transporter on 08/06/19 at 8:15am. Refer to the interview with the ED and DRC on 08/06/19 at 4:45pm. Interview with the Director of Resident Care (DRC) and a medication aide/supervisor (MA/S) on 08/02/19 at 8:12am revealed: -The process for specialty referral appointments was as follows for assisted living (AL): after the referral was ordered, the DRC, the MA/S or MAs called to schedule the appointment; whoever made the appointment wrote it down in the appointment book. -There was no set time frame to get the appointment scheduled unless the ordering PCP had already sent a referral to the specialist. -They knew the PCP had sent the referral because it would show on the PCP order. -The DRC, MA/Ss or a MA would "usually" call to schedule the specialty appointment if was	D 273		

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D 273	Continued From page 56 ordered on the paperwork from the hospital. -Sometimes, the appointments had already been by the hospital and staff would just write the appointment in the appointment book. Interview with the Transporter on 08/06/19 at 8:15am revealed: -The facility had an appointment book which was used to coordinate and track all residents' appointments. -She transported the residents to the majority of their appointments in the facility's van. -When a resident returned from the hospital with an order for a consult, the appointment was written on the calendar by the MA if it had already been scheduled while the resident was in the hospital. -If the consult appointment had not already been scheduled while the resident was in the hospital, the MAs were responsible for looking at hospital discharge orders, calling to schedule the follow up appointments, and writing the appointments in the appointment book. -Referrals to specialty appointments could be made by the facility staff or the referring provider, depending on the situation. -Sometimes the ordering provider made the referral and the facility staff faxed over the referral and scheduled the specialty appointment. -If there was a need to see if a resident went to an appointment, one could look in the appointment book and the residents' progress notes. -If a resident went to a specialty appointment, it would be documented in their progress notes. Interview with the ED and DRC on 08/06/19 at 4:45pm revealed: -Referral appointments were supposed to be followed-up on within 24 hours to schedule the	D 273		

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D 273	Continued From page 57 appointment. -The MAs and DRC were supposed to use the "bucket system" to assure follow-up appointments were completed. -The DRC was responsible for assuring follow-up was completed. -Prior to the survey, the facility had a different "bucket system" for orders that was used "sporadically." -The ED and DRC thought the previous bucket system was working but the facility "obviously missed" orders prior to the survey. c. Review of Resident #3's physician renewal orders dated 03/07/19 revealed an order for finger stick blood sugars (FSBS) before meals. Document results on medication administration record (MAR) and notify provider if less than (<) 70 or greater than (>) 401." Review of a verbal order (VO) for Resident #3 dated 04/12/19 revealed: -The resident's blood sugar was 546. -There was an order to give 10 units of Lantus. (Lantus is a long acting insulin used to lower blood sugar). -There was an order to please notify endocrinology of all increased FSBS readings. -The VO was signed by Resident #3's primary care provider (PCP) and dated 04/15/19 Review of an order for Resident #3 dated 04/15/19 from Resident #3's endocrinologist revealed an order to notify endocrinology of FSBS results < 60 or > 450. Review of an order dated 05/16/19 from Resident #3's endocrinologist revealed: -There was order to increase Lantus to 10 units at bedtime.	D 273		

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D 273	Continued From page 58 -There was also an order to "check blood glucose at bedtime for several days ..." and fax results to the endocrinologist's office. Review of Resident #3's May 2019 electronic medication administration records (eMARs) revealed: -There was an entry to check FSBS three times daily before meals with scheduled times of 7:00am, 12:00pm, and 5:00pm and documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401." -There was a second entry to check FSBS three times daily before meals with scheduled times of 8:00am, 12:00pm, and 5:00pm and documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401. Notify endocrinology of all blood glucose readings < 60 or > 450." -There was an entry to check FSBS every night scheduled at 8:00pm with a start date of 05/17/19. -Resident #3's FSBS results were documented before meals on the first eMAR entry. -Of 99 FSBS opportunities documented for May 2019, 10 were > 450, requiring notification of the endocrinologist. -For example: from 05/01/19-05/03/19 at 7:00am, Resident #3's FSBS result was 515 on 05/04/19; 480 on 05/18/19; and 522 on 05/19/19. -For example: 05/01/19-05/03/19 at 12:00pm, Resident #3's FSBS result was 498 on 05/05/19 and 567 on 05/28/19. -For example: from 05/01/19-05/03/19 at 5:00pm, Resident #3's FSBS result was documented as high on 05/15/19; high on 05/22/19; and 567 on 05/26/19. -For example: from 05/17/19-05/31/19 at 8:00pm, Resident #3's FSBS result was documented as	D 273		

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D 273	Continued From page 59 "high" on 05/21/19 and 05/22/19. -There was no documentation on the eMAR of the endocrinologist being notified of the FSBS outside of the ordered parameter of > 450. -Of 99 opportunities documented for May 2019, 21 were > 400, requiring PCP notification. -For example: from 05/01/19-05/03/19 at 7:00am, Resident #3's FSBS result was 442 on 05/03/19 and 411 on 05/10/19. -For example: 05/01/19-05/03/19 at 12:00pm, Resident #3's FSBS result was 450 on 05/13/19 and 445 on 05/23/19. -For example: from 05/01/19-05/03/19 at 5:00pm, Resident #3's FSBS result was 431 on 05/13/19 and 407 on 05/27/19. -There was no documentation of PCP notification of the FSBS outside of the ordered parameter of > 400 on the eMAR. -Resident #3's FSBS was not documented at 7:00am on the following dates: 05/05/19 "not administered: on hold"; 05/12/19- 05/13/19 and 05/22/19 "not administered: refused." -Resident #3's FSBS was not documented at 12:00pm on the following dates: 05/07/19 and 05/30/19 "resident refused"; 05/14/19 and 05/22/19 "resident unavailable." -Resident #3's FSBS was not documented at 5:00pm on 05/18/19 with documentation the resident was out of the facility. Review of Resident #3's progress notes dated May 2019 revealed: -There was no documentation the facility notified the endocrinologist of the FSBS > 450. -There was documentation of PCP on 05/21/19 at 9:37pm for FSBS of "high" on the glucometer and 05/22/19 at 10:34pm for FSBS of "high on glucometer." -There was no other documentation of PCP notification.	D 273		

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D 273	Continued From page 60 Review of Resident #3's PCP orders dated 05/15/19 revealed on 05/15/19, there was documentation of PCP notification of FSBS > 400 with a new verbal order for a one time insulin dose. Review of Resident #3's June 2019 eMARs revealed: -There was an entry to check FSBS three times daily before meals with scheduled times of 7:00am, 12:00pm, and 5:00pm with documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401." -There was a second entry to check FSBS three times daily before meals with scheduled times of 8:00am, 12:00pm, and 5:00pm with documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401. Notify endocrinology of all blood glucose readings < 60 or > 450." -There was an entry to check FSBS every night scheduled at 8:00pm. -Resident #3's FSBS results were documented before meals on the first eMAR entry. -Of 117 FSBS opportunities documented for June 2019, 16 were > 450, requiring notification of the endocrinologist. -For example: from 06/01/19-06/30/19 at 7:00am, Resident #3's FSBS was 478 on 06/06/19, 537 on 06/24/19, and 530 on 06/28/19. -For example: from 06/01/19-06/30/19 at 12:00pm, Resident #3's FSBS was 541 on 06/14/19 and 588 on 06/17/19. -For example: from 06/01/19-06/30/19 at 8:00pm, Resident #3's FSBS was documented as "high" on 06/07/19, 507 on 06/13/19, and 537 on 06/23/19. -There was no documentation on the eMAR of	D 273		

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D 273	Continued From page 61 the endocrinologist being notified of the FSBS outside of the ordered parameter of > 450. -Of 117 FSBS opportunities documented for June 2019, 25 were > 400, requiring PCP notification. -For example: from 06/01/19-06/30/19 at 7:00am, Resident #3's FSBS was 410 on 06/18/19, and 419 on 06/20/19. -For example: from 06/01/19-06/30/19 at 12:00pm, Resident #3's FSBS was 427 on 06/07/19, 440 on 06/12/19, and 428 on 06/15/19. -For example: from 06/01/19-06/30/19 at 8:00pm, Resident #3's FSBS was 408 on 06/06/19, and 410 on 06/24/19. -There was no documentation on the eMAR of PCP notification for the FSBS outside of the ordered parameter of > 400. -Resident #3's FSBS was not documented at 7:00am on 06/17/19 "resident refused." -Resident #3's FSBS was not documented at 12:00pm on 06/09/19 with documentation the resident was out of the facility with family. -Resident #3's FSBS was not documented at 5:00pm on 06/06/19 with documentation the resident was out of the facility. Review of Resident #3's progress notes dated June 2019 revealed: -There was no documentation the facility notified the endocrinologist of the FSBS > 450. -There was documentation of PCP notification on 06/28/19 at 3:03pm for FSBS of 530 with new orders received. -There was no other documentation of PCP notification. Review of Resident #3's July 2019 eMARs revealed: -There was an entry to check FSBS three times daily before meals with scheduled times of 7:00am, 12:00pm, and 5:00pm with	D 273		

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D 273	Continued From page 62 documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401." -There was a second entry to check FSBS three times daily before meals with scheduled times of 8:00am, 12:00pm, and 5:00pm with documentation in the special instructions section which read "document results on MAR and notify provider if < 70 or > 401. Notify endocrinology of all blood glucose readings < 60 or > 450." -There was an entry to check FSBS every night scheduled at 8:00pm. -Resident #3's FSBS results were documented before meals on the first eMAR entry. -Of 141 FSBS opportunities documented for July 2019, 18 were > 450, requiring notification of the endocrinologist. -For example: from 07/01/19-07/31/19 at 7:00am, Resident #3's FSBS was 595 on 07/04/19, 517 on 07/10/19, 572 on 07/18/19, and "high" on 07/25/19. -For example: on 07/13/19 at 12:00pm, Resident #3's FSBS was 500. -For example: on 07/05/19 at 5:00pm, Resident #3's FSBS was 500. -There was no documentation on the eMAR of the endocrinologist being notified of the FSBS outside of the ordered parameter of > 450. -Of 117 FSBS opportunities documented for July 2019, 26 were > 400, requiring PCP notification. -For example: from 07/01/19-07/31/19 at 7:00am, Resident #3's FSBS was 443 on 07/03/19, 433 on 07/08/19, and 454 on 07/19/19 . -For example: from 07/01/19-07/31/19 at 12:00pm, Resident #3's FSBS was 424 on 0715/19 and 421 on 07/24/19. -There was no documentation on the eMAR of PCP notification for the FSBS outside of the ordered parameter of > 400. -Resident #3's FSBS was not documented at	D 273		

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	HAL010007	A. BUILDING: _____ B. WING _____	C 08/06/2019

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D 273	Continued From page 63 7:00am on 07/13/19 with documentation the resident "refused." -Resident #3's FSBS was not documented at 12:00pm on 07/20/19 with documentation the resident was out of the facility and 07/30/19 with documentation the resident was "unavailable." -Resident #3's FSBS was not documented at 5:00pm on 07/19/19 with documentation the resident was unavailable "out with family." Review of Resident #3's progress notes dated July 2019 revealed: -There was no documentation the facility staff notified the endocrinologist of the FSBS > 450. -There was documentation of PCP notification on 07/17/19 at 12:47pm for FSBS of 429 and 07/25/19 at 10:04am for FSBS "over 600." -There was no other documentation of PCP notification. -There was documentation on 07/19/19 at 11:01am that the resident's FSBS had been higher than 400 almost every morning this week "....I think that we need to contact her PCP and have her insulin changed or increased." Interview with a medication aide (MA) on 08/01/19 at 11:00am revealed: -When Resident #3's FSBS was high, she notified the resident's PCP if the FSBS was > 400. -She had never notified the endocrinologist. -"... I should have done that." Interview with a second MA on 08/026/19 at 10:10am revealed: -She had never notified endocrinology of Resident #3's FSBS results. -When Resident #3's FSBS was high, she notified the resident's PCP. Interview with a third MA on 08/06/19 at 2:30pm	D 273		

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D 273	Continued From page 64 revealed: -The process followed by the MAs when a resident's FSBS was outside of the ordered parameters was as follows: call the PCP; document the notification on the progress notes; document any new verbal orders; if the FSBS was too low, document the insulin was not given on the eMAR; recheck the FSBS as ordered. -When Resident #3's FSBS was outside of parameters, she notified the PCP. -She did not notify endocrinology. -She had never been told to notify endocrinology and had not seen it on the resident's eMARs. Interview with the Licensed Health Professional Support (LHPS) nurse on 08/05/19 at 9:20am revealed: -She expected the resident's blood sugars to be documented on the eMAR. There was a section in the eMAR that asked if the blood sugar was within parameters. If the blood sugar was not within parameters, the MA would document in the eMAR the provider was contacted and follow up in a progress note. -The provider was to be called and not faxed to inform of any blood sugars that were not within the ordered parameters. -She expected provider contact, or attempted provider contact, to be documented in the resident's eMAR and any follow up in the resident's progress notes. Interview with the Director of Resident Care (DRC) and a medication aide/supervisor (MA/S) on 08/02/19 at 8:12am revealed: -The medication aide (MA) who checked the FSBS was responsible for notifying the provider by phone of FSBS outside of the ordered parameters. -There was always a provider on call.	D 273		

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D 273	Continued From page 65 -The MA should document the notification in the electronic progress notes. -The MA could also put a note on the eMAR of the notification. -Resident #3 had high and low FSBS. -When Resident #3's FSBS was high or low, she had no symptoms and was usually unaware. -Resident #3's PCP was expected to be notified of FSBS outside of ordered parameters. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -Her FSBS had been running high (300's to 400's). -She saw her PCP about a week ago for the high FSBS. -The PCP changed her diabetic medications; she got a new pill and change in her insulin dose. Interview with the Executive Director on 08/01/19 revealed: -She did not know Resident #3's endocrinologist was not notified of the FSBS outside of the ordered parameters. -The endocrinologist should be notified as ordered of FSBS outside of the ordered parameters. -The PCP should be notified as ordered of FSBS outside of the ordered parameters. -The MAs would be responsible for notifying the endocrinologist and documenting in the progress notes. -She did not know if the DRC reviewed for notification of FSBS outside of parameters; she would follow up with the DRC. Telephone interview with a Registered Nurse (RN) at Resident #3's endocrinologist's office on 08/01/19 at 4:00pm revealed: -The facility was supposed to notify the	D 273		

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D 273	Continued From page 66 endocrinologist's office when the resident's FSBS was > 450 due to the resident's uncontrolled diabetes. -The facility had not notified the endocrinology office of any FSBS outside of the ordered parameter of >450. -The last notification from the facility was during the resident's last appointment on 04/11/19. -The endocrinologist was not aware of the many elevated FSBS results > 450 and would "definitely" expect to be notified in order to change and/or adjust the resident's insulin. -There was "no coordination of care" by the facility between the PCP and endocrinologist. -The endocrinologist was the specialist for the resident. -The endocrinologist should be monitoring and adjusting the resident's medications and the resident should not be followed by the PCP for medication changes related to diabetes. -Any orders for insulin written by the PCP should be clarified by the endocrinologist. -The failure of the facility to notify endocrinology and coordinate care with endocrinology impacted the resident negatively because the endocrinology specialist was of no benefit to the resident. -Outcomes to the resident included increased risk for high and low FSBS, elevated hemoglobin A1C, risk for diabetic ketoacidosis, and kidney damage. Telephone interview with Resident #3's current PCP on 08/05/19 at 12:23pm revealed: -She took over as Resident #3's PCP on 06/01/19. -She would want to be notified by text, fax, or phone of Resident #3's FSBS results outside of the ordered parameters. -She had not seen the endocrinology order for	D 273		

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D 273	Continued From page 67 notification of FSBS outside of parameters. -She recalled maybe seeing an endocrinology note in Resident #3's record. -She was adjusting Resident #3's medications. -She was "not alarmed" if endocrinology was not being notified of the resident's FSBS, regardless of the endocrinology order, as long as the facility was notifying her. -She thought all orders from a specialist would need to be clarified with [her named office] first since she was the PCP, but she was not sure. Interview with Resident #3's former PCP on 08/01/19 revealed: -She was Resident #3's PCP from November 2018-April 2019. -She expected Resident #3's endocrinologist to be notified of any FSBS outside of the ordered parameters Attempted telephone interview with a second former PCP (from April 2019-May 2019) of Resident #3 on 08/05/19 at 9:23am was unsuccessful. 5. Review of Resident #1's current FL-2 dated 07/08/19 revealed a diagnosis of dementia with behaviors. Review of a Continuing Care/ discharge Summary from a behavioral center revealed Resident #1 was admitted to the center on 06/15/19 and discharged back to the facility on 07/08/19. Review of Resident #1's physician's order dated 07/15/19 revealed an order for counseling services for bipolar and depression. Review of Resident #1's record revealed:	D 273		

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D 273	Continued From page 68 -There were no handwritten progress notes from facility staff in the resident's record. -There was no documentation of counseling services for the resident. Review of electronic progress notes for Resident #1 from 06/04/19 through 07/30/19 revealed: -On 07/15/19 at 1:42pm, staff documented the resident was seen by the Primary Care Provider (PCP). -On 7/15/19 at 3:02pm, the Memory Care Manager (MCM) documented the resident was seen by the PCP, new orders were written, a prescription for Lorazepam (used to treat behaviors) 1mg was sent to the pharmacy. -On 07/17/19 at 11:11pm, the resident was a "little upset", and a "little fussy" but calmed down at the end of the shift. -On 07/18/19 at 2:02pm, the resident had been "on edge today" about wanting to call a family member to come get her and wanted to continuously call the family member back. -On 07/20/19 at 4:29pm, the resident did well until around 2:00pm when the resident got upset that a family member had not come to see her, wanted to call family member numerous times, and became more upset when the resident was not able to contact family by telephone. -On 07/21/19 at 9:15pm, the resident became upset and cried after trying to contact a family member by telephone unsuccessfully. The resident clamed down after sitting and talking with the staff. -On 07/22/19 at 2:41pm, the resident stayed in bed all day. -On 07/24/19 at 3:25pm, the resident was seen by the provider and the provider wrote an order to encourage resident to attend activities. -On 07/28/19 at 1:06am, the resident became "very combative, agitated around 8pm; walked	D 273		

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D 273	Continued From page 69 out of the memory care unit behind another aide, refusing to come back and threatening to hurt myself and the other aide that was trying to get her back". -On 07/28/19 at 2:32pm, the resident packed a small bag and got her purse after she was unsuccessful at contacting family members by telephone. -On 07/29/19 at 10:47pm, the resident was "really upset" because she could not find a ride home. The resident was "lashing". -On 07/30/19 at 10:35pm, the resident had behaviors of banging on the door window and throwing objects. -There was no documentation that counseling services had been arranged for the resident. Interview with a Personal Care Aide (PCA) on 07/31/19 at 3:12pm revealed: -Resident #1 stayed in bed most of the time. -The resident liked to use the telephone to call family members. -The resident sometimes wanted to leave the facility. -The resident "fussed" sometimes but not too often. Interview with a second PCA on 07/31/19 at 3:20pm revealed: -Resident #1 was swinging at staff on 07/30/19. -The resident would get agitated. -The resident wanted her family to come get her. -The resident packed her clothes every day. Observation of Resident #1 on 07/31/19 at 3:20pm revealed: -The resident was laying in her bed awake. -When staff opened the resident's room door, the resident raised her head up off the pillow and stated "I don't wanna see anybody."	D 273		

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D 273	Continued From page 70 Observation of Resident #1 on 07/31/19 at 4:40pm revealed: -The resident entered the dining room and sat in a chair at the end of a table. -Another female resident entered the dining room and sat in a chair across from Resident #1 at the same table. -Resident #1 got up from the table, moved to another table in the dining room, and begin talking to the resident sitting at that table. Interview with the Medication Aide (MA) on 08/01/19 at 4:10pm revealed she thought Resident #1 had counseling services. Interview with the Executive Director (ED) on 08/01/19 at 4:35pm revealed: -She was not sure if counseling services had been arranged for Resident #1. -The MCM would be responsible for arranging the counseling services. -She would follow up with staff about the status of the counseling services ordered. Interview with the MCM on 08/05/19 at 11:55am revealed: -Resident #1 had not yet been scheduled for the counseling services to begin. -She was waiting on paperwork from Resident #1's family member to arrange the counseling services. -She had contacted Resident #1's family member on the day of the order about the counseling. -If she documented the contact with the family member, the documentation would be in the resident's progress notes, and she did not always document everything. -She contacted Resident #1's family member again on 08/02/19 and was told by the family	D 273		

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D 273	Continued From page 71 member that she had forgotten to return the paperwork to the facility authorizing the counseling services. -She had been out of the facility from 07/25/19 to 08/02/19. -The PCP did not know Resident #1 had not yet been scheduled for the counseling. -She did not know why the PCP had not been notified that Resident #1 had not been scheduled for the counseling as ordered. Interview with the PCP on 08/05/19 at 12:40pm revealed: -She ordered counseling for Resident #1 on 07/15/19 when she had a face-to-face visit with the resident. -She did not know counseling had not been started. -She denied concerns about the delay in starting counseling because Resident #1 was more compliant now with medications. -She expected the facility staff to keep track of when they were not getting a response back regarding services needing to be referred to external providers. Interview with a family member for Resident #1 on 08/06/19 at 8:20am revealed: -Resident #1 had been back at the facility for about two weeks from an inpatient admission at a behavioral center. -The resident kept going to the behavioral center because she refused medications. -She received paperwork from the MCM on 08/05/19 about arranging the counseling services. -The MCM had called her last week (no specific date provided) to send paperwork, but she guessed the email bounced back. -She thought the PCP had recommended the	D 273		

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D 273	Continued From page 72 counseling. The facility failed to assure the health care needs were met for 5 of 8 sampled residents including missed medical appointments (#3, #15), failure to coordinate follow up and specialty care (#1, #3, #4, #15), and delays in notification for the acute health care needs and change in status (#3, #4, #13, #15) resulting in the residents not receiving the health care services necessary to maintain their physical and mental health. The facility failed to report Resident #4's complaints of pain and itching under her right arm to the primary care provider (PCP) and failed to schedule medical appointments for the resident who was diagnosed with an axillary abscess with a bacterial infection of methicillin resistant Staphylococcus aureus (MRSA);this resulted in a delay in the treatment of the abscess, the resident notifying the PCP herself and scheduling her own appointments, the resident missing multiple doses of antibiotics, and experiencing prolonged pain, infection and requiring surgical intervention. Resident #13's primary care provider (PCP) was not notified when the resident had a fall on 06/23/19, became non-ambulatory and unable to use her legs requiring 4 people to transfer as the resident continued to deteriorate over 6 days before being seen by the physician and sent to the emergency room where diagnosed with paraplegia. Resident #15 missed a dental appointment and had a delay in starting antibiotics resulting in a procedure for a tooth extraction being rescheduled and the resident experiencing ongoing facial swelling and pain. The facility failed to coordinate care for Resident #3, a diabetic, between the PCP and endocrinologist resulting in the resident having multiple hospital visits for high and low blood sugar, placing the resident at risk for serious complications of diabetes including	D 273		

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D 273	Continued From page 73 kidney damage and diabetic ketoacidosis. The facility's failure to coordinate timely care and follow-up with physicians resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/01/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2019.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 358	10A NCAC 13F .1004(a) Medication Administration Medication cart audits implemented on 8/8/19 to include comparing medication administration record to medications on hand, documentation, parameters and administration times. Cart to medication administration record audits are conducted weekly per cart. Supervisors conduct medication cart to MAR audits in coordination with the Care Mgrs. ED reviews cart audits for compliance weekly and follows up with Care Managers. The Memory Care Manager and Director of Resident Care are responsible to assure completion of audits and medication availability in coordination with the Medication Aides.	09/05/2019 ongoing 09/5/2019

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D 358	Continued From page 74 Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration; failed to assure medications were administered as ordered for 2 of 6 residents (#9, #10), observed during the medication passes, including errors with insulins (#9, #10), an antiarrhythmic (#9), an oral antidiabetic and bulk fiber (#10); and for 4 of 7 residents sampled for record reviews (#1, #3, #4, #15) including delays in starting and missed doses of antibiotics (#4, #15), a delay is administration of an antifungal (#3) a delay in starting an antidepressant (#3), errors with rapid and long acting insulins (#3), and a medication used to treat hypothyroidism (#1). The findings are: Interview with the Corporate Registered Nurse (RN) on 08/01/19 at 5:25pm revealed: -The facility did not have a written medication administration policy. -The facility's policy for medication administration was to follow the rules and statutes related to medication administration. Confidential staff interview revealed: -The facility had problems with medication administration and it was "unsafe." -The problems started a few months ago when the facility started using a brand new system. -Nobody knew what was going on with the new system. -When medications were discontinued, they "recycled" which meant they would continue to show on the electronic medication administration records (eMARs) and were still in the multi-dose packs (MDPs). -MDPs were sent from the pharmacy for one	D 358	The Executive Director will monitor daily to assure the order processing system is effective and continues to be utilized. Medication compliance reports will be run daily by the Memory Care Manager and Director of Resident Care to assure all medications and physician orders are followed as ordered. These reports will be brought to the morning dept head meeting and signed off on by the ED. Medication administration training was provided by the Pharmacy to include order processing, administration, documentation, insulin preparation, availability/delivery of medications and pharmacy notification and access . Training provided on 8/20/19. A "Red Sash" program was implemented to alert all personnel, families and Residents that medication administration is in process to minimize interruptions on 8/27/19. Registered nurse provided training on diabetes and insulin administration on 8/27/19. Med Aides were retrained on Matrix system, order processing/delivery, med administration process, six rights of med administration, disruption during medication pass, cart audits and accurate measuring of meds on 8/8/19 & 8/20/19. Medication order audits (white paper) was completed by a Registered Pharmacy Nurse on 8/19 & 8/22 in coordination with facility personnel to identify medications are scheduled as ordered, including entires for vital signs, blood sugar results, required actions to include monitoring for duplicate orders.	09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019 09/05/2019

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D 358	Continued From page 75 week at a time, but sometimes there would be blister pack cards for some medications for the resident too. -The medications did not "fall off" the eMARs until a member of management took them off. -Management was the Executive Director (ED), Memory Care Manager (MCM), or Supervisors. -Management was supposed to approve all orders on the eMARs, but they did not do it like they should. -For example, a medication would be given at a specific time on a different shift (shift and time withheld to maintain staff confidentiality) and there would be two MDPs with two different times due, but the medication was only ordered once a day; or there would be no MDP that matched the time due on the eMAR. -If there was not a blister pack card, and only one MDP, it was "usually" easier to know if the medication was already given. This was because if it was not in the only MDP, it was already given. -The times due on the MDP label did not match the times due on the eMAR because management was not approving the orders. -The MAs had "no idea what is going on." -There were "all kinds" of medication errors; this staff member had given duplicate doses of a named medication to a named resident (information withheld to maintain staff confidentiality). -Other staff would not report when they had medication errors. -Staff had reported the medication administration problems to management and they said, "we're working on it." -The staff member was never told or trained on the facility's medication administration policy, but it was common sense there was a problem if you could not tell what was given or when it was given.	D 358	Routine FSBS results will be submitted to the primary care provider for review weekly. Care Managers will be responsible to assure this procedure is accomplished each week. Training was provided to the medication aides, supervisors and care managers on the "Down Time Process" which is a process that allows the medication administration process to continue should in Internet or electricity be interrupted, once back on-line the electronic medication administration system will update and sync all entries from the system. This process assures consistent medication administration. Medication pass observations are being conducted weekly by registered nurse or qualified designee to include, but not limited to proper medication administration procedures infection control, security, documentation, six rights of medication administration. Any concerns will be discussed with the person being observed, provided with guidance an additional training as necessary. Observation will follow up with the Care Magrs and ED on the medication pass observations conducted weekly. Monitoring of medication administration compliance will be conducted through internal systems, tools and processes as outlined in the plan of correction for 13F. 1004(a), Tag D358.	09/05/2019 09/05/2019 09/05/2019 ongoing ongoing

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D 358	Continued From page 76 -This staff member was not trained on the new system and was just told to follow the prompts and "do the best you can." -The staff members could call one of the named Supervisors or the MCM when they needed help. Confidential interview with a second staff member revealed: -There were "a lot" of medication errors because medications popped up as due when the resident had already taken the medication. -If you did not know the residents, you could give the medication again (duplicate dose). -Management (which was the ED, two named Supervisors, or MCM) were supposed to approve the orders to make changes to the eMAR any time orders were changed. -Management had to approve medication orders that were discontinued, or the medication would still show as due on the eMAR. -Management was not approving the orders which caused the time on the MDP not to match the time due on the computer. -An example would be a medication would be given at a specific time (time withheld to maintain staff confidentiality) and then it would pop up as due again 4 hours later but it was only ordered once a day. -If the MDP did not match the eMAR, the MAs had to stop and research the chart notes and orders to check what was correct. -Many MAs did not know to do that and some did not care, so they had a lot of medication errors. Confidential interviews with a third staff member revealed: -The staff member had "no clue" how the orders were entered on the eMAR but they were "messed up." -The facility's medication administration system	D 358		

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D 358	Continued From page 77 did not really tell what time a medication was given. -An example would be a resident would ask for their pain medication and say it was due to be given, but the system would not allow the pain medication to be given. This was because staff were told by management to hit the box for "charted late." -The residents got mad when they did not get their pain medication and complained of pain. -The system would allow medications to be given only when the box was blue without choosing charted or given late. -When the box "turned red" on the eMAR, it required a choice of either charted late or given late. -Staff were told to always choose charted late so they were no late medications. Late medications were errors. -Staff had one hour before and one hour after the scheduled time to give the medication when the screen was blue. If it was not administered within the one hour before or one hour after, the screen turned red and staff had to make the choice. -The facility's medication administration system was "confusing"; it was hard knowing what time medications were due because medications would show as due on the eMAR at a specific time (time withheld to maintain staff confidentiality) but would be in the multi-dose pack (MDP) labeled due at another time (time withheld to maintain staff confidentiality). -The staff member was not trained or told what to do when this happened. -When this happened, the staff member usually did not give the medication because the time due did not match the dose pack. -The staff member did not know if the medication appear on the eMAR at the time that was on the MDP (on the other shift) because the staff was	D 358		

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D 358	Continued From page 78 not working at that time. (Time and shift withheld to maintain staff confidentiality). -The staff acknowledged the problems increased the risk for medication errors. Interview with the Executive Director (ED) on 08/01/19 at 10:02am revealed: -The facility had been using the current named electronic health record system EHR/eMAR system since March 2019. -The system had some "glitches" which meant the system would go down and be unavailable for use at unscheduled/unknown times, there would be duplicate entries on the eMARs for some medications, and the administration times for some medications would revert by "default" to 1:00am. -She did not know why the glitches appeared. -The process for medication orders was as follows: the Director of Resident Care (DRC), medication aide, (MA) or MA/Supervisor (MA/S) would send the orders to the pharmacy, the pharmacy would enter the orders onto the eMAR, the DRC or MA/S would verify the orders on the eMAR every day when new orders arrived or with any order changes, and compare the orders faxed to pharmacy against the eMAR, if the orders did not match they would contact the ordering provider or the pharmacy to correct the discrepancy. -The facility used MDPs of medication and sometimes the pharmacy would send duplicate MDPs with different label instructions. The example provided by the ED was as follows: there would be one MDP with label directions to administer the medications at 8:00am, 2:00pm, and 8:00pm and a second MDP with label directions to administer the medications prn (as needed). -There was no current system in place to assure	D 358		

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D 358	Continued From page 79 safe medication administration to include determining if medications were given on time or to assure duplicate doses of medications were not given when there was a duplicate MDP or eMAR entry. -To address the concerns with medication administration, she had contacted facility's corporate Registered Nurse and a named corporate EHR contact person in the past (no dates provided); neither had any suggestions to address the concerns. -Other things implemented to address safe medication administration procedures (no date of implementation provided) was the MAs being told to take the medication cart to each residents' room when administering medications and to document at the time of administration. (In the past, the residents came to the clinic for their medication); and medication cart audits were done. -She acknowledged she had concerns for medication errors due to the system glitches. Interview with the Corporate Registered Nurse (Corporate RN) and DRC on 08/01/19 at 11:27am revealed: -The facility had been using the current medication administration system since March 2019. -With the current system in place, there was no way to determine if a medication was administered late if the MA documented the medication was charted late but given on time. -When a medication was documented by a MA as charted late/administered on time, the only way to know if a medication was given at the scheduled administration time would be to have observed the medication being administered. -Both acknowledged that the only way to know if a medication was given in duplicate would be to	D 358		

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D 358	Continued From page 80 have observed the medication being administered. -The MAs had been trained how to document correctly. -The duplicate medication orders on the eMAR came from each new prescription put into the eMAR system. -Every time there was a new prescription (whether it was a change or a renewal), there was a new prescription number and it would come up as a duplicate entry on the eMAR. -The old order was supposed to drop off the eMAR when there was a new order, but this was not always happening. -"Something is not linking" and there was an issue of the old order not falling off the eMAR. -Corporate was made aware of the duplication several months ago and worked to fix the problem then. -The problem was still ongoing, and they were still working to correct it. -When told by a MA of any duplicate entries, the DRC tried to go into the eMAR and remove it, but sometimes they would pop back up on the eMAR because the pharmacy put them back in. -The DRC "constantly" looked at the eMARs. (When asked what constantly meant, the DRC did not respond with an answer). -The DRC had provided re-education to the MAs when there was a problem identified with medication administration. -When questioned as to what else the facility had put in place to assure safe medication administration procedures neither the DRC or Corporate RN responded. Interview with the Licensed Health Professional Support (LHPS) nurse on 08/05/19 at 9:20am revealed: -The facility had a new eMAR system that	D 358		

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D 358	Continued From page 81 included two steps when administering medications. -The first step was to prepare the medications. After the medications were prepared for the resident the MA would click on the "prepare" link. -The second step was to administer the medications. The MA would click on the "administer" link immediately after the medications were administered to the resident. -A late medication would be any medication administered outside of the 1-hour time frame for administering medications. For example, if a medication was due at 8:00am and administered at 9:01am the medication would be late. -If the MA were to click the "administer" link and the medication was administered late the eMAR would populate a pop-up box that would require the MA to enter a reason the medication was administered late before signing off the medications as administered. -The MA would choose from a drop down menu the reason the medication was administered late, and there would be a place to enter a note. -There was no way to determine if a medication was administered late unless it was charted by the MA as administered late. Telephone interview with a pharmacist at the facility's contracted pharmacy provider on 08/02/19 at 8:55am revealed: -The pharmacy did not have anything to do with the facility's EHR/eMAR system; it was a separate (named) system. -The pharmacy provided services of receiving orders from the facility and dispensing medications to the facility. -The process used by the facility for a new medication order was as follows: the facility faxed the order to the pharmacy; the pharmacy "profiled" the order which meant adding the order	D 358		

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D 358	Continued From page 82 to the system as it was written; the facility's designated staff was responsible for reviewing and accepting the profiled order for it to show up on the eMAR as ordered and due for administration. -The pharmacy used the same process for discontinued orders as for new orders. -It was the facility's responsibility to remove all discontinued order entries from the eMARs or the medication would still show on the eMAR as due for administration. -The facility used MDPs for medication. When an order changed or was discontinued, it was the facility's responsibility to put a sticker on the MDP that the order change or was discontinued. -When a medication was discontinued, the facility was supposed to remove the medication from the MDP at the time of administration and dispose of it per the facility's disposal policy at that time. -The pharmacy did not have access to print reports or review the facility's eMARs. Telephone interview with an Information Technology (IT) representative of the facility's electronic health record (EHR) provider on 08/02/19 at 9:45am revealed: -The facility utilized the provider's EHR which included the eMAR system. -He did not have access to how long the facility had been using the EHR/eMAR system. -Medication orders could be imported into the EHR/EMARs two ways, which was manual entry or electronic entry. -Manual entry meant someone at the facility manually keyed the order into the EMR/eMAR. -Electronic entry meant the order was sent electronically to the EHR provider from the pharmacy. -The process for electronic entry was as follows: the pharmacy sent the order the EHR where it	D 358		

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D 358	Continued From page 83 was "profiled" to the residents' current orders; then the order went through the approval process. The approval process meant someone in the facility had to review and approve the order. -After it was approved by someone in the facility, the order showed on the residents' current eMAR orders. -All discontinued orders had to be approved by someone in the facility or they would continue to show on the eMAR. -When there was an order change (an old order and a new order), both orders would require someone in the facility to approve them before the order change was reflected on the eMAR. -Based on documentation he had available for review, the facility had been manually entering orders from March 2019 through sometime in May 2019 (he could not provide exact dates). -Sometime in May 2019, the facility started utilizing the electronic import option and process for new orders (could not provide exact dates). -Importing orders electronically took the control from the facility staff from manually entering the orders which could reduce potential errors. -The reason for duplicate entries in the EHR/eMARs was the facility using the manual and electronic imported options of entering orders and the facility was not approving/deleting when orders were discontinued or changed. -The only way to determine if duplicate medications were administered would be by what staff documented as administered on the eMARs. -The system allowed a one hour time frame before and after the scheduled administration time for the medication to be administered on time. For example: a medication scheduled for administration at 9:00am allowed staff to administer the medication from 8:00am-10:00am. -The EHR/eMAR would automatically prompt staff with choice of comments for any medication	D 358		

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D 358	Continued From page 84 administered outside of the one hour before or one hour after administration time frame. -Staff could not document a medication as having been administered outside of the two hour window without choosing a comment; there was also a section for staff to type in additional comments. -The only way the system could determine whether or not a medication was administered late would be based on the documentation and comments the staff chose and documented. -The only way the system could track if a medication was charted late would be based on the documentation and comments the staff chose and documented. -He did not have a way to run reports for the facility's medication administration or how medication orders were imported for entry. -The facility could print reports related to medications administered, medication orders imported, and comments entered by staff. Interview with the Corporate RN on 08/02/19 revealed the facility could not print or provide exception reports related to medication administration or how medication orders were imported. Interview with the ED and DRC on 08/06/19 at 4:45pm revealed: -When the MAs saw a problem with the eMAR, they had been notifying the DRC; and when brought to the DRC's attention, corrections were made. -The (named) Supervisor had been notifying the pharmacy when the MAs reported eMAR and order discrepancies. -Medication cart audits were done weekly by the DRC or designee and MCM which consisted of the orders being compared to the medications on	D 358		

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D 358	Continued From page 85	D 358		

hand and eMARs.
-The last medication cart audit the ED had received from the DRC was 07/31/19; prior to that, the last audit was one week before 07/31/19.
-Residents should get their medications administered as ordered and should get their medications on time.

1. The medication error rate was 35% as evidenced by observation of 10 errors out of 28 opportunities during the 8:00am and 5:00pm medication passes on 08/01/19.

a. Review of Resident #10's current FL-2 dated 02/18/19 revealed:
-Diagnoses included diabetes mellitus type 2, polycythemia vera, hyperlipidemia, hypertension, atrial fibrillation, osteoarthritis right and left knees, gastroesophageal reflux disease, and depression.
-There was an order for Levemir 50 units subcutaneously twice daily. (Levemir is a long-acting insulin used to lower blood sugar.)

Review of Resident #10's subsequent physician order sheets dated 06/24/19 revealed there was an order for Levemir 50 units subcutaneously (SQ) twice daily.

Review of Resident #10's August 2019 electronic administration record (eMAR) revealed:
-There was an entry for Levemir 50 units twice daily to be administered at 8:00am and 8:00pm.
-There was documentation Levemir 50 units was administered at 8:00am.
-The residents blood sugar was 213 at 8:00am.

Observation of the 8:00am medication pass on 08/01/19 at 7:30am revealed:
-Resident #10 was sitting in her wheelchair

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D 358	Continued From page 86 located in the medication room. -The medication aide (MA) reviewed Resident #10's eMAR. -The MA stated Resident #10 would receive Levemir 50 units. -The MA removed the Levemir vial from the medication cart and wiped the stopper with an alcohol pad. -The MA inserted the needle into the vial. -The MA withdrew 52 units of Levemir. -The MA held up the syringe and looked at the insulin in the vial. -The top of the black plunger in the syringe that contained the Levemir was on the 52-unit mark. -The MA wiped Resident #10's left upper arm with an alcohol pad. -She pinched the skin of Resident #10's left upper arm. -The MA began to administer Levemir 52 units to Resident #10's left upper arm. -The MA was stopped prior to administering Levemir 52 units to Resident #10. Interview with the MA on 08/01/19 at 7:39am revealed: -Resident #10 was to be administered Levemir 50 units. -She had drawn up Levemir 50 units to administer to Resident #10. -The MA was asked to re-examine the amount of Levemir in the syringe. Observation of the MA on 08/01/19 at 7:40am revealed the MA held up Resident #10's prepared insulin syringe and looked at the amount of insulin that was in the syringe. A second interview with the MA on 08/01/19 at 7:40am revealed: -She had drawn up Levemir 50 units.	D 358		

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D 358	Continued From page 87 -The top of the black plunger in the insulin syringe the MA prepared for Resident #10 was on the 50-unit mark. -She did not see the top of the black plunger in the insulin syringe on the 52-unit mark. -She thought the top of the black plunger in the insulin syringe was on the 50-unit mark. -She would waste the extra 2 units. Observation of the MA on 08/01/19 at 7:41am revealed: -She returned to the medication room. -Resident #10 was sitting in the medication room. -The MA administered Levemir 50 units to Resident #10. A third interview with the MA on 08/01/19 at 12:35pm revealed: -She did not see the order "take with breakfast" on the eMAR. -If she had seen the order "take with breakfast" on the eMAR she would have waited until Resident #10 had been served breakfast. Interview with the Executive Director (ED) on 08/01/19 at 9:20am revealed: -The MA was an experienced MA, who probably made the error because she was nervous. -She expected the MAs to follow orders on the resident's eMARs. Interview with the Corporate Registered Nurse (Corporate RN) on 08/02/19 at 9:28am revealed: -The facility did not have a specific insulin policy. -The facility followed physician orders and the North Carolina State Rules and Regulations for Medication Administration for Adult Care Homes. -The MAs received online training and additional training by the Licensed Health Professional Support (LHPS) nurse when performing skills	D 358		

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D 358	Continued From page 88 check offs. Telephone interview with Resident #10's Primary Care Provider (PCP) on 08/05/19 at 1:00pm revealed: -She expected the correct dose of Levemir to have been administered to the resident. -If Resident #10 was administered 52 units instead of 50 units of Levemir it probably would not have harmed the resident because the resident normally had elevated blood sugars. -She was uncertain of the resident's blood sugar ranges. b. Review of Resident #10's current FL-2 dated 02/18/19 revealed: -Diagnoses included diabetes mellitus type 2, polycythemia vera, hyperlipidemia, hypertension, atrial fibrillation, osteoarthritis right and left knees, gastroesophageal reflux disease, and depression. -There was an order for Novolog 35 units subcutaneously before meals. Hold for blood sugars less than 70. (Novolog is a rapid-acting insulin used to lower blood sugar.) Review of Resident #10's subsequent physician order sheet dated 06/24/19 revealed there was an order for Novolog 35 units SQ three times a day before meals. Hold for blood sugar less than 70. Interview with Resident #10 on 08/01/19 at 7:38am revealed the resident had not eaten. Observation of the 8:00am medication pass on 08/01/19 at 7:30am revealed: -Resident #10 was sitting in the medication room. -The medication aide (MA) removed the Novolog vial from the medication cart. -The MA drew up 35 units of Novolog.	D 358		

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D 358	Continued From page 89 -The MA began to administer the insulin. -The MA did not obtain a finger stick blood sugar. -The MA was stopped before administering the insulin. Interview with MA on 08/01/19 at 7:43am revealed: -She did not need to obtain a fingerstick blood sugar on Resident #10 because she had received report from the medication aide/supervisor (MA/S) that the residents fingerstick blood sugar was 132 at 6:00am. -Resident #10's blood sugar was documented on the blood sugar log shift report. Observation of the MA on 08/01/19 at 7:46am revealed: -She administered Novolog 35 units to Resident #10. -She returned to the medication cart to sign off on the insulin. -She pointed to a section on the electronic Medication Administration Record (eMAR) where Resident #10's fingerstick blood sugar should have been documented. Review of Resident #10's eMAR computer screen at 7:48am revealed there was no documentation to include Resident #10's 08/01/19 fingerstick blood sugar had been obtained. Review of the 08/01/19 shift report reported by the MA to have documentation of Resident #10's blood sugar revealed: -There was a section to document Resident #10's fingerstick blood sugar. -The section to document Resident #10's fingerstick blood sugar was blank. Observation of Resident #10 on 08/01/19 at	D 358		

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D 358	Continued From page 90 7:47am revealed the resident went to the dining room for breakfast. A second interview with the MA on 08/01/19 at 7:48am revealed: -The 08/01/19 fingerstick blood sugar result for Resident #10's 08/01/19 was not in the eMAR. -The 08/01/19 fingerstick blood sugar result for Resident #10 was not documented on the shift report. -She did not know who obtained Resident #10's fingerstick blood sugar this morning because the MA/S took the shift report. Interview with the MA/S on 08/01/19 at 7:50am revealed: -She did not receive report that Resident #10's blood sugar had been obtained this morning. -Resident #10's fingerstick blood sugar had not been obtained this morning. -If Resident #10 had a fingerstick blood sugar obtained this morning it would have been documented in the eMAR. Observation of Resident #10 on 08/01/19 at 7:52am revealed: -The resident was escorted back to the medication room by the MA/S. -The resident's fingerstick blood sugar result was 213. -The resident returned to the dining room. Interview with Resident #10 on 08/01/19 at 7:55am revealed today was the first time she had been administered Novolog without first having her fingerstick blood sugar obtained. Observation of Resident #10 on 08/01/19 at 8:02am revealed she took her first bite of food.	D 358		

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D 358	Continued From page 91 Interview with the Executive Director (ED) on 08/01/19 at 9:20am revealed: -She expected the MAs to follow orders on the resident's eMARs. -The MA had the five- and ten-hour training, shadowed on the medication cart, and had observations and skill check offs with observations by the Licensed Health Professional Support (LHPS) nurse before staffing the medication cart. Interview with the Corporate Registered Nurse (Corporate RN) on 08/02/19 at 9:28am revealed: -The facility did not have a specific insulin policy. -The facility followed physician orders and the North Carolina State Rules and Regulations for Medication Administration for Adult Care Homes. -The MAs received online training and additional training by the Licensed Health Professional Support (LHPS) nurse when performing skills check offs. Telephone interview with Resident #10's Primary Care Provider (PCP) on 08/05/19 at 1:00pm revealed: -Novolog was a rapid acting insulin with an onset that varied per person but could be within fifteen minutes to one hour and would cover a spike in blood sugars with meals. -Novolog administered without checking a blood sugar before administration could cause a drop in blood sugar. -A drop in blood sugar could cause hypoglycemia which would result in clammy skin, weakness, not feeling alert, blurred vision, and coma if the blood sugar dropped low enough. -Blood sugar signs and symptoms varied person and each person responded to blood sugars differently because of what that person's body was accustomed to.	D 358		

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D 358	Continued From page 92 -She expected facility staff to follow orders. -She expected Resident #10's blood sugar to have been obtained before administration of Novolog and to have followed the specific parameters. c. Review of Resident #10's current FL-2 dated 02/18/19 revealed: -Diagnoses included diabetes mellitus type 2, polycythemia vera, hyperlipidemia, hypertension, atrial fibrillation, osteoarthritis right and left knees, gastroesophageal reflux disease, and depression. -There was an order for Voltaren 1% gel, apply 1 gram topically to both knees twice daily. (Voltaren is a non-steroidal anti-inflammatory used to treat joint pain caused by arthritis.) Review of Resident #10's subsequent physician order sheet dated 06/24/19 revealed there was an order for Voltaren gel 1% apply 1 gram (g) topically to both knees twice daily. Observation of the 8:00am medication pass on 08/01/19 at 7:30am revealed: -Resident #10 was sitting in the medication room. -The MA pointed to the Voltaren order on the eMAR. -Voltaren was not administered to Resident #10. Interview with the MA on 08/01/19 at 07:36am revealed Resident #10 was to have Voltaren administered per the eMAR. Review of Resident #10's August 2019 electronic administration record (eMAR) revealed: -There was an entry for Voltaren 1% apply 1g topically to both knees twice daily at 8:00am and 8:00 pm. -There was documentation Voltaren was administered to Resident #10 at 8:00am on	D 358		

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D 358	Continued From page 93 08/01/19. A second interview with the medication aide (MA) on 08/01/19 at 12:35pm revealed: -She did not administer Voltaren to Resident #10 during the 8:00am medication pass because she "forgot". -She did not have a reason she signed off the Voltaren as administered when she did not administer the medication. Interview with Resident #10 on 08/02/19 at 1:15pm revealed: -She was not administered Voltaren on 08/01/19. -She had not been administered Voltaren in " ...a while". -Voltaren should have been discontinued because she had not had knee pain in two months. -She would refuse the Voltaren when the MA would ask if she needed the medication. Interview with the Executive Director (ED) on 08/01/19 at 4:05pm revealed she expected medications to be administered per the eMAR. Telephone interview with Resident #10's Primary Care Provider (PCP) on 08/05/19 at 1:00pm revealed: -Resident #10 was prescribed Voltaren for osteoarthritis and knee pain. -She last saw Resident #10 on 07/22/19 and the resident did not have knee pain. -She expected the Voltaren to be administered to Resident #10 as ordered unless the resident refused. d. Review of Resident #10's current FL-2 dated 02/18/19 revealed there was an order for Metamucil 0.52g four times daily with meals and	D 358		

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D 358	Continued From page 94 at bedtime. (Metamucil is a bulk forming fiber used to treat constipation.) Review of Resident #10's subsequent orders dated 06/24/19 revealed there was an order for Metamucil 0.4g with meals and at bedtime. Review of Resident #10's August 2019 electronic administration record (eMAR) revealed there was an entry for Metamucil 0.4g with meals and at bedtime at 7:00am, 12:00pm, 5:00pm, and 9:00pm. Observation of the 8:00am medication pass on 08/01/19 at 7:30am revealed: -Resident #10 was in the medication room. -The MA popped Resident #10's oral medications from a pre-packaged dispensing packet which included the Metamucil into a medication cup. -The MA gave Resident #10 the medication cup containing the Metamucil. -The resident took the pill cup and poured the medications in her mouth. -The resident swallowed the medications with water at 7:37am. Interview with Resident #10 on 08/01/19 at 7:38am revealed the resident had not yet eaten breakfast. Observation of Resident #10 on 08/01/19 at 8:02am revealed she took her first bite of grits. Interview with the MA on 08/01/19 at 12:35pm revealed: -She saw on Resident #10's eMAR to administer the Metamucil with meals. -There was not a reason she did not administer Resident #10 the Metamucil with breakfast. -It was important to follow orders in the eMAR	D 358		

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D 358	Continued From page 95 because it was what the PCP had ordered. Interview with the Executive Director on 08/01/19 at 4:05pm revealed: -She expected medications to be administered per the eMAR. -If the order was to administer medications with food, she expected to the medication to have been administered with food. Telephone interview with Resident #10's Primary Care Provider (PCP) on 08/05/19 at 1:00pm revealed: -Metamucil was prescribed to Resident #10 for constipation. -She was not concerned that Resident #10 did not have the Metamucil administered with meals if she was drinking plenty of fluids to prevent constipation. -If Resident #10 did not drink plenty of fluids she would be constipated while on the Metamucil. -The order for Metamucil was written by another provider before she assumed Resident #10's care and she did not realize it was ordered to administer with meals. Interview with Resident #10 on 08/05/19 at 1:15pm revealed: -She normally was administered Metamucil with her meals. -She had not been constipated. e. Review of Resident #10's subsequent orders dated 06/24/19 revealed there was an order for Jardiance 10mg daily with breakfast. (Jardiance is a medication used to help lower blood sugar.) Review of Resident #10's August 2019 electronic medication administration record (eMAR) revealed:	D 358		

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D 358	Continued From page 96 -There was an entry for Jardiance 10mg daily with breakfast at 8:00am. -There was documentation Jardiance was administered at 8:00am on 08/01/19. -There was documentation the residents blood sugar was 213 at 8:00am on 08/01/19. Observation of the 8:00am medication pass on 08/01/19 at 7:30am revealed: -Resident #10 was in the medication room. -The MA popped Resident #10's oral medications from a pre-packaged dispensing packet which included the Jardiance into a medication cup. -The MA gave Resident #10 the medication cup containing the Jardiance. -The resident took the pill cup and poured the medications in her mouth. -The resident swallowed the medications with water at 7:37am. Interview with Resident #10 on 08/01/19 at 7:38am revealed the resident had not yet eaten breakfast. Observation of Resident #10 on 08/01/19 at 8:02am revealed she took her first bite of grits. Interview with the MA on 08/01/19 at 12:35pm revealed: -She did not see on Resident #10's eMAR the order to administer Jardiance with breakfast. -If she had seen the order on Resident #10's eMAR to administer Jardiance with breakfast she would have waited until the resident was served breakfast to administer the Jardiance. Interview with Resident #10 on 08/05/19 at 1:15pm revealed she was normally administered Jardiance with breakfast.	D 358		

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D 358	Continued From page 97 Interview with the Administrator on 08/01/19 at 4:05pm revealed: -She expected medications to be administered per the eMAR. -If the order was to administer medications with food, she expected to the medication to have been administered with food. Telephone interview with Resident #10's Primary Care Provider (PCP) on 08/05/19 at 1:00pm revealed: -Jardiance was a diabetic medication prescribed for Resident #10. -She was not concerned Jardiance was not administered to Resident #10 with breakfast because it could be administered with or without food. -There was no reason for Jardiance to be administered with food to Resident #10. -Resident 10's blood sugar was controlled. She was uncertain of the range. -The order for Jardiance was written by another provider before she assumed Resident #10's care and she did not realize it was ordered to administer with meals. f. Review of Resident #9's current FL-2 dated 07/30/19 revealed: -Diagnoses included diabetes mellitus, hypertension, dementia, stage 3 chronic kidney disease, and acute cholecystitis. -There was an order for Levemir 22 units subcutaneously with dinner. (Levemir is a long acting insulin used to lower blood sugar). Review of Resident #9's August 2019 electronic medication administration records' (eMAR's) revealed: -There was an electronic entry for Levemir FlexTouch inject 22 units subcutaneously with	D 358		

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D 358	Continued From page 98 dinner at 5:00pm. -There was documentation Levemir was administered at 5:00pm on 08/01/19. -The residents blood sugar was checked three times daily before meals and was from 124 - 443. Observation of the 5:00pm medication pass on 08/01/19 at 4:45pm revealed: -The MA walked into the hallway and escorted Resident #9 to a chair located beside the medication cart in the dining room. -The MA removed the Levemir FlexTouch pen from the medication cart. -The MA attached a needle to the Levemir FlexTouch pen. -The MA dialed the dosage to 22 units. -The MA administered the Levemir to the Resident at 5:01pm. -The MA did not perform a 2-unit air shot after applying the needle to the pen. Interview with the MA on 08/01/19 at 5:20pm revealed: -She did not know what an air shot was. -She had received training and had been shadowed using insulin pens. -She was checked off on insulin pen and insulin injections by the Licensed Health Professional Support (LHPS) nurse on 07/29/19. -She could have been trained to perform air shots with insulin pens. She could not remember. -She did not know if she had performed air shots with insulin pens during her insulin pen training, observations, and check offs. -She always followed the orders on the MARs. Interview with the MA on 08/01/19 at 5:25pm revealed the MA remembered she had performed air shots during observations and skills check offs by the LHPS nurse.	D 358		

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D 358	Continued From page 99 Interview with the LHPS nurse on 08/05/19 at 9:20am revealed: -The MA's had received insulin and diabetic training. -The MA's received a series of diabetic training online before allowed to work on the medication carts. -There was no specific insulin administration class required. -There were in-services throughout the year that were specific to general diabetes. -She could not remember in-services specific to insulin administration that had been offered. -Insulin pens were covered in detail through online training. -After completing online training, the new MA would shadow with an experienced MA for 3 - 4 shifts. -She would perform skills check offs on the new MA after the MA shadowed on the medication cart. -She would always observe insulin pen injections when performing MA skills check offs. -After completing the skills check offs the new MA would work on the medication cart and be shadowed by an experienced MA for 1 -2 shifts before working independently. -The reason for a 2-unit air shot was to prime the pen so the resident would be administered the full dose of insulin. -She expected insulin pens to be primed with a 2-unit air shot before dialing up the residents ordered insulin dose and administering the dose. g. Review of Resident #9's current FL-2 dated 07/30/19 submitted by the director of resident care (DRC) on 08/02/19 revealed: -Diagnoses included diabetes mellitus, hypertension, dementia, stage 3 chronic kidney	D 358		

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D 358	Continued From page 100 disease, and acute cholecystitis. -There was no order for Novolog. Review of Resident #9's physicians order sheet dated 06/03/19 revealed: -There was an order for FSBS checks every morning. -There was an order for Novolog SSC (sliding scale coverage) special instructions: three times daily before meals for blood sugar less than 250 = 0 units, 251-300 units = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 401 = 8 units and call physician. Review of Resident #9's August 2019 electronic medication administration record (eMAR) revealed: -There was an electronic entry dated 07/26/19 for Novolog 6 units subcutaneously three times a day before meals when blood sugar was greater than 260 at 7:00am, 12:00pm, and 5:00pm. -The effective date was 07/26/19. -There was documentation Novolog was administered to Resident #9 at 12:00 pm and 5:00pm on 08/01/19. -The resident's blood sugar was checked three times on 08/01/19 and was from 124 - 443. Observation of the 5:00pm medication pass on 08/01/19 at 4:45pm revealed: -The MA walked into the hallway and escorted Resident #9 to a chair located beside the medication cart in the dining room. -The MA removed the Novolog Flex pen from the medication cart. -The MA attached a needle to the Novolog Flex pen. -The MA dialed the dosage to 6 units. -The MA administered the Novolog to the Resident at 5:04pm.	D 358		

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D 358	Continued From page 101 Interview with the Director of Resident Care (DRC) on 08/01/19 at 8:10pm revealed: -There was not a current order for Novolog for Resident #9. -Resident #9 returned to the facility from inpatient care on 07/23/19. -There was an order for Novolog dated 07/26/19 which was a clarification order. -The current FL-2 dated 07/30/19 was completed and sent to Resident #9's Primary Care Provider (PCP) for signature. -No one had contacted Resident #9's PCP for an order for Novolog until this evening because no one knew there was not a current order for Novolog on the current 07/30/19 FL-2. Interview with the Memory Care Manager (MCM) on 08/06/19 at 8:58 am revealed: -Resident #9's FL-2 dated 07/26/19 was from an inpatient facility. -The FL-2 dated 07/26/19 had the wrong level of care marked and the MA completed a new FL-2 for Resident #9's PCP to sign with the correct level of care and medications transcribed from the 07/26/19 FL-2. -The MA would have reviewed the FL-2 after it was returned signed by Resident #9's PCP. -Normally she reviewed the FL-2's to ensure all the medications were listed, compared to the resident's previous orders. -If all the medications were not included on the new FL-2 she would have requested a clarification order for any medication not listed on the FL-2 the resident was previously taking prior to the new FL-2 within 24 hours. -She did not review Resident #9's current 07/30/19 FL-2 because she was not working during that time frame.	D 358		

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D 358	Continued From page 102 Telephone interview with Resident #9's PCP on 08/06/19 at 1:16pm revealed: -The resident had returned to the facility from inpatient rehabilitation sometime prior to 07/24/19, because she saw the resident on 07/24/19. -The resident was previously on Novolog. -Resident #9's previous FL-2 dated 07/26/19 was from an inpatient facility. -Resident #9's previous FL-2 dated 07/26/19 did not have the correct level of care documented so the facility sent the current FL-2 dated 07/30/19 for her to sign. -She thought Resident #9 had a current order for Novolog. -She was not concerned about the resident being administered Novolog 6 units for blood sugar greater than 260 without a current order because the resident needed the insulin. -She would have given an order for the Novolog if the facility had of requested. Review of a previous order for Resident #9 dated 07/25/19 submitted by the MCM on 08/06/19 revealed it was a clarification order for Novolog 6 units when blood sugar was greater than 260. Review of Resident #9's previous FL-2 dated 07/26/19 submitted by the MCM on 08/06/19 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, dementia, and chronic kidney disease stage 3. -There was documentation "see med sheet". -There was not an order for Novolog. Review of Resident #9's inpatient facility medication sheet dated 07/22/19 submitted by the MCM on 08/06/29 revealed there was not an order for Novolog.	D 358		

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D 358	Continued From page 103 h. Review of Resident #9's previous FL-2 dated 05/16/18 revealed: -Diagnoses included diabetes, hypertension, hyperlipidemia, dementia, and history of cerebrovascular attack. -There was an order for Novolog sliding scale coverage (SSC) for finger stick blood sugars 201-250 = 2 units, 251-300= 4 units, 301-350=6 units, 351-400=8 units, less than 60 and greater than 400 call the residents Primary Care Provider (PCP). (Novolog insulin is rapid-acting insulin used to lower blood sugar. The manufacturer recommends eating a meal within 5 to 10 minutes after the injection. The Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.) Review of Resident #9's physicians order sheet dated 06/03/19 revealed: -There was an order for blood sugar checks every morning. -There was an order for Novolog SSC special instructions: three times daily before meals for blood sugar less than 250 = 0 units, 251-300 units = 4 units, 301-350 = 6 units, 351-400 = 8 units, greater than 401 = 8 units and call physician. Review of Resident #9's August 2019 electronic medication administration record (eMAR) revealed: -There was an electronic entry dated 07/26/19 for Novolog 6 units subcutaneously three times a day before meals when blood sugar was greater than 260 at 7:00am, 12:00pm, and 5:00pm. -There was documentation Novolog was administered to Resident #9 at 12:00 pm and 5:00pm on 08/01/19.	D 358		

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D 358	Continued From page 104 -The resident's blood sugar was checked three times on 08/01/19 and ranged from 124 - 443. Observation of the 5:00pm medication pass on 08/01/19 at 4:45pm revealed: -The MA walked into the hallway and escorted Resident #9 to a chair located beside the medication cart in the dining room. -The MA removed the Novolog Flexpen from the medication cart. -The MA attached a needle to the Novolog Flex pen. -The MA dialed the dosage to 6 units. -The MA administered the Novolog to the Resident at 5:04pm. -The MA did not perform a 2-unit air shot after applying the needle to the pen. Interview with the MA on 08/01/19 at 5:20pm revealed: -She did not know what an air shot was. -She had received training and had been shadowed using insulin pens. -She was checked off on insulin pen and insulin injections by the Licensed Health Professional Support (LHPS) nurse on 07/29/19. -She could have been trained to perform air shots with insulin pens. She could not remember. -She did not know if she had performed air shots with insulin pens during her insulin pen training, observations, and check offs. Interview with the MA on 08/01/19 at 5:25pm revealed the MA remembered she had performed air shots during observations and skills check offs by the LHPS nurse. Interview with the LHPS nurse on 08/05/19 at 9:20am revealed: -The MAs had received insulin and diabetic	D 358		

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D 358	Continued From page 105 training. -The MAs received a series of diabetic training online before allowed to work on the medication carts. -There was no specific insulin administration class required. -There were in-services throughout the year that were specific to general diabetes. -She could not remember in-services specific to insulin administration that had been offered. -Insulin pens were covered in detail through online training. -After completing online training, the new MA would shadow with an experienced MA for 3 - 4 shifts. -She would perform skills check offs on the new MA after the MA shadowed on the medication cart. -She would always observe insulin pen injections when performing MA skills check offs. -After completing the skills check offs the new MA would work on the medication cart and be shadowed by an experienced MA for 1 -2 shifts before working independently. -The reason for a 2-unit air shot was to prime the pen so the resident would be administered the full dose of insulin. -She expected insulin pens to be primed with a 2-unit air shot before dialing up the residents ordered insulin dose and administering the dose. Review of Resident #9's current FL-2 dated 07/30/19 submitted by the director of resident care (DRC) on 08/02/19 revealed: -Diagnoses included diabetes mellitus, hypertension, dementia, stage 3 chronic kidney disease, and acute cholecystitis. -There was no order for Novolog. Review of a previous order for Resident #9 dated	D 358		

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D 358	Continued From page 106 07/25/19 submitted by the MCM on 08/06/19 revealed it was a clarification order for Novolog 6 units when blood sugar was greater than 260. Review of Resident #9's previous FL-2 dated 07/26/19 submitted by the memory care manager on 08/06/19 revealed: -Diagnoses included diabetes mellitus type 2, hypertension, dementia, and chronic kidney disease stage 3. -It was from an inpatient facility. -There were 20 medications listed. -There was not an order for Novolog. -There was documentation "see med sheet". Review of Resident #9's inpatient facility medication sheet dated 07/22/19 submitted by the MCM on 08/06/29 revealed there was not an order for Novolog. Attempted telephone interview with Resident #9's family member on 08/05/19 at 1:02pm was unsuccessful. I. Review of Resident #9's current FL-2 dated 07/30/19 revealed: -Diagnoses included diabetes mellitus, hypertension, dementia, stage 3 chronic kidney disease, and acute cholecystitis. -There was an order for Coreg 25 milligrams (mg) twice daily with meals. Review of Resident #9's August 2019 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Coreg 25mg twice daily with meals at 7:00am and 5:00pm -There was documentation Coreg was administered at 7:00am and 5:00pm on 08/01/19,	D 358		

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D 358	Continued From page 107 Observation of the 5:00pm medication pass on 08/01/19 at 4:45pm revealed: -The MA walked into the hall way and escorted Resident #9 to a chair located beside the medication cart in the dining room. -The MA placed Resident #9's Coreg 25mg into a pill cup and gave to the Resident. -Resident #9 swallowed the Coreg with water at 5:06pm Observation of Resident #9 on 08/01/19 at 5:30pm revealed she took her first bite of food, macaroni and cheese. Interview with the MA on 08/01/19 at 5:20pm revealed: -Resident #9 had not eaten yet because the meals were late being served. -She always followed the orders on the MARs -Normally Resident #9's meals were on the table when she was given her medications. Interview with the Administrator on 08/01/19 at 4:05pm revealed: -She expected medications to be administered per the eMAR. -If the order was to administer medications with food, she expected the medication to have been administered with food. Interview with Resident #9's Primary Care Provider on 08/06/19 at 1:16pm revealed: -She did not have concerns regarding Resident #9 being administered Coreg without a meal. -There was no reason why Coreg would need to be administered with food. -The Coreg order was written to administer with meals from the inpatient facility center. -She would have never ordered Coreg to be administered with meals.	D 358		

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D 358	Continued From page 108 Review of the Physician's Desk Reference instructions advise Coreg is to be taken with food. "Administer with food to reduce the rate of absorption. This minimizes the risk of orthostatic hypotension (a condition resulting in a drop in blood pressure upon standing which increases risk for falls)." Attempted telephone interview with Resident #9's family member on 08/05/19 at 1:02pm was unsuccessful. 2. Review of Resident #3's current, hospital generated FL-2 dated 02/13/19 revealed diagnoses included chronic kidney disease, congestive heart failure (CHF), coronary artery disease (CAD), bipolar disorder, and hypoglycemia. a. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for finger stick blood sugars (FSBS) three times a day and Novolog sliding scale insulin (SSI) three times daily with meals according to the following scale: for FSBS result of 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 350 = 10 units; 350 - 400 =12 units; greater than 400 = 14 units. (Novolog is rapid-acting insulin that starts to work about 15 minutes after injection to lower blood sugar). Interview with a medication aide (MA) on 08/02/19 at 11:00am revealed: -SSI was given before meals. -Insulin would not be given when a resident was eating. -For breakfast, SSI was given between 7:30am and 7:40am and breakfast was served at 7:30am	D 358		

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D 358	Continued From page 109 in assisted living (AL). -For lunch, SSI was given between 11:00am and 12:30pm and lunch was served on AL at 12:30pm. -Resident #3's FSBS was checked before meals and her SSI was given before meals. Review of Resident #3's July 2019 electronic medication administration records (eMARs) revealed there was an entry to inject Novolog SSI subcutaneously three times daily with meals according to the following scale: for FSBS result of 141 - 180, give units; 181 - 220, give 4 units; 221 - 260, give 6 units; 261 - 300, give 8 units; 301 - 350 = 10, give units; 350 - 400, give12 units; if blood sugar is greater than 400, give 14 units. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -She was a diabetic and took insulin. -The MAs took her FSBS three or four times a day. -She went to the clinic and the MA checked her FSBS then administered her SSI before meals. Observation on 08/05/19 from 12:03pm - 12:05pm revealed: -Resident #3 was in the clinic sitting on the seat of her rollator walker. -The MA told Resident #3 her FSBS was 213. -The MA drew up 4 units of Novolog insulin from a vial into a syringe using aseptic technique. -The MA administered 4 units of Novolog to Resident #3 in her left upper extremity using aseptic technique at 12:05pm. -Resident #3 walked out of the clinic using her rollator. Interview with the MA who administered Resident	D 358		

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D 358	Continued From page 110 #3's SSI on 08/05/19 at 12:07pm revealed Resident #3 always received her SSI before meals. Interview with a second MA on 08/05/19 at 12:07pm revealed: -Resident #3's SSI was always given before meals. -The MAs had one hour before and one hour after the schdueld time to administer medications, including SSI. Observations on 08/05/19 from 12:10pm - 12:43pm revealed: -Resident #3 was seated in the dining room waiting on her lunch meal. -At 12:40pm, the dietary aide served Resident #3 a glass of tea. -At 12:43pm, Resident #3 was served her meal. -The resident began to eat immediately after being served her plate. Telephone interview with Resident #3's current PCP on 08/05/19 at 12:23pm revealed: -She had been Resident #3's PCP since June 2019. -She expected Resident #3's SSI to be administered within one hour before or within one hour after her meal even though it was ordered with meals. -She was not concerned that Resident #3 was administered her SSI prior to meals. -She did not know the facility's medication administration policy in relation to medications ordered with meals, but expected medication administration times to be per the facility policy. Interview with the Corporate Registered Nurse (Corporate RN) on 08/02/19 at 9:28am revealed: -The facility did not have a specific insulin policy.	D 358		

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D 358	Continued From page 111 -The facility followed physician orders and the North Carolina State Rules and Regulations for Medication Administration for Adult Care Homes. Interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm revealed if Resident #3's SSI was ordered to be given with meals, it was expected be administered when the resident was eating her meal and not before the meal. Attempted telephone interview with Resident #3's previous primary care provider (PCP) on 08/05/19 at 9:23am was unsuccessful. b. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for Novolog sliding scale insulin (SSI) three times daily with meals according to the following scale: for FSBS result of 141 - 180 = 2 units; 181 - 220 = 4 units; 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 350 = 10 units; 350 - 400 =12 units; greater than 400 = 14 units. (Novolog is rapid-acting insulin that starts to work about 15 minutes after injection to lower blood sugar). Review of Resident #3's July 2019 electronic administration record (eMAR) revealed: -There was an entry to inject Novolog SSI subcutaneously (SQ) three times daily with meals according to the following scale: for FSBS result of 141 - 180, give units; 181 - 220, give 4 units; 221 - 260, give 6 units; 261 - 300, give 8 units; 301 - 350 = 10, give units; 350 - 400, give 12 units; if blood sugar is greater than 400, give 14 units with administration times scheduled at 7:30am, 12:30pm, and 5:30pm. -There were start and end dates documented on the first Novolog SSI entry: the start date was documented as 03/04/19 and the end date was	D 358		

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D 358	Continued From page 112 documented as 07/29/19. There was documentation 07/29/19 was the discontinued date. -There was a second entry to inject Novolog SSI SQ three times daily with meals according to the following scale: for FSBS result of 141 - 180, give units; 181 - 220, give 4 units; 221 - 260, give 6 units; 261 - 300, give 8 units; 301 - 350 = 10, give units; 350 - 400, give12 units; if blood sugar is greater than 400, give 14 units with administration times scheduled at 7:30am, 12:00pm, and 5:00pm. -There was a start date beside the second Novolog SSI entry which read "07/31/19." There was no discontinue date documented on the second Novolog SSI entry. -On the first Novolog SSI entry, there was documentation Novolog SSI was administered three times daily at 7:30am, 12:30pm, and 5:30pm from 07/01/19-07/29/19 with the following exceptions when documented as not administered: 07/04/19 at 12:30pm -07/05/19 at 12:30pm due the resident being on therapeutic leave; 07/13/19 at 7:30am due to resident refused; 07/19/19 at 5:30pm resident out with family; 07/20/19 at 7:30am due to resident refused; and 07/20/19 at 12:30pm due to resident out of facility. -On the second Novolog SSI entry, there was documentation Novolog SSI was administered at 7:30am, 12:00pm, and 5:00pm on 07/31/19. -There was no documentation Novolog SSI was administered on 07/30/19 on either of the two Novolog SSI entries. -On 07/30/19, there were X marks on each of the three times the Novolog SSI was due for both Novolog SSI entries which indicated the SSI was not due for administration. -Resident #3's FSBS results ranged from 119 -571 from 07/01/19-07/29/19 and 07/31/19.	D 358		

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D 358	Continued From page 113 -There were no FSBS results documented on 07/30/19. -On 07/29/19 at 5:30pm, Resident #3's FSBS result was documented as 571 with documentation of 14 units of Novolog SSI having been administered at 5:30pm. -There was an entry to check FSBS each night at bedtime to be completed at 8:00pm; Resident #3's FSBS results was documented as 318 on 07/29/19 at 8:00pm. Interview with the Executive Director (ED) on 08/01/19 at 10:02 am revealed: -An X mark on the eMAR meant the medication was not due to be administered. -Parentheses around a staffs' initials on the eMAR meant the medication was not given. -A blank on the eMAR also meant the medication was not given. Interview with a medication aide (MA) on 08/06/19 at 2:30pm revealed an X mark on the eMAR meant the medication was not due to be administered. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -She "never" refused her insulins. -She saw her primary care provider (PCP) "about a week ago" and the PCP changed her diabetes medications because her FSBS had been running high (results 300 to 400). -The PCP ordered a pill for her diabetes and changed one of her insulins from 10 units to 20 units. -She did not know if her SSI was changed by the PCP. -She always got her SSI unless her FSBS was ok and she was not supposed to get it. -She did not get her SSI "few days last week"	D 358		

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D 358	Continued From page 114 (she could not recall what dates). Confidential staff interview revealed: -The staff member had never known Resident #3 to refuse her insulin. -Resident #3's FSBS ran high. Telephone interview with a pharmacist at Resident #3's provider pharmacy on 08/05/19 at 10:48am revealed: -Resident #3's most current order on file at the pharmacy for SSI was dated 02/15/19. -The SSI order dated 02/15/19 was for Novolog insulin three times daily with meals according to the following scale: for FSBS result of 141 - 180, give units; 181 - 220, give 4 units; 221 - 260, give 6 units; 261 - 300, give 8 units; 301 - 350 = 10, give units; 350 - 400, give 12 units; if blood sugar is greater than 400, give 14 units. -Novolog insulin was last dispensed from the pharmacy for Resident #3 on 07/29/19 at 11:00pm and would have arrived at the facility in the early morning hours of 07/30/19. -The Novolog SSI order had not changed. -He could not say why the Novolog SSI was not documented as administered on 07/30/19; Resident #3 had a valid order and the Novolog was last dispensed on 07/29/19. Interview with the Executive Director (ED) and Divisional Director of Clinical Services on 08/05/19 at 5:46pm revealed: -Resident #3 was not administered SSI on 07/30/19 as ordered. -There should not have been any missed doses of the SSI on 07/30/19. -They were not aware Resident #3 missed the SSI on 07/30/19 prior to that time (08/05/19 at 5:46pm). -They could not explain why Resident #3's SSI	D 358		

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D 358	Continued From page 115 did not show due and did not answer when asked why the SSI was not administered as ordered. Telephone interview with a Registered Nurse (RN) at Resident #3's endocrinologist's office on 08/06/19 at 11:35am revealed: -Resident #3 was expected to receive her insulins as ordered. -Failure to receive SSI as ordered could cause kidney damage and diabetic ketoacidosis. (Diabetic ketoacidosis can develop when FSBS is high and the body produces high levels of blood acids called ketones). A second telephone interview with Resident #3's PCP on 08/06/19 at 11:45am revealed: -There had been no change to Resident #3's SSI orders. -She did not know Resident #3's SSI was not administered on 07/30/19. -"That should not happen." -Resident #3's SSI should have been administered as ordered on 07/30/19. Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. c. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for Lantus flexpen give 8 units subcutaneously (SQ) every night. (Lantus is a long acting insulin used to lower blood sugar).	D 358		

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D 358	Continued From page 116 Review of a medication order for Resident #3 dated 06/29/19 revealed an order to change Lantus flexpen to 10 units SQ every night. Review of a subsequent medication order for Resident #3 dated 07/29/19 revealed an order to increase Lantus flexpen to 20 units SQ every night at bedtime. Review of Resident #3's July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Lantus flexpen inject 10 units subcutaneously (SQ) at bedtime with administration time scheduled at 8:00pm. There were start and ends dates documented as 06/26/19-07/30/19. 07/30/19 was documented as the discontinued date. -On 07/30/19, there was documentation Lantus 10 units was not administered with documentation which read: "Not administered: other; Comment: new order awaiting to be approved." -There was an entry for Lantus inject 20 units SQ at bedtime with administration time scheduled at 8:00pm. There were start and ends dates documented as 07/29/19-07/30/19. 07/30/19 was documented as the discontinue date. -There was a second entry for Lantus flexpen inject 20 units at bedtime with administration time scheduled at 8:00pm. The start date was documented as 07/30/19. There was no discontinued date documented on the second entry. -There was a third entry for Lantus flexpen inject 20 units SQ daily with administration time scheduled at 1:00am. There were start and end dates documented as 07/29/19-07/30/19. 07/30/19 was documented as the discontinue	D 358		

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D 358	Continued From page 117 date on the third Lantus entry. -There was no documentation Lantus 20 units was administered on 07/30/19 on either of the three Latus 20 unit entries. -There was an entry to check finger stick blood sugar (FSBS) at bedtime with administration time of 8:00pm. -On 07/30/19, Resident #3's FSBS result was documented as 318 at 8:00pm Interview with the medication aide (MA) on duty on 07/30/19 on 08/06/19 at 2:30pm revealed: -Her initials were present on Resident #3's July 2019 eMAR on 07/30/19 documenting 10 units of Lantus was not administered due to a new order awaiting approval. -Parentheses around a staffs' initials on the eMAR meant the medication was not given. -An X mark on the eMAR meant the medication was not due to be given. -She did not know what a blank box meant on specific dates on the eMAR. -She "felt sure" she gave Resident #3 20 units of Lantus on 07/30/19. -She could not explain why there was not any documentation the Lantus 20 units was administered. -Resident #3 had not complained of high blood sugar on 07/30/19. Telephone interview with an Information Technology (IT) representative of the facility's electronic health record (EHR)/eMAR provider on 08/02/19 at 9:45am revealed a blank space on the eMAR indicated a missed administration. Interview with the Executive Director (ED) on 08/01/19 at 10:02 am revealed: -An X mark on the eMAR meant the medication was not due to be administered.	D 358		

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D 358	Continued From page 118 -Parentheses around a staffs' initials on the eMAR meant the medication was not given. -A blank on the eMAR meant the medication was not given. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -She "never" refused her insulins. -She saw her primary care provider (PCP) "about a week ago" and the PCP changed her Lantus from 10 units to 20 units a day because her FSBS had been running high. -She did not know if the MAs knew her Lantus changed to 20 units a day, "but they should know." -She did not know if she had missed any doses of Lantus. -She felt different and could tell when her blood sugar was low but could not tell when it was high. Telephone interview with a pharmacist at Resident #3's provider pharmacy on 08/05/19 at 10:48am revealed: -The pharmacy received an electronic prescription order change on 07/29/19 at 1:00pm to change Lantus to 20 units at bedtime. -The pharmacy keyed the Lantus 20 units order into Resident #3's medication profile on 07/29/19, then it went to the eMAR server. -The facility would have been responsible for approving the Lantus 20 units order for it to show on the eMAR. -The facility would have had to discontinue the order for Lantus 10 units daily from the eMAR for it to discontinue off the eMAR. -The Lantus 20 units would not have shown as due to be administered on the resident's eMAR if the facility did not approve the order after it was profiled. -Lantus insulin was last dispensed from the	D 358		

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D 358	Continued From page 119 pharmacy for Resident #3 on 07/29/19 at 11:00pm and would have arrived at the facility in the early morning hours of 07/30/19. -He could not say why the Lantus was not documented as administered on 07/30/19; Resident #3 had a valid order for Lantus and it had been dispensed on 07/29/19. Telephone interview with Resident #3's primary care provider (PCP) on 08/05/19 at 12:23pm revealed: -Resident #3's blood sugars were "running high." -The facility was reporting the resident's blood sugars to her and she was adjusting her medications. -She last saw Resident #3 on 07/29/19 and increased her Lantus order from 10 units to 20 units each night. -She expected the dose change to be documented and started "timely." Timely depended on when the medication was received from the pharmacy in case there was a delay in receipt. -She expected the facility to follow their policy, as long as the order was implemented within a week. Interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm revealed: -Resident #3 was not administered Lantus 20 units on 7/30/19 at 8:00pm as ordered. -Per the documentation on the eMAR, it looked like the Lantus was showing an administration time of 1:00am and they "assumed" when the MA saw the 1:00am administration time, she did not administer the medication. -The MA should have seen the Lantus 20 unit order was not approved and had not been given and called "somebody" to get it approved. -Lantus 20 units should have been given on	D 358		

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D 358	Continued From page 120 07/30/19. -They acknowledged it was a problem that Resident #3 did not get the Lantus and the resident's last documented FSBS result was elevated. -They were not aware Resident #3 was not administered Lantus as ordered on 07/30/19 until that time (08/05/19 at 5:46pm). -Part of the reason the Lantus was not administered as ordered on 07/30/19 was the facility was not using their established "bucket system" for new medication orders. -There had been a system in place for new orders, but it was not the correct system. -Staff had now been trained on the correct "bucket system." Telephone interview with a Registered Nurse (RN) at Resident #3's endocrinologist's office on 08/06/19 at 11:35am revealed: -Resident #3 was a diabetic and had history chronic kidney disease. (Chronic kidney disease is a condition when the kidneys cannot filter the blood as they should). -Resident #3 was expected to receive her insulins as ordered, without delay. -Resident #3 should have received the Lantus as ordered. -Failure to receive Lantus and SSI as ordered could cause kidney damage and diabetic ketoacidosis. (Diabetic ketoacidosis can develop when FSBS is high and the body produces high levels of blood acids called ketones). A second telephone interview with Resident #3's PCP on 08/06/19 at 11:45am revealed: -The resident's Lantus order changed so she could see a "glitch" with it not being given on 07/30/19. -Failure to receive the SSI and Lantus as ordered	D 358		

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D 358	Continued From page 121 could cause high blood sugar and diabetic ketoacidosis. -Since Resident #3's FSBS ran high anyway, diabetic ketoacidosis "may not be a big deal" for the resident. -The facility had not notified her that Resident #3 had missed the Lantus and SSI on 07/30/19. Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. d. Review of a copy of an electronic prescription for Resident #3 dated 06/10/19 revealed a medication order for Diflucan 150mg one dose. (Diflucan is an antifungal used to treat fungal and yeast infections). There was handwritten documentation which read "done 6/13/19" on the electronic prescription. Review of Resident #3's June 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Fluconazole 150mg one time a time for one day. (Fluconazole is generic Diflucan). -There was documentation Fluconazole 150mg was administered on 06/15/19 as a one-time dose. Telephone interview with a representative of Resident #3's provider pharmacy on 08/02/19 at 7:00am revealed:	D 358		

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D 358	Continued From page 122 -The pharmacy received the order for Fluconazole 150mg by fax from the facility on 06/10/19 at 8:43pm. -The pharmacy dispensed Fluconazole 150mg to the facility on 06/11/19 and it was delivered to the facility on 06/11/19. Interview with the Director of Resident Care (DRC) and a Supervisor on 08/02/19 at 8:12am revealed: -Medication orders were to be faxed to the pharmacy upon receipt by a medication aide (MA), Supervisor (S), or Director of Resident Care (DRC); whoever was on duty. -There was no expectation of a start date or time for a medication if the prescriber did not write urgent on the order. -Medications came in from the pharmacy every night. -When the medications came in, a MA on duty signed for them, checked off what was in the bag to make sure it matched the receipt slip, and put the medication on the medication cart. -If the medication order was urgent or it was for an antibiotic or pain medication, the facility used their back up pharmacy as needed and started those medications as soon as possible (ASAP). -The pharmacy may take "a day or two" to profile a medication and the then facility management staff had to approve the order for the medication to show due for administration. -Resident #3 had not had any delays in any of her medications. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -She had some burning when urinating so her primary care provider (PCP) gave her a medication for it. -The medication helped.	D 358		

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D 358	Continued From page 123 -She did not know the dates of she felt the burning and itching or when got the medication for treatment. -As far as she knew, she had not had any delays in getting her medications. Telephone interview with Resident #3's PCP on 08/05/19 at 12:23pm revealed: -She expected a new medication order to be documented and started "timely." -Timely depended on when the medication was received from the pharmacy in case there was a delay in receipt. -She expected the facility to follow their policy, as long as the order was implemented within a week. Interview with the Executive Director (ED) and the Divisional Director of Clinical Services on 08/05/19 at 5:46pm revealed they were not aware of the delay form 06/11/19-06/15/19 in Resident #3 being administered Fluconazole. Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. e. Review of Resident #3's medication orders dated 05/06/19 revealed an order for Lexapro 10mg daily for depression/anxiety. Give ½ tablet daily for 8 days then increase to whole tablet. (Lexapro in an antidepressant used to treat the symptoms of depression and anxiety). There was	D 358		

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D 358	Continued From page 124 handwritten documentation on the medication order which read "done 5/14/19." Review of Resident #3's May 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Escitalopram 10mg Take 1/2 tablet (5mg) every day for 8 days with administration time scheduled at 9:00am. (Escitalopram is generic Lexapro). There were start and end dates documented by the entry which read 05/09/19-05/14/19. - There was a second entry for Escitalopram 10mg Take 0.5 tablet (5mg) every day for 8 days with administration time scheduled at 9:00am. There were start and end dates documented by the entry which read 05/15/19-05/22/19. -The first dose of Escitalopram 10mg ½ tablet (5mg) was documented as having been administered on 05/15/19. -There was documentation 8 doses of Escitalopram 10mg ½ tablet (5mg) was administered from 05/15/19-05/22/19. Interview with Resident #3 on 08/05/19 at 10:20am revealed: -As far as she knew, she had not had any delays in getting her medications. -When she felt "down" she talked to her mental health provider. Telephone interview with a representative of Resident #3's provider pharmacy on 08/02/19 at 7:00am revealed: -The pharmacy received the order dated 05/06/19 for Escitalopram 10mg take ½ tablet (5mg) daily for eight days then increase to whole tablet by fax from the facility on 05/06/19 at 5:13pm. -The pharmacy dispensed Escitalopram 10mg to the facility for Resident #3 on 05/07/19 and it was	D 358		

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D 358	Continued From page 125 delivered to the facility on 05/07/19. Interview with the Director of Resident Care (DRC) and a Supervisor on 08/02/19 at 8:12am revealed: -There was no expectation of a start date or time for a medication if the prescriber did not write urgent on the order. -The pharmacy may take "a day or two" to profile a medication and the then facility management staff had to approve the order for the medication to show due for administration. -Resident #3 had not had any delays in any of her medications. Attempted telephone interview with Resident #3's previous primary care provider (PCP) on 08/05/19 at 9:23am was unsuccessful. Interview with the Executive Director (ED) and the Divisional Director of Clinical Services on 08/05/19 at 5:46pm revealed they were not aware of the delay form 05/06/19- 05/15/19 in Resident #3 being administered Escitalopram 10mg ½ tablet (5mg). Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm.	D 358		

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D 358	Continued From page 126 3. Review of Resident #4's FL-2 dated 01/17/19 revealed diagnoses included major depressive disorder, unspecified personality disorder, chronic pain with disk disease, and hypotension. Review of the Primary Care Physicians (PCP) "After Visit Summary" for Resident #4 dated 05/01/19 revealed: -Resident #4 was seen at the PCP office for abscess of the right axilla on 05/01/19. -Resident #4 was started on an antibiotic for 10 days and referred to be seen by a surgeon that same day (05/01/19). Review of a physician's order for Resident #4 dated 05/01/19 revealed an order for Doxycycline Hyclate (an antibiotic used to treat bacterial infections) 100mg one tablet two times daily for ten days. Review of the surgeons "After Visit Summary" for Resident #4 dated 05/01/19 revealed: -Resident #4 was seen for an abscess of the right axilla. -Resident #4 was prescribed Doxycycline Hyclate 100mg to be taken two times daily for ten days. -Resident #4 was to return to the surgeon's office in 48 hours after taking the antibiotic to assess the need for incision and drainage. Interview with Resident #4 on 07/31/19 at 3:17pm revealed: -She had been prescribed an antibiotic two different times for the abscess under her arm. -She had been having a hard time getting the abscess to resolve. -It did not seem like she took the antibiotics for very long, so she was unsure if she was administered the antibiotic as prescribed.	D 358		

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D 358	Continued From page 127 Review of the surgeon's "After Visit Summary" for Resident #4 dated 05/03/19 revealed Resident #4 was instructed to take the full course of antibiotics, which were "not seen on medication sheet as being started". Review of a fax sent to the facility by the Primary Care Physician (PCP) dated 05/06/19 revealed: -The PCP notified the facility that the resident (Resident #4) had a right axilla abscess that had a positive culture for methicillin resistant Staphylococcus aureus (MRSA). -The PCP reiterated the importance of the resident (Resident #4) completing all the prescribed Doxycycline Hyclate. Review of Resident #4's Medication Administration Record for May 2019 revealed: -There was an entry for Doxycycline Hyclate 100mg with administration times scheduled at 8:00am and 8:00pm. -There was documentation was administered on 05/06/19, 05/07/19, 05/08/19, 05/09/19, 05/10/19, and 05/11/19 at 8:00am and 8:00pm. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00pm on 05/01/19. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 05/02/19. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 05/03/19. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 05/04/29. -There was documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 05/05/29.	D 358		

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D 358	Continued From page 128 -Resident #4 was not administered eight of twenty prescribed doses of Doxycycline Hyclate. Review of a second Physicians Order for Resident #4 dated 07/12/19 revealed an order for Doxycycline Hyclate (used to treat bacterial infections) 100mg one tablet two times daily for seven days. Review of the PCP's "After Visit Summary" for Resident #4 dated 07/17/19 revealed: -Resident #4 had drainage from the same abscess and symptoms of fever and chills. -The PCP was concerned the abscess was MRSA and started the resident (Resident #4) on Doxycycline Hyclate 100mg one tablet two times daily for seven days beginning on 07/12/19. -The PCP noted to continue the Doxycycline Hyclate for a period of 10 days and recommended using bactericidal soap. -The PCP was concerned the area had not improved after being prescribed 10 days of antibiotic therapy in May 2019. -Resident #4 was referred to the surgeon that day (07/17/18) to have the abscess lanced and drained. Review of Resident #4's July 2019 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Doxycycline Hyclate 100mg with administration times scheduled at 8:00am and 8:00pm. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00pm on 07/12/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Doxcycline Hyclate 100mg was administered at 8:00am and 8:00pm on 07/13/19 and there was nothing documented	D 358		

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D 358	Continued From page 129 in the "Exceptions" section. -There was no documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 07/14/19 and there was nothing documented in the "Exceptions" section. -There was documentation Doxycycline Hyclate 100mg was administered at 8:00am and 8:00pm on 07/15/19, 07/16/19, 07/17/19, and 07/18/19. -Resident #4 was not administered six of fourteen doses of the seven days of prescribed Doxycycline Hyclate. -There was no documentation of follow-up with the PCP regarding his note to continue the Doxycycline Hyclate for ten days. Telephone interview with a registered nurse (RN) of Resident #4's Primary Care Provider's Office on 08/06/19 at 10:35am revealed: -Resident #4 was prescribed Doxycycline Hyclate by the PCP as soon as the resident called the PCP's office and described the symptoms of the abscess under her arm. -The PCP was concerned the abscess was still positive for MRSA. -The pharmacy representative read the PCP's note to extend the Doxycycline Hyclate for ten days, but she was unsure if the facility was sent a new order. -If Resident #4 did not get all her prescribed antibiotic in May 2019, when the MRSA was first treated, it decreased the chances of the abscess healing. -If the resident did not get all of her prescribed antibiotic in July 2019, it decreased the chances of the abscess healing. Telephone interview with a representative of Resident #4's contracted pharmacy on 08/06/19 at 1:50pm revealed: -On 05/02/19, the pharmacy received an order for	D 358		

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D 358	Continued From page 130 Resident #4 for Doxycycline Hyclate 100mg to be administered two times daily for ten days and the order was delivered to the facility on 05/04/19. -On 07/12/19 the pharmacy received an order for the Resident #4 for Doxycycline Hyclate 100mg to be administered two times daily for seven days and the order was delivered to the facility on the same day (07/12/19). Interview with the Director of Resident Care (DRC) on 08/02/19 at 12:00pm revealed she had no idea why the resident was not given her Doxycycline Hyclate as prescribed in the month of May and July 2019. A second interview with the DRC on 08/02/19 at 12:15pm revealed: -To her knowledge, Resident #4 had never tested positive for MRSA in the abscessed area under her arm. -If she (Resident #4) had a prior positive MRSA culture in the abscess under her arm, she (DRC) would have considered it to be very important for her to get her antibiotic as prescribed. Confidential staff interview revealed: -Resident #4 may not have received her medication as prescribed if it was entered onto the eMAR incorrectly. -She could not say for sure why Resident #4 did not get her Doxycycline Hyclate as ordered in the months of May 2019 and July 2019. Interview with the medication aide/supervisor (MA/S) on 08/05/19 at 10:30am revealed she did not know why the Resident #4 did not receive her antibiotic as prescribed in May 2019 and July 2019. Interview with the Executive Director (ED) on	D 358		

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D 358	Continued From page 131 08/06/19 at 11:25am revealed: -She was unable to look at Resident #4's eMARs and explain why the resident's Doxycycline Hyclate was not administered as ordered in the months of May 2019 and July 2019. -Considering the positive culture for MRSA, she would have considered it to be very important that the resident get her antibiotics as prescribed. Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the Executive Director and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the ED and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. 4. Review of Resident #15's FL-2 dated 01/17/19 revealed diagnoses included anxiety, type 2 diabetes, acquired hypothyroidism, essential hypertension, and history of transient ischemic attacks. Review of a physician's order for Resident #15 dated 07/25/19 revealed: -An order for Penicillin (an antibiotic used to treat bacterial infections) 500mg one tablet given four times daily for five days. -The order was time stamped for 2:43pm. Review of an electronic progress note for Resident #15 dated 07/25/19 revealed Resident #15 had an order for Penicillin 500mg one tablet to be given four times daily for five days. Review of Resident #15's July 2019 electronic Medication Administration Records (eMARs) revealed:	D 358		

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D 358	Continued From page 132 -There was no documentation Penicillin 500mg was administered at 5:00pm and 9:00pm on 07/25/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Penicillin 500mg was administered at 9:00am, 1:00pm, 5:00pm, and 9:00pm on 07/26/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Penicillin 500mg was administered at 9:00am, 1:00pm, 5:00pm and 9:00pm on 07/27/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Penicillin 500mg was administered at 9:00am, 1:00pm, 5:00pm and 9:00pm on 07/28/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Penicillin 500mg was administered at 9:00am, 1:00pm, 5:00pm and 9:00pm on 07/29/19 and there was nothing documented in the "Exceptions" section. -There was no documentation Penicillin 500mg was administered at 9:00am, 1:00pm, 5:00pm on 07/30/19 and there was nothing documented in the "Exceptions" section. -There was documentation Resident #15 received the first dose of Penicillin at 9:00pm on 07/30/19. Interview with Resident #15 on 08/01/19 at 6:47am revealed: -Resident #15 saw a dental provider on 07/25/19 and received the diagnosis of a tooth abscess. -It was the recommendation of the dental provider that she begin taking an antibiotic that day (07/25/19). -Since her dental appointment on 07/25/19, she had asked several staff members why she was not being given her antibiotic and they told her it was "not here yet". -Resident #15 was to begin the prescribed antibiotic on the evening of 07/25/19, to take four	D 358		

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D 358	Continued From page 133 times daily for five days, and then to return to the office to have the tooth extracted "today" (08/01/19). -Resident #15 did not receive her prescribed antibiotic from the staff until the day before yesterday. (7/30/19). -Resident #15 asked the Business Office Manager (BOM) to call the dental provider on her behalf to inquire if the tooth could still be extracted as scheduled, since she did not receive her Penicillin until several days after the order was given. -The dental provider said they could not extract the tooth until the infection was properly treated. -The dental provider rescheduled the tooth extraction until 08/08/19 due to Resident #15 not being given the penicillin as ordered for five days prior to the scheduled extraction. Interview with the Director of Resident Care on 08/01/19 at 9:00am revealed: -She remembered Resident #15 had been having issues with her tooth "for a while". -She did not know why Resident #15 was not administered her Penicillin until several days after the order was given. -She "had no way to know" when the order was sent to the pharmacy. -She was not aware Resident #15 was supposed to take her Penicillin for five days before her abscessed tooth could be extracted. Interview with a medication aide (MA) on 08/01/19 at 12:22pm revealed: -She was sure she faxed Resident #15's order for Penicillin to the Pharmacy on 07/25/19, the date the order was prescribed. -Anytime she faxed something to the pharmacy, she stapled the order to the fax cover sheet and the fax confirmation.	D 358		

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D 358	Continued From page 134 -She located a fax cover sheet dated 07/25/19 with the order for Penicillin attached, but she could not locate a fax confirmation page. Interview with a medication aide/supervisor (MA/S) on 08/01/19 at 12:23pm revealed: -She did not have the eMAR in front of her but Resident #15 "probably started taking her Penicillin last week right after she saw the dentist". -She did not know anything about the resident not receiving her antibiotic for several days after it was ordered. -The staff always stapled their fax confirmation to any orders sent to the pharmacy. -She could not locate a fax confirmation showing the date the Penicillin order was sent into the pharmacy. Telephone interview with Resident #15's Dentist on 08/01/19 at 4:33pm revealed: -Resident #15 was seen for dental care on 07/25/19 and had a significant tooth abscess. -She prescribed Resident #15 an antibiotic that day (07/25/19) to be completed for at least five days prior to the tooth extraction. -The appointment scheduled for "today", 08/01/19, to extract the tooth, had to be rescheduled until next week due to the resident not getting her prescribed antibiotic in time to treat the infection. -Resident #15 "was sure to have ongoing pain and swelling if she did not begin the prescribed antibiotic last week". -The "biggest alleviation of the resident's pain would be taking the antibiotic to clear up the infection and then getting the tooth pulled". Interview with Resident #15 on 08/02/19 at 10:05am revealed:	D 358		

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D 358	Continued From page 135 -She was in a great deal of pain from her tooth abscess. -She did not feel like getting out of bed. -She had missed several meals due to the pain from tooth abscess. -She had received her Penicillin as ordered since she started getting it on the evening of 07/30/19 but she wished she had been given the antibiotic when it was ordered so the tooth could have been pulled out "yesterday" (08/01/19). Confidential staff interview revealed the staff person did not know why the Resident #15 had not received her Penicillin as order but she remembered hearing the resident asking a staff person why she was not getting it. Interview with the Executive Director (ED) on 08/06/19 at 11:25am revealed: -She did not know why Resident #15 did not receive the prescribed antibiotic when it was prescribed unless it did not arrive from the pharmacy until later. -It would have been her expectation that the resident (Resident #5) would have taken her antibiotic as prescribed so that her tooth extraction did not have to be rescheduled. Telephone interview with a representative from Resident #15's contracted pharmacy on 08/06/19 at 1:50pm revealed: -On 07/29/19 the pharmacy received a fax request from the facility to fill Penicillin 500mg for Resident #15. -There was a cover sheet with the request that was dated for 07/25/19 but it was not sent to the pharmacy until 07/29/19. -The medication was filled on the evening of 07/29/19.	D 358		

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D 358	Continued From page 136 Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the Executive Director and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. 5. Review of Resident #1's current FL-2 dated 07/08/19 revealed a diagnosis of dementia with behaviors (vascular). Review of medication orders listed on the FL-2 dated 07/08/19 and a provider prescription revealed there was an order for Levothyroxine (used to treat hypothyroidism) 112.5 mcg (micrograms) daily. Review of a physician's order dated 07/16/19 revealed an order for Levothyroxine 50mcg tablet every day. Review of Resident #1's July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Levothyroxine 50mcg every day and special instructions to "start on 06/10/2019" with documentation of administration everyday beginning 07/12/19. -There was documentation for the Levothyroxine 50mcg on 07/09/19 and 07/10/19 of "not administered refused". -There was documentation for the Levothyroxine 50mcg on 07/11/19 of "not administered" and comment of "third shift". -There was no documentation for the levothyroxine 112.5mcg being administered daily	D 358		

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D 358	Continued From page 137 from 07/08/19 through 07/16/19 as ordered. Interview with a medication aide on 07/31/19 at 3:25pm revealed she administered medications according to the medications that "popped up" on the eMAR for a specific time. Interview with the Memory Care Manager (MCM) on 08/05/19 at 12:10pm revealed: -She did not know why Resident #1 had not been administered the Levothyroxine 112.5mcg every day as ordered from 07/08/19 through 07/16/19. -She doubted if there was documentation for administration for the Levothyroxine 112.5mcg daily. -When a resident returned to the facility with new orders, the MAs, MCM, or RCD were responsible for faxing the new FL-2 and orders to the provider pharmacy, contacting the physician to verify the orders, and ensuring new orders were implemented. -The MAs were responsible to verify medications ordered were received in the facility by reviewing the packaging slip from the pharmacy provider. -She relied on the MAs to let management know if a medication was not received or was not entered on the eMAR. -Resident #1's physician discontinued all prior orders on 07/15/19 and wrote new orders for the levothyroxine on 07/16/19. -Resident #1 should have been administered Levothyroxine 112.5mcg as ordered. -The facility should go by the orders on the FL-2 until the physician gave further orders for a medication. Interview with Resident #1's physician on 08/05/19 at 12:35pm revealed: -If the resident had been hospitalized and returned to the facility with a new FL-2, she	D 358		

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D 358	Continued From page 138 expected the facility to follow the orders on the new FL-2 or clarify the orders if there was a question. -She might have seen the 07/08/19 FL-2 at the facility when there was a re-visit assessment for Resident #1. -She sent an order to the facility on 07/16/19 for Levothyroxine 50mcg every day. -She did not remember if she knew Resident #1 had been prescribed Levothyroxine 112.5mcg daily from a recent inpatient hospitalization but knew Resident #1 had been hospitalized due to refusing medications and uncontrolled behaviors. -Resident #1's thyroid stimulating hormone (TSH) laboratory value was 0.01 in March 2019 (the recommended range for TSH laboratory value is 2-10 and values vary between labs) when the resident was prescribed levothyroxine 125mcgs, and was 0.07 on 05/31/19, which meant the resident was still getting too much levothyroxine. That was why she decreased the Levothyroxine to 50mcg. -She suspected the behavioral center prescribed the Levothyroxine 112.5mcg daily from old hospital records. -There would not be any harm to Resident #1 due to her not being administered the Levothyroxine 112.5mcg for the time period of 07/08/19 through 07/16/19 and it took at least three weeks to reach a steady level after a dose change for Levothyroxine. Interview with the Executive Director (ED) on 08/06/19 at 11:45am revealed: -She was not aware Resident #1 had not been administered the Levothyroxine 112.5mcg as ordered. -She expected resident medications to be administered as ordered by the physician.	D 358		

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D 358	Continued From page 139 Refer to the interview with the Medication Aide on 08/02/19 at 10:48am. Refer to the interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm. Refer to the interview with the Executive Director (ED) and Director of Resident Care (DRC) on 08/06/19 at 4:45pm. Interview with a medication aide (MA) on 08/02/19 at 10:48pm revealed: -When orders were received, they were placed in a book called the "bucket book" so the staff knew to fax the order to the pharmacy. -All MA staff were responsible for faxing orders to the pharmacy and for monitoring for receipt of the medication fills. -The medication aides/supervisor (MA/S) usually checked the bucket book regularly to make sure orders were faxed. -Once an order was faxed, the order was then placed into the "faxed to pharmacy" folder. -Proper procedure was to staple the fax cover sheet, the order, and the fax confirmation sheet together. -If a medication did not arrive within a couple of days, the order was supposed to be moved to the "medication not in building" folder where it was all the MA's responsibility to follow-up on getting the medication. -Once a medication was filled, the order was moved to the "cleared box". -Only a few Supervisors had the ability to "clear" the medication in the electronic medication administration system so the medication would be visible on the eMAR. -If the medication was not "cleared", the MAs would not know to give the medication.	D 358		

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D 358	Continued From page 140 Interview with the ED and Divisional Director of Clinical Services on 08/05/19 at 5:46pm revealed: -Medication orders were expected to be implemented "right away" which meant within 24 hours of receipt of order to allow for the medication to come in from the pharmacy. -Prior to the survey, the facility was not using their established "bucket system" for new medication orders. -There had been a system in place for new orders, but it was not the current bucket system. -Staff had now been trained on the correct "bucket system." Interview with the ED and DRC on 08/06/19 at 4:45pm revealed: -Prior to the survey, the facility had a different "bucket system" for orders that was used "sporadically." -The ED and DRC thought the previous bucket system was working but the facility "obviously missed" orders prior to the survey. -Since the start of the survey, the bucket system had been updated and now color coded; the system had not been color coded prior to the survey. -The facility's new bucket system started with a new order. -The bucket system was as follows: the green folder was for a new order; the blue folder was for orders faxed to the pharmacy; the red folder was for orders or medications not coming back in the allotted time frame of 24 hours. The folder would be monitored daily; the orange folder was used for waiting on a response; the yellow folder meant the order was completed and ready to be filed in the chart. -The medication aides (MAs) were responsible for moving orders through the folders of the	D 358		

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D 358	Continued From page 141 updated bucket system every day. -The MAs would be the "first line" in checking orders as they moved through the bucket system; the DRC and Memory Care Manager (MCM) would be the "second line" in checking the orders in the bucket system; and the ED would "oversee" the bucket system. -The DRC and MCM would be "physically" checking orders every day. -The MAs, Supervisors, DRC, and MCM would also check the electronic medication administration records (eMARs) daily. -Medication was expected to be given as ordered and on time. -If there were problems, the ED expected the problem to be fixed. -It negatively impacted the residents when they did not get their medications as ordered. The facility failed to assure a safe and effective system was established and maintained for medication administration and failed to assure medications were administered as ordered placing the residents at increased risk for medication errors and resulted missed doses of rapid and long acting insulins and antibiotics. Resident #15 had a delay in starting an antibiotic ordered for infection which resulted in the resident being unable to have a dental procedure as scheduled due to the resident not receiving the antibiotics as ordered prior to the procedure and the resident having swelling and ongoing pain. Resident #4 had a delay and missed doses of an antibiotic ordered on two occasions to treat an axillary abscess for a bacterial infection of methicillin resistant Staphylococcus aureus (MRSA) resulting in delayed healing of the abscess and the resident later required surgery to lance the abscess. Resident #3 missed doses of both long and short acting insulins when on	D 358		

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D 358	Continued From page 142 07/30/19 due to failure to have a system in place for new orders. The residents blood sugar was 358 on 07/30/19 at 8:00pm, placing the resident at risk for diabetic ketoacidosis and kidney damage. The medication pass observations revealed a 35% error rate with 10 errors out of 29 opportunities including multiple errors with insulin (Resident #9 and Resident #10) which placed the residents at risk of high and low blood sugar; and antiarrhythmic (#9) being given without food, as ordered which placed the resident at risk for a slow heart rate and low blood pressure. The facility's failure resulted in the residents not receiving their medications ordered to maintain their physical and mental health and well-being and resulted in serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/01/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2019.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.	D 366		

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D 366	Continued From page 143 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure medications were documented directly after administration for 7 of 8 sampled residents (#1, #3 #4, #5, #6, #11, #15) and failed to maintain a safe system to assure medications were documented at the time of administration. The findings are: Observations on 08/01/19 at 10:00am revealed the Executive Director (ED) was reviewing the comments documented on a resident's electronic administration records (eMARs). Interview with the ED on 08/01/19 at 10:00am revealed: -She acknowledged there were numerous entries on the resident's eMAR of multiple medications documented as administered on time, charted late; many entries had additional typed comments also documented. -She did not know why there would be so many medications documents as charted late on the eMARs. -She expected the medication aides (MAs) to document administration of medications at the time the medication was administered to the resident and not chart late. -If the MAs documented charted late on the eMAR, it meant the medication was administered at the scheduled time but charted on late. (This documentation indicated the medication was not	D 366	10A NCAC 13F .1004 (i) Medication Administration Medication administration training was provided by [redacted] Pharmacy on 8/20/19 to include order process, administration, documentation, insulin preparation, proper medication administration procedures and practices, availability/delivery of medications and pharmacy notification. 09/20/2019 The Memory Care Manager and Resident Care Director will monitor daily and bring the Medication Compliance report and facility activity report to morning stand up meeting to be reviewed & initialed by the Executive Director. 09/20/2019 Medication compliance reports are run daily by the care mgrs, reviewed to verify medications have been administered per physician order, documented and assure no duplicate orders are noted. Reports are submitted to the ED during daily dept head meetings for review. Reports are monitored weekly by the divisional director of clinical services or qualified designee. Ongoing process. 09/20/2019	

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D 366	Continued From page 144 charted at the time of administration). -Reasons for medications to be charted late could be due to different scenarios such as resident falls or the system being down. -Documentation on the eMARs that read administered late, charted late, "system issues" meant the system was "down" and the MAs were not able to chart administration of medication right then. -The MAs were told to take the medication cart to each residents' room when administering medications and to document at the time of administration. (In the past, the residents came to the clinic for their medication); -She acknowledged she had concerns for medication errors when medications were not documented at the time of administration. Interview with the Corporate Registered Nurse (RN) on 08/01/19 at 5:25pm revealed: -The facility did not have a written medication administration policy. -The facility's policy for medication administration was to follow the rules and statutes related to medication administration. 1. Review of Resident #11's current FL-2 dated 02/18/19 revealed: -Diagnoses included diabetes myelitis type 2, glaucoma, positional vertigo, and hypothyroidism. -There was a medication order for Hydrochlorothiazide 12.5mg twice daily. (Hydrochlorothiazide is a medication used to treat high blood pressure and fluid retention.) Observation of the 4:00pm medication pass on 07/31/19 at 3:21pm revealed: -The medication aide (MA) punched Resident #11's Hydrochlorothiazide into a medication cup while in the medication room.	D 366	Diabetic and insulin administration training provided by Registered Nurse on 8/27/19. Medication cart audits implemented on 8/9/19, carts are audited weekly by the medication aide and supervisors in coordination with the care managers. This process compares the medication administration record to the medication on hand, labels,checking documentation, parameters per physician orders, and expired medications. Audits are submitted to the ED for review weekly. Medication pass observations are being conducted weekly by registered nurse or qualified designee to include, but not limited to proper medication administration procedures infection control, security, documentation, six rights of medication administration. Any concerns will be discussed with the person being observed, provided with guidance an additional training as necessary. Observation will follow up with the Care Mgrs and ED on the medication pass observations conducted weekly. Divisional Team will monitor medication administration compliance weekly through on-site visits and reviewing system outcomes with the ED. Senior Level Management to include SVP will conduct weekly status calls and site visits at least twice monthly to review previously mentioned systems, tools & processes and verify compliance. Monitoring of medication administration compliance will be conducted through internal systems, tools and processes as outlined in the plan of correction for 13F. 1004(i), Tag D366.	09/20/2019 09/20/2019 09/20/2019 ongoing 09/20/2019 ongoing 09/20/2019 ongoing ongoing

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D 366	Continued From page 145 -The MA carried the medication cup containing the Hydrochlorothiazide down the 200-hall looking for Resident #11. She did not take the medication cart with her. -The MA was unable to locate Resident #11 down the 200 hall. -The MA returned to the medication room with the Hydrochlorothiazide in the medication cup. -The MA opened the top drawer of the medication cart and proceeded to place the cup in the drawer. -The MA removed the medication cup containing Resident #11's Hydrochlorothiazide from the top drawer of the medication cart. -The MA walked to the main lobby of the facility. The medication cart remained in the medication room. -Resident #11 was sitting in a chair in the main lobby of the facility. -The MA gave the medication cup containing the Hydrochlorothiazide to Resident #11. -Resident #11 swallowed the Hydrochlorothiazide with water at 3:35pm. -The MA returned to the medication cart located in the medication room and began to prepare medications for another resident. -The MA did not document Resident #11's medications were administered. Review of Resident #11's 08/01/19 electronic medication administration record (eMAR) revealed: -There was an entry for Hydrochlorothiazide 12.5mg twice daily at 8:00am and 4:00pm. -There was no documentation the Hydrochlorothiazide was administered to Resident #11 at the 4:00pm medication pass on 08/01/19. Interview with the MA on 07/31/19 at 4:30pm	D 366		

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D 366	Continued From page 146 revealed she did document on Resident #11's eMAR the Hydrochlorothiazide was administered during the 4:00pm medication pass. Observation of the MA on 07/31/19 at 4:30pm revealed she reviewed the documentation on Resident #11's eMAR that showed administration section was blank for the Hydrochloride. A second interview with the MA on 07/31/19 at 4:30pm revealed: -She did not know why Resident #11's 08/01/19 eMAR did not show where she had documented the Hydrochlorothiazide was administered at the 4:00pm medication pass. -She must have documented Resident #11's Hydrochlorothiazide was administered on the 08/01/19 eMAR after the eMARs were printed. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. 2. Review of Resident #6's current FL-2 dated 12/24/18 revealed diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), fibromyalgia, lung mass, and rib pain. a. Review of Resident #6's current FL-2 dated 12/24/18 revealed there was an order for Oxycodone 15 milligram (mg) twice daily. (Oxycodone is a controlled substance used to treat moderate to severe pain.)	D 366		

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D 366	Continued From page 147 Review of Resident #6's physician's order sheet dated 03/25/19 revealed there was an order for Oxycodone 10mg twice daily. Review of an additional subsequent physician's order for Resident #6 dated 06/03/19 revealed an order for Oxycodone 10mg twice daily. Observation of the 8:00am medication pass on 08/01/19 at 7:15am revealed: -The medication aide (MA) punched one tablet from Resident #6's Oxycodone medication pack into a medication cup. -The MA clicked on "given" in Resident #6's eMAR before administering the Oxycodone to Resident #6. -The resident swallowed the Oxycodone, along with 11 other medications at 7:28am. Interview with the MA on 08/01/19 at 7:26am revealed she was trained to click "given" on all controlled substances prior to administration so the controlled substance count would be correct. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of a physician's order dated 06/04/19 for Resident #6 revealed an order for Xanax 0.5mg twice daily. (Xanax is a controlled substance used to relieve anxiety and panic disorder.) Observation of the 8:00am medication pass on	D 366		

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D 366	Continued From page 148 08/01/19 revealed: -The medication aide (MA) punched one tablet from Resident #6's Xanax medication pack into a medication cup. -The MA clicked on "given" in Resident #6's eMAR before administering the Xanax to Resident #6. -The resident swallowed the Xanax along with 11 other medications at 7:28am. Interview with the MA on 08/01/19 at 7:26am revealed she was trained to click "given" on all controlled substances prior to administration so the controlled substance count would be correct. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. 3. Review of Resident #15's current FL-2 dated 01/17/19 revealed diagnoses included pheochromocytoma of right adrenal gland, anxiety, type 2 diabetes, acquired hypothyroidism, essential hypertension, and history of transient ischemic attacks. a. Review of a physician's order for Resident #15 dated 03/01/19 revealed an order for Lantus 100 insulin (a long acting insulin used to lower blood sugar) 13 units subcutaneously (SQ) at bedtime. Review of Resident #15's June 2019 and July 2019 electronic medication administration record (eMARs) revealed: -There was an entry for Lantus 13 units to be	D 366		

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D 366	Continued From page 149 administered at 8:00pm -Lantus was documented as charted late on 10 of 31 opportunities in July 2019 -Lantus was documented as charted late on 8 of 31 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of a physician's order for Resident #15 dated 05/15/19 revealed an order for Topiramate (used to control seizures or mood disorders) 100mg one tablet twice daily. Review of Resident #15's June 2019 and July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Topiramate 100mg being administered daily at 8:00am and 8:00pm. -Topiramate was documented as charted late but administered on time for 10 of 30 opportunities in June 2019. -Topiramate was documented as charted late for 8 of 30 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm.	D 366		

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D 366	Continued From page 150 4. Review of Resident #4's current FL-2 dated 01/17/19 revealed diagnoses included major depressive disorder, unspecified personality disorder, chronic pain with disk disease, and hypotension. Review of a physician's order for Resident #4 dated 04/03/19 revealed a medication order for Fluoxetine (used to treat mood disorders) 20mg three capsules (60mg) every day. Review of Resident #4's May 2019 and July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Fluoxetine 20mg three capsules (60mg) scheduled at 8:00am daily. -Fluoxetine was documented as charted late on 3 of 31 opportunities in May 2019. -Fluoxetine was documented as charted late on 9 of 3 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of Resident #4's physician's orders revealed a medication order dated 04/15/19 for Pantoprazole 40mg once daily. Review of Resident #4's July 12019 electronic medication administration records (eMARs) revealed: -There was an entry for Pantoprazole 40mg daily. -Pantoprazole was documented as charted late 10 of 31 opportunities.	D 366		

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D 366	Continued From page 151 Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. c. Review of a physician's order for Resident #4 dated 07/12/19 revealed a medication order for Doxycycline Hyclate (used to treat bacterial infections) 100mg one tablet two times daily for seven days. Review of Resident #4's July 2019 electronic Medication Administration Records (eMARs) revealed: -There was an entry for Doxcycline Hyclate 100mg twice daily at 8:00am and 8:00pm. -There was documentation that a total of 8 doses of Doxycycline Hyclate were administered from 07/15/19 - 07/18/19. -Three of 8 doses administered were documented as charted late, but administered on time. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. 5. Review of Resident #3's current, hospital generated FL-2 dated 02/13/19 revealed diagnoses included chronic kidney disease,	D 366		

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D 366	Continued From page 152 congestive heart failure (CHF), coronary artery disease (CAD), bipolar disorder, and hypoglycemia. a. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for Lantus flexpen give 8 units subcutaneously (SQ) every night. (Lantus is a long acting insulin used to lower blood sugar). Review of a medication order for Resident #3 dated 06/29/19 revealed and order to change Lantus flexpen to 10 units SQ every night. Review of a subsequent medication order for Resident #3 dated 07/29/19 revealed an order to increase Lantus flexpen to 20 units SQ every night at bedtime. Review of Resident #3's June 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Lantus flexpen inject 10 units subcutaneously (SQ) at bedtime with administration time scheduled at 8:00pm. There were start and ends dates documented as 05/18/19-06/27/19. -There was a second entry for Lantus flexpen inject 20 units at bedtime with administration time scheduled at 8:00pm. The start date was documented as 06/26/19. -Lantus was documented as charted late on 11 of 30 opportunities in June 2019. Review of Resident #3's July 2019 eMARs revealed: -There was an entry for Lantus flexpen inject 10 units subcutaneously (SQ) at bedtime with administration time scheduled at 8:00pm. There were start and ends dates documented as	D 366		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 153 06/26/19-07/30/19. 07/30/19 was documented as the discontinued date. -There was an entry for Lantus flexpen inject 20 units at bedtime with administration time scheduled at 8:00pm. The start date was documented as 07/30/19. There was no discontinued date documented on the second entry. -There was a second entry for Lantus flexpen inject 20 units SQ daily with administration time scheduled at 1:00am. There were start and ends dates documented as 07/29/19-07/30/19. The discontinue date was documented as 07/30/19 on the third Lantus entry. -Lantus was documented a charted late on 12 of 30 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for Clopidogrel 75mg daily. (Clopidogrel is used to inhibit blood clotting). Review of Resident #3's June 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Clopidogrel 75mg every day at 9:00am. -Clopidogrel was documented as charted late on 5 of 30 opportunities in June 2019. Refer to the six confidential staff interviews.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 366	Continued From page 154 Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. 6. Review of Resident #5's current FL-2 dated 07/08/19 revealed diagnoses included hypertension, gastroesophageal reflux disease (GERD), vitamin D deficiency, arthritis, cerebrovascular accident, and microdiscectomy. a. Review of Resident #5's current FL-2 dated 07/08/19 revealed there was a medication order for Simvastatin 10mg 1 tablet by mouth at bedtime. (Simvastatin is used to treat high cholesterol.) Review of Resident #5's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Simvastatin 10mg daily at 8:00pm. -Simvastatin was documented as administered on time and charted late 7 out of 31 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of Resident #5's current FL-2 dated 07/08/19 revealed there was a medication order for Ranitidine 150mg 1 tablet by mouth at	D 366		

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D 366	Continued From page 155 bedtime. (Ranitidine is used to treat GERD) Review of Resident #5's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Ranitidine 150mg daily at 8:00pm. -Ranitidine was documented as given on time and charted late 7 out of 31 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. c. Review of Resident #5's current FL-2 dated 07/08/19 revealed there was a medication order for Buspirone 5mg 1 tablet by mouth four times a day. (Buspirone is used to treat anxiety.) Review of Resident #5's July 2019 electronic medication administration record (eMAR) revealed: -There was an entry Buspirone was to be administered daily at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Buspirone was documented as given on time and charted late 9 of 31 opportunities in July 2019. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am.	D 366		

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D 366	Continued From page 156 Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. 7. Review of Resident #1's current FL-2 dated 07/08/19 revealed a diagnosis of dementia with behaviors (vascular). Review of s previous FL-2 for Resident #1 dated 01/15/19 revealed additional diagnoses of dementia, bipolar disorder current manic state, Alzheimer's disease with behavioral disturbance, coronary artery disease, and hypothyroidism. a. Review of a physician orders for Resident #1 dated 01/15/19 revealed there was a physician's order for Depakote ER (used to treat seizure disorders and behaviors) 250mg every morning and every night. Review of subsequent physician orders for Resident #1 dated 02/20/19, 06/03/19, 07/08/19, and 07/15/19 revealed a medication order for Depakote ER 250mg two times a day. Review of Resident #1's May 2019 electronic medication administration records (eMARs) revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at 8:00am and 8:00pm. -Depakote was documented as "charted late" 6 of 62 times. Review of Resident #1's June 2019 eMARs revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at	D 366		

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D 366	Continued From page 157 8:00am and 8:00pm. -Depakote was documented as "charted late" 1 of 25 times. Review of Resident #1's July 2019 eMARs revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at 8:00am and 8:00pm. -Depakote was documented as "charted late" 2 of 44 times. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. b. Review of a physician orders for Resident #1 dated 01/15/19 revealed there was a physician's order for Depakote ER (used to treat seizure disorders and behaviors) 250mg every morning and every night. Review of subsequent physician orders for Resident #1 dated 02/20/19, 06/03/19, 07/08/19, and 07/15/19 revealed a medication order for Depakote ER 250mg two times a day. Review of Resident #1's May 2019 electronic medication administration records (eMARs) revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at 8:00am and 8:00pm.	D 366		

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D 366	Continued From page 158 -Depakote was documented as "charted late" 6 of 62 times. Review of Resident #1's June 2019 eMARs revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at 8:00am and 8:00pm. -Depakote was documented as "charted late" 1 of 25 times. Review of Resident #1's July 2019 eMARs revealed: -There was an entry printed for Depakote Sprinkles (divalproex) capsule, delayed release sprinkle 125mg two capsules twice a day at 8:00am and 8:00pm. -Depakote was documented as "charted late" 2 of 44 times. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. c. Review of a physician orders for Resident #1 dated 01/15/19 revealed there was a physician's order for Lithium Carbonate (used to treat behaviors) 150mg three times daily. Review of subsequent physician's orders for Resident #1 revealed: -There were physician orders dated 02/20/19, 06/03/19, 07/08/19, and 07/15/19 for Lithium Carbonate (used to treat behaviors) 150mg three	D 366		

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D 366	Continued From page 159 times daily. -There was a physician's order dated 04/19/19 to discontinue Lithium capsules and start Lithium liquid 8meq/5ml 2.5ml three times daily, and subsequent orders dated 06/03/19 and 07/15/19 continuing the Lithium liquid 8meq/5ml 2.5ml three times daily. Review of Resident #1's May 2019 eMARs revealed: -There was an entry printed for Lithium "100's" oral suspension take 2.5ml (4meq) three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Lithium suspension was documented as "charted late" 5 of 84 times. Review of Resident #1's June 2019 eMARs revealed: -There was an entry printed for Lithium "100's" oral suspension take 2.5ml (4meq) three times daily and scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Lithium was documented as "charted late" 1 of 28 times. Review of Resident #1's July 2019 eMARs revealed: -There was an entry printed for Lithium "100's" oral suspension take 2.5ml (4meq) three times daily and scheduled for administration at 8:00am, 12:00pm, and 8:00pm. -Lithium was documented as "charted late" 1 of 42 times. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am.	D 366		

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D 366	Continued From page 160 Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. d. Review of physician orders for Resident #1 dated 02/20/19, 06/03/19, 07/08/19, and 07/15/19 revealed there was a physician's order for Levothyroxine (used to treat hypothyroidism) 125mcg every morning. Review of subsequent physician orders for Resident #1 revealed: -There was a physician's order dated 03/29/19 to discontinue Levothyroxine 125mcg daily and start Levothyroxine 88mcg daily. -There was a subsequent order dated 06/10/19 to start Levothyroxine 50mcg every day. -There was a physician's order dated 07/08/19 for Levothyroxine 112.5mcg every day. -There was a subsequent order dated 07/16/19 for Levothyroxine 50mcg every day. Review of Resident #1's May 2019 eMARs revealed: -There was an entry for Levothyroxine 88mcg one tablet every morning with an end date of 06/04/19 and scheduled for administration at 6:00am. -Levothyroxine was documented as "charted late" or "administered late" 2 of 31 times. Review of Resident #1's June 2019 eMARs revealed: -There was an entry for Levothyroxine 88mcg one tablet every morning with a start date of 06/04/19 and an end date of 06/09/19 and scheduled for administration at 6:00am. -Levothyroxine was documented as "charted late" 1 of 5 times. Review of Resident #1's July 2019 eMARs	D 366		

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D 366	Continued From page 161 revealed there was no documentation of late charting for administration of the Levothyroxine. Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. e. Review of Resident #1's FL-2 dated -1/15/19 revealed there was a physician's orders for Exelon (used to treat dementia) 1.5mg twice daily. Review of physician orders for Resident #1 dated 02/20/19, 06/03/19, 07/08/19, and 07/15/19 revealed there was a physician's order for Exelon (used to treat dementia) 1.5mg twice daily. Review of a subsequent physician order for Resident #1 revealed there was a physician's order dated 06/03/19 to discontinue Exelon 1.5mg capsule twice daily. Review of Resident #1's May 2019 eMARs revealed: -There was an entry for Rivastigmine (generic for Exelon) 1.5mg capsule twice a day with a begin date of 04/03/19 and an end date of 06/05/19 scheduled for administration at 8:00am and 8:00pm. -Exelon was documented as "charted late" or "administered late" 7 of 58 times. Review of Resident #1's July 2019 eMARs revealed there was no documentation of late charting for administration of the Exelon.	D 366		

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D 366	Continued From page 162 Refer to the six confidential staff interviews. Refer to the interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am. Refer to the interview with the ED and DRC dated 08/06/19 at 4:45pm. Confidential staff interview revealed: -If "charted late" was documented on the eMAR, it meant the medication was given on time, but it was late being charted. -There would be different reasons to cause late charting. -The MA could get held up helping a resident. -There could be late starts due to the night shift (11:00pm-7:00am) being busy. -"Late start" could mean the MAs did not start on time, something happened while getting report, there was a delay due to counting medications, or the MA from the previous shift was still giving out medications. Confidential interview with a second staff member revealed: -If the medication was given on time but charted late then the resident's name in the eMAR system would have been blue when the medication was pulled. -If the medication was given on time but documented late there would have to be a reason given documented. -The internet going down and getting kicked out of the system could cause late charting. -Medications should not be given late or charted late. -Medications should be documented immediately after administration.	D 366		

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D 366	Continued From page 163 Confidential interview with a third staff member revealed: -Charted late was used when the medication was given on time but was documented late on the eMAR system. -Charted late was sometimes due to bad weather and the internet going out. Confidential interview with a fourth staff member revealed medications were supposed to be documented as soon as the resident was observed swallowing the medication. Confidential interview with a fifth staff member revealed: -The MAs had one hour before and one hour after the scheduled time to give a medication or they would have to click on an extra box and choose given late or charted late. -The process used was to prepare the medications by popping into a cup, then go to deliver the medication. -The next step was to administer "a few" residents' medications. -By the time the medications were actually documented, the eMAR showed late. This was why medications documented as charted late were "technically" administered on time. Confidential interview with a sixth staff member revealed: -The staff would administer "two or three" residents' medications then go back and document the medications were given. -The staff was taught by [two medication aide/supervisor's names] to click on the red box on the eMAR and choose charted late. -It took time to click the medications off after administration for each of the multiple residents	D 366		

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D 366	Continued From page 164 so that was why the staff charted given on time, charted late. The medication was not late. Interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care on 08/01/19 at 11:27am revealed: -Medications were expected to be documented at the time of administration. -Medications were expected to be documented as soon as the resident was administered the medication. -With the current system in place, there was no way to determine if a medication was administered late if the MA documented the medication was charted late but given on time. -When a medication was documented by a MA as charted late/administered on time, the only way to know if a medication was given at the scheduled administration time would be to have observed the medication being administered. -The MAs had been trained how to document correctly. Interview with the ED and DRC on 08/06/19 at 4:45pm revealed: -Medications were expected to be charted by the MAs at the time of administration. -The process the MAs were expected to follow was to give the medication the document the medication right after giving it; before going to another resident. The facility failed to assure medications including insulin and controlled substances were documented at the time of administration and failed to maintain an effective system to assure verification of medication being documented when administered. This facility's failure placed the residents at risk for medication errors, medications being administered late, and	D 366		

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D 366	Continued From page 165 administration of duplicate doses of medication all of which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided Plan of Protection in accordance with G.S. 131D-34 on 08/05/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2019	D 366		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

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D 367	Continued From page 166 This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure accuracy of the electronic medication administration records (eMARs) for 3 of 3 sampled residents (Residents #1, #3, #4) related to as needed orders without indication for administration and duplication of eMAR entries for finger stick blood sugars and an antiplatelet medication (#3); duplicate administration times for a medication ordered once daily for treatment of gastric reflux (Resident #4), and an incorrect dose transcribed to the eMAR for a medication used to treat hypothroidism (#1). The findings are: 1. Review of Resident #3's current, hospital generated FL-2 dated 02/13/19 revealed diagnoses included chronic kidney disease, congestive heart failure (CHF), coronary artery disease (CAD), bipolar disorder, and hypoglycemia. a. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for Clopidogrel 75mg daily. (Clopidogrel is used to inhibit blood clotting). Review of Resident #3's May 2019 electronic medication administration record (eMAR) revealed: -There was an entry for Clopidogrel 75mg daily	D 367	10A NCAC 13F .1004 (j) Medication Administration Medication administration training was provided 8/20/19 by the Pharmacy to include order process, administration, documentation, insulin preparation, availability/delivery of medications and pharmacy notifications. Medication order audits (white paper) were conducted by the pharmacy registered nurse on 8/19 & 8/22 in coordiantion with facility personnel to identify medications were scheduled as ordered, including entries for vital signs, blood glucose results, parameters, and checking for duplicate orders. Medication compliance reports are run daily to verify medications are administered per physician order, availability of medications, documentation, compliance with parameters. Compliance reports are obtained by the Care Mgrs, reviewed and submitted to the ED for review during daily dept head meetings. Training provided to the Care Managers on the order processing system on 8/8/19. The Care Managers are responsible for processing orders. Care Managers follow up daily on the order processing files to assure any pending items are addressed. ED monitors and reviews order processing files daily at dept heads meetings to assure compliance and utilization of the process. Medication cart audits implemented on 8/9/19, carts are audited weekly by the medication aide and supervisors in coordination with the care managers. This process compares the medication administration record to the medication on hand, labels,checking documentation, parameters per physician orders, and expired medications. Audits are submitted to the ED for review weekly.	09/20/2016 09/20/2019 09/20/2019 ongoing 09/20/2019 ongoing ongoing 09/20/2019

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D 367	Continued From page 167 with administration time scheduled at 8:00am. There were start and end dates documented as 03/04/19 and 05/17/19. -There was a second entry for Clopidogrel 75mg daily with administration time scheduled at 9:00am. There were start and end dates documented as 04/10/19 and 05/14/19. -There was a third entry for Clopidogrel 75mg daily with administration time scheduled at 9:00am. There was a start date documented as 05/14/19; there was no end date documented. -Clopidogrel 75mg was documented as administered on 05/16/19 and 05/17/19 on the first and third eMAR entries (duplicated dosing). Review of Resident #3's July 2019 eMAR revealed: -There was an entry for Clopidogrel 75mg every day at 9:00am. -There was documentation on 07/09/19 at 9:16am which read " ...I believe these are duplicate will confirm." -There was documentation on 07/10/19 at 9:10am which read "duplicates given at 8a.m." -There was documentation on 07/11/19 at 8:38am which read "ALL ARE DUPLIATES" [sic]. Interview with a medication aide (MA) on 07/31/19 at 3:20pm revealed: -Some medications populated on the eMAR at 8:00am and duplicated again at 9:00am. -The duplicate medications for the 9:00am dose would not be due at 9:00am. -She did not know why some medications would duplicate at the 9:00am dose. -She would document duplicate orders at 9:00am as administered even if not administered to close the duplicate order in the eMAR. -She would determine the correct administration time for the medications by pulling the pill pack	D 367	The Memory Care Manager and Director of Resident Care are responsible to assure completion of weekly audits, accuracy, no duplications and medication availability in coordination with the Medication Aides ED monitors compliance and reviews audits weekly. MCM & DRC will run medication admin compliance reports, to assure medication administration, documentation, parameters for compliance and present the Executive Director during daily dept head meetings. Training and education was provided to the medication aides and Care Managers to facilitate understanding and application of the "Down Time Process" , which is a process to assure to ensure consistent medication administration by syncing the documentation and system data when back on-line. Med Aides were retrained on electronic medication administration system, order processing/delivery, med administration process, six rights of med administration, disruption during medication pass, cart audits and accurate measuring of meds on 8/8/19 &8/20/19. by RN.	09/20/2019 09/20/2019 09/20/2019 09/20/2019

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D 367	Continued From page 168 and comparing the instructions on the pill pack to the orders in the eMAR. Interview with the Executive Director (ED) on 08/01/19 at 10:02am revealed the electronic health record/eMAR system had some "glitches" and there would sometimes be duplicate entries on the eMARs. Review of Resident #3's Pharmacist Drug Regimen Review dated 07/12/19 revealed: -There was no recommendation related to the duplicate doses of Clopidogrel 75mg documented as administered or the duplicated entries on the eMAR for Clopidogrel 75mg daily scheduled at both 8:00am and 9:00am. -There was documentation the resident's "chart" was reviewed; "no recommendations." Interview with the Corporate Registered Nurse (Corporate RN) and Director of Resident Care (DRC) on 08/01/19 at 11:27am revealed: -The facility had been using the current medication administration system since March 2019. -Every time there was a new prescription (whether it was a change or a renewal), there was a new prescription number and it would come up as a duplicate entry on the eMAR. -When told by a MA of any duplicate entries, the RDC tried to go into the eMAR and remove it, but sometimes they would pop back up on the eMAR because the pharmacy put them back in. -There was no way to determine if Resident #3 was administered duplicate doses of Clopidogrel without physically observing the medication passes. Refer to the interview with the Pharmacy Consultant from the facility's contracted	D 367	Medication order audits (white paper) was completed by a Registered Pharmacy Nurse on 8/19 & 8/22 in coordination with facility personnel to identify medications are scheduled as ordered, including entires for vital signs, blood sugar results, required actions to include monitoring for duplicate orders. MCM & DRC are responsible for the medication administration monitoring and oversight to assure compliance through reports, audits and observations. ED will review reports, audits and complete observations daily during dept head meetings. Monitoring of medication administration compliance will be conducted through internal systems, tools and processes as outlined in the plan of correction for 13F. 1004(j), Tag D367. Divisional Team will monitor medication administration compliance weekly through onsite visits and reviewing system outcomes with the ED. Senior Level Management to include SVP will conduct weekly status calls and site visits at least twice monthly to review previously mentioned systems, tools and processes and verify compliance.	09/20/201 09/20/2019 ongoing ongoing 09/20/2019 ongoing 09/20/2019 ongoing

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D 367	Continued From page 169 pharmacy provider on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. b. Review of Resident #3's physician renewal orders dated 03/07/19 revealed a medication order for finger stick blood sugar (FSBS) three times daily before meals scheduled daily at 7:00am, 12:00pm, and 5:00pm. Review of Resident #3's May 2019 through-July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for FSBS three times a day before meals scheduled at 7:00am, 12:00pm, and 5:00pm. -There was a second entry for FSBS three times a day before meals scheduled at 8:00am, 12:00pm, and 5:00pm. Review of Resident #3's Pharmacist Drug Regimen Review dated 07/12/19 revealed; -There was no recommendation to remove the second entry for FSBS three times daily scheduled at 8:00am, 12:00pm, and 5:00pm which did not match the order dated 03/07/19. -There was documentation the resident's "chart" was reviewed; "no recommendations." Interview with the Pharmacist from the contracted pharmacy provider on 08/05/19 at 10:10am revealed: -He had no recommended for Resident #3 on 07/12/19 when there should be one. -Resident #3 should not have 2 different FSBS orders. -He should have recommended to discontinue the 8:00am, 12:00pm, and 5:00pm FSBS.	D 367		

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D 367	Continued From page 170 Interview with the Executive Director (ED) on 08/05/19 at 2:45pm revealed she was not aware of any problems or concerns regarding Resident #3's FSBS orders. Refer to the interview with the Pharmacy Consultant from the facility's contracted pharmacy provider on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. c. Review of a medication order for Resident #3 dated 06/10/19 revealed: -There was an order for Tramadol 50mg take 0.5 tablet (25mg) every 6 hours as needed. (Tramadol is a controlled substance used to treat pain). -There was no indication on the order for the as needed administration of the Tramadol. Review of Resident #3's June 2019 and July 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Tramadol 50mg take 0.5 tab (25mg) every 6 hours as needed (prn). -There was no indication for the as needed administration of the Tramadol. -Sixteen doses of Tramadol were documented as administered in June 2019. -Twenty doses of Tramadol were documented as administered in July 2019. Review of Resident #3's Pharmacist Drug Regimen Review dated 07/12/19 revealed: -There was no recommendation to clarify the indication for as needed administration of Tramadol. -There was documentation the resident's "chart" was reviewed; "no recommendations."	D 367		

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D 367	Continued From page 171 Interview with the Pharmacist from the contracted pharmacy provider on 08/05/19 at 10:10am revealed: -According to his notes, he had no recommendations for Resident #3 on 07/12/19, when there should be one. -Normally, he would recommend, "need listed reasoning of given prn." Interview with the Executive Director (ED) on 08/05/2019 at 2:45pm revealed she was not aware of any problems or concerns regarding Resident #3 with no indication for the as needed administration of the Tramadol Refer to the interview with the Pharmacy Consultant from the facility's contracted pharmacy provider on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. d. Review of Resident #3's physician renewal orders dated 03/07/19 revealed: -There was a medication order for Acetaminophen 325mg take two tablets every 4 hours as needed. (Acetaminophen is an analgesic used to treat mild pain and reduce fever). -There was no indication on the order for the as needed administration of the Acetaminophen. Review of Resident #3's May 2019-August 2019 electronic medication administration records (eMARs) revealed: -There was an entry for Acetaminophen 325mg take two tablets ever for hours as needed. -There was no indication for the as needed administration.	D 367		

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D 367	Continued From page 172 -Acetaminophen was documented as administered on 06/10/19 at 12:00pm. -Acetaminophen was documented as administered on 07/31/19 at 7:34am. Review of Resident #3's Pharmacist Drug Regimen Review dated 07/11/19 revealed: -There was no recommendation to clarify the indication for as needed administration of Acetaminophen. -There was documentation the resident's "chart" was reviewed; "no recommendations." Interview with the Pharmacist from the contracted pharmacy provider on 08/05/19 at 10:10am revealed: -He had no recommendation for Resident #3 on 07/12/19 according to his notes when there should be one -Normally, he would recommend, "need listed reasoning of given prn." Interview with the Executive Director (ED) on 08/05/2019 at 2:45pm revealed she was not aware of any problems or concerns regarding no indication for the as needed administration of the Acetaminophen for Resident #3. Refer to the interview with the Pharmacy Consultant from the facility's contracted pharmacy provider at on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. 2. Review of Resident #4's current FL-2 dated 01/17/19 revealed diagnoses included major depressive disorder, unspecified personality disorder, chronic pain with disk disease, hypotension, and unspecified somatization	D 367		

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D 367	Continued From page 173 disorder. Review of Resident #4's physician's orders revealed a medication order dated 04/15/19 for Pantoprazole 40mg once daily (Pantoprazole is used to treat gastric reflux). Review of Resident #4's July 12019 electronic medication administration record (eMAR) revealed: -There was an entry for Pantoprazole 40mg daily with scheduled administration times documented as 6:00am and 7:00am on the same entry. -There was documentation Pantoprazole 40mg was administered at 7:00am from 07/01/19-07/30/19. -There was documentation Pantoprazole 40mg was administered at 6:00am on 07/31/19. Interview with the Executive Director (ED) on 08/01/19 at 10:02am revealed the electronic health record/eMAR system had some "glitches" and there would sometimes be duplicate entries on the eMARs. Review of Resident #4's Pharmacist Drug Regimen Review dated 07/12/19 revealed there was no recommendation regarding the duplicate administration time for Pantoprazole. Refer to the interview with the Pharmacy Consultant from the facility's contracted pharmacy provider on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. 3. Review of Resident #1's current FL-2 dated 07/08/19 revealed: -There was a diagnosis of dementia with	D 367		

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D 367	Continued From page 174 behaviors (vascular). -There was a medication order for levothyroxine (used to treat hypothyroidism) 112.5mcg daily. Review of a subsequent physician's order for Resident #1 dated 07/16/19 revealed a physician's order for levothyroxine 50mcg tablet every day. Review of the July 2019 electronic medication administration record (eMAR) for Resident #1 revealed: -There was an entry for levothyroxine tablet 50mcg take one tablet every day. -There was no entry for levothyroxine 112.5mcg daily. Review of the pharmacist Drug Regimen Review for Resident #1 dated 07/12/19 revealed: -There was no recommendation regarding the discrepancy in the entry on the eMARs for the levothyroxine 112.5mcg daily that was prescribed on the 07/08/19 current FL-2. -There was no recommendation regarding the discrepancy in the documentation for administration of the levothyroxine 50mcg daily instead of levothyroxine 112.5mcg daily that was prescribed on the current FL-2 dated 07/08/19. Review of a separate pharmacy consultation report for Resident #1 dated 07/12/19 revealed: -The pharmacy review was completed by a representative from the contracted pharmacy. -There was a printed comment documenting clarification of the following item of "currently there are two active orders for Divalproex in the computer" on the consultation report. -There were no recommendations printed on the consultation report.	D 367		

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D 367	Continued From page 175 Interview with Resident #1's physician on 08/05/19 at 12:35pm revealed Resident #1's thyroid stimulating hormone (TSH) laboratory value was 0.01 in March 2019 when the resident was prescribed levothyroxine 125mcg, and was 0.07 on 05/31/19, which meant the resident was still getting too much levothyroxine. That was why she decreased the levothyroxine to 50mcg. Refer to the interview with the Pharmacy Consultant from the facility's contracted pharmacy provider at on 08/05/19 at 10:10am. Refer to the interview with the Executive Director (ED) on 08/01/19 at 10:02am. Interview with the Pharmacy Consultant from the contracted pharmacy provider on 08/05/19 at 10:10am revealed: -His most recent pharmacy reviews were completed on 07/12/19. -The previous pharmacy review completed on 04/04/19 was a paper review; not an electronic review. -The facility had gone 100% all electronic documentation of medications (eMARs). -Because of the new eMAR system, there were limited things that he could do. -He could only verify the orders with what was in the eMAR system on the date the pharmacy review was completed. -The eMAR system did not allow him to review 3 months before the date the pharmacy review was completed (April 2019-June 2019). Interview with the Executive Director (ED) on 08/01/19 at 10:02am revealed: -The facility had been using the current named electronic health record system EHR/eMAR system since March 2019.	D 367		

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D 367	Continued From page 176 -The system had some "glitches" which meant there would be duplicate entries on the eMARs for some medications, and the administration times for some medications would revert by "default" to 1:00am. -She did not know why the glitches appeared. -She acknowledged she had concerns for medication errors due to the system glitches. _____ The facility failed to assure the electronic medication administration records (eMARs) were accurate for 3 of 3 samples residents (#1, #3, #4) resulting in medications ordered for as needed administration (to include a controlled substance) being administered by unlicensed staff without a reason indicated for administration and resulted in duplicate medication entries on the eMARs. The facility's failure increased the risk for medication errors which was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ A Plan of Protection in accordance with G.S. 131D-34 was requested on 08/29/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 20, 2019.	D 367		
D 449	10A NCAC 13F .1211 (b) Written Policies And Procedures 10A NCAC 13F .1211Written Policies And Procedures (b) In addition to other training and orientation requirements in this Subchapter, all staff shall be trained within 30 days of hire on the policies and	D 449	10A NCAC 13F .1211(b) Written Policies and Procedures Training provided on 8/20/19 by pharmacy on written policies and procedures associated with medication administration and insulin administration, where to locate pharmacy written policies and procedures outlined in the pharmacy manual. Training provided by the pharmacy registered nurse to include medication administration process and med error prevention.	09/20/2019

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D 449	Continued From page 177 procedures listed as Subparagraphs (3), (4), (6), (7), (8), (9), (10) and (11) in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews and interview, the facility failed to assure written policies and procedures were maintained for safe administration of medications to include documentation of medications administered when the electronic medication administration system was not operational. The findings are: Interview with the Corporate Registered Nurse (RN) on 08/01/19 at 5:25pm revealed: -The facility did not have a written medication administration policy. -The facility's policy for medication administration was to follow the rules and statutes related to medication administration. A second interview with the Corporate RN on 08/02/19 at 9:27am revealed the facility did not have a specific written policy on insulin administration; the policy was to follow the state rules and regulations. Confidential staff interview revealed the staff member was never told or trained on the facility's medication administration policy. Confidential interviews with a second staff member revealed: -The staff member had not been trained on the facility's medication administration policy or the electronic health record (EHR)/electronic	D 449	Training and education provided to the medication aides and care managers to facilitate understanding and application of the "Down Time Process" , which is a process that allows documentation of medication administration during off-line activities to ensure consistent electronic medication administration. Once the system is back on-line, the system will sync any documentation of data and transactions during the off-line time frames. Training also included when to use and proper use of paper medication administration records. This process will be monitored by the Memory Care Manager and Director of Resident Care. Ed will monitor compliance through observations and follow-up with Care Managers.	09/20/2019 ongoing

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D 449	Continued From page 178 medication administration record (eMAR) system. -The staff acknowledged the problems increased the risk for medication errors. Confidential interviews with three staff revealed: -The eMAR system was down sometimes. -Staff just had to wait to chart the medications as being administered after the eMAR system came back up. -Staff had to remember what medication they gave or had to give when the system was down the then document it was given when the system came back up. -Staff had not been trained on a policy for when the eMAR system was down. Review of Resident #3's July 2019 eMAR revealed: -There were multiple medications documented with comments related to the eMAR system being non-operation. -For example: there was an entry Buspirone 5mg (used to treat anxiety) scheduled for administration at 8:00am and 8:00pm. On 07/03/19 and 07/05/19 at the 8:00pm dose, there was documentation which read " ...system issues administered right time." -For example: there was an entry for Lantus (a long acting insulin used to lower blood sugar) 10 units at bedtime scheduled for administration at 8:00pm. On 07/03/19 and 07/05/19 there was documentation which read " ...system issues administered right time." -For example: there was an entry Aspirin 81mg (used to thin the blood) scheduled for administration at 8:00am. On 07/12/19, there was documentation which read " ...computer down ...given on time." -For example: there was an entry Clopidogrel 75mg (used to deter blood clotting) scheduled for	D 449	ED will review compliance with written policies and procedures during observations, review of systems, tools and processes during daily, weekly and monthly meetings. Divisional Team will ensure compliance with written policies and procedures weekly through onsite visits and reviewing system outcomes with the ED.	09/20/2019 ongoing 09/20/2019 ongoing

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D 449	Continued From page 179 administration at 9:00am. On 07/12/19, there was documentation which read " ...computer down ...given on time." -For example: there was an entry Duloxetine 60mg (used to treat nerve pain and anxiety) scheduled for administration at 9:00am. On 07/12/19, there was documentation which read " ...computer down ...given on time." -For example: there was an entry Escitalopram 10mg (used to treat depression) scheduled for administration at 9:00am. On 07/12/19, there was documentation which read " ...computer down ...given on time." -For example: there was an entry to inject Novolog (a rapid acting insulin used to lower blood sugar) sliding scale insulin (SSI) subcutaneously three times daily with meals according to the following scale: for finger stick blood sugar (FSBS) result of 141 - 180, give units; 181 - 220, give 4 units; 221 - 260, give 6 units; 261 - 300, give 8 units; 301 - 350 = 10, give units; 350 - 400, give 12 units; if blood sugar is greater than 400, give 14 units scheduled at 7:30am, 12:30pm, and 5:30pm. On 07/12/19 at 7:30am, there was documentation which read " ...medication was given on time. Computer program not working correctly." Interview with the ED on 08/01/19 at 10:02am revealed: -When the EHR/eMAR system was down/unavailable, paper MARs should be used for documentation of medication administration. -She was not sure, but thought papers MARs could be printed at the first of the month. -She had asked the medication aides (MA's) on every shift to print resident's paper MAR's the first of every month to be used if the eMAR went down. -She had not checked to confirm the paper MARs	D 449		

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D 449	Continued From page 180 were printed the first of every month. -Staff would know to use the paper MAR's by the verbal shift to shift report. -She would look for and provide the paper MAR's if any had been completed when the system was down. -In addition to unscheduled down time, the system had scheduled "down time." The last scheduled down time was "last Sunday" (no date specified) from 1:00am-4:00am, -Papers MARs should have been used during the scheduled down time; she was "unsure" if the paper MARs had been used during that time. Interview with the Corporate RN and DRC on 08/01/19 at 11:27am revealed: -If the power was out or the eMAR system was down due to Internet issues or other reasons, the facility was supposed to use paper MARs for documentation. -They did not know where the paper MARs came from. -The paper MARs would be in each residents' record or kept in the clinic. -The DRC would look for the paper MARS and provide copies. Telephone interview with an Information Technology (IT) representative of the facility's HER provider on 08/02/19 at 9:45am revealed: -When the system had scheduled or unscheduled down time, there was an "offline" system available for the facility to document medication administration. -The system had schedule downtime for quarterly updates which was usually from 1:00am-5:00am central time. -Prior to scheduled down time, the system had a red banner that provided specifics of the down	D 449		

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D 449	Continued From page 181 time and reminders were sent to the facility to assure the offline MARs were completed prior to the downtime. -He was not able to track the facility's use of the offline MARs. Confidential interviews with three staff revealed: -Three of three staff had never used paper MARs when the eMAR system was down. -Three of three staff had not been trained or told to use paper eMARs at any time. Paper MARs were requested on 08/01/19 at 10:02am and 11:27am, but were not provided prior to survey exit. Interview with the Executive Director (ED) on 08/01/19 at 4:20pm revealed: -The facility did not have a written medication administration policy. -The facility's policy for medication administration was to follow the state regulations for medication administration. Refer to tag D 358 10A NCAC 13F. 1004(a) Medication Administration. Refer to tag D 366 10A NCAC 13F. 1004(i) Medication Administration.	D 449		
D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible	D 454		

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D 454	Continued From page 182 person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to contact the responsible party for 1 of 2 sampled residents (#16) after incidents in which the resident required emergent hospital evaluation. The findings are: Review of Resident #16's current FL-2 dated 03/09/19 revealed diagnoses included stroke, diabetes mellitus, and hypertension. Observations on 07/31/19 from 4:20pm- 4:43pm revealed: -Resident #16 was pushed to the medication room in a wheelchair. -Resident #16 was leaning forward over his right leg and holding his right leg in his hands; he was	D 454	10A NCAC 13F .1212(e) Reporting of Accidents and Incidents Training conducted on 8/22/19 for medication aides and care managers on requirement for reporting accident and incidents to include notificationof primary care provider, DSS as required by regulation, responsible party, guardians, 24 hr communication, proper reporting procedures and documenation. Care Managers are responsible and required to review incident reports and the 24 hr communication log to assure accurate and timely reporting of incident and accident reports as outline in the rule. Executive Director will review all incidents and accidents reports tduring daily dept head meetings to assure timely reporting and notifications as outlined in the rule. Divisional Team will monitor incident and accident reporting procedures for compliance weekly through onsite visits and reviewing system outcomes with the ED. Senior Level Management to include SVP will conduct weekly status calls and site visits at least twice monthly to review previously mentioned internal systems, tools and processes to verify compliance.	09/20/2019 09/20/2019 ongoing 09/20/2019 ongoing 09/20/2019 ongoing 09/20/2019 ongoing

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D 454	Continued From page 183 rubbing his right knee and lower leg. -The resident's right knee was swollen and red. -The resident was moaning. -Emergency medical services (EMS) arrived with a stretcher. -The medication aide (MA) reported to EMS that Resident #16 fell today (07/31/19) at 7:31am, had seen his primary care provider (PCP), and his PCP wanted the resident to have an x-ray. -The Licensed Health Professional Support (LHPS) nurse reported to EMS Resident #16 had not seen his PCP, and Physical Therapy wanted the resident sent out for an x-ray. -Resident #16 complained of pain from his right knee down to his right lower leg to EMS. -Resident #16 was lifted from his wheelchair by EMS and placed on the stretcher. -Resident #16 kept his right leg bent and moaned when EMS attempted to extend his right leg after transfer to the EMS stretcher. Interview with the MA on 07/31/19 at 4:40pm revealed Resident #16 had a fall today (07/31/19). Review of an Accident/Incident Report for Resident #16 dated 07/31/19 at 11:55am revealed: -The resident had an unwitnessed fall in his room. -In the section titled notifications, there was documentation the resident's "representative" was not notified. Review of a hospital After Visit Summary for Resident #16 dated 07/31/19 revealed: -The resident was evaluated and discharged on 07/31/19. -Resident #16's diagnosis was documented as effusion of the right knee.	D 454		

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D 454	Continued From page 184 Observations on 08/02/19 at 3:48pm revealed: -Resident #16 was laying in his bed in his room. -His right lower leg was wrapped in a white bandage. -EMS was in Resident #16's room preparing him for transport out of the facility. Interview with a MA on 08/02/19 at 3:38pm revealed: -Resident #16 had a fall on 07/31/19 and had not been himself since that time and his knee was swollen. -The PCP was notified and gave an order to send the resident to the hospital. Telephone interview with Resident #16's family member on 08/06/19 at 1:50pm revealed: -Resident #16 was sent to the hospital on 07/31/19 after a fall. -The family was not notified by the facility that he was sent to the hospital on 07/31/19. -The resident was sent to the hospital again on 08/02/19. -The family was not notified by the facility that he was sent to the hospital on 08/02/19. -A family friend went to the facility to see the resident on the evening of 08/02/19 and was told by staff the resident was not at the facility but was at the hospital. -The friend called the resident's family member on 08/02/19. -The family would not have known the resident was in the hospital if the friend had not gone to the facility on 08/02/19 and called the family member. -When the family got to the hospital to be with Resident #16 on 08/02/19, the hospital staff told the family the resident had also been evaluated at the hospital on 07/31/19. -The resident was admitted to the hospital on	D 454		

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D 454	Continued From page 185 08/02/19. -Resident #16 had very limited communication and the family member was concerned the resident would not be able to communicate with hospital staff without a family member present because they could not understand the resident. -The family expected to be notified by the facility of the resident's hospital visits. -The facility was aware they were supposed to call the family for any hospital visits. -The family member was going to contact the Executive Director (ED) about her concerns of not being notified but had not yet contacted the ED. Interview with a MA on 07/31/19 at 6:30am revealed: -When a resident was sent to the hospital, it was the facility's procedure to notify the Executive Director (ED), the PCP, and family. -The MAs were responsible for completion of the notifications. Interview with a second MA on 08/06/19 at 9:50am revealed in an emergency when a resident was sent to the hospital, the MAs were responsible for notifying the resident's family and PCP. Interview with the ED and Director of Resident Care (DRC) on 08/06/19 at 4:45pm revealed when a resident was sent to the hospital, their family or guardian was supposed to be notified by the MA, Supervisor, Memory Care Manager (MCM), or DRC.	D 454		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff	D 465		

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D 465	Continued From page 186 (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) for 15 of 24 shifts sampled on 05/14/19, 05/22/19, 06/13/19, 07/20/19-07/22/19, and 08/03/19-08/04/19. The findings are: Review of the facility's current license effective 01/01/19 revealed: -The facility was licensed for a total capacity of 78 residents. -The facility was licensed for 24 residents in the SCU. Confidential staff interview revealed: -First shift was 7:00am-3:00pm. -Second shift was 3:00pm-11:00pm. -Third shift was 11:00pm-7:00am. -On first and second shifts, there was typically one medication aide (MA) and two personal care aides (PCAs) on duty in the SCU. -On third shift, there was typically one MA and one PCA on duty in the SCU.	D 465	10A NCAC 13F. 1308(a) Special Care Unit Staff Executive Director provided training to Care Managers on 8/7/19 in reference to the special care unit staffing requirements and the assisting living staffing requirements. Care Staff provided training per the NC Adult Care Licensure Rules and Regulations on proper staffing ratios. Training provided on 8/7/19 by the Executive Director. Staffing schedules are reviewed each day to include an overview of the week by the Care Managers and the scheduler to assure adequate staff coverage in accordance with the rule. ED reviews schedule and discusses coverage with the Care Managers daily during dept head meetings to assure compliance and assist with solving any staffing concerns. Shift staff analysis reports are provided to the DVPO weekly for review with the Executive Director to assure compliance. These internal reports are a part of a quality assurance system that provides overview of staffing.	09/05/2019 09/05/2019 09/05/2019 ongoing 09/05/2019 ongoing

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D 465	Continued From page 187 Confidential interview with a second staff member revealed: -There were not enough staff on third shift in the SCU to take care of the residents. -There was no Supervisor on duty on second and third shift. -For several months, there had been only one MA and two PCAs on duty in the entire facility on third shift. -When there was only one MA on duty for the entire facility, the MA had to go to the Assisted Living (AL) side to give medications and respond to falls and other incidents. -The MA could not be two places at one time; it was "unsafe." -The residents in the SCU suffered from the short staffing. -Every resident on the SCU needed some assistance with toileting or was incontinent and required bathroom rounds every two hours. -The 2 hour bathroom rounds did not get done like they should because there was not enough staff. -There were two residents in the SCU who required two person assistance "with everything." -When those two residents needed assistance, the SCU MA or the PCA from AL had to come help the SCU PCA. -Some residents had missed their showers (no dates provided). -Medications were sometimes late due to MAs assisting with resident care; the resident care came first. -Staff did the best they could. -Somebody was going to get hurt because there was not enough staff. -The procedure for staff call outs was as follows: staff were supposed to call in at least 4 hours before the start of their shift; staff calling out were	D 465		

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D 465	Continued From page 188 supposed to find their own coverage. -Sometimes coverage was not found. -Not all staff adhered to the call out procedure and did not even look for coverage when they called out. -"We can only do so much." Staff could not be two places at one time. -The medication aide/supervisor (MA/S) who made the staff schedule knew the SCU was short staffed. -The MA/S would sometimes help look for coverage when they were short staffed, but the MA/S would not help on the floor. -The Executive Director (ED) was aware of the short staffing. -The Memory Care Manager (MCM) would help sometimes, but not on third shift. Confidential interview with a third staff revealed: -Residents in the SCU were not bathed or checked on like they should be because there was not enough staff on duty. -Rounds were "regularly" late because there was not enough staff on duty on third shift. -"A lot" of the residents had falls and wandered so staff needed to watch them closely; there was not enough staff to do this. Confidential interview with a fourth staff revealed: -Sometimes there was not enough staff for SCU. -A MA/S and MCM came in to cover a shift but the staff member did not remember when. Observations on 08/02/19 between 9:10am and 9:20am on the SCU revealed: -There was a resident in a hospital bed in the SCU. -Incontinent care was provided to the resident. -The resident was turned, repositioned, and supported in place on his side by one PCA.	D 465		

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D 465	Continued From page 189 -Incontinent care was provided to the resident by a second PCA while being supported in place by the first PCA. -The resident was unable to provide any assistance with turning and positioning and required the assistance of two staff. Interview with a PCA on 08/02/19 at 9:10am revealed: -The resident required total care. -The resident received hospice services and was bathed by the hospice aide three times a week. -The PCAs helped the hospice aide with bathing the resident. Review of the Daily Census Report (DCR) dated 05/14/19 revealed the SCU census was 24, requiring 24 staff hours on first and second shifts and 19.2 staff hours on third shift. Review of the individual employee time card punch detail reports dated 05/14/19 revealed: -SCU staff clocked in for a total of 17.3 hours on first shift, a shortage of 6.7 staff hours. -SCU staff clocked in for a total of 17.25 hours on second shift, a shortage of 6.75 staff hours. -SCU staff clocked in for a total of 13.75 hours on third shift, a shortage of 5.45 staff hours. Review of the DCR dated 05/22/19 revealed the SCU census was 24, requiring 24 staff hours on first and second shifts and 19.2 staff hours on third shift. Review of the individual employee time card punch detail reports dated 05/22/19 revealed: -SCU staff clocked in for a total of 18.72 hours on first shift, a shortage of 5.28 staff hours. -SCU staff clocked in for a total of 14.53 hours on second shift, a shortage of 9.47 staff hours.	D 465		

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D 465	Continued From page 190 -SCU staff clocked in for a total of 19 hours on third shift, a shortage of 0.2 staff hour. Review of the DCR dated 06/13/19 revealed: -The SCU census was 24, requiring 24 staff hours on first and second shifts. -The Assisted Living (AL) census was 50. Review of the Assignment Sheet dated 06/13/19 revealed there was only one medication aide (MA) scheduled on third shift for the entire facility census of 74. Review of the individual employee time card punch detail reports dated 06/13/19 revealed: -SCU staff were clocked in for a total of 16.23 hours on first shift, a shortage of 7.77 staff hours. -SCU staff were clocked in for a total 18 hours on second shift, a shortage of 6 staff hours. Review of the DCR dated 07/20/19 revealed the SCU census was 22, requiring 22 staff hours on first and second shifts and 17.6 staff hours on third shift. Review of the individual employee time card punch detail reports dated 07/20/19 revealed: -SCU staff were clocked in for a total of 20 hours on first shift, a shortage of 2 staff hours. -SCU staff were clocked in for a total of 16 hours on third shift, a shortage of 1.6 staff hours. Review of the DCR dated 07/21/19 revealed the SCU census was 22, requiring 17.6 staff hours on third shift. Review of the individual employee time card punch detail reports dated 07/21/19 revealed SCU staff clocked in for a total of 15.75 hours on third shift, a shortage of 1.85 staff hours.	D 465		

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D 465	Continued From page 191 Review of the DCR dated 08/03/19 revealed: -The SCU census was 22, requiring 22 staff hours on first and second shifts. -The AL census was 46. Review of the Assignment Sheet dated 08/03/19 revealed there was only one MA scheduled on third shift for the entire facility census of 68. Review of the individual employee time card punch detail reports dated 08/03/19 revealed: -SCU staff clocked in for a total of 13.5 hours on first shift, a shortage of 8.5 staff hours. -SCU staff clocked in for a total 17.25 hours on second shift, a shortage of 4.75 staff hours. Review of the DCR dated 08/04/19 revealed; -The SCU census was 22, requiring 22 staff hours on first and second shifts and 17.6 staff hours on third shift. -The AL census was 46. Review of the Assignment Sheet dated 08/04/19 revealed there was only one MA scheduled on third shift for the entire facility census of 68. Review of the individual employee time card punch detail reports dated 08/04/19 revealed: -SCU staff clocked in a total of 16.25 hours on first shift, a shortage of 5.75 staff hours. -SCU staff clocked in for a total 10.25 hours on second shift, a shortage of 11.75 staff hour. Interview with the MCM on 08/02/19 at 11:46am revealed: -The SCU had 24 residents. -Normally, there should be one MA and two PCAs on duty on all shifts in the SCU. -The SCU had some "challenges" related to short	D 465		

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D 465	Continued From page 192 staffing. -She was a MA and nurse aide (NA) and she helped as needed to cover shifts. :Interview with the Executive Director (ED) on 08/06/19 10:20am revealed: -There should normally be one MA on duty for each medication cart. -The facility had 3 medication carts: two in the AL and one in the SCU. -Normally when the facility was short MAs, one of two (named) MAs would work the medication carts in the AL and/or SCU. -One of the MA/S was responsible for completing the staff schedule and she (the ED) reviewed it with the MA/S. -Sometimes there was only one MA on duty for the entire facility; this happened when someone called out or was off. -There were three MAs who worked third shift in the facility. -The facility had three PCAs who were currently working third shift in the facility. -She acknowledged the MA/Supervisor who completed the staff schedule was not aware of the required staffing ratios. -The Memory Care Manager (MCM) and the ED would look over the schedule before it was finalized. -She was aware of the daily staffing schedule for the facility. -There have been no complaints from residents or family members when the facility was short of staff. -She was unsure how many residents in the SCU were incontinent or needed toileting assistance. -Currently, there were two residents in the SCU who were heavy-care; they required total care assistance from staff with all activities of daily living (ADLs).	D 465		

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D 465	Continued From page 193 Interview with the MA/S on 08/06/19 11:32am revealed: -She did the staff schedule. -The staff schedule also known as the assignment sheets were done on weekly basis (Wednesday to Wednesday). -The MA/S and the ED would go over the staff scheduling before it was finalized. -A copy of the final schedule would be given to the ED. -When the facility staff called out, the policy was to contact the MA/S four hours prior to the shift and the facility staff would have to contact three alternates to discuss coverage of the shift. -If the facility staff called out, the MA/S had come into work (no dates provided). -The ED and the other supervisors had also come in to work to cover the staff shortage. -She was not aware there were only three facility staff members (one MA and two PCAs) for the entire facility on third shift on some dates. -She wasn't sure of the exact number of residents on SCU that required total care. A second interview with the MCM on 08/06/19 at 2:33pm revealed: -She was not involved with the production of the staff schedule. -She acknowledged there were "maybe" some shifts in the SCU that were short staffed. -The MA/S assigned to complete the staff schedule did her best to assure all shifts had adequate coverage. -When a staff called out for a shift, she attempted to call other staff to cover the shift. -She was aware the weekend of 08/03/19-08/04/19 there was a staff shortage in the SCU. -On Sunday, 08/04/19, she came in at 8:45am	D 465		

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D 465	Continued From page 194 and left at 3:00pm due to the staff shortage. -On Sunday, 08/04/19, on second shift, there were two PCAs and one MA. -On Sunday, 08/04/19, third shift, she was not aware of the number of PCAs or MAs working in the SCU. Interview with the ED and Director of Resident Care (DRC) on 08/06/19 at 4:45pm revealed: -First shift was 7:00am-3:00pm. -Second shift was 3:00pm-11:00pm. -Third shift was 11:00pm-7:00am. -They were aware there was a problem with short staffing. -The facility was "constantly" hiring. -The process for staff call outs was as follows: the staff called the Supervisor, the Supervisor attempted to call other staff in to cover the shift, the two Supervisors or MCM covered the medication carts when the facility was short staffed; the process did not happen the previous weekend (08/03/19-08/04/19). -"We were short staffed anyway" (over the weekend 08/03/19-08/04/19). -The weekend of 08/03/19-08/04/19 was short staffed in the SCU and AL. -Over the weekend (08/03/19 and 08/04/19), the Supervisor sent out a "mass text" to staff and notified her of the short staffing, but could not get staff to come in. -The DRC, MA/Ss, and MCM were unavailable to come in on 08/03/19 or 08/04/19; the ED did not know why they were unavailable. -The ED expected staffing to be maintained in accordance with the rules and to meet the residents' needs.	D 465		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 195 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to training on cardio-pulmonary resuscitation and medication administration. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to assure at least one staff person was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 14 of 15 shifts on third shift from July 1, 2019 through July 15, 2019. [Refer to Tag 167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to assure accuracy of the electronic medication administration records (eMARs) for 3 of 3 sampled residents (Residents #1, #3, #4) related to as needed orders without indication for administration and duplication of eMAR entries for finger stick blood sugars and an antiplatelet	D912	G.S. 131D-21(2) Declaration of Resident Rights Resident Rights training was provided by the ombudsman on 8/30/2019. Refer to Plan of Correction for Tag 167 10A NCAC 13F .0507	

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D912	Continued From page 196 medication (#3); duplicate administration times for a medication ordered once daily for treatment of gastric reflux (Resident #4), and an incorrect dose transcribed to the eMAR for a medication used to treat hypothroidism (#1). [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure medications were documented directly after administration for 7 of 8 sampled residents (#1, #3 #4, #5, #6, #11, #15) and failed to maintain a safe system to assure medications were documented at the time of administration. [Refer to Tag 366, 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)].	D912	Refer to Plan of Correction for Tag 367 10A NCAC 13F .1004(j) Refer to Plan of Correction for Tag 366 10A NCAC 13F .1004(i)	
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure each resident was free of neglect as related to health care, medication administration, and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure the acute and chronic health care needs were met for 5 of 8 sampled residents (#1, #3, #4, #13, and #15)	D914	G.S. 131D-21(4) Declaration of Residents Rights Resident Rights training provided by the Omsbudsman on 8/30/2019.	

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D914	Continued From page 197 related to notification of the health care providers for a change in status (#13); coordination of care between the primary care provider (PCP) and endocrinologist, scheduling of endocrinology and orthopedic consults as ordered, and notification of the endocrinologist and the PCP for finger stick blood sugars outside of the ordered parameters (#3); PCP notification of the failure to receive antibiotics as ordered and for continued pain and signs and symptoms of infection for an axillary abscess (#4); missed and rescheduling of dental appointments and notification to the PCP and/or dental provider of ongoing facial swelling and oral pain after missed doses of an antibiotic ordered prior to the dental procedure; and coordination of a referral for counseling services (#1). [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration; failed to assure medications were administered as ordered for 2 of 6 residents (#9, #10), observed during the medication passes, including errors with insulins (#9, #10), an antiarrhythmic (#9), an oral antidiabetic and bulk fiber (#10); and for 4 of 7 residents sampled for record reviews (#1, #3, #4, #15) including delays in starting and missed doses of antibiotics (#4, #15), a delay is administration of an antifungal (#3) a delay in starting an antidepressant (#3), errors with rapid and long acting insulins (#3), and a medication used to treat hypothyroidism (#1). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 3. Based on observations, interviews and record reviews, the Executive Director/Administrator	D914	Refer to Plan of Correction for TAg 273 10A NCAC 13F .0902(b) Refer to Plan of Correction for Tag 358 10A NCAC 13F .1004(a)	

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D914	Continued From page 198 failed to assure the overall management of the facility's operations and policies/procedures in order to maintain each residents' rights and substantial compliance with the rules and statutes regarding medication administration, health care, and training on cardio-pulmonary resuscitation. [Refer to Tag 980, G.S. 131D-25 Implementation (Type A1 Violation)].	D914	Refer to Plan of Correction for Tag 980 G.S. 131D-25	
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the Executive Director/Administrator failed to assure the overall management of the facility's operations and policies/procedures in order to maintain each residents' rights and substantial compliance with the rules and statutes regarding medication administration, health care, and training on cardio-pulmonary resuscitation. The findings are: Review of the facility's license effective 01/01/19 revealed the Executive Director (ED) was also the facility's Administrator. Confidential interview with a staff revealed:	D980	G.S. 131D-25 Implementation The Executive Director will attend enhanced training at the next scheduled event. The training will focus on problem solving, action planning, execution, root cause analysis and how to access available resources to ensure quality care and service delivery to our Residents. The Executive Director was provided additional education and training on the NC Adult Care Licensure Rules and the responsibility of the Executive Director to assure the implementation of policies and procedures, oversee overall operations and to maintain substantial compliance and assure Residents' Rights to adequate care and services. Training provided by the DVPO. Note: Senior Vice President (SVP) provided the Executive Director with training, guidance and support with a review of the violations, plan of correction, follow-up, monitoring and oversight responsibilities. SVP will continue to provide training, guidance and support to the Executive Director, Community and the Divisional Team to assure ultization of systems, tools and processes to achieve and maintain compliance.	09/05/2019 09/05/2019 ongoing process

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D980	Continued From page 199 -There were times when the facility was short staffed for medication aides (MAs) and personal care aides (PCAs). -Sometimes residents ran out of medications. -The ED and other management staff did not always answer telephone calls or call back when out of the facility. -The ED knew of residents at the facility who had a change in condition but nothing was done as a result. Confidential interview with a second staff revealed: -The ED knew about the short staffing but nothing changed. -There were staff who were "habitually" late and they continued to work there. -The ED was aware of all of the problems with the medications and electronic medication administration records (eMARs); the problems had been going on "for months." -Staff were only told the system was being worked on put no improvements were observed. -Staff were not really trained on the new eMAR system; they were just told it was new and to do the best they could. -The facility had not had a Resident Care Coordinator (RCC) "for months." [DRC's staff name] just started working in the facility within the last month. -The ED was always in her office and not out on the floor. Confidential interview with a concerned citizen revealed: -Resident concerns were brought to the ED and the citizen did not think the ED did anything to address the concerns. -The ED stayed in her office with the door closed. -The ED was not seen making rounds in the	D980	The Executive Director will be responsible for ensuring compliance with all Plans of Correction. to include daily and clinical operations. ED will provide a report of progress to Divisional Management during weekluy site visits on weekly conference calls. Divisional Management will monitor ongoing compliance through on-site monitoring by reviewing systems, tools and processes to include survey binder and plan of correction. Divisional Management has the ability to review internal quality assurance electronic systems, tools and processes that allows an extra level of oversight remotely in between site visits. Divisional Vice President of Operations(DVPO) in coordination with the divisional team will provide guidance, support and oversight to the Executive Director and the community with immediate access to Senior Management Leadership for assistance. Senior Level Management to include SVP will conduct weekly status calls and site visits at least twice monthly to monitor progress, utilization of systems, tools and processes to assure compliance and provide guidance, education and support to the community and divisional personnel.	09/05/2019 09/05/2019 09/20/2019 ongoing

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D980	Continued From page 200 facility. Confidential interview with a second concerned citizen revealed: -Medications were often administered late in the facility. -Missing medications were a common issue at the facility. Interview with the ED on 08/01/19 at 10:02am revealed: -She did not know a lot about the facility's electronic health record/medication administration system. -She would need to ask [two staff's names] about it. -She had no set system she used for oversight of medication administration. -The facility had a Director of Resident Care (DRC) now; prior to the DRC, there were supervisors who had oversight of electronic medication administration records (eMARS). -She did no know the last time they reviewed the eMARS. -She reviewed the eMARS "at times" and had last looked at them in June or July. -She was unsure if there was any system in place to prevent medication errors. -She did not know what the facility's medication administration policy was but felt sure there was a policy. -She would look for and provide a copy of the medication administration policy. -Interventions she had implemented to ensure safe medication administration was to "train and re-train" staff on the new system (no implementation date provided). -She acknowledged she had not done anything to fix the problems when training the staff did not work.	D980		

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D980	Continued From page 201 -There was nothing currently in place to correct the problems. -She was responsible for the whole building such as medication administration, overall policies, and resident safety. A second interview with the Executive Director on 08/06/19 at 10:20am revealed: -The facility had not had supervisors on 2nd and 3rd shift. -She did not know a supervisor was required on 2nd and 3rd shift. A third interview with the ED on 08/06/19 at 4:45pm revealed: -The facility had been without an RCC for a few months and got a DRC in July 2019. -She was aware the facility was short staffed and specific shifts were short. -She did not know if there was one or two MAs on duty over the previous weekend (08/03/19 and 08/04/19). -"We were short to start with" over the weekend (08/03/19 and 08/04/19). -There were times (3rd shift) when she expected one MA to work all three medication carts for the entire facility (both the assisted living and special care unit, which was a census of over 70 residents) because fewer medications were due on third shift. -There was no system in place to assure staff coverage to meet staffing hour requirements. -She was aware there needed to be one staff on each shift who was trained in cardio-pulmonary resuscitation (CPR) within the last two years. -She knew there were shifts when there was not at least on staff scheduled/on duty with valid CPR. -"We tried to have someone on every shift but could not on 3rd shift."	D980		

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D980	Continued From page 202 -"We just didn't have anyone on 3rd who had CPR." -The facility had turn over which impacted CPR coverage. -A lot of staff had been previously trained but it had expired. -The last CPR class was held in February 2019. -If needed, she expected staff to perform CPR, even though they were not certified; there was a good Samaritan rule and staff knew to perform CPR. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, record reviews and interviews, the facility failed to assure at least one staff was always on the premises who had completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 14 of 15 shifts on third shift from July 1, 2019 through July 15, 2019 [Refer to Tag 167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to assure the acute and chronic health care needs were met for 5 of 8 sampled residents (#1, #3, #4, #13, and #15) related to notification of the health care providers for a change in status (#13); coordination of care between the primary care provider (PCP) and endocrinologist, scheduling of endocrinology and orthopedic consults as ordered, and notification of the endocrinologist and the PCP for finger stick blood sugars outside of the ordered parameters (#3); PCP notification of the failure to receive antibiotics as ordered and for continued pain and signs and symptoms of infection for an axillary abscess (#4); missed and rescheduling of dental	D980	Refer to Plan of Correction for Tag 167 10A NCAC 13F .0507	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010007	A. BUILDING: _____ B. WING _____	C 08/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

(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
D980	Continued From page 203 appointments and notification to the PCP and/or dental provider of ongoing facial swelling and oral pain after missed doses of an antibiotic ordered prior to the dental procedure; and coordination of a referral for counseling services (#1). Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure safe policies and procedures were established and maintained for medication administration, failed to assure medications were administered as ordered for 2 of 6 residents (#9, #10) observed during the medication passes including errors with insulins (#9, #10), an antiarrhythmic (#9), an oral antidiabetic and bulk fiber (#10); and for 4 of 7 residents sampled for record reviews (#1, #3, #4, #15) including delays in starting and missed doses of antibiotics (#4, #15), a delay is administration of an antifungal (#3) a delay in starting an antidepressant (#3), errors with rapid and long acting insulins (#3), and a medication used to treat hypothyroidism (#1). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to assure medications were documented directly after administration for 7 of 8 sampled residents (#1, #3 #4, #5, #6, #11, #15) and failed to maintain a safe system to assure medications were documented at the time of administration.[Refer to Tag 366, 10A NCAC 13F .1004(i) Medication Administration (Type B Violation)]. 5. Based on record reviews and interviews, the facility failed to assure accuracy of the electronic medication administration records (eMARs) for 3	D980	Refer to Plan of Correction for Tag 273 10A NCAC 13F .0902(b) Refer to Plan of Correction for Tag 358 10A NCAC 13F .1004(a) Refer to Plan of Correction for Tag 366 10A NCAC .1004(i)	

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D980	Continued From page 204 of 3 sampled residents (Residents #1, #3, #4) related to as needed orders without indication for administration and duplication of eMAR entries for finger stick blood sugars and an antiplatelet medication (#3); duplicate administration times for a medication ordered once daily for treatment of gastric reflux (Resident #4), and an incorrect dose transcribed to the eMAR for a medication used to treat hypothroidism (#1). [Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration (Type B Violation)]. The Executive Director/Administrator failed to assure policies and procedures were implemented and maintained in the facility in a manner to assure substantial compliance with the rules and statutes of adult care homes resulting in the residents not receiving the care and services necessary to maintain their physical and mental health and safety. The Executive Director/Administrator's failure resulted unsafe medication administration procedures and inaccurate electronic administration records, causing medication errors; no system in place to assure new physician orders were implemented resulting in delays in multiple residents receiving medications and medical evaluation and treatment; and the facility not having at least one staff on duty on each shift with current CPR certification. Resident #13 had a change in status and was unable to use her legs which was not reported to her health care provider. The resident was later diagnosed with paraplegia. Resident #15 missed a dental appointment and had a delay in starting antibiotics resulting in a procedure for a tooth extraction being rescheduled and the resident having ongoing facial swelling and complaints of pain. Resident #4 missed multiple doses of antibiotics ordered for an axillary abscess and had a delay in care for	D980	Refer to Plan of Correction for Tag 367 10A NCAC 13F .1004(j)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D980	Continued From page 205 the treatment of the abscess which was determined to be a bacterial infection of methicillin resistant Staphylococcus aureus (MRSA). The resident sustained prolonged pain and signs and symptoms of infection to include swelling, drainage, and warmth to the area that required treatment by surgical intervention. The facility failed to coordinate care for Resident #3, who was a diabetic between the primary care provider and endocrinologist resulting in the resident having falls and multiple hospital visits for high and low blood sugar, and placed the resident at risk for serious complications of diabetes to include kidney damage and diabetic ketoacidosis. The Administrator's failure to oversee the overall operations of the facility resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/06/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2019.	D980		

Leland House
PO Box 2568
Hickory, NC 28603

September 29, 2019

Hope Forte, RN Licensure Consultant
Adult Care Licensure Section
2708 Mail Service Center
Raleigh, NC 27699

Facility: Leland House
County: Brunswick
Licensure Number: HAL-010-007

Re: Amended/Revised Plan of Correction (Survey Completed August 6, 2019)

Dear Ms. Forte:

The original Plan of Correction was submitted as required on September 19, 2019. Based on a conversation you had with the Executive Director on Friday, September 27th a request was made to amend/revise the plan of correction submitted on September 19, 2019.

Upon further conversation, with you and I on Friday, September 27th we committed to reviewing the plan of correction based on your questions and comments.

I have reviewed the Plan of Correction, amended providing clarity on some of our internal systems and placed emphasis on training, monitoring of our systems, tools and processes to include disciplines providing the oversight. The amended/revised Plan of Correction has been reviewed and discussed with the Executive Director on September 28th & 29th, 2019.

Leland House has implemented intense oversight and monitoring to assure quality care and services to the Residents. We have systems, tools and processes that will be utilized at Leland House to achieve and maintain compliance.

We have enhanced our strategic processes and partnerships by persistent collaboration within our organization. Our Senior Leadership Professionals have met with the Divisional Team and committed resources to support and provide oversight in specific areas of expertise.

Our internal Senior Leadership Team including Senior Vice President will work in unison with the Divisional and onsite teams to address, direct and support continuity of care and compliance. We have taken measures to improve all systematic procedures and deliberately restructured executive level onsite monitoring of all operational and clinical processes.

Thank you for working with Leland House so we could provide additional information and clarity on the Plan of Correction. Please let us know if you have any questions.

Sincerely,

Sandra Korzeniewski
Sandra Korzeniewski
Senior Vice President

Enclosure: Amended/Revised POC
Signature Page 1

cc: File

Forte, Hope

From: Leland House, ADM - Sholar-Mason, Paula <lela.adm@affinitylivinggroup.com>
Sent: Sunday, September 29, 2019 2:59 PM
To: Forte, Hope
Subject: [External] Emailing - Revised POC for Leland House State Survey August 2019 part 1.pdf
Attachments: Revised POC for Leland House State Survey August 2019 part 1.pdf

Good afternoon,
Please see the attached cover letter, signature page and revised pages 1-100 of POC from State Survey 07/31 – 08/06 from Leland House.

Thanks,

Paula Sholar-Mason
Executive Director
Leland House
Affinity Living Group
P: 910-383-6235, M: 910-470-1993, F: 910-383-6248, E: lela.admin@affinitylivinggroup.com

Forte, Hope

From: Leland House, ADM - Sholar-Mason, Paula <lela.adm@affinitylivinggroup.com>
Sent: Sunday, September 29, 2019 3:05 PM
To: Forte, Hope
Subject: [External] Emailing - Revised POC for Leland House State Survey August 2019 Part 2.pdf
Attachments: Revised POC for Leland House State Survey August 2019 Part 2.pdf

Good afternoon, Hope,
Please see page 101 – 206 of revised POC for State Survey 07/31 – 08/06 from Leland House.

Thanks,

Paula Sholar-Mason
Executive Director
Leland House
Affinity Living Group
P: 910-383-6235, M: 910-470-1993, F: 910-383-6248, E: lela.admin@affinitylivinggroup.com