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SOMERSET COURT OF ROCKY MOUNT	918 WESTWOOD DRIVE ROCKY MOUNT, NC 27802

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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a COVID-19 focused Infection Control survey with an onsite visit on August 05, 2020 and a desk review survey on July 28, 2020 to July 31, 2020; August 03, 2020 to August 07, 2020 and a telephone exit on August 07, 2020.	{D 000}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Non-compliance continues resulting in detriment to health, safety and welfare. TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure notification of the primary care provider (PCP) for 3 of 5 sampled residents (#2, #3 and #4) when there was a 4 day delay of administering an antibiotic after a resident was evaluated and treated in the emergency department (#2), increased lower extremity swelling and weekly refusals to wear thrombo-embolic deterrent (TED) hose as ordered (#3) and a weight gain of 29lbs from June 2020 to August 2020 (#4). The findings are: 1. Review of Resident #2's current FL-2 dated 02/20/20 revealed: -Diagnoses included dementia, congestive heart	{D 273}		

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failure, neuromuscular dysfunction and iron deficiency anemia.
-The resident was intermittently disoriented and wandered.

Review of Resident #2's current Assessment and Care Plan dated 05/23/20 revealed:
-The resident was intermittently disoriented and was forgetful requiring reminders.
-The resident had an indwelling urinary catheter. (An indwelling urinary catheter is a flexible tube that passes through the urethra and into the bladder to drain urine).
-The resident required limited staff assistance with ambulation, dressing, grooming and extensive staff assistance with toileting.

Review of Resident #2's electronic progress notes dated 06/25/20 revealed the resident was sent to emergency department (ED) per the primary care provider's (PCP's) request due to an extended bladder and possible catheter malfunction.

Review of an accident/incident report dated 06/25/20 at 2:31pm for Resident #2 revealed:
-Resident #2 had no urine going into the urinary catheter bag.
-The resident was seen by the PCP prior to being sent to the ED.
-The form was generated by a medication aide (MA).
-The Administrator was notified.
-The form was completed by the Resident Care Coordinator (RCC).

Review of an ED visit summary for Resident #2 dated 06/25/20 revealed:
-The resident was seen in the ED for a urine catheter insertion or check.

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-The resident's indwelling urinary catheter was replaced, and urine was obtained "which appears to be possibly infected" .
-The resident's laboratory tests included a urinalysis and a urine culture.
-The resident was diagnosed with an obstruction of the urinary catheter and a urinary tract infection (UTI) with no blood in the urine.
-The resident received Cipro at 7:52pm. (Cipro is an antibiotic used to treat bacterial urinary tract infections).
-There were instructions to start Cipro 500mg twice daily for 7 days and to follow-up with the resident's PCP and urology for further management of the indwelling urinary catheter.
-There was a printed stamped date of 06/29/20 at the bottom of the ED visit summary form.

Review of Resident #2's electronic progress revealed:
-On 06/29/20 at 1:49am, there was an entry the resident had a urology appointment at 1:30pm.
-On 06/29/20 at 1:39pm, there was an entry the resident had an appointment today. The resident stated that he felt fine but "his appetite hadn't been that great" and had eaten "maybe" 40 percent of his breakfast, and 50 percent of his lunch, otherwise the resident had no concerns or complaints.

Review of Resident #2's urologist visit note dated 06/29/20 revealed:
-The resident was being seen for a follow-up.
-The resident's indwelling urinary catheter was changed and he was to follow up in one month.
-There was no documentation the resident had been evaluated at the ED on 06/25/20 and was ordered Cipro for a UTI.

Review of Resident #2's electronic progress note

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{D 273}	Continued From page 3 dated 06/30/20 at 10:21am revealed there was an entry the resident had fell and had "a lot of blood in his catheter bag", the resident was transported to the ED by emergency medical services (EMS) and the resident's PCP was notified. Review of an accident/incident report dated 06/30/20 at 7:39am for Resident #9 revealed: -The resident fell trying to get back into his bed and had blood in his urinary catheter bag. -The resident was taken to the ED. -In the "Record status of Resident after ER/Hospital" section of the form, to continue medication, the diagnosis was a UTI. -In the Evaluation Notes" section of the form, the resident would follow-up with the PCP at the next facility visit. -The form was generated by a MA. -The Administrator was notified. -The form was completed by the RCC. Review of an ED visit for Resident #2 dated 06/30/20 revealed: -The resident was seen in the ED for a fall, urine catheter insertion and blood in the urine. -The resident's laboratory tests included a urinalysis and a urine culture. -The resident was diagnosed with a fall, blood in the urine and prostate cancer metastatic to bone. -There were instructions to continue Cipro for a UTI and to follow-up with a urologist regarding the bleeding in the urinary drainage bag. Review of Resident #2's June 2020 electronic medication administration record (eMAR) revealed: -There was an entry for Cipro 500mg, twice daily scheduled at 8:00am and 8:00pm with a start date on 06/30/20 and a discontinued date as 07/04/20.	{D 273}		

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{D 273}	Continued From page 4 -There were parentheses around the staff's initials documenting the Cipro 500 mg was not administered on 06/30/20 at 8:00am with a reason as the resident was unavailable. -There was documentation Cipro 500 mg was administered on 06/30/20 at 8:00pm. -There was no documentation that Cipro was administered starting 06/25/20 - 06/29/20 as ordered from the ED visit on 06/25/20. Review of Resident #2's PCP visit note dated 07/02/20 revealed: -The resident was being seen for an ED follow-up visit. -The resident had no complaints. -The resident's diagnoses included benign prostate trophy with urinary disruption and a UTI. -The resident would continue the present medications. Review of Resident #2's electronic progress notes revealed: -On 07/11/20, the resident had a fall trying to get to his breakfast tray, had blood in his catheter and was sent to the ED. -On 07/16/20, the resident was found on the floor, was confused and was sent to the ED. Review of a discharge summary for Resident #2 from a local hospital dated 07/24/20 revealed: -The resident was admitted on 07/16/20 and discharged to a skilled nursing facility on 07/24/20. -The residents discharge diagnosis was generalized weakness. Telephone interview with Resident #2's power of attorney (POA) on 07/31/20 at 6:07pm revealed: -The resident was out of the hospital and currently in a rehabilitation facility.	{D 273}		

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{D 273}	Continued From page 5 -The resident was diagnosed with a "severe" UTI. -The POA thought the UTI started the last part of June 2020. Telephone interview with a MA on 07/31/20 at 11:45am revealed the RCC was responsible for residents' medical appointments and referral and follow up needs. Telephone interview with a second MA on 07/31/20 at 3:20pm revealed: -Resident #2 had declined in the last month or two. -Resident #2 was diagnosed with a UTI and the antibiotic that was ordered was not working. -MAs were responsible to place all resident orders received in the RCC's box located on the wall in the medication room and the RCC would follow-up and process those orders. Telephone interview with the RCC on 07/31/20 at 3:37pm revealed: -She was responsible to follow up on all orders. -The facility used a "Bucket System" for processing and filing all orders to ensure all orders were implemented. -On 06/25/20, a MA informed her Resident #2 had not voided "much". -Resident #2's PCP was in the facility on 06/25/20, saw Resident #2 and told staff to send the resident out to be evaluated in the ED. Review of the facility's Bucket System revealed: -When an order was received, the order was faxed to the facility's contracted pharmacy provider and the order awaited approval in the eMAR system. -The order moved to an orange folder while the facility waited for the delivery of the medication until the delivery sheet was completed and the	{D 273}		

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order was placed in a green folder. If the medication was not delivered, follow up was needed and the order was placed the order in the red folder.
-When the order was in the red folder, the order was incomplete and required physician clarification, needed a hard copy (i.e., controlled medication) requiring authorization by the physician.
-All orders needing medical equipment, labs, oxygen therapy and required follow up from a hospital visit were placed in the blue folder.
-All orders ready to be scanned into the electronic system in the residents' record were placed in the green folder and once scanned, that item would be stamped, scanned and placed in the current month bin.

Telephone interview with the RCC on 08/06/20 at 11:09am revealed:
-She was aware that Resident #2 had been "back and forth" to the ED in June and July 2020.
-She could not recall an issue with Resident #2 not starting Cipro after an ED visit on 06/25/20.
-She remembered when Resident #2 was ordered Cipro 500mg, the medication was not helping the resident's UTI.
-The MAs could contact the residents' PCP but she was responsible for contacting the PCP "most of the time" when there were any issues or concerns with medications.
-Resident #2 was having falls the end of June and beginning of July because he had a UTI.

Second telephone interview with the RCC on 08/06/20 at 2:42pm revealed:
-She had reviewed Resident #2's record and the printed date of 06/29/20 on Resident #2's ED visit summary on 06/25/20 was "throwing me off".
-Resident #2 should have come from the ED on

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06/25/20 with the visit summary and the Cipro prescription in hand.
-She was not sure what happened and could not recall what happened when Resident #2 returned back to the facility after his ED visit on 06/25/20 but he should have returned from the ED with a visit summary and the prescription for the Cipro 500mg.
-Staff were expected to contact the ED if a resident returned to the facility without documentation.
-The local hospital usually called when residents' documentation was left at the ED but typically residents always returned with ED documentation.

Review of a ED note for Resident #2 dated 06/29/20 provided by the facility on 08/07/20 revealed:
-The note was entered and signed by a registered nurse (RN).
-Resident #2's prescription for Cipro was left in the ED.
-The RN had spoken with a named MA at the facility and faxed Resident #2's Cipro prescription to the facility.

Telephone interview with the RCC on 08/07/20 at 11:10am revealed:
-She was aware Resident #2 was sent to the ED on 06/25/20 because his PCP wanted him sent out to be evaluated and treated.
-She did not contact Resident #2's PCP concerning the 4 -day delay of starting the Cipro to treat the resident's UTI but the resident was placed on the list to be seen by the PCP on his next visit to the facility.
-On 07/02/20, the PCP reviewed his hospital records when he saw Resident #2.
-Resident #2's PCP should have been notified

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that the Cipro was not started after the ED visit on 06/25/20.
-She could not answer why Resident #2's PCP was not notified.
-She could not recall if Resident #2 returned from the ED with a visit summary after being evaluated and treated on 06/25/20 or how the facility received Resident #2's ED summary.

Telephone interview with the MA named in the nurse's ED note dated 06/29/20 on 08/07/20 at 12:08 revealed:
-She was working second shift as a MA on duty on 06/25/20.
-Resident #2 went to the ED on 06/25/20 due to weakness and blood in his urine.
-She received a verbal report from a nurse at the ED for Resident #2 that the resident had been evaluated and treated.
-The nurse informed her Resident #2's urinary catheter had been changed, the resident was given Cipro and the resident was ready for transport back to the facility.
-The nurse from the ED did not tell her what Resident #2's prescription was for, but she assumed it would be Cipro since he had received a dose of Cipro while at the ED.
-When Resident #2 arrived back to the facility, she did not see any paperwork from his ED visit.
-MAs on duty were responsible to receive the follow-up paperwork when a resident was evaluated in the ED.
-She sent the RCC a text message that Resident #2 had returned to the facility from the ED and had no paperwork, but she did not get a response back from the RCC and thought the RCC received the text message the next morning.
-She contacted the hospital during her shift on 06/25/20 to request a faxed copy of Resident #2's ED visit note.

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{D 273}	Continued From page 9 -She had spoken with a staff at the hospital and was told they would fax Resident #2's ED notes to the facility, however, she never received a fax. -She "guessed" the RCC followed up on the need for the ED note and prescription because she knew she received Resident #2's prescription on 06/29/20 and once she relayed the message to the RCC it would have been "left up" for the RCC to follow up on it from there. -She received a call from the ED on 06/29/20 and was told Resident #2 had a prescription left there and the facility could go pick the prescription up or could fax the prescription. -Resident #2 was always complaining of pain in his pelvic area prior to going to the ED and she thought it was coming from the resident's UTI, but the resident also had a diagnosis of bone cancer. -On 06/29/20, after she had spoken with the nurse from the ED regarding Resident #2's Cipro prescription, she told the RCC but did not call the resident's PCP and did not know she was supposed to contact the PCP. Telephone interview with the Administrator on 08/07/20 at 11:50am revealed: -She was aware Resident #2 went to the ED on 06/25/20 but was not sure if the resident returned to the facility with an ED visit summary. -When Resident #2 returned to the facility from the ED on 06/25/20, the MA on duty should have received the resident' s visit summary note and the MA would have been responsible to assure follow up was done immediately by calling the ED if no documentation was provided from the resident's ED visit. -If the MA did not receive any documentation when Resident #2 returned from the ED on 06/25/20, the RCC should have been notified. -She would have expected the facility to have called the ED immediately to follow up on what	{D 273}		

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treatment and follow up needs the resident had and if there was no documentation returned to the facility with Resident #2 on 06/25/20.
-When Resident #2 did not start Cipro 500mg as ordered, she would have expected the PCP to have been notified immediately what was going on, would have expected specific timeframes to have been given when the resident had not received the medication.
-She was not sure why Resident #2's PCP notification of the delay in treatment did not occur.

Telephone interview with Resident #2's PCP on 08/06/20 at 1:12pm revealed:
-He only came to the facility on Thursdays and there "may have been a gap" when he was not aware Resident #2 had not started Cipro 500mg as ordered from the ED visit on 06/25/20.
-Cipro 500mg was ordered for Resident #2 to treat an infection and when not treated for that infection, the resident could have continued to experience changes in his mental status, falls and confusion from the side effects of the infection.
-Resident #2 would have been at risk for experiencing systemic problems such as fever, tachycardia and ultimately sepsis, however, he did not think the resident reached a point of becoming septic because of the infection.
-He expected to be notified if a medication was not started as prescribed to treat Resident #2's UTI.
-It would have been important for him to have been notified of Resident #2 not starting Cipro as ordered on 06/25/20 because if he had assumed the resident was being treated and the resident was not making any improvement which would be different from not knowing he was on a prescribed antibiotic treatment .
-He would have expected to be notified if

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{D 273}	Continued From page 11 Resident #2 did not start Cipro 500mg for follow up purposes. 2. Review of Resident #3's current FL-2 dated 01/14/20 revealed: -Diagnoses dementia, hypertension, venous insufficiency peripheral, lymphedema, amnesia, anemia and hypothyroidism. -Resident #3 was semi-ambulatory and needed a rollator walker as an assistive device. -Resident #3 was intermittently disorient. -Resident #3 had an order for TED hose. Review of Resident #3's Licensed Health Professional Support (LHPS) review dated 05/09/20 revealed Resident #3 had a task to apply and remove TED hose. Review of an appointment verification form for Resident #3 dated 07/18/20 revealed: -The form was signed by a Geriatric Nurse Practitioner (GNP). -There was an order to elevate Resident #3's feet and legs. -Resident #3's was to wear TED hose (compression socks). -The staff was to notify the Primary Care Provider (PCP) about the swelling in Resident #3's feet and legs. Review of Resident #3's April 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry to apply TED hose at 8:00am and remove at 8:00pm. -There was documentation of a "x" where the TED hose had not been applied or removed on 04/14/20, 04/23/20 and 04/28/20. Review of Resident #3's May 2020 eMAR	{D 273}		

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revealed:
-There was an entry to apply TED hose at 8:00am and remove at 8:00pm.
-There was documentation of a "x" where the TED hose had not been applied or removed on 05/07/20, 05/14/20, 05/21/20 and 05/28/20.

Review of Resident #3's June 2020 eMAR revealed:
-There was an entry to apply TED hose at 8:00am and remove at 8:00pm.
-There was documentation of a "x" where the TED hose had not been applied or removed on 06/04/20, 06/11/20, 06/18/20 and 06/25/20.

Review of Resident's #3 electronic progress notes recorded on 07/08/20 at 10:25pm revealed:
-Resident #3 feet and legs were swollen.
-He was asked to keep his feet and legs elevated to relieve some of the swelling.

Review of Review of Resident #3's electronic progress notes recorded on 07/21/20 at 10:28pm revealed:
-Resident #3's feet were "extremely swollen".
-He was asked to keep his feet elevated "at all times" to relieve some of the swelling.

Review of Resident #3's electronic progress notes recorded on 07/27/20 at 10:23pm revealed he was asked to keep his feet and legs elevated throughout the day to relieve some of the swelling.

Telephone interview with a personal care aide (PCA) on 08/05/20 at 5:09pm revealed:
-She assisted with activities of daily living (ADL), toileting, baths and feeding assistance.
-She knew that Resident #3 wore TED hose.
-She had not seen Resident #3 wear his TED

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{D 273}	Continued From page 13	{D 273}		

hose.
-Resident #3 had refused to wear his TED hose at least one to two times a week.
-She had informed the Medication Aide (MA) of Resident #3 refusal to wear his TED hose.

Telephone interview with a MA on 08/05/20 at 4:34pm revealed:
-She had applied TED hose for Resident #3.
-Resident #3 had issues with his feet swelling because of his lymphedema.
-Resident #3 had refused to wear his TED hose when his feet and legs would swell.
-Resident #3 was encouraged to keep his feet and legs elevated to relieve some of the swelling.
-Resident #3 was compliant with keeping his legs and feet elevated.
-Resident #3 would not refuse to wear his TED hose often.
-She had not contacted Resident #3's PCP when he had refused to wear his TED hose.
-She would contact a Resident #3's PCP if refusal to wear TED hose had occurred at least 5 days in a row.

Telephone interview with the Resident Care Coordinator (RCC) on 08/06/20 at 11:14am revealed:
-She knew that Resident #3 had worn TED hose.
-She was aware of a time when the MA was not able to put the TED hose on Resident #3 due to his legs swelling.
-The residents' PCPs were notified when a resident had refused to wear their TED hose.
-She had not informed Resident #3's PCP when he had refused to wear his TED hose.

Telephone interview with the Licensed Practical Nurse from Resident #3's PCP office on 08/06/20 at 4:39pm revealed:

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{D 273}	Continued From page 14 -Resident #3 kept his appointments. -Resident #3's last appointment was on 06/29/20 with his PCP. -There had been a physician's order in January 2020 to wear TED hose due to his diagnosis of lymphedema. -The PCP had not been informed of Resident #3's swelling of the feet and legs. -The PCP had not been informed of Resident #3 refusal to wear the TED hose. -Resident #3 needed to be encouraged to wear the TED hose because of his diagnosis of dementia. -The TED hose would had helped with Resident #3's swelling of his feet and legs had he worn the TED hose daily. Telephone interview with the Administrator on 08/06/20 at 3:43pm revealed: -The MAs and/or RCC notified the residents' PCP when medications were missed for three consecutive days and refusals to wear TED hose for two to three consecutive days. -Resident #3's PCP had not been notified when he had refused to wear his TED hose. -There was a policy to notify the residents' PCP if the residents refused to wear their TED hose two or three consecutive days. -The LHPS nurse would be notified when residents refused to wear their TED hose. -Resident #3 was capable of putting on his TED hose depending his memory. -Resident #3 liked to lay down and did not like to put on his TED hose. -Resident #3 wore his TED hose when he sat up in his chair. -Resident #3's PCP had not been informed about his refusal to wear the TED hose due to the swelling of his feet and legs because it was not often that Resident #3 had refused to wear his	{D 273}		

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{D 273}	Continued From page 15 TED hose. -She reviewed the MAR and saw it was documented he Resident #3 did not wear his TED hose in May 2020 and June 2020. -The MAs were expected and responsible for contacting all residents' PCPs, LHPS nurse and RCC of the refusal of medication orders or other physician orders. 3. Review of Resident #4's current FL-2 dated 01/09/20 revealed: -Diagnoses included anxiety disorder, left lower quadrant pain, emphysema and osteoarthritis. -The resident was semi-ambulatory and used a wheelchair. -There was a physician order to check vital signs on the 15th each month. -There was no weight listed for Resident #4. Review of Resident #4's current Assessment and Care Plan dated 02/06/20 revealed: -The resident was semi-ambulatory and used a wheelchair. -She weighed 193 pounds. -She was oriented, and her memory was adequate. Review of Resident #4's physician orders dated 01/09/20 revealed there was a physician's order to check vitals on the 15th of the month, once a day between 7:00am-3:00pm. Review of the facility's vitals report from 06/15/20-07/15/20 revealed: -There was an entry on 06/15/20 at 1:11pm with Resident #4's weight at 220.6 pounds. -There was an entry on 07/15/20 at 10:13am with Resident #4's weight at 249 pounds. -There was documentation on the vitals report of a 5.0 percent change in weight in 30 days on the	{D 273}		

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{D 273}	Continued From page 16 07/15/20 weight entry. -There was no documentation of Resident #4's primary care physician (PCP) being notified of the 5.0 percent weight change. Telephone interview with a medication aide (MA) on 08/05/20 at 4:33pm revealed: -Residents were weighed on the first shift by a MA on the 15th of each month. -The Resident Care Coordinator (RCC) should be notified by the MA if there was a 5-10 pound weight loss or gain. -The RCC was responsible for notifying the PCP of a 5-10 pound weight loss or gain. -If a resident was in a wheelchair the weight of the wheelchair was subtracted from their total weight. Telephone interview with a second MA on 08/07/20 at 12:25pm revealed: -When a resident had a weight loss or weight gain of 5 pounds, the RCC should be notified. -When a weight variation of 5.0 percent or more was recorded, there was a notification on the vitals report, which indicated there was a change in weight of 5.0 percent or more in the past 30 days. -The notification on the vitals report was a reminder for the MA to notify the RCC of a 5.0 percent or more weight change in the past 30 days. -The RCC was responsible for notifying the resident's PCP of the weight change immediately. Telephone interview with the RCC on 08/07/20 at 11:11am revealed: -She sent the PCP the weight variance report at a minimum of every 3 months. -If a resident had a 10-pound weight loss or gain she would notify the PCP that day.	{D 273}		

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{D 273}	Continued From page 17 -She expected the first shift MA to inform her immediately if a resident had a weight loss or gain of 5-10 pounds. -It was her routine to send a weight variance report to each resident's PCP every 3 months. -Resident #4 weighed 249 pounds on 07/15/20. -Resident #4's PCP had not been notified of her 29 pound weight gain on 07/15/20. -When she reviewed reports for anything "outlandish" such as a 20-50 pound weight loss or gain she would expect the MA to weigh the resident again. -The MA failed to notify her of the 29 pound weight gain obtained for Resident #4 on 07/15/20. -The MA had not notified Resident #4's PCP of her 29 pound weight gain on 07/15/20. -She felt that the weight discrepancy was due to the shower chair weight of 20.4 not being subtracted from her total weight. -Resident #4 would have weighed 228.6 pounds after subtracting the shower chair weight of 20.4; which would have resulted in a 21 pound weight gain. Telephone interview with Resident #4's PCP on 08/06/20 at 1:10pm revealed: -The facility notified him of a resident's weight loss and/or gain by sending him a weight variance report or by calling him to inform him of a weight loss or gain of 5-10 pounds. -Resident #4's weight gain was caused by her medication, decrease in physical activity, gastrointestinal problems and fluid from her pulmonary difficulties. -He expected staff to encourage her to increase her physical activity and to decrease the amount of time she spent in bed. -Her weight gain could cause difficulties with her hypertension and cause an increased strain on her heart.	{D 273}		

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{D 273}	Continued From page 18 -He expected the facility to notify him immediately of any weight loss or weight gain of 5-10 pounds. Telephone interview with the Administrator on 08/06/20 at 3:42pm revealed: -The MA was responsible for weighing residents on the 15th of each month per Resident #4's PCP orders listed on the eMAR. -There was a shower chair on the scales that weighed 20.4 pounds. -When a resident was in a wheelchair, they were weighed in the shower chair for consistency of weights. -The MA was expected to subtract 20.4 pounds from the total weight of the resident sitting on the shower chair to obtain their correct weight. -Resident #4 weighed 230.4 pounds on 08/06/20 when weighed in the shower chair. -Resident #4's accurate weight should have been 210 pounds after subtracting the 20.4 pounds for the weight of the shower chair. Telephone interview with the Administrator on 08/07/20 at 11:51am revealed: -Resident #4 weighed 249 pounds on 07/15/20. -The MA and RCC should have subtracted the weight of the shower chair of 20.4 pounds, which would have Resident #4's weight as 228.6 pounds on 07/15/20. Requests for the facility's Weight Policy on 08/6/20 and 08/7/20 from the facility were unsuccessful. _____ The facility failed to notify Resident #2's primary care provider (PCP) when the resident did not receive an antibiotic ordered on 06/25/20 by the ED physician for 4 days to treat a urinary tract infection (UTI). The resident was also evaluated again on 06/30/20 in the ED for a fall and blood in	{D 273}		

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{D 273}	Continued From page 19 his urine with discharge instructions to continue the same ordered antibiotic for a UTI. The facility's failure resulted in a 4-day delay in Resident #2 being treated for a UTI placing the resident at increased risk for urinary symptoms, continued falls, confusion fever, tachycardia and ultimately could have led to sepsis; and failed to notify Resident #4's PCP of a 21 pound weight gain in one month, placing the resident at increased risk for hypertension complications and increased strain on the resident's heart. Failure to notify Resident #2 and Resident #4's PCP was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/07/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2020	{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 B VIOLATION	D 358		

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Based on interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 1 residents sampled (#2) which resulted in a 4 day error related to an antibiotic .

The findings are:

Review of Resident #2's current FL-2 dated 02/20/20 revealed:
-Diagnoses included dementia, congestive heart failure, neuromuscular dysfunction and iron deficiency anemia.
-The resident was intermittently disoriented and wandered.

Review of a faxed prescription order dated 06/25/20 for Resident #2 revealed:
-There was a stamped received date of 06/29/20 at 8:18pm from the local emergency department (ED) at the top of the form.
-There was a prescription for Cipro 500mg, twice daily for 7 days with a quantity dispense of 14 tablets and no refills. (Cipro is an antibiotic used to treat bacterial urinary tract infections (UTIs) .

Review of a telephone order unsigned by the primary care provider (PCP) for Resident #2 dated 06/29/20 revealed:
-There was an order for Cipro 500mg twice daily for 7 days.
-The telephone order was signed by the Resident Care Coordinator (RCC).

Telephone interview with a medication aide (MA) on 08/05/20 at 4:35pm revealed:
-Resident #2 was being treated for a UTI the end of June and the beginning of July 2020.
-She remembered Resident #2's antibiotic was changed to a different antibiotic.

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-She was not sure if Resident #2 had a delay starting Cipro 500mg to treat a UTI but the RCC would be the only one to know and why.
-Resident #2 started getting weaker and had to be checked on more.

Review of an ED note for Resident #2 dated 06/29/20 provided by the facility revealed:
-The note was entered and signed by a registered nurse (RN).
-Resident #2's prescription for Cipro was left in the ED.
-The RN had spoken with a named MA at the facility and faxed Resident #2's Cipro prescription to the facility.

Second telephone interview with the MA named in the nurse's ED note dated 06/29/20 on 08/07/20 at 12:08 revealed:
-She was working second shift as a MA on duty on 06/25/20.
-Resident #2 went to the ED on 06/25/20 due to weakness and blood in is urine.
-She received a verbal report for Resident #2 from a nurse at the ED after the resident had been evaluated and treated.
-The nurse informed her Resident #2's urinary catheter had been changed, the resident was given Cipro and the resident was ready for transport back to the facility.
-The nurse from the ED did not tell her what Resident #2's prescription was for, but she assumed it would be Cipro since he had received a dose of Cipro while at the ED.
-When Resident #2 arrived back to the facility, she did not see any paperwork from his ED visit.

Review of Resident #2's June 2020 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 22 -There was an entry for Cipro 500mg, twice daily scheduled at 8:00am and 8:00pm with a start date as 06/30/20 and a discontinued date as 07/04/20. -There were parentheses around the staff's initials documenting the Cipro 500 mg was not administered on 06/30/20 at 8:00am with a reason as the resident was unavailable. -There was documentation Cipro 500 mg was administered on 06/30/20 at 8:00pm. -There was no documentation that Cipro was administered from 06/25/20 - 06/29/20 as ordered from the ED visit on 06/25/20. Review of subsequent PCP's orders for Resident #2 dated 07/04/20 revealed to discontinue Cipro and start Keflex 500mg every 6 hours for 10 days. (Keflex is an antibiotic used to treat bacterial urinary tract infections). Review of Resident #2's July 2020 eMAR revealed: -There was an entry for Cipro 500mg, twice daily for 7 days scheduled at 8:00am and 8:00pm with a start date as 06/30/20 and a discontinued date of 07/04/20. -There was documentation Cipro 500mg was administered at 8:00am and 8:00pm from 07/01/20 - 07/04/20 at 8:00am. -There was an entry for Keflex 500mg, every 6 hours for 10 days scheduled at 12:00am, 6:00am, 12:00pm and 6:00pm. -There was documentation Keflex was administered every 6 hours from 12:00am on 07/05/20 through 6:00pm on 07/14/20. Review of Resident #2's electronic progress note dated 06/25/20 revealed the resident was sent to the ED per the PCP's request due to an extended bladder and possible catheter malfunction.	D 358		

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D 358	Continued From page 23 Review of an accident/incident report dated 06/25/20 at 2:31pm for Resident #2 revealed: -Resident #2 had no urine going into the urinary catheter bag. -The resident was seen by the PCP prior to being sent to the ED. -The form was generated by a MA. -The Administrator was notified. -The form was completed by the RCC. Review of an ED visit summary for Resident #2 dated 06/25/20 revealed: -The resident was seen in the ED for a urine catheter insertion or check. -The resident's indwelling urinary catheter was replaced, and urine was obtained "which appeared to be possibly infected". -The resident's laboratory tests included a urinalysis and a urine culture. -The resident was diagnosed with an obstruction of the urinary catheter and a UTI with no blood in the urine. -The resident received Cipro at 7:52pm. -There were instructions to start Cipro 500mg twice daily for 7 days and to continue to follow-up with the resident's PCP and urology for further management of the indwelling urinary catheter. -There was a printed stamped date of 06/29/20 at the bottom of the ED visit summary form. Review of Resident #2's electronic progress notes revealed: -On 06/29/20 at 1:49am, there was an entry the resident had a urology appointment at 1:30pm. -On 06/29/20 at 1:39pm, there was an entry the resident had an appointment today. The resident stated that he felt fine but "his appetite hadn't been that great" and had eaten "maybe" 40 percent of his breakfast, and 50 percent of his	D 358		

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lunch, otherwise the resident no concerns or complaints.

Review of Resident #2's electronic progress dated 06/30/20 at 10:21am revealed there was an entry the resident had fell and had "a lot of blood in his catheter bag", the resident was sent to the ED by emergency medical services (EMS) and the resident's PCP was notified.

Review of an accident/incident report dated 06/30/20 at 7:39am for Resident #9 revealed:
-The resident fell trying to get back into his bed and had blood in his urinary catheter bag.
-The resident was taken to the ED.
-In the "Record status of Resident after ER/Hospital" section of the form, to continue medication, the diagnosis was a UTI.
-In the Evaluation Notes" section of the form, the resident would follow-up with the PCP at the next facility visit.
-The form was generated by a MA.
-The Administrator was notified.
-The form was completed by the RCC.

Review of an ED visit for Resident #2 dated 06/30/20 revealed:
-The resident was seen in the ED for a fall, urine catheter insertion or check and blood in the urine.
-The resident's laboratory tests included a urinalysis and a urine culture.
-The resident was diagnosed with a fall, blood in the urine and prostate cancer metastatic to bone.
-There were instructions to continue Cipro for a UTI and to follow-up with a urologist regarding the bleeding in the urinary drainage bag.

Telephone interview with the RCC on 07/31/20 at 3:37pm revealed the MAs were responsible to fax medication orders to the facility's contracted

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pharmacy provider and place the order in her box.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/03/20 at 8:33am revealed:
revealed:
-The pharmacy dispensed 14 Cipro 500mg tablets on 06/29/20 with instructions to take 1 tablet twice a day for Resident #2.
-The order received 06/29/20 was a telephone order signed by a "nurse" and was the only order received for Cipro 500mg to be filled for Resident #2.
-The Cipro 500mg would have been delivered the same day (06/29/20) or the next day if the order was faxed late on 06/29/20.

Telephone interview with a personal care aide (PCA) on 08/05/20 at 5:09pm revealed Resident #2 had a few falls and needed more assistance with emptying his indwelling urinary catheter bag and had to be checked on more often after returning from the hospital.

Telephone interview with the RCC on 08/06/20 at 11:09am revealed:
-When a medication order was received, the MA on duty was responsible to fax the medication order to the pharmacy.
-The MAs were responsible for placing the residents order in her box.
-The residents' order would go through the facility's "Bucket System" until the order is processed and ready to be filed in the residents' record.
-The facility's contracted pharmacy staff entered the medication orders in eMAR system.
-The new medications added to the eMAR by the facility's contracted pharmacy would be labeled

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D 358	Continued From page 26 as "pending". -She was responsible for reviewing and approving the pending medication orders in the eMAR system. -Once approved, the order would flow over to the resident's eMAR and the MA could administer the medication and could document the administration. -She and the Administrator were the only staff that could approve orders added to the eMAR system. -There were times that she and the Administrator could enter medications into the eMAR system if it was a tapering medication dose or treatment orders for a skin tear, however, "typically", the contracted pharmacy provider enters all medication orders in the eMAR system. -She occasionally performed residents' record audits and the facility's nurse done record audits. -She could not say if she had done a record audit in Resident #2's record since 06/25/20. -She performed medication cart audits on all residents weekly and if a new medication order was added she made sure the medication was received. -She compared the residents' medication sent from the facility's contracted pharmacy with the order to assure all medications were listed on the eMAR, she checked to assure all medications were in date and available. Second telephone interview with the pharmacy technician with the facility's contracted pharmacy provider on 08/07/20 at 8:17am revealed: -She found a copy of the prescription written by the ED on 06/25/20 for Resident #2's Cipro attached to Resident #2's telephone order that was not signed by the resident's PCP dated 06/29/20 for Cipro 500mg. -The pharmacy received the copy of the	D 358		

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D 358	Continued From page 27	D 358		

prescription on 06/29/20 after the medication had been filled by the telephone order for Cipro 500mg on 06/29/20 for Resident #2.
-Resident #2's healing from the UTI could have been delayed by not starting Cipro as ordered on 06/25/20.

Second telephone interview with the RCC on 08/06/20 at 2:32pm revealed:
-The facility had a "hard script" for Cipro 500mg for Resident #2 dated 06/25/20.
-The facility did not receive the prescription on 06/25/20 from the ED but the facility faxed the prescription on 06/29/20 at 8:18pm.
-She could not recall any specific information but thought the ED "forgot" or did not send the prescription for the Cipro on 06/25/20 when the resident was treated in the ED.
-Resident #2's Cipro 500mg was received from the facility's contracted pharmacy provider on 06/30/20 at 12:10am.

Telephone interview with the RCC on 08/07/20 at 11:10am revealed:
-The RN from the ED contacted the facility and spoke with the MA (named) on 06/29/20 concerning Resident #2's Cipro prescription.
-The MA informed her Resident #2's prescription was left at the ED.
-She received the faxed prescription on 06/29/20 and "wrote it up" with a telephone order and faxed both to the facility's contracted pharmacy provider.
-She sent a telephone order first to the pharmacy because that was what she had on hand so the resident could go ahead and start the medication then she sent the prescription faxed from the ED later to the pharmacy.
-She was not sure how the facility received the 06/25/20 ED visit notes for Resident #2 and was

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not sure why a printed date of 06/29/20 was on the bottom of the form.
-Resident #2's Cipro 500mg was delivered to the facility on 06/30/20 at 12:10am and then he went back to the ED on 06/30/20.

Review of the facility's Medication Administration policy revealed:
-The form was labeled as the pharmacy services and procedures manual for the documentation of New or Changed Physician/Physician/Prescriber's Orders.
-The form described processes related to new or changed medication orders for residents who were assisted with medication administration.
-Physician/Prescriber medications orders were required for all medications.
-The residents' prescription medications were accepted included a verbal order communicated in writing to the facility and an order faxed by the Physician/Prescriber's office and communicated in writing to the facility.

Telephone interview with the Administrator on 08/07/20 at 11:50am revealed:
-She would have expected the facility to have called the ED immediately to follow up on what treatment and follow up needs the resident had if there was no documentation returned to the facility with Resident #2 on 06/25/20.
-When a medication was ordered for a resident, the medication order should be immediately faxed to the contracted pharmacy provider and the order should have been given to the RCC who would have processed the order through the "Bucket System" to assure follow up was done.

Telephone interview with Resident #2's PCP on 08/06/20 at 1:12pm revealed:
-He could not remember why Resident #2's

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D 358	Continued From page 29 treatment regimen for Cipro was changed to Keflex 500mg on 07/04/20, but thought it was because he saw the resident's urine culture that showed the bacteria causing the infection in his urinary tract was resistant to Cipro. -Cipro 500mg was ordered for Resident #2 to treat an infection and when not treated for that infection, the resident could have continued to experience changes in his mental status, falls and confusion from the side effects of the infection. -Resident #2 would have been at risk for experiencing systemic problems such as fever, tachycardia and ultimately sepsis, however, he did not think the resident reached a point of becoming septic because of the infection and delay in starting the Cipro 500mg. Based on interviews and record reviews, Resident #2 was not interviewable. _____ The facility failed to administer medications to Resident #2, who was ordered to start Cipro after being treated on 06/25/20 at a local ED for a urinary tract infection (UTI). Resident #2 was evaluated and treated again for a fall and blood in his urine at the same local ED on 06/30/20 with written instructions to continue the same ordered antibiotic but, the resident was not administered Cipro for 4 days, missing 9 doses from 06/26/20-06/29/20. This failure resulted in a delay of treatment, an increased risk for UTI, continued falls, confusion fever, tachycardia and ultimately could have led to sepsis which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection (POP) in	D 358		

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D 358	Continued From page 30 accordance with G.S. 131D-34 on 08/06/20 with a POP addendum on 08/07/20 . CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2020	D 358		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to assure provision of adequate and appropriate care and services to residents regarding health care and medication administration. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure notification of the primary care provider (PCP) for 3 of 5 sampled residents (#2, #3 and #4) when there was a 4 day delay of administering an antibiotic after a resident was evaluated and treated in the emergency department (#2), increased lower extremity swelling and weekly refusals to wear thrombo-embolic deterrent (TED) hose as ordered (#3) and a weight gain of 29lbs from June 2020 to August 2020 (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care	{D912}		

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{D912}	Continued From page 31 (Type B Violation)]. 2. Based on interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 1 residents sampled (#2) which resulted in a 4 day error related to an antibiotic. [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		