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	HAL016018	A. BUILDING: _____ B. WING _____	R 05/17/2021

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CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey with an onsite visit from May 11-12, 2021 and a desk review survey from May 13-14, 2021 and May 17, 2021 with a telephone exit on May 17, 2021.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards as evidenced by 9 of 14 oxygen tanks being stored in a unsecured manner on the floor without a stand or storage rack to prevent tipping in an unlocked storage closet. The findings are: Observation of a storage closet next to the medication aide's (MA's) desk on 05/11/21 at 9:50am revealed: -There was a sign on the door which read "O2 [oxygen] Closet". -There was another sign on the door which read "Oxygen". -The door to the closet was not locked when opened by surveyor. -There were four large oxygen tanks in non-tip	D 079		

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stands on the floor stored in various areas of the room in front of the wire shelving.
-There was one small oxygen tank stored on the floor in an unsecured manner in a padded carrying case.
-There was one small oxygen tank and eight medium oxygen tanks stored unsecured and free-standing on the floor in various areas of the room in front of the wire shelving that contained frequently used supplies.
-The four large oxygen tanks were full of oxygen.
-Two of the medium oxygen tanks had intact seals indicating they had not been used.
-There were eight small to medium oxygen tanks with broken seals.
-There was very little room to walk in the closet due to the multiple oxygen tanks being stored on the floor and scattered throughout the closet.

Interviews with a MA on 05/11/21 at 9:50am and 2:05pm revealed:
-They used the closet for supply and oxygen tank storage since COVID-19 began because they had to separate the sick residents who had the COVID-19 virus and their supplies from the well residents.
-The facility was no longer in COVID-19 outbreak status, but they had not cleaned out the closet yet.
-The closet was unlocked, but the staff tried to lock the door it if they walked away and the closet was not supervised by facility staff.
-She was not sure why they had the large oxygen tanks but thought they had them on-hand leftover from hurricane preparedness 2-years ago in case the facility lost power.
-The tanks without a blue seal were empty tanks.
-She was not sure of the proper way to store oxygen tanks but they used to chain oxygen tanks to the walls several years ago as the facility's

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storage process.
-The oxygen tanks should be in a storage racks so they would not tip over, especially if the tanks were full.
-The facility did not have storage racks for the unsecured tanks.
-The facility had always stored the tanks standing upright on the floor.
-The personal care aides (PCA) and MAs were in and out of the closet all day to access frequently used supplies that were stored on the wire shelved being the tanks they needed to care for the residents.
-It would be easy for staff to knock the tanks over due to how messy the closet was and how little room there was to walk causing a safety issue.
-She thought it was the MAs or the Resident Care Coordinator's (RCC) responsibility to order new tanks and have the empty tanks picked up by the durable medical equipment (DME) provider.
-There was no facility process in place or education for staff to ensure safe storage of oxygen tanks.
-She had not reported any concerns regarding oxygen tank storage to anyone because she didn't realize it was a problem.

Interview with the Maintenance Director on 05/11/21 at 2:21pm revealed:
-Oxygen tanks were supposed to be stored in the O2 closet.
-He did not normally handle oxygen tanks and did not know how they were to be stored.
-The closet was supposed to stay locked and was ventilated for safety purposes.
-He did not normally enter the O2 closet unless he had a work order for repairs to do so.
-He was not aware that the oxygen tanks were stored unsecured on the floor or that it was a problem.

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D 079	Continued From page 3 Interview with the RCC on 05/11/21 at 2:37pm revealed: -Oxygen tanks that were not in use were to be stored in the O2 closet. -When the tanks were empty, the MA's or the RCC would call the DME provider to come pick them up. -There was no documentation of safe oxygen storage monitoring for the O2 closet. -There should have been crates or stands in the room to store the full and empty oxygen tanks in order to prevent tipping of the oxygen tanks. -She could not remember the last time she entered the O2 closet because it was the MAs responsibility to keep "an eye on when to reorder" the oxygen tanks. -She was not aware that the tanks had been stored unsecured on the floor. Interview with the Administrator on 05/11/21 on 2:37pm revealed: -There was no process in place to ensure the safe storage of oxygen tanks; she did not know why, except that she was still in the process of fixing other process issues within the facility since she started. -She was not aware that the door to the O2 closet was unlocked and that the oxygen tanks were not stored safely. -It was important to properly store oxygen tanks because they did not want the tanks to fall over and cause an explosion. Telephone interview with a representative from the facility's contracted DME provider on 05/14/21 at 1:03pm revealed: -The large oxygen tanks were provided to the facility in the event of a power outage for any length of time as emergency back-up to ensure	D 079		

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D 079	Continued From page 4 residents who used oxygen via a concentrator in their rooms would have access to oxygen until power had been restored. -Oxygen tanks should be stored in a crate or stand to stabilize them and prevent tipping if stored upright. -If an oxygen tank tipped over it could injure someone by falling on them, fly across the room due to pressure build-up, or explode leading to injury or death. -If the oxygen tanks were stored in frequently accessed areas, there would be a greater risk of knocking the tanks over causing injury or an explosion. -Care facility residents were generally at a higher fall risk than the rest of the general population and could easily knock an oxygen tank over if they had access to it. -The DME provider could supply a non-tip stand to store oxygen tanks upon request. -She could not recall if the facility had previously requested non-tip stands from the DME provider. -Storing oxygen tanks in an unsecured fashion was a safety risk.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 5 of 5 sampled residents	D 273		

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(#1, #2, #3, #4, and #5) related to the omission of a referral to an endocrinologist (#1), rectal bleeding not reported to the primary care provider (PCP) (#3), complaints of urinary discomfort not reported to the PCP, a urinalysis and laboratory orders and follow-up with an ophthalmologist (#1), not reporting blood pressures outside of parameters to the PCP (#4), and not reporting fingerstick blood sugars (FSBS) outside of parameters to the PCP (#5).

The findings are:

1.Review of Resident #2's FL-2 dated 03/25/21 revealed:
-Diagnoses included diabetes mellitus type II (DMII), hemiparesis, muscle weakness, aphasia following cerebral infarction, heart failure, unspecified atrial flutter, history of a cardiovascular accident, history of a bilateral total knee arthroplasty, and right sided weakness.
-She was on a regular diet with no added table salt and was intermittently disoriented.

Review of Resident #2's primary care provider (PCP) note dated 10/01/20 revealed an order to have the resident follow up with endocrinology for a diagnosis of poorly controlled DMII.

Review of Resident #2's PCP note dated 02/04/21 revealed:
-The resident was non-compliant with her diet per the facility staff.
-The resident's blood sugars remained elevated with a large fluctuation of FSBS values.
-There was an order to have the resident follow up with endocrinology for a diagnosis of poorly controlled DMII.
-The facility was to send Resident #2's blood glucose levels to the endocrinology office for

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evaluation and assistance to manage the resident's care.

Review of Resident #2's laboratory results dated 05/05/21 revealed:
-The residents hemoglobin A1C (HgBA1c) result was 10.2. (HgBA1c is used to measure average blood glucose levels over a 3-month period to see how well diabetes is being managed.)
-Normal range for HgBA1c was 4.8-5.6.
-Desired ranged for the diabetic resident was less than 7.0.
-There was a handwritten order signed by the PCP to have the resident follow up with endocrinology on 05/06/21.

Review of Resident #2's record revealed no documentation that the resident had been seen by an endocrinologist or that an appointment with the endocrinologist had been made.

Interview with Resident #2 on 05/12/21 at 4:35pm revealed she did not see the PCP or any specialty physicians on a regular basis and would like them to check on her more often.

Telephone interview with a medication aide (MA) at Resident #2's endocrinologist's office on 05/17/21 at 8:21am revealed:
-Resident #2 had not been seen by the endocrinologist since 01/06/2010.
-They had not received any communication or referral information from the facility to schedule an appointment until 05/14/21.
-She would expect the facility to follow the PCP orders in referring the resident and communicating information to the endocrinologist.
-Having uncontrolled blood glucose requiring additional insulin along with an elevated HBA1c was concerning because it meant the resident's

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blood sugars needed to be managed and better controlled.
-Long term health factors related to increased blood glucose from diabetes could affect the resident's cardiovascular system, vision, increased risk for infection and delayed wound healing, kidney damage, and risk of diabetic ketoacidosis (a serious condition that could lead to a diabetic coma).
-Interventions that could have been provided by the endocrinologist would have helped to protect the resident from harmful diabetic co-morbidities that accompany a diabetes diagnosis.
-If they had heard from the facility regarding Resident #2 needing to be seen, there would have been very little to no wait time to get an appointment with the endocrinologist.

Telephone interview with Resident #2's PCP on 05/14/21 at 8:46am and 05/17/21 at 9:52am revealed:
-He expected the facility staff to make the resident an appointment with the endocrinologist as ordered.
-He expected the facility staff to notify the endocrinologist of the resident's blood sugars and HBA1c as ordered as he had "discussed with the staff".
-He was not an endocrinologist and expected the resident to be seen by the endocrinologist for the management of her poorly controlled diabetes.
-The resident could have negative outcomes related to her diabetes that included renal failure, ophthalmic (eye) issues, and circulation issues with severity depending on the length of time her blood sugars were poorly controlled.
-The resident having an HBA1c of 10 meant that Resident #2's diabetes had been poorly controlled.
-He was unaware that Resident #2 did not receive

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an appointment at the endocrinologist's office.
-The facility should have called Resident #2's endocrine provider for an appointment prior to 05/14/21.

Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:32pm revealed:
-New orders (medications, lab orders, or referrals) from the PCP were scanned into the "system" by her or the Administrator for implementation using the "bucket system".
-Physician referrals were then sent to the transportation coordinator who would then call to set up the appointment for a resident.
-The transportation coordinator would tell her when the appointment was made, and she would add it to a calendar in the computer that would be printed off.
-She would also document the appointment in the resident record via a progress note.
-All orders should be processed within 24 business hours.
-There was no audit system in place to ensure orders were completed except the bucket system.
-She did not document her steps of action in the bucket system; she just worked on things until they were completed.
-If orders were not placed into the bucket system, she would not know to follow up on them.
-She did not know that Resident #2 needed an appointment with the endocrinologist.

Telephone interview with the Administrator on 05/17/21 at 3:00pm revealed:
-Referrals to outside providers were scheduled by the transportation coordinator.
-She expected all referrals to be scheduled as soon as the order was received and seen by the outside provider as soon as possible.

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-The transportation coordinator was expected to schedule the appointment, attach it to a post-it note, then return the order back to the RCC or Administrator where it would be placed into the "bucket system".
-The RCC was responsible to follow up on residents' orders in the bucket system daily.
-The process for scheduling resident referral appointments was put into place approximately one month ago.
-The RCC reviewed orders and placed them into the bucket system to ensure the orders were completed..
-She and the RCC did not know about several orders, including Resident #2's order to follow up with an endocrinologist.
-She would have expected the facility staff to capture orders within the PCP notes if they had access to them in order to implement the orders as needed.
-As soon as the facility was aware of the orders brought to their attention, they immediately looked in the record to review and implement the orders, and the transportation coordinator began making appointments right away.
-The transportation coordinator did not call and make an appointment until 05/14/21 because she had to figure out which endocrinologist Resident #2 was supposed to see.
-She was concerned that Resident #2 had been delayed in seeing an endocrinologist.

Attempted interview with Resident #2's guardian on 05/14/21 at 12:49pm was unsuccessful.

2. Review of Resident #5's current FL-2 dated 12/10/20 revealed:
-Diagnoses included cerebrovascular accident, urinary tract infection, hypertension, diabetes mellitus, and depression.

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-The resident's ambulatory status was documented as a wheelchair.
-She was disoriented intermittently.

Review of Resident #5's primary care provider (PCP) order report from 11/09/20-12/10/20 revealed:
-Orders to check fingerstick blood sugars (FSBS) before meals and at bedtime.
-Call PCP with FSBS <80 or >300 four times a day; 7:30am, 11:30am, 4:30pm, and 8:00pm.

Review of Resident #5's PCP order dated 04/12/21 revealed:
-Check FSBS before meals and at bedtime.
-Call PCP with FSBS <80 or >350.

Review of Resident #5's electronic medication administration record (eMAR) dated March 2021 revealed:
-There was an entry to check a FSBS at bedtime (8:00pm) and to call PCP for blood sugar <80 or >300.
-On 03/03/21, the FSBS was documented as 383 mg/dl.
-On 03/07/21, the FSBS was documented as 336 mg/dl.
-On 03/09/21, the FSBS was documented as 360 mg/dl.
-On 03/10/21, the FSBS was documented as 340 mg/dl.
-On 03/13/21, the FSBS was documented as 324 mg/dl.
-On 03/14/21, the FSBS was documented as 355 mg/dl.
-On 03/16/21, the FSBS was documented as 346 mg/dl.
-On 03/26/21, the FSBS was documented as 333 mg/dl.
-There was no documentation on the eMAR that

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Resident #5's PCP was notified of the 8 episodes of the FSBS >300.

Review of Resident #5's progress notes dated March 2021 revealed there was no documentation the PCP was notified of the FSBS above parameters on 03/03/21, 03/07/21, 03/09/21, 03/10/21, 03/13/21, 03/14/21, 03/16/21, and 03/26/21.

Review of Resident #5's eMAR dated April 2021 revealed:
-There was an entry to check a FSBS at bedtime (8:00pm) and to call PCP for blood glucose <80 or >300.
-There was an entry for Humalog U-100 Insulin inject 7 units subcutaneously daily at 8:00am, hold for FSBS <200 (Humalog insulin is used to treat diabetes).
-On 04/01/21, the FSBS was documented as 346 mg/dl.
-On 04/02/21, the FSBS was documented as 347 mg/dl.
-On 04/10/21, the FSBS was documented as 337 mg/dl.
-On 04/19/21, the FSBS was documented as 41 mg/dl.
-On 04/24/21, the FSBS was documented as 66 mg/dl.
-On 04/30/21, the FSBS was documented as 66 mg/dl. .
-There was no documentation on the eMAR that Resident #5's PCP was notified of the 6 episodes of the FSBS <80 or >300 in April 2021.

Review of Resident #5's progress notes dated April 2021 revealed:
-There was no documentation the PCP was notified of the FSBS above parameters on 04/01/21, 04/02/21, and 04/10/21 >300.

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-There was no documentation the PCP was notified of the FSBS below parameters on 04/19/21, 04/24/21, and 04/30/21 <80.

Telephone interview with a medication aide (MA) on 05/13/21 at 4:47pm revealed:
-She was responsible for obtaining FSBS and administering or holding medications for FSBS <200mg/dl to Resident #5 on 04/19/21, 04/24/21, and 04/30/21 as indicated by her initials on the electronic medication administration records.
-Resident #5 was not administered any Humalog insulin on 04/19/21, 04/24/21, and 04/30/21 at 8:00am due to having FSBSs <200 and she did not notify Resident #5's PCP.
-She did not notify Resident #5's PCP of FSBS results of 41 mg/dl on 04/19/21, 66 mg/dl on 04/24/21, and 66 mg/dl on 04/19/21.
-She was not sure why she did not notify Resident #5's PCP of the FSBS results.
-She was aware of Resident #5's FSBS ordered parameters to notify the PCP with FSBS <80 or >300 four times a day.
-When a resident's FSBS was below parameters they were at risk for hypoglycemia.

Interview with a medication aide on 05/12/21 at 7:51am revealed:
-For a resident FSBS result below or above parameter, she would call the PCP with the results and follow the PCP's verbal order.
-For after hours, she would notify the on-call PCP by phone.
-She would fax a PCP notification to the PCP if unable to reach the PCP by phone.
-Also, a resident progress note would be completed outlining the resident's FSBS result and the outcome of the PCP notification.

Interview with a MA/Supervisor on 05/12/21 at

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D 273	Continued From page 13 10:21am revealed: -For a resident who had a change in health status from baseline, running a temperature, a low oxygen saturation, or a FSBS result above/below the ordered parameters before 5:00pm, she would call the resident's PCP. -For any resident changes or results above/below parameters, she would notify the on-call PCP after 5:00pm. -She would also fax the PCP notification of any resident changes or results above/below parameters. -The faxed PCP notification would then be placed into a folder within the facility's bucket system. -The Administrator or the RCC were responsible for following the faxed PCP notification through the bucket system process. -The faxed PCP notification would remain in the facility's bucket system process until the Administrator or the RCC spoke with the resident's PCP or until the facility received the faxed PCP notification back signed and dated which meant it was received and reviewed. Telephone interview with the RCC on 05/14/21 at 1:30pm revealed: -She expected for a resident who had a FSBS below/above the PCP ordered parameters, the resident's PCP should receive notification by phone by the staff member immediately. -If staff were unable to reach the resident's PCP by phone, staff should fax the resident's PCP with the results. -Any PCP faxed notifications would be placed in the red folder within the facility's bucket system process. -Once the PCP faxed notification was placed in the red folder,the RCC was to follow up immediately. -She would follow the faxed PCP notification	D 273		

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through the facility's bucket system process until it made it to the green folder, ready to be filed in the resident's record.
-She also expected staff to also complete a resident progress note.

Telephone interview with Resident #5's primary care provider (PCP) on 05/14/21 at 8:46am revealed:
-He expected to be notified of the resident's FSBS results below or above his ordered parameters by a phone call, fax, or a text message the same day of the occurrence.
-If he was not notified by the facility of the resident's FSBS result below or above his ordered parameters, he could not do much about it or provide an intervention.
-He expected to be notified so he could "address" the result.

Telephone interview with the Administrator on 05/14/21 at 10:30am revealed:
-She expected staff to follow the PCP's orders related to notification when a resident had a FSBS below/above parameters.
-She expected staff to notify the PCP immediately when a resident had a FSBS below/above parameters.
-There was not a current monitoring process at the facility for the RCC or herself to confirm the PCP was notified of any abnormal FSBS.
-She had "concerns" if the resident had a FSBS outside the ordered parameters.
-The resident could have experienced low blood sugar, shakiness, dizziness, confusion, sweating, heart palpitations or hospitalization.
-She had "concerns" for the resident if the PCP was not notified of the resident's FSBS, the PCP could not implement any action.

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3. Review of Resident #3's current FL-2 dated 06/24/20 revealed:
-Diagnoses included hypothyroidism, gastroparesis, anxiety and anorexia.
-The resident was semi ambulatory.

Review of Resident #3's current assessment and care plan dated 01/28/21 revealed the resident was sometimes disoriented, forgetful and needed reminders.

Review of Resident #3's progress note documented by a medication aide (MA) dated 03/08/21 at 2:59am revealed:
-The resident reported when she went to the bathroom there was a bunch of "dark, dark blood" that came out of her rectum.
-The MA did not witness the rectal bleeding.
-The MA faxed the resident's primary care provider (PCP) to report the rectal bleeding.

Interview with Resident #3 on 05/11/21 at 10:30am revealed:
-Her health was declining due to her diagnosis.
-She saw her PCP on a regular basis.

Attempted second interview with Resident #3 on 05/12/21 at 9:45am was unsuccessful.

Telephone interview with the MA, who documented Resident #3's progress note dated 03/08/21 at 2:59am on 04/17/21 at 2:15pm revealed:
-She frequently provided care to Resident #3.
-Resident #3 reported to her she saw blood in the toilet on 03/08/21.
-She was not sure if the resident had the bleeding after having a bowel movement because she did not observe the blood.
-The resident had flushed the toilet when the

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rectal bleeding was reported to her.
-The resident was not having any pain or discomfort at that time and she told Resident #3 when she used the toilet again to call her and not to flush the toilet.
-The resident denied seeing any further bleeding the remainder of the shift on 03/08/21.
-She asked the resident days after 03/08/21 if she had seen any further bleeding and at that time, the resident did not remember reporting to her that she saw blood in the toilet.
-If she had seen any blood in the resident's toilet, she would have called 911 and sent the resident for evaluation at the emergency room.
-She remembered that it was in the middle of the night and she sent a fax notification to Resident #3's PCP related to the resident's reports of rectal bleeding.
-She attached the confirmation page to the fax sent to Resident #3's PCP, then reported Resident #3's rectal bleeding to the next shift (first shift) MA.
-She placed the confirmation page and fax sent to Resident #3's PCP in one of "6 folders" filed in the "copier room".
-She did not receive a response from the fax she sent to Resident #3's PCP regarding the reports of rectal bleeding.

Review of Resident #3's PCP orders and notifications from the facility revealed there was no documentation of a fax sent to the resident's PCP related to rectal bleeding.

Telephone interview with the receptionist for Resident #3's PCP on 04/17/21 at 11:15am revealed:
-There was no documentation in Resident #3's record that the facility contacted the resident's PCP regarding any rectal bleeding in March 2021.

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-The resident's PCP had on-call staff for after hour care assistance.
-If the facility faxed Resident #3's information into the office concerning the reports of rectal bleeding on 03/08/21, the information would have been in the system.

Telephone interview with the facility's PCP who provided as needed care for Resident #3 on 05/17/21 at 10:05am revealed:
-He could not remember any specific information regarding any reports of the resident having any rectal bleeding.
-He could not recall every phone call he received and was currently not at the office.

Telephone interview with the Resident Care Coordinator (RCC) on 05/17/21 at 2:59pm revealed she was not aware of any issues with Resident #3 having any rectal bleeding.

Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed:
-She was not aware of any issues with Resident #3 having any rectal bleeding.
-The MA should have communicated Resident #3's reports of rectal bleeding to her or the RCC in order to ensure follow-up occurred with the PCP.

Telephone interview with a nurse for Resident #3's PCP on 04/17/21 at 11:20am revealed:
-The last appointment the resident had at the PCP's office was 02/18/21.
-There was no notification in the resident's record regarding any rectal bleeding from March 2021 - current.
-She reviewed all the faxed documents received since March 2021 and there was no fax received regarding the resident's rectal bleeding.

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-The resident had a 3-month follow-up appointment tomorrow, 04/18/21.
-It would have been important to contact Resident #3's PCP regarding any concerns of rectal bleeding.
-The facility should have contacted the PCP immediately because passing large amounts of blood could have caused anemia.
-The resident had a history of iron deficiency anemia.
-A one-time occurrence could have been related to constipation and would not be of great concern, however the PCP would have expected to be notified and could have possibly ordered blood work for the resident.
-When a facility faxed any documents to the PCP, the information was printed for the PCP and after the PCP reviewed the information a return fax would have been sent back to the facility with an order if an order was indicated.
-It was expected for the facility to have contacted the resident's PCP in a day or so when there was no response back concerning the resident's rectal bleeding.

4. Review of Resident #1's current FL-2 dated 02/09/21 revealed:
-Diagnoses included hyperlipidemia, obesity, diabetes mellitus type II and schizoaffective disorder of bipolar type.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #1's current assessment and care plan dated 02/04/21 revealed the resident was oriented with an adequate memory.

Attempted interview with Resident #1 on 05/12/21 at 4:54pm was unsuccessful.

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a. Review of Resident #1's progress notes documented by a medication aide (MA) dated 02/23/21 revealed:
-The resident was complaining of pain when she urinated.
-The resident reported that there was a burning sensation "really bad" and an odor.
-The resident reported that this had been going on for a while.
-There was no documentation the resident's primary care provider (PCP) was notified.

Review of Resident #1's PCP visit note dated 02/25/21 revealed:
-The resident was being seen for complaints of burning when urinating as well as hesitancy, urinary frequency and urgency.
-The PCP would order a urine for culture and sensitivity and treat accordingly.

Review of Resident #1's PCP orders dated 02/25/21 revealed an order for a urinalysis (U/A) with a culture and sensitivity (C/S). (A U/A is a urine test to detect urinary tract infections and a C/S tests for the types of bacteria and organisms in the urine to determine what type of antibiotics to treat infections).

Review of Resident #1's laboratory results revealed:
-There was a urine C/S collected by on 03/03/21.
-The final report date was dated 03/05/21.
-The results were less than 10,0000 organisms per millimeter with no abnormal results.
-The PCP signed the report with his initials and no date.

Review of Resident #1's PCP visit note dated 03/18/21 revealed:
-The resident was being seen for a routine

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follow-up.
-The resident had a neurogenic bladder with a history of painful and difficult urination.
-The resident had been evaluated by a Urologist in the past.
-The resident was voiding independently at that time with no further complaints of inability to pass urine, no abnormal large amounts of urine, no frequency of urinating at night and no voiding discomfort.
-The resident had a Computed Tomography (CT) scan which revealed a right renal cyst (no date provided). (A CT scan is a diagnostic computerized scan that takes a series of x-ray images of bones, blood vessels and soft tissue).

Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:33pm revealed:
-She had been the RCC for approximately one month.
-The MA would have been responsible to contact the PCP on 02/23/21 concerning Resident #1's complaints of pain when urinating on 02/23/21.
-When a resident had a change in status the MA would have been responsible to contact the PCP immediately.
-There should have been documentation by the MA if contact was made with Resident #1's PCP on 02/23/21.
-The RCC was concerned if Resident #1's PCP was not contacted on 02/23/21 because the resident was having pain and no orders to collect a U/A were given until two days later (02/25/21).

Telephone interview with a registered health information technologist with the Resident #1's PCP's office on 05/17/21 at 10:12am revealed:
-There was documentation of contact made from the facility on 02/20/21 at 11:21am regarding

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concern of "light bleeding" with a possible UTI .
-The message was given to the on-call provider who ordered Resident #1 to have a urinalysis.
-There was no other documentation in the resident record regarding any complaints with urination on 02/23/21.
-There were no laboratory results since August 2020.

Review of Resident #1's PCP orders and notifications from the facility revealed there was no documentation of the resident's light bleeding or an order for a urinalysis.

Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed:
-She was not aware Resident #1 had an order on 02/20/21 for a U/A due to reports of light bleeding.
-There was no documentation in Resident #1's record of any urinary symptoms or light bleeding when urinating for 02/20/21 or an order for a U/A.
-There was no documentation in Resident #1's record staff had attempted to collect a U/A.
-She would have expected staff to have contacted Resident #1's PCP and reported the resident's symptoms on 02/23/21.
-She had concerns Resident #1 had symptoms that could have affected her overall health including her mental status and that her symptoms were causing her pain.

Telephone interview with Resident #1's PCP on 05/14/21 at 8:45am and 05/17/21 at 10:05am revealed:
-He was currently not at the office.
-He was not aware of any issues or concerns of any laboratory orders not being completed for the resident.
-He received the resident's laboratory results from the facility or from the facility's laboratory

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provider that collected the samples.
-He expected all orders including any laboratory orders given for the resident to be completed as ordered.

b. Review of a primary care provider (PCP) order for Resident #1 dated 03/25/21 revealed an order for a complete blood count (CBC) in 30 days. (A CBC is a blood test containing full blood count levels).

Review of Resident #1's laboratory results dated 03/24/21 revealed:
-On 03/24/21, the resident's laboratory results included a CBC with differential. (A differential measured and counts the different types of white blood cells from a blood sample).
-The resident had an abnormal red blood cell (RBC) result of 3.57. (A normal RBC reference range was 3.6 - 4.9).
-The resident had an abnormal hemoglobin (HGB) result of 10.9. (A normal HGB reference range was 11.0 - 15.0).
-There was a handwritten circle around the resident's RBC and HGB level with an error pointing below to a handwritten order.
-There was a handwritten order dated 03/25/21 for Ferrous Sulfate 325mg daily and a CBC in 30 days. (Ferrous Sulfate is an iron supplement).
-There were no additional CBC laboratory results for the resident.

Review of Resident #1's PCP visit notes dated 04/29/21 revealed:
-The resident's CBC results dated 12/30/20 and 02/03/20 were documented In the Labs/Tests section of the visit note.
-There was no documentation for the resident's CBC results ordered 03/25/21.

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Telephone interview with a registered health information technologist with the Resident #1's PCP's office on 05/17/21 at 10:12am revealed:
-All of Resident #1's PCP notes and orders were not scanned into the resident's record.
-Currently there were no orders for a CBC in 30 days dated 03/25/21 in the resident's record.
-There were no CBC laboratory results for Resident #3 dated after 03/25/21.
-The only laboratory results Resident #1 had in her record were from August 2020.
-She would review Resident #1's record and information to scan and would forward the results if found.

At the time of exit there was no additional information provided from Resident #1's PCP regarding any additional laboratory results.

Telephone interview with a client service staff with the facility's contracted laboratory provider on 05/17/21 at 8:05am revealed the facility had access to all the residents' laboratory results through an electronic provider portal.

Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed:
-She and the Resident Care Coordinator (RCC) were responsible for processing and scheduling residents' labs.
-Resident #1's order dated 03/25/21 for a CBC in 30 days was missed.
-She thought Resident #1's order was overlooked when the order was received from the PCP because it was possibly stapled together.
-She expected all orders to be implemented as ordered by the PCP.

Telephone interview with Resident #1's PCP on 05/14/21 at 8:45am and 05/17/21 at 10:05am

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revealed:
-He was currently not at the office.
-He was not aware of any issues or concerns of any laboratory orders not being completed for Resident #1.
-He received the resident's laboratory results from the facility or from the facility's laboratory provider that collected the samples.
-He expected all orders including any laboratory orders given for the resident to be completed as ordered.

c. Review of Resident #1's orders revealed 04/15/21 an order to obtain a Depakote level, CBC, CMP and a TSH on next blood draw.

Telephone interview with a registered health information technologist with the Resident #1's primary care provider's (PCP's) office on 05/17/21 at 10:12am revealed:
-All of Resident #1's PCP notes and orders were not scanned in the resident's record.
-Currently there were no orders for a Depakote level, CBC, CMP and a TSH dated 04/15/21 in the resident's record.
-There were no Depakote level, CBC, CMP and a TSH laboratory results for Resident #3 for the order dated 04/15/21.
-The only laboratory results Resident #3 had in her record were from August 2020.

Telephone interview with a client service staff with the facility's contracted laboratory provider on 05/17/21 at 8:05am revealed the facility had access to all the residents' laboratory results through an electronic provider portal.

Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:33pm revealed:

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-She was responsible to follow up on all residents' orders.
-Residents' laboratory orders were set up through the facility's contracted laboratory provider.
-The facility used a "Bucket System" for processing and filing all orders to ensure all orders were implemented.

Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed:
-The residents' laboratory testing orders were currently entered into the facility's contracted electronic laboratory portal.
-The facility had switched around the middle of April 2021 to electronically entering all residents' laboratory orders through the facility's contracted electronic laboratory portal.
-She and the RCC were responsible for processing the residents' laboratory orders, however, the RCC was having issues with using the facility's contracted laboratory portal and unable to currently use the system.
-Prior to using the facility's contracted laboratory electronic portal, a copy of the residents' laboratory order was placed in a binder for the phlebotomist who came to the facility on a routine basis weekly.
-During this time of transition (around the middle of April 2021), there was not a phlebotomist from the facility's contracted laboratory making weekly visits to the facility because it was "assumed" all residents' lab request would be entered into the electronic portal system.
-She had implemented a process to track the completion of resident orders using the facility's Bucket System within the last month when the RCC started her position.
-The residents' laboratory order went into a designated blue folder within the facility's Bucket System, documentation was handwritten on the

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residents' order when the order was completed and then moved to another folder within the facility's Bucket System file for the residents' order to be filed in the residents' record.
-Resident #1's lab order dated 04/15/21 to obtain a Depakote level, CBC, CMP and a TSH on next blood draw was around the time the facility transitioned to entering the residents labs into the facility's contracted laboratory portal and the facility was having difficulty entering the resident's laboratory requests.
-She thought she had sent the lab results for Resident #1's order dated 04/15/21 for the Depakote level, CBC, CMP and a TSH for review but would check again and forward the results.

Telephone interview with Resident #1's PCP on 05/14/21 at 8:45am and 05/17/21 at 10:05am revealed:
-He was currently not at the office.
-He was not aware of any issues or concerns of any laboratory orders not being completed for the resident.
-He received the resident's laboratory results from the facility or from the facility's laboratory provider that collected the samples.
-He expected all orders including any laboratory orders given for the resident to be completed as ordered.

At the time of exit on 05/17/21 there was no additional information provided from the facility for Resident #1's Depakote level, CBC, CMP and a TSH laboratory results ordered 04/15/21.

d. Review of Resident #1's primary care provider (PCP) visit notes revealed an entry to please follow-up with ophthalmology; diagnosis was deteriorating vision bilateral on 14 visit notes from 12/21/21 - 04/29/21.

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D 273	Continued From page 27 Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:33pm revealed: -She was responsible to follow up on all residents' orders. -The transporter coordinator scheduled the residents' appointments to outside providers. -The transporter coordinator provided her and the Administrator a calendar when the residents' appointments were made. -Recently a new process had been put into place to also document in the residents' progress note when the referral had been scheduled. -The facility used a "Bucket System" for processing and filing all orders to ensure all orders were implemented. Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed: -When a resident had a referral to an outside provider, the order was given to the transporter coordinator. -She expected all resident referrals to be scheduled as soon as the order was received and seen by the outside provider as soon as possible. -The transporter coordinator was responsible for scheduling the residents' appointments, document the appointment on a "post it" note attached to the order and return the order to the her. -It was "now" expected for the transporter coordinator to also document in the residents' progress note when the referral was made. -Resident referrals were monitored by placing the referral into the Bucket System and if there were no notes in the residents' progress note section or if the residents' referral was not returned back she would follow-up with the transporter coordinator to check on the status of the referral.	D 273		

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-She had implemented this system to process residents' referrals "probably" within the last month using the facility's Bucket System.
-The RCC was responsible to monitor the residents' orders in the Bucket System daily.
-Resident orders were reviewed by the RCC when received and placed into the Bucket System to ensure the orders were completed.
-She and the RCC were unable to view and print the residents' PCP notes until last week.
-She and the RCC did not realize PCP notes were available to review and print and received access to the residents' PCP electronic system approximately 1 and ½ weeks ago.
-The only resident orders she and the RCC had were PCP orders that were written and left at the facility or if a residents' orders were faxed to the facility.
-When orders were only included on the residents' PCP visit notes, they would not have been aware there was an order for the resident since no visit notes were left at the facility by the PCPs.
-Since she had been employed as the Administrator, she had not requested any notes from the residents' PCPs.
-She and the RCC were not aware the resident needed to follow-up with an ophthalmologist until Resident #1's PCP visit notes were requested.
-Resident #1's ophthalmology appointment was scheduled last week after the resident's notes were reviewed and calls were placed to find out which ophthalmologist the resident had seen in the past.

Telephone interview with a scheduler at Resident #1's ophthalmologist office on 05/17/21 at 12:12pm revealed:
-The resident was last seen in January 2013.
-A call was received from the facility on Friday,

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05/14/21, and an appointment was made 09/10/21.

Telephone interview with Resident #1's PCP on 05/17/21 at 10:05am revealed he expected resident referrals to any speciality provider to be followed up as soon as possible rather than later.

5. Review of Resident #4's FL-2 dated 12/21/20 revealed:
-Diagnoses included conduction disorder (heart disorder), hyperlipidemia, hypertension, anemia, coronary artery disease, and heart valve replacement.
-The resident was constantly disoriented.

Review of Resident #4's miscellaneous records revealed:
-He had a heart valve replacement on 09/12/12.
-He had a pacemaker placed on 01/10/14.
-He was diagnosed with Adam Stokes syndrome (a syndrome that causes period fainting spells in which there is intermittent complete heart block or other high grade arrythmias resulting in loss of spontaneous circulation and inadequate blood flow to the brain) on 04/20/21.

Review of Resident #4's physicians orders dated 03/02/21 revealed an order to check blood pressure twice daily with parameters to call the primary care provider (PCP) for a systolic blood pressure (SBP) less than 110 or greater than 180, or a diastolic blood pressure (DBP) less than 50 or greater than 90 at 8:00am and 8:00pm.

Review of Resident #4's April 2021 medication administration records (MAR) revealed:
-There was an entry to check the resident's blood pressure twice daily with parameters to report to the PCP of SBP less than 110 or great than 180,

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or a DBP less than 50 or great than 90 at 8:00am and 8:00pm.
-There was documentation on 04/02/21 at 8:00am of a blood pressure of 160/97 which was outside of parameter.
-There was an documentation on 04/05/21 at 8:00pm of a blood pressure of 157/92 which was outside of parameter.
-There was an documentation on 04/11/21 at 11:00pm of a blood pressure of 143/92 which was outside of parameter.
-There was an documentation on 04/12/21 at 8:00am of a blood pressure of 160/93 which was outside of parameter.
-There was no documentation the provider was notified of the blood pressures being outside of the ordered parameters.

Review of Resident #4's progress notes revealed there was no documentation that the provider was notified of the resident's blood pressures that were outside of parameter.

Review of Resident #4's PCP encounter notes revealed there was no documentation that the facility made him aware of the resident's blood pressures outside of parameter.

Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed:
-The MAs were responsible for obtaining vital signs as ordered.
-The MAs would call the PCP if vital sign results were outside of parameters as ordered.
-Calls to the PCP would be documented on the resident's progress note.
-She did not know if Resident #4's PCP was contacted regarding his DBP outside of the parameter if it was not documented.

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D 273	Continued From page 31 Telephone interview with a medication aide/supervisor (MA/S) on 05/13/21 at 4:48pm revealed: -She worked on 04/12/21 and obtained resident #4's blood pressure that was outside of the parameter. -She did not call Resident #4's PCP or cardiologist as ordered and did not remember why. -She should have called the resident's PCP because the result was outside of the parameter. -The result outside of the parameter was a risk to the resident because he took blood pressure medications and his blood pressure was too high. Telephone interview with Resident #4's PCP on 05/14/21 at 8:46am revealed: -He expected to be notified of blood pressure results outside of the ordered parameter. -If a blood pressure was out of range and he did not know about it, he would not be able to address the problem and provide further intervention or evaluate a pattern. -If a resident was followed by a cardiologist, he would expect the facility to notify the cardiologist of blood pressure results outside of the parameter as well. -He did not remember being notified of Resident #4's blood pressure outside of the parameters. -He was concerned that Resident #4 had increased blood pressures outside of the parameters because it could cause the resident to experience eye issues, headaches, dizziness, or put the resident at increased risk of stroke and heart attack. -If he had been notified of the resident's increased blood pressure, he would have ordered for the resident to have the blood pressure rechecked and to notify the resident's cardiologist.	D 273		

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D 273	Continued From page 32 Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:32pm revealed: -It was expected for facility staff to notify a resident's PCP right away for blood pressure ranges outside of the parameter via fax, phone, or on-call provider. -If the notification had been faxed, the RCC would have followed up to ensure the notification had been received. -Notification of blood pressures outside of the parameters was expected to be documented on the resident's progress notes. Telephone interview with the Administrator on 05/14/21 at 1:32pm and 05/17/21 at 3:00pm revealed: -The staff were expected to contact the PCP for blood pressures outside of the parameters, even after hours, per the PCP request. -She would be concerned if orders were not followed because the resident could have potential harm if the PCP was unaware and unable to address any issues. -Orders should have been carried out to ensure residents received care for their safety and overall health. Interview with a medication aide on 05/12/21 at 7:51am revealed: -For after hours, she would notify the on-call PCP by phone. -She would fax a PCP notification to the PCP if unable to reach the PCP by phone. Interview with a MA/Supervisor on 05/12/21 at 10:21am revealed: -For any resident changes or results above/below parameters, she would notify the on-call PCP	D 273		

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after 5:00pm.
-She would also fax the PCP notification of any resident changes or results above/below parameters.
-The faxed PCP notification would then be placed into a folder within the facility's bucket system.
-The Administrator or the RCC were responsible for following the faxed PCP notification through the bucket system process.
-The faxed PCP notification would remain in the facility's bucket system process until the Administrator or the RCC spoke with the resident's PCP or until the facility received the faxed PCP notification back signed and dated which meant it was received and reviewed.

Telephone interview with the RCC on 05/14/21 at 1:30pm revealed:
-She expected for a resident who had a blood pressure reading below/above the PCP ordered parameters, the resident's PCP should receive notification by phone by the staff member immediately.
-If staff were unable to reach the resident's PCP by phone, staff should fax the resident's PCP with the results.
-Any PCP faxed notifications would be placed in the red folder within the facility's bucket system process.
-Once the PCP faxed notification was placed in the red folder,the RCC was to follow up immediately.
-She would follow the faxed PCP notification through the facility's bucket system process until it made it to the green folder, ready to be filed in the resident's record.
-She also expected staff to also complete a resident progress note.

Telephone interview with Resident #4's primary

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care provider (PCP) on 05/14/21 at 8:46am revealed:
-He expected to be notified of the resident's blood pressure result below or above his ordered parameters by a phone call, fax, or a text message the same day of the occurrence.
-If he was not notified by the facility of the resident's blood pressure result below or above his ordered parameters, he could not do much about it or provide an intervention.
-He expected to be notified so he could "address" the result.

Telephone interview with the Administrator on 05/14/21 at 10:30am revealed:
-She expected staff to follow the PCP's orders related to notification when a resident had a blood pressure reading below/above parameters.
-She expected staff to notify the PCP immediately when a resident had a blood pressure reading below/above parameters.
-There was not a current monitoring process at the facility for the RCC or herself to confirm the PCP was notified of any abnormal blood pressures.
-She had "concerns" if the resident had a blood pressure outside the ordered parameters.
-The resident could have experienced heart palpitations or hospitalization.
-She had "concerns" for the resident if the PCP was not notified of the resident's blood pressures, the PCP could not implement any action.

Attempted telephone interview with Resident #4's cardiologist on 05/14/21 at 11:32 was unsuccessful.

_____

The facility failed to ensure referral and follow-up for 5 of 5 sampled residents to include delay in a referral appointment to an endocrinologist for

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D 273	Continued From page 35 seven months for a resident who had uncontrolled diabetes (#2); failure to notify the primary care provider (PCP) for a resident's report of rectal bleeding who had a history of anemia (#3); delayed contact with the PCP for urinary pain to collect a urine sample for 5 days which posed a risk of ongoing pain and failed to follow-up with an ophthalmologist for at least 4 months (#1), and not reporting fingerstick blood glucose outside of parameters (#5); and not reporting blood pressures outside of parameters for a resident who had a history of severe cardiac disease (#4). The facility's failure resulted in substantial risk of serious harm and pain and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/21 and revised and accepted on 05/18/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#2) regarding weekly blood pressures.

The findings are:

1.Review of Resident #2's FL-2 dated 03/25/21 revealed:
-Diagnoses of diabetes mellitus type II (DMII), hemiparesis, muscle weakness, aphasia following cerebral infarction, heart failure, unspecified atrial flutter, history of a cardiovascular accident, history of a bilateral total knee arthroplasty, and right sided weakness.
-She was on a regular diet with no added table salt and was intermittently disoriented.
-There was an order for weekly blood pressures.

Review of Resident #2's previous FL-2 dated 03/23/20 revealed an order for weekly blood pressures.

Review of Resident #2's electronic medication administration record (eMAR) dated March, April, and May 2021 revealed no documentation of weekly blood pressures.

Interview with the Administrator on 05/12/21 at 3:34pm revealed:
-Implementation of orders on the FL-2 were expected to be implemented by the Resident Care Coordinator (RCC) or the Administrator

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within 24 business hours.
-She did not know why Resident #2's orders on her FL-2 had not been implemented.

Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed:
-When the primary care provider (PCP) wrote an order, it was faxed to the pharmacy.
-The pharmacy placed the order on eMAR and the RCC or Administrator would approve the order.
-It was the MA's responsibility to obtain resident blood pressures.
-She was not aware Resident #2 had an order for weekly blood pressures.

Telephone interview with a medication aide/supervisor (MA/S) on 05/13/21 at 3:54pm revealed orders were processed by faxing them to the pharmacy who would subsequently place the order on the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am revealed:
-The pharmacy placed new orders on the eMAR after they received the faxed order from the facility.
-The pharmacy would generate a discontinue order for a previous order.
-They were unable to view the facility eMARs.
-The facility must accept the discontinue order to have the previous order removed from the eMAR.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/17/21 at 11:10am revealed:
-They did not have the FL-2 dated 03/25/21 on file for Resident #2.
-They did not have an order on file for weekly

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blood pressures for Resident #2.
-If they had received an order for Resident #2 to have weekly blood pressures, the pharmacy would have entered the order on the eMAR to be carried out.
-It was important for Resident #2's safety to have weekly blood pressures obtained due to the resident's fall risk and history of stroke.

Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 8:46am revealed:
-He ordered weekly blood pressures for Resident #2.
-He expected the order for weekly blood pressures to be carried out as ordered.
-He did not know that Resident #2's blood pressures had not been obtained.

Telephone interview with the RCC on 05/14/21 at 1:32pm revealed:
-She did not know why Resident #2's order for weekly blood pressures was missed.
-She was responsible for scanning orders and faxing them to the pharmacy for implementation.
-She was responsible for ensuring medication orders showed up accurately on the eMAR.
-She would check the written order against the order on the eMAR to ensure accuracy, then approve the order on the eMAR.
-There was no system in place to check behind the RCC.

Telephone interview with the Administrator on 05/14/21 at 1:32pm and 05/17/21 at 3:00pm revealed:
-Orders were faxed to the pharmacy, then placed on the eMAR, and had to be approved by the RCC.
-Staff were not able to see orders on the eMAR

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D 276	Continued From page 39 that had not been approved. -Resident #2's weekly blood pressure would have been documented on the eMAR if it had been implemented. -She did not know why Resident #2's weekly blood pressure order had never been implemented. -She would have expected Resident #2's weekly blood pressure order to have been implemented within 24 business hours of receiving the order. -She was concerned that Resident #2's weekly blood pressure order had never been implemented. -She expected the eMAR to reflect accurate orders and documentation of what the resident was administered for the resident's safety.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure 1 of 5 sampled residents (#1) was served meals as ordered with an order for no caffeine. The findings are:	D 310		

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Review of Resident #1's current FL-2 dated 02/09/21 revealed:
-Diagnoses included hyperlipidemia, obesity, diabetes mellitus type II and schizoaffective disorder of bipolar type.
-The resident was intermittently disoriented.
-There was no diet order on the FL-2.

Review of previous diet orders for Resident #1 revealed there was an order dated 12/10/20 for a regular diet with no caffeine.

Review of the resident's diet list posted in the dining room on 05/11/21 at 11:00am revealed:
-There were two diet lists posted.
-Resident #1 was on a regular diet on an undated diet list.
-Resident #1 was on a regular diet with no caffeine on a diet list dated 01/26/21.

Observation of Resident #1 on 05/12/21 at 12:00pm revealed:
-She was seated at a table alone in the dining room for lunch.
-She was served approximately 12 ounces of tea with two packets of artificial sweetener with her plated food for lunch.
-She completed 75% of her lunch at 12:38pm and had consumed approximately 50% of her tea.

Interview with Resident #1 on 05/12/21 at 12:38pm revealed:
-She loved to drink her sweet tea, but sometimes it "tore her stomach up".
-She had a time with her stomach on the previous evening and she thought it may have been from drinking her sweet tea.

Observation in the facility's kitchen on 05/12/21 at 4:40pm revealed:

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-There was a box of tea labeled as black iced tea blend.
-There was no labeling to include the tea was decaffeinated.

Interview with a cook on 05/12/21 at 4:41pm revealed:
-She was not present during the residents' lunch meal service today, (05/12/21).
-The facility only had one type of tea on hand to serve to the residents.
-The tea on hand was not decaffeinated.
-Resident #1's dietary restrictions included no caffeine.
-Resident #1 was served either milk, juice, or water during her meals.
-Resident #1 should not have been served tea with her lunch meal.
-She was not sure why Resident #1 could not have caffeine.

Telephone interview with a registered health information technologist with the Resident #1's primary care provider's (PCP's) office on 05/17/21 at 10:12am revealed:
-In the resident's past medical history dated 01/20/15, there was documentation the resident was on a regular no caffeine diet because the resident had frequent headaches.
-There was documentation in the record the resident continued to have frequent headaches.

Telephone interview with Resident #1's PCP on 05/17/21 at 10:05am revealed:
-He could not remember any specific orders regarding Resident #1's diet order or reason the resident should not have caffeine.
-He was currently not at the office and did not have access to the resident's records.
-He expected all orders to be followed as

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D 310	Continued From page 42 ordered. Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed: -She and the Resident Care Coordinator (RCC) monitored the residents' meal service often since communal dining had resumed. -During her observations of the residents' meal service, she monitored the food served to the residents. -She thought the tea served to the residents was decaffeinated. -Resident #1 had been on a caffeine restricted diet for some time now. -Resident #1 loved to drink tea. -After 05/12/21, she met with one of the cook's who was responsible for ordering food for the facility and discussed purchasing decaffeinated tea in the event Resident #1 wanted tea with her meals.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the administration of medications as ordered for 2 of	D 358		

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5 sampled residents (#3 and #4) regarding a medication for pain (#3) and a medication for seizures (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 06/24/20 revealed diagnoses included hypothyroidism, gastroparesis, anxiety and anorexia.

Review of a subsequent medication order for Resident #3 dated 03/29/21 revealed:
-There was an unsigned entry from facility staff the resident had requested Acetaminophen 350mg added with her 8:00pm medications so the resident would not have to ask for it every night. (Acetaminophen was a medication used to treat mild pain).
-There was an order for Acetaminophen 350mg every hour of sleep.

Review of a pharmacy request from the facility's contracted pharmacy provider to Resident #3's primary care provider (PCP) dated 03/29/21 revealed:
-The order for Acetaminophen was written for 350mg.
-Acetaminophen did not have a strength of 350mg.
-"Did you mean 325mg or 650mg?"
-There was an entry to please clarify the dosage.

Review of a subsequent medication order for Resident #3 dated 03/29/21 revealed there was an order for Acetaminophen 325mg every hour of sleep.

Review of Resident #3's March 2021 electronic medication administration record (eMAR)

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revealed there was no entry for Acetaminophen 325mg every hour of sleep.

Review of a subsequent medication order for Resident #3 revealed there was an order for Acetaminophen 500mg at bedtime and to discontinue Acetaminophen 325mg dated 04/20/21.

Review of Resident #3's April 2021 eMAR revealed:
-There was an entry for Acetaminophen 325mg at bedtime with a scheduled administration time at 9:00pm.
-There was documentation Acetaminophen was administered from 04/01/21 - 04/25/21 with exceptions on 04/06/21 with a reason documented as the medication not being available, on 04/07/21 with a reason documented as waiting on family to bring supply, on 04/22/21 with a reason documented as not arrived from pharmacy yet and 04/24/21 with a reason documented as waiting on family to bring in.
-There was an entry for Acetaminophen 325 mg to be discontinued on 04/25/21.
-There was an entry for Acetaminophen 500mg at bedtime with a scheduled administration of 9:00am.
-There was documentation Acetaminophen 500mg was administered on 04/21/21.
-There was documentation Acetaminophen was discontinued on 04/22/21.
-There were no additional entries or documentation of administration for Acetaminophen 500mg at bedtime.

Review of Resident #3's May 2021 eMAR revealed there was no entry for Acetaminophen 500mg at bedtime.

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Observation of Resident #3's medications on hand on 05/12/21 revealed one bottle of Acetaminophen 325mg tablets.

Interview with Resident #3 on 05/11/21 at 10:30am revealed:
-She had severe pain in her legs, hip and back.
-She had neuropathy in her legs which caused a lot of pain and instability in her legs.
-Her health was declining due to her diagnosis.
-She took Acetaminophen from the medication aides (MAs) to control her pain and a prescribed medication to help with nerve pain.

Interview with the Resident Care Coordinator (RCC) on 04/12/21 at 1:08pm revealed:
-Resident #3 had a standing order for Acetaminophen as needed for pain.
-She was not sure why Acetaminophen 325mg at bedtime was not started in March 2021.
-She was not sure why Acetaminophen 500mg at bedtime was documented as administered on 04/12/21 then discontinued.
-She was not sure why Acetaminophen 500mg at bedtime was not on Resident #3's eMAR in May 2021.
-She would review Resident #3's medication orders and provide follow-up information.

Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 04/14/21 revealed:
-The resident complained of right leg pain when standing.
-Acetaminophen was ordered every 4 hours and scheduled at hour of sleep.
-The resident received a dose (Acetaminophen) prior the nurse's assessment.

Interview with a MA on 04/17/21 at 2:15pm

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revealed:
-She had provided care to Resident #3 often.
-Resident #3 was in "tremendous severe pain" in her hip, knees and legs.
-The resident took Acetaminophen for pain when needed but was not on any scheduled pain medications.
-She had administered Acetaminophen for pain when needed to Resident #3.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 05/17/21 at 11:55am revealed:
-The resident was a profile only meaning no medications were dispensed from the pharmacy and the resident's medication orders were added to the facility's eMAR system.
-On 05/13/21, there was an order to discontinue Acetaminophen 500mg at hour of sleep and start Acetaminophen 500mg twice daily.

Telephone interview with the RCC on 05/17/21 at 2:59pm revealed:
-Resident #3's scheduled Acetaminophen was inadvertently discontinued off the eMAR.
-She and the RCC were able to discontinue residents' medications from the eMAR.
-She contacted Resident #3's primary care provider (PCP) last week and advised the PCP that the resident's scheduled Acetaminophen was discontinued in error.
-She and the PCP reviewed how often Resident #3 was administered the as needed Acetaminophen.
-The PCP provided an order for the resident to receive Acetaminophen twice daily on a scheduled basis.
-She was not aware of any issues of Resident #3 having any increased, uncontrolled pain.

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D 358	Continued From page 47 Telephone interview with the Administrator on 05/17/21 at 2:59pm revealed: -Resident #3's order for the scheduled Acetaminophen was discontinued inadvertently from the eMAR. -Resident #3's order for the scheduled Acetaminophen was discontinued when the RCC was learning the eMAR system. -She and the RCC were now pulling a report daily and reviewed all changes to ensure medications were correct and accurate. -Resident #3 should have received Acetaminophen scheduled as ordered by her PCP. Telephone interview with Resident #3's PCP on 05/14/21 at 8:45am revealed: -He expected all medications to be administered to the residents as ordered. -Acetaminophen was ordered for Resident #3 to help the resident's pain, help the resident relax and rest at night. 2. Review of Resident #4's FL-2 dated 12/21/20 revealed: -Diagnoses included conduction disorder (heart disorder), hyperlipidemia (high cholesterol), hypertension (high blood pressure and when left untreated could complicate heart disease), anemia (low hemoglobin which carries oxygen through the body), coronary artery disease, and heart valve replacement. -The resident was constantly disoriented. Review of Review of Resident #4's medication orders dated 03/02/21 revealed and order for Keppra (a medication used to treat seizure disorders) 500mg every 12 hours at 8:00am and 8:00pm.	D 358		

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Review of Resident #4's electronic medication administration record (eMAR) dated April 2021 revealed:
-There was an entry to administer Keppra 500mg at 8:00am and 8:00pm as ordered.
-There was no documentation Keppra 500mg was administered on 04/08/21 at 8:00am.
-There was no documentation Keppra 500mg was administered on 04/26/21 at 8:00pm.
-There was no documentation Keppra 500mg was administered on 04/27/21 at 8:00am.
-There was no documentation why Keppra was not administered on any of the above dates.

Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed:
-When administering medications, she ensured the resident received accurate medications by comparing what she was administering to the resident's eMAR.
-She did not know why it was not documented that Resident #4 received his Keppra on 04/08/21, 04/26/21, or 04/27/21.
-The Keppra tablets came in the bubble packs with other pills that were supplied by the pharmacy, so the resident should have received the medication as ordered if the other medications had been administered.

Telephone interview with Resident #4's primary care provider (PCP) on 05/14/21 at 8:46am revealed:
-He expected medications to be administered as ordered.
-If medications were not administered as ordered, it could affect the resident's blood level of the medication, and possible cause negative outcomes.
-He had not been notified that Resident #4 had not receive his Keppra medication on 04/08/21,

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04/26/21, or 04/27/21.
-Resident #4's blood level could have dropped due to missing his doses of Keppra causing a seizure.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am revealed:
-The pharmacy dispensed 56 pills (28-day supply) of Keppra for Resident #4 on 03/18/21.
-The pharmacy dispensed 56 pills (28-day supply) of Keppra for Resident #4 on 04/15/21.
-There was no order on file to hold the doses of Keppra on 04/08/21, 04/26/21, or 04/27/21.
-There was no reason for Resident #4 to miss any doses of his Keppra.
-Resident #4 could have experienced a seizure due to missing his doses of Keppra.

Observation of Resident #4's medication on hand on 05/12/21 at 12:00 revealed that Resident #4 had Keppra available for administration.

Telephone interview with the Resident Care Coordinator (RCC)on 05/17/21 at 1:32pm revealed:
-She expected Resident #4's medications to be administered as ordered.
-She was not sure why it was not documented that Resident #4 received his Keppra on 04/08/21, 04/26/21, or 04/27/21.

Telephone interview with the Administrator on 05/17/21 at 3:00pm revealed:
-She expected Resident #4's medications to be administered as ordered.
-She was not sure why it was not documented that Resident #4 received his Keppra on 04/08/21, 04/26/21, or 04/27/21.
-She was concerned that the order was not

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D 358	Continued From page 50 carried out and could have caused potential harm to the resident. -She expected residents to receive their medications for their safety and overall health.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 3 of 5 sampled residents (#2, #3, #4) regarding duplicate medication orders on the eMARs and the omission of documenting	D 367		

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additional insulin medication orders and administration on the eMARs.

The findings are:

1.Review of Resident #2's FL-2 dated 03/25/21 revealed:
-Diagnoses of diabetes mellitus type II (DMII), hemiparesis, muscle weakness, aphasia following cerebral infarction, heart failure, unspecified atrial flutter, history of a cardiovascular accident, history of a bilateral total knee arthroplasty, and right sided weakness.
-She was intermittently disoriented.

Review of Resident #2's care plan dated 03/18/21 revealed the resident required LHPS tasks for finger stick blood sugar (FSBS) testing and insulin injections.

a. Review of Resident #2's renewed physician's orders dated 03/25/21 revealed:
-There was an order for Novolog U-100 aspart solution; 100unit/ml per sliding scale three times per day before meals at 7:30am, 11:30am, and 5:30pm, with a directive to call the primary care provider (PCP) for a FSBS greater than 400.
-There was an order for FSBS testing before bedtime at 8:00pm with a directive to call the PCP for a FSBS less than 80 or greater than 350.

Review of Resident #2's progress notes revealed:
-There was an entry dated 01/07/21 that the PCP was notified of the resident's FSBS outside of parameter at 559 at 8:00am with an order from the PCP to administer 5 units of additional insulin and to recheck the blood sugar in 30-minutes. The PCP was notified of the 30-minute re-check of FSBS at 482 with no additional orders.
-There was an entry dated 02/02/21 10:51pm that

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the PCP was notified of the resident's FSBS outside of parameter at 362.
-There was an entry dated 02/09/21 at 11:42 pm that the PCP was notified of the resident's FSBS outside of parameter at 413 with 5 units of insulin administered.
-There was an entry on 04/03/21 at 8:30pm that the PCP was notified of the resident's FSBS outside of parameter at 454 with 5 units of insulin administered and an order to administer 10 units of additional insulin.
-There was an entry dated 05/06/21 at 9:00pm that the PCP was notified of the resident's FSBS outside of parameter at 393 with an order to administer 10 units of insulin.
-There was an entry dated 05/09/21 at 8:30pm that the PCP was notified of the resident's FSBS outside of parameter at 558 with an order to administer 10 units of insulin and recheck the FSBS in 2-hours.
-There was an entry on 05/10/21 at 8:35pm that the PCP was notified of the resident's FSBS outside of parameter at 375.

Review of Resident #3's electronic medication administration records (eMARs) dated March, April, and May 2021 revealed:
-There was an entry to administer sliding scale insulin three times per day before meals and before bed.
-There was documentation on 04/03/21 in which the resident's FSBS was 454 which was outside parameter.
-There was documentation on 05/06/21 in which the resident's FSBS was 393 which was outside parameter.
-There was documentation on 05/09/21 in which the resident's FSBS was 558 which was outside parameter.
-There was documentation on 05/10/21 in which

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the resident's FSBS was 375 which was outside parameter.
-There were no entries documenting the additional FSBS checks or orders of insulin administered to the resident on the MARs for FSBS that were outside of parameters as indicated by the resident's progress notes.

Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed:
-Verbal or telephone orders from the PCP or on-call provider would be documented on a physician order sheet, faxed to the pharmacy, then submitted to the Resident Care Coordinator (RCC) or Administrator except for insulin orders.
-Insulin orders were not faxed to the pharmacy and were only documented on the 24-hour shift report.
-Other shifts would know what was administered to the resident per verbal report or review of the 24-hour shift report.
-She was unsure why they did not document additional insulin on the eMAR.

Telephone interview with a medication aide/supervisor (MA/S) on 05/13/21 at 3:54pm revealed:
-Verbal or telephone orders for additional FSBS and insulin were documented on the resident progress notes.
-Other verbal or telephone medication orders were written on a physician order sheet and faxed to the pharmacy.
-The pharmacy was available to the facility 24-hours per day.
-One-time doses orders of insulin were not faxed to the pharmacy like other medication orders were.
-She did not know why the facility's process did not fax additional insulin orders to the pharmacy.

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-If it was not documented on a resident progress note, it was documented on the 24-hour shift report.
-Additional insulin was the only medication they did not document on the eMAR.
-She was concerned that additional insulin not documented on the eMAR could be safety issue due to insulin being a high risk/high alert medication and risk the resident getting too much insulin if not documented accurately.
-She had not reported her concerns to anyone and did not know why.

Attempted review of the facility's 24-hour shift reports on 05/13/21 and 05/17/21 was unsuccessful and not provided by the facility by survey exit.

Telephone interview with Resident #2's PCP on 05/14/21 at 8:46am and 05/17/21 at 9:52am revealed:
-He expected the facility staff to document all insulin administration on the resident's eMAR so when he assessed the resident he could review the eMAR for patterns in the resident's FSBS outside of parameters and additional needs of insulin to provide further interventions, and possibly adjust her diet order to properly manage her diabetes until she saw the endocrinologist.
-He was not aware the facility did not document additional FSBS and insulin on the eMAR.
-It was impossible for him to remember everything about every resident he serviced.
-The resident could have negative outcomes related to her diabetes that included renal failure, ophthalmic (eye) issues, and circulation issues with severity depending on the length of time her FSBS were poorly controlled.

Interview with a pharmacist at the facility's

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contracted pharmacy provider on 05/17/21 at 11:10am revealed:
-There was no documentation that the facility had faxed additional orders of insulin needed for FSBS outside of parameters to the pharmacy to be placed on the eMAR for documentation.
-If the facility did not fax the order to the pharmacy, the order would not be placed on the eMAR for the facility staff to document administration.
-If the additional insulin needs were not documented on the eMAR, it would affect the consultant pharmacist's ability to make recommendations to Resident #2's PCP or endocrine provider to guide the resident's care.
-With Resident #2's history of high FSBS, she was concerned that the providers could not see the documentation of additional needs for insulin on the eMAR because it could affect their decision to make medication adjustments for the resident that would be beneficial in preventing hypoglycemia (low blood sugar).
-Increased FSBS could lead to renal issues, kidney failure, circulation issues, eyesight issues, increased risk for infection and delayed wound healing, a decrease in the overall quality of life, diabetic coma, or death.

Telephone interview with the RCC on 05/14/21 at 1:32pm revealed:
-She was responsible for ensuring medication orders showed up accurately on the eMAR.
-The facility's process to document extra FSBS and doses of insulin was to place the documentation of the medication into a progress note or a 24-hour shift report.
-The 24-hour shift report was not part of the resident record.
-If the PCP did not see what he was looking for on the eMAR, the staff would pull the information

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D 367	Continued From page 56 for him if he asked for it. Telephone interview with the Administrator on 05/17/21 at 3:00pm revealed: -Medications should be documented on the eMAR to accurately reflect what a resident was administered. -She expected the eMAR to reflect accurate orders and documentation of what the resident was administered for the resident's safety. b. Review of Resident #2's renewed medication orders signed by the primary care provider (PCP) on 03/25/21 revealed: -There was a duplicate order for Levemir FlexTouch U-100 insulin. -There was an order with a start date of 12/24/20 with no end date for Levemir FlexTouch U-100 insulin (used to lower elevated blood sugar levels), inject 48 units subcutaneously, every morning at 8:00am. -There was another order with a start date of 02/07/21 and no end date for Levemir FlexTouch U-100 insulin, inject 48 hours subcutaneously, every morning at 8:00am. Review of Resident #2's electronic medication administration record (eMAR) dated March 2021 revealed: -There were duplicate entries for Levemir FlexTouch U-100 insulin. -There was an entry with a start date of 12/24/20 to administer Levemir FlexTouch U-100 insulin daily, 48 units at 8:00am. -The Levemir with a start date of 12/24/20 was documented as administered as ordered 03/01/21-03/31/21. -There was an entry with a start date of 02/07/21 to administer Levemir FlexTouch U-100 insulin, 48 units daily at 8:00am.	D 367		

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-The Levemir with a start date of 02/07/21 was documented as administered on 03/21/21.
-The Levemir with a start date of 02/07/21 was documented as "Not Administered: Other Comment: Duplicate Order" from 03/04/21-03/20/21 and 03/22/21-03/31/21.
-There was documentation that Resident #2 received two doses of Levemir insulin (96 units) on 03/21/21.

Review of Resident #2's eMAR dated April 2021 revealed:
-There were duplicate entries for Levemir FlexTouch U-100 insulin.
-There was an entry with a start date of 12/24/20 and an end date of 04/14/21 to administer Levemir FlexTouch U-100 insulin daily, 48 units at 8:00am.
-The Levemir with a start date of 12/24/20 was documented as administered as ordered for 12 of 30 days on 04/01/21-04/08/21 and 04/11/21-04/14/21.
-The Levemir with a start date of 12/24/20 was documented as "Not Administered: Other Comment: Duplicate Order" 2 of 30 days from 04/09/21-04/10/21.
-There was an entry with a start date of 02/07/21 to administer Levemir FlexTouch U-100 insulin 48 units daily at 8:00am.
-The Levemir with a start date of 02/07/21 was documented as administered as ordered 17 of 30 days on 04/09/10-04/10/21 and 04/15/21-04/30/21.
-The Levemir with a start date of 02/07/21 was documented as "Not Administered: Other Comment: Duplicate Order" 12 of 30 days from 04/01/21-04/08/21 and 04/11/21-04/14/21.

Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 8:46am

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revealed:
-He expected duplicate medications to be clarified and administered as ordered.
-He could not recall if facility staff had contacted him regarding Resident #2's medications.

Telephone interview with a MA at Resident #2's endocrinology office on 05/17/21 at 8:21am revealed:
-They had not received any communication from the facility regarding the resident's medication order or care.
-It was important to administer medications correctly as ordered to prevent resident harm.
-If the resident had received a double dose of the Levemir insulin, the resident would have required 30-minute blood glucose monitoring with a snack nearby due to the risk of hypoglycemia from receiving too much insulin.
-The endocrinologist would have expected to be notified if the resident received a double dose of the insulin.

Review of Resident #2's record revealed there was no documentation that the resident had any adverse outcome from receiving the double dose of Levemir on 03/21/21 or that the resident's PCP or endocrinologist were notified of the duplicate administration of Levemir insulin on 03/21/21.

Refer to the telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm.

Refer to the telephone interview with a medication aide/supervisor (MA/S) on 05/13/21 at 3:54pm.

Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am.

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Refer to the telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:32pm.

Refer to the interview with the Administrator on 05/12/21 at 3:34pm.

Refer to the telephone interview with the Administrator on 05/14/21 at 1:32pm.

2. Review of Resident #4's FL-2 dated 12/21/20 revealed:
-Diagnoses included conduction disorder (heart disorder), hyperlipidemia, hypertension, anemia, coronary artery disease, and heart valve replacement.
-The resident was constantly disoriented.

a.Review of Resident #4's record revealed an order dated 04/29/21 for Coumadin (a blood thinner used to prevent blood clots) 5mg daily except 7.5mg on Mondays and Fridays.

Review of Resident #4's electronic medication administration (eMAR) record dated May 2021 revealed:
-There was an entry to administer Coumadin 5mg daily.
-There was an entry to administer Coumadin 2.5mg with a 5mg tablet on Mondays and Fridays to equal 7.5mg.
-There was another entry on 05/03/21 to administer Coumadin 5mg daily.
-There was another entry on 05/03/21 to administer Coumadin 2.5mg with a 5mg tablet on Mondays and Fridays to equal 7.5mg.
-There was documentation by a MA that the resident was administered Coumadin 5mg and 2.5mg to equal 7.5mg on 05/03/21.
-There was also documentation by the Resident Care Coordinator (RCC) that the resident was

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administered a second dose of Coumadin 5mg and 2.5mg to equal 7.5mg on 05/03/21.

Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed she was very careful when administered high risk medications such as Coumadin to ensure safety.

Review of Resident #4's record revealed there was no order to administer the Coumadin 7.5mg twice on 05/03/21.

Telephone interview with Resident #4's primary care provider (PCP) on 05/14/21 at 8:46am revealed:
-He expected duplicate medications to be clarified and administered as ordered.
-He had not been notified that Resident #4 had been given a double dose of Coumadin 7.5mg on 05/03/21.
-Coumadin 7.5mg had not been ordered to be administered twice on 05/03/21.
-Resident #4's international normalized ratio (INR) value (how thin the resident's blood was) was already too high and having an extra dose of Coumadin 7.5mg was concerning because it could have caused the resident to have issues related to bleeding.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am revealed:
-The pharmacy had not received an order to administer Resident #4's Coumadin 7.5mg twice on 05/03/21.
-If Resident #4 had received a double dose of Coumadin, his blood would have been too thin and he would have been at risk of bleeding to death if he had experienced an injury.
-Resident #4's PCP or cardiologist should have

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been notified if Resident #4 had received too much Coumadin to ensure proper monitoring and management of his medication.

Telephone interview with the RCC on 05/14/21 at 1:32pm revealed:
-On 05/03/21, she had received a new delivery of Resident #4's Coumadin 2.5mg and 5mg doses.
-She had forgotten to enter the medication at a schedule IV medication so that the system would count the number of pills administered and number of pills on hand in the computer system.
-She discontinued the original entry and reentered the medication correctly.
-She documented that she administered the 7.5mg of Coumadin on 05/03/21 to Resident #4 to show the number of medication tablets on hand to be correct in the system.
-She did not actually give Resident #4 the 7.5mg of Coumadin on 05/03/21, she only documented it.
-There was no way to go back and un-chart the administration of a medication to show accuracy on the eMAR of what Resident #4 was administered.
-She should have written a note on the MAR to explain that she did not actually administer the medication to clarify the entry.

b. Review of Resident #4's medication orders dated 03/02/21 revealed:
-There was an order with a start date of 11/12/19 for Lipitor (a medication used to treat high cholesterol) 20mg daily at 8:00am.
-There was an order with a start date of 02/03/21 for Lipitor 40mg daily at 8:00am.

Review of Resident #4's electronic medication administration record (eMAR) for March 2021 revealed:

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D 367	Continued From page 62 -There was an entry for Lipitor 20mg daily at 8:00pm. -There was an entry for Lipitor 40mg daily at 9:00pm. -Lipitor 20mg was documented as administered for 16 of 31 days in March 2021 on 03/01/21, 03/03/21, 03/05/21, 03/08/21, 03/14/21, 03/16/21-03/17/21, 03/19/21-03/20/21, 03/22/21-03/23/21, and 03/27/21-03/31/21. -Lipitor 20mg was documented as "Not Administered: Other Comment: Resident is on 40mg", "Not Administered: On Hold: Needs Clarifications", or "Not Administered: Discontinued Comment: dosage changed to 40mg" for 15 of 31 days in March 2021 on 03/02/21, 03/04/21, 03/06/21, 03/07/21, 03/09/21-03/13/21, 03/15/21, 03/18/21, 03/21/21, 03/24/21-03/26/21. -Lipitor 40mg was documented as administered as ordered from 03/01/21-03/31/21. Review of Resident #4's eMAR dated April 2021 revealed: -There was an entry for Lipitor 20mg daily at 8:00pm with a discontinue date of 04/21/21. -There was an entry for Lipitor 40mg daily at 9:00pm. -Lipitor 20mg was documented as administered for 17 of 21 days in April 2021 on 04/01/21-04/06/21, 04/08/21, 04/10/21-04/14/21, and 04/16/21-04/19/21. -Lipitor 20mg was documented as "Not Administered: Other Comment: Resident takes 40mg not 20mg" or "Not Administered: On Hold: Resident is on 40mg not 20mg" for 4 of 21 days in April 2021 on 04/07/21, 04/09/21, 04/15/21 and 04/20/21. -Lipitor 40mg was documented as administered as ordered from 03/01/21-03/31/21.	D 367		

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Telephone interview with a medication aide (MA) on 05/13/21 at 3:00pm revealed:
-Resident #4's last cart audit was performed on 05/10/21.
-If there was a duplicate order, she would clarify the order and confirm which order to follow.
-She did not recall Resident #4 having both Lipitor 20mg and Lipitor 40mg on hand.

Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 8:46am revealed:
-He expected duplicate medications to be clarified and medications to be administered as ordered.
-He had not been notified by facility staff regarding Resident #4's duplicate Lipitor medication orders.
-Having too much Lipitor could have dropped Resident #4's cholesterol too low and he would need a cholesterol laboratory evaluation to ensure the Resident's levels were okay.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am revealed:
-Resident #4's Lipitor 20mg should have been discontinued on 11/02/20 per orders on file.
-It was the facility's responsibility to discontinue the Lipitor 20mg on the eMAR.
-Resident #4's Lipitor 40mg began on 11/02/20.
-Resident #4's orders dated 03/02/21 had been faxed to the pharmacy, but the facility was responsible to clarify duplicate orders and the pharmacy assumed the most recent order for Lipitor 40mg was the accurate order.
-If Resident #4 had been administered too much Lipitor it could have caused liver toxicity and muscle aches.
-Lipitor came in multi-dose packs with other pills from the pharmacy for the resident.

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-Lipitor 20mg had not been dispensed to the facility for Resident #4 since it had been discontinued.

Telephone interview with the RCC on 05/14/21 at 1:32pm revealed:
-She was not sure why facility staff documented administering Resident #4 both the 20mg and 40mg Lipitor if the 20mg was not on hand.
-She expected facility staff to compare the medication on hand that they administered to the eMAR and document accurately.
3. Review of Resident #1's current FL-2 dated 02/09/21 revealed:
-Diagnoses included hyperlipidemia, obesity, diabetes mellitus type II and schizoaffective disorder of bipolar type.
-There was a handwritten entry in the medication section of the FL-2 to "see" the attached signed physician orders.
-There was a medication order attached to the FL-2 for Risperidone 1 mg every morning. (Risperidone is used to treat certain mental/mood disorders).

Review of Resident #1's April 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Risperidone 1 mg every morning with a scheduled administration time of 8:00am with a discontinued date of 04/09/21.
-There was documentation Risperidone 1 mg was administered from 04/01/21 - 04/09/21.
-There was a second entry for Risperidone 1 mg every morning with a scheduled administration time of 8:00am.
-There was documentation Risperidone 1 mg was administered from 04/10/21 - 04/30/21.
-There was a third entry for Risperidone 1 mg every morning with a scheduled administration

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time of 8:00am.
-There was documentation Risperidone 1 mg was administered from on 04/16/21, 04/17/21, 04/18/20 and 04/20/21.
- Risperidone 1 mg every morning was documented as being administered twice on 04/16/21, 04/17/21, 04/18/20 and 04/20/21 at 8:00am.

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 05/14/21 at 9:54pm revealed:
-A 7 day supply of Resident #1's medications was delivered to the facility in a multi-dose packaging for the scheduled times of administration.
-Resident #1 was dispensed only one dose of Risperidone 1 mg every morning.
-The two entries of Risperidone 1 mg every morning was documented as being administered twice on 04/16/21, 04/17/21, 04/18/20 and 04/20/21 at 8:00am was a duplicate entry on the eMAR.
-The pharmacy could not view the residents' eMARS from the facility for documentation of administration.

Telephone interview with the Resident Care Coordinator (RCC) on 05/14/21 at 1:33pm revealed:
-There was currently not a process for reviewing the residents' eMARS for accuracy of medication.
-She had informed the medication aides (MAs) when there were any times duplicate medications were seen on the residents' eMARs to notify her.
-She was not aware there were two entries on Resident #1's April 2021 eMAR Risperidone 1 mg every morning with a scheduled administration time of 8:00am.

Refer to the telephone interview with a MA on

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D 367	Continued From page 66 05/13/21 at 3:00pm. Refer to the telephone interview with a medication aide/supervisor (MA/S) on 05/13/21 at 3:54pm. Refer to the telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am. Refer to the telephone interview with the RCC on 05/14/21 at 1:32pm. Refer to the interview with the Administrator on 05/12/21 at 3:34pm and via telephone on 05/14/21 at 1:32pm. _____ Telephone interview with a MA on 05/13/21 at 3:00pm revealed: -She ensured medication orders were correct by looking at the active orders and reporting any duplicate orders to the RCC. -When the PCP wrote an order, it was faxed to the pharmacy. -Pharmacy then placed the order on the eMAR and the RCC or Administrator would approve the order. -Cart audits were done Mondays - Thursdays and turned into the RCC to ensure eMAR orders were accurate and medications on hand were available. -Cart audits included comparing the resident's active medication orders to the medications on hand and throwing away medications that were out of date. -When administering medications, she ensured the resident got the accurate medications by comparing what she was administering to the eMAR. -If there was a duplicate order, she would clarify the order and confirm which order to follow.	D 367		

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D 367	Continued From page 67 Telephone interview with a MA/S on 05/13/21 at 3:54pm revealed: -Medications orders were processed by faxing them to the pharmacy who would subsequently place the order on the eMAR. -The pharmacy was available as a resource to the facility staff 24-hours per day. -Having duplicate orders or duplicate administration of medications on the eMAR could pose a safety risk to the resident. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am revealed: -The pharmacy placed medication orders on the eMAR after they received the faxed order from the facility. -They were unable to view the facility eMARs and see documentation or duplicate orders. -New orders for a medication that were previously ordered would generate a discontinue order on the previous orders. -The facility must accept the discontinue order to have the previous order removed from the eMAR. -If the facility did not accept the discontinue order, there would be a duplicate order on the eMAR. -Duplicate medications on the MAR could pose a safety issue to a resident. -Duplicate medication orders could be administered twice causing a medication error. -The facility was responsible to ensure eMAR accuracy and carefully manage the resident's eMAR. Telephone interview with the RCC on 05/14/21 at 1:32pm revealed: -She was responsible for scanning orders and faxing them to the pharmacy. -She was responsible for ensuring medication	D 367		

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orders showed up accurately on the eMAR.
-She would check the written order against the order on the eMAR to ensure accuracy, then approve the order on the eMAR.
-There was no audit system in place to check behind the RCC.
-The MAs were responsible to perform cart audits once per week comparing the eMAR to the physician orders, to the medications on hand, and then turn the audits into the RCC.
-She reviewed the cart audits and followed up on them.
-She had been aware that there were "a lot of duplicate" medication orders on the eMARs.
-She expected staff to call her, day or night, to notify her of this issue because only the RCC and the Administrator had access to fix the issue on the eMAR.

Interview with the Administrator on 05/12/21 at 3:34pm revealed:
-The RCC was new and still in training.
-Clarification of medications was expected to be completed by the RCC within 24 business hours.
-Orders were faxed to the pharmacy, then placed on the eMAR, then had to be approved by the RCC.
-Staff were not able to see medication orders on the eMAR that had not been approved.
-The RCC was responsible to accept the discontinued orders to have them removed from the eMAR.

Telephone interview with the Administrator on 05/14/21 at 1:32pm revealed:
-The RCC assumed that the previous orders had been automatically discontinued and she had not been going back to manually accept the discontinued orders.
-Identifying duplicate medication orders had been

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D 367	Continued From page 69 challenging and was being corrected via on-going education with the facility staff. -She expected the MAs to call and clarify duplicate medications that appeared on the MAR. -It was concerning that duplicate medications were not identified because she wanted the residents to receive the proper dosing of medication for their safety and overall health. -It was important to clarify medications to ensure the resident was administered medications properly as ordered to prevent wrong doses and unnecessary testing. -She expected the eMAR to reflect accurate orders and documentation of what the resident was administered for the resident's safety.	D 367		
D 406	10A NCAC 13F .1009(b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to follow up on pharmacy review recommendations for 2 of 5 sampled residents (#1 and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 02/09/21 revealed: -Diagnoses included hyperlipidemia, obesity,	D 406		

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diabetes mellitus type II and schizoaffective disorder of bipolar type.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #1's record revealed there were no quarterly pharmacy reviews or documentation the primary care provider (PCP) had been informed of any of the findings and recommendations.

Review of a fax received from the facility's pharmacy provider on 05/14/21 revealed Resident #1's quarterly pharmacy reviews from June 2020 - March 2020.

Review of Resident #1's quarterly pharmacy review dated 03/03/21 revealed:
-There was a recommendation to please consider monitoring the resident's Depakote level, complete blood count (CBC) and complete metabolic profile (CMP) on the next convenient lab day.
-There was an entry if done at the primary care provider's (PCP's) office recently to comment below.
-The resident recently experienced a fall on 01/31/21.
-A comprehensive review of the medical record was conducted, identifying the following medications which might contribute to falls Xanax, Haldol, Depakote, Risperdal, Sertraline and Trazadone. (Xanax is a medication used to treat anxiety. Haldol is a medication used to treat mood and behavior, Depakote is a medication used to treat and stabilize mood. Risperdal is a medication used to treat mental disorders, Sertraline is used to treat mental and mood disorders. Trazodone is used to treat depression and anxiety).

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D 406	Continued From page 71 -There was a recommendation to please evaluate these medications as possibly causing or contributing to the fall and consider dose reduction as deemed appropriate. Review of Resident #1's quarterly pharmacy review dated 12/07/20 revealed: -The resident recently experienced a fall on 11/01/20. -A comprehensive review of the medical record was conducted, identifying the following medications which might contribute to falls Xanax, Haldol, Depakote, and Risperdal. -There was a recommendation to please evaluate these medications as possibly causing or contributing to the fall and consider dose reduction as deemed appropriate. -The resident's electronic medication administration record (eMAR) or PCP order sheets included items that needed clarification. -Sertraline 100mg with special instructions to take 1.5 tablets (150mg) every day for depression daily at 8:00am. -Sertraline 50mg with special instructions to take one tablet daily at 8:00am. -There was documentation of administration of both orders on the eMAR. -There was a recommendation to please clarify the dosage of the Sertraline order to be administered and if the Sertraline 50 mg should be removed from the physician's order sheet/eMAR. -During the resident's medical record review, the following irregularities were noted on the eMAR and PCP order sheets: Four Humira orders on the eMAR (please remove inactive orders from the eMAR. -There was a recommendation to please clarify or correct these items on the eMAR.	D 406		

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Review of Resident #1's quarterly pharmacy review dated 09/01/20 revealed:
-Sertraline 100mg with special instructions to take 1.5 tablets (150mg) every day for depression daily at 8:00am.
-Sertraline 50mg with special instructions to take one tablet daily at 8:00am.
-There was documentation of administration of both orders on the eMAR.
-There was a recommendation to please clarify the following items, communicating with the PCP and pharmacy as appropriate, the dosage of Sertraline order to be administered and if the Sertraline 50mg order should be removed from the physician's order sheet/eMAR.
-Documentation in the resident's medical record indicated doses of Haldol, Xanax, Vitamin B6 were not administered,
-There was a recommendation to please ensure that the PCP had been made aware of any missed doses, contact the pharmacy as necessary and remind staff to document why doses were missed and what action was taken to improve adherence.
-During the review of the resident's medical record, the following irregularities were noted on the eMAR/PCP order sheets: two Haldol orders twice daily and three times daily.
-There was a recommendation to please clarify which Haldol order was correct and if Haldol three times daily was correct to please update the eMAR with administration times of 8:00am, 2:00pm and 8:00pm.

Review of Resident #1's quarterly pharmacy review dated 06/12/20 revealed:
-Sertraline 100mg with special instructions to take 1.5 tablets (150mg) every day for depression daily at 8:00am.
-Sertraline 50mg with special instructions to take

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one tablet daily at 8:00am.
-There was documentation of administration of both orders on the eMAR.
-There was a recommendation to please clarify the dosage of the Sertraline ordered to be administered and if the Sertraline 50mg order should be removed from the PCP order/eMAR

Interview with Resident #1's PCP on 05/14/21 at 8:45am and 05/17/21 at 9:52am revealed:
-He normally reviewed pharmacy reviews when on-site at a facility, but sometimes the facility would fax him the review recommendations.
-He could not recall if he had been contacted about Resident #4's pharmacy review recommendations.
-He expected the facility to follow up with him on pharmacy review recommendations.

A request was made to the Administrator on 05/12/21 and 05/13/21 for Resident #1's quarterly pharmacy reviews and documentation the resident's PCP had been informed of any of the findings and recommendations.

At the time of exit on 05/17/21, there was no additonal information provided by the Administrator for Resident #1's quarterly pharmacy reviews and documentation the resident's PCP had been informed of any of the findings and recommendations.

Refer to the telephone interview with the Administrator on 05/17/21 at 3:00pm.

2. Review of Resident #4's FL-2 dated 12/21/20 revealed:
-Diagnoses included conduction disorder (heart disorder), hyperlipidemia (high cholesterol), hypertension (high blood pressure and when left

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untreated could complicate heart disease), anemia (low hemoglobin which carries oxygen through the body), coronary artery disease, and heart valve replacement.
-The resident was constantly disoriented.

Review of Resident #4's record revealed there were no quarterly pharmacy reviews or documentation the primary care provider (PCP) had been informed of any of the findings and recommendations.

Review of a fax received from the facility's contracted pharmacy provider on 05/14/21 revealed Resident #4's quarterly pharmacy reviews from June 2020 - March 2020.

Review of Resident #4's medication orders dated 03/02/21 revealed:
-There were two orders for Lipitor.
-There was an order for Lipitor 20mg daily.
-There was an order for Lipitor 40mg at bedtime.

Review of Resident #4's March 2021 electronic medication administration records (eMAR) revealed:
-There were two orders for Lipitor on the resident's eMAR.
-There was an entry to administer Lipitor 20mg daily.
-There was an entry to administer for Lipitor 40mg at bedtime.

Review of Resident #4's April 2021 eMAR revealed:
-There were two orders for Lipitor on the resident's eMAR.
-There was an entry to administer Lipitor 20mg daily.
-There was an entry to administer for Lipitor

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D 406	Continued From page 75 40mg at bedtime. Review of Resident #4's quarterly pharmacy review dated 12/07/20 revealed: -There were two orders for Lipitor on the resident's eMAR. -There was an order for Lipitor 20mg daily. -There was an order for Lipitor 40mg at bedtime. -There was a recommendation to clarify with Resident #4's primary care provider (PCP) which order was correct and to update the eMAR accordingly. Review of Resident #4's quarterly pharmacy review dated 03/04/21 revealed: -There were two orders for Lipitor on the resident's eMAR. -There was an order for Lipitor 20mg daily. -There was an order for Lipitor 40mg at bedtime. -There was a recommendation to clarify with Resident #4's primary care provider (PCP) which order was correct and to update the eMAR accordingly. Review of Resident #4's record revealed there was no documentation that the Lipitor 20mg and Lipitor 40mg had been clarified with the resident's PCP. Interview with Resident #4's PCP on 05/14/21 at 8:45am and 05/17/21 at 9:52am revealed: -If he had been notified of pharmacy review recommendations, he would have provided a clarification order or called the pharmacy to update the order. -He normally reviewed pharmacy reviews when on-site at a facility, but sometimes the facility would fax him the review recommendations. -He could not recall if he had been contacted about Resident #4's pharmacy review	D 406		

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recommendations.
-He expected the facility to follow up with him on pharmacy review recommendations.
-Resident #4's Lipitor orders for two different doses should have been clarified and updated by the facility.

Telephone interview with the Administrator on 05/17/21 at 3:00pm revealed:
-She was not aware that Resident #4's eMAR still showed both doses of Lipitor until it had been brought to her attention that day, 05/17/21.
-Resident #4's Lipitor 20mg had been discontinued in November 2020 and should have been removed from the resident's orders and eMAR.
-The duplication of orders with different doses had been missed on Resident #4's eMAR.
-The facility should have accepted the discontinue order to have the order removed from the eMAR.
-The pharmacy had not dispensed the Lipitor 20mg since November 2020, so the resident had received the correct medication.

At the time of exit on 05/17/21, there was no additonal information provided by the Administrator for Resident #4's quarterly pharmacy reviews and documentation the resident's PCP had been informed of any of the findings and recommendations.

Refer to the telephone interview with the Administrator on 05/17/21 at 3:00pm

2. Review of Resident #2's FL-2 dated 03/25/21 revealed:
-Diagnoses of diabetes mellitus type II (DMII), hemiparesis, muscle weakness, aphasia following cerebral infarction, heart failure,

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D 406	Continued From page 77 unspecified atrial flutter, history of a cardiovascular accident, history of a bilateral total knee arthroplasty, and right sided weakness. a.Review of Resident #2's quarterly pharmacy review dated 06/12/20 revealed: -The order for the resident's sliding scale insulin was incomplete and missing finger stick blood glucose readings on the order. -There was a recommendation to clarify the order to have the finger stick blood sugars added to the order. Review of Resident #2's record revealed a clarification order signed by the primary care provider (PCP) on 01/28/21 to have the finger stick blood glucose added to the resident's sliding scale insulin order three times per day before meals. Review of Resident #2's medication orders dated 03/25/21 revealed the order for the resident's sliding scale insulin was incomplete and missing finger stick blood glucose readings on the order. Review of Resident #2's electronic medication administration record (eMAR) dated March 2021 revealed the entry for the resident's sliding scale insulin was incomplete and missing finger stick blood glucose readings on the order. Review of Resident #2's eMAR dated April 2021 revealed the entry for the resident's sliding scale insulin was incomplete and missing finger stick blood glucose readings on the order. Review of Resident #2's eMAR dated May 2021 revealed the entry for the resident's sliding scale insulin was incomplete and missing finger stick blood glucose readings on the order.	D 406		

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D 406	Continued From page 78 Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am and 05/17/21 at 11:10am revealed: -The facility had been provided with the pharmacy reviews and were responsible to relay the recommendations to the PCP, then fax any new orders or rationale from the PCP to the pharmacy. -The pharmacy placed updated orders on the eMAR after they received the faxed order from the facility. -They were unable to view the facility eMARs. -They had not received an order to update Resident #2's sliding scale insulin order to include finger stick blood glucose monitoring. Interview with Resident #2's PCP on 05/14/21 at 8:45am and 05/17/21 at 9:52am revealed: -If he had been notified of pharmacy review recommendations, he would have provided a clarification order or called the pharmacy to update the order. -He normally reviewed pharmacy reviews when on-site at a facility, but sometimes the facility would fax him the review recommendations. -He could not recall if he had been contacted about Resident #2's pharmacy review recommendations. -He expected the facility to follow up with him on pharmacy review recommendations. Refer to interview with the Administrator on 05/17/21 at 3:00pm. b. Review of Resident #2's quarterly pharmacy review dated 12/07/20 revealed: -Resident #2's order for oxycodone/acetaminophen was missing the acetaminophen maximum daily dose.	D 406		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL016018	A. BUILDING: _____ B. WING _____	R 05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTERET HOUSE	3020 MARKET STREET NEWPORT, NC 28570

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D 406	Continued From page 79	D 406		

- Resident #2's as needed order for acetaminophen was missing the acetaminophen maximum daily dose.
-There was a recommendation to have the orders clarified to include a maximum daily dose from all sources of acetaminophen to show be 3 grams/24 hours and show up on the Resident's medication orders.

Review of Resident #2's quarterly pharmacy review dated 03/04/21 revealed:
-Resident #2's order for oxycodone/acetaminophen was missing the acetaminophen maximum daily dose.
- Resident #2's as needed order for acetaminophen was missing the acetaminophen maximum daily dose.
-There was a recommendation to have the orders clarified to include a maximum daily dose from all sources of acetaminophen to show be 3 grams/24 hours and show up on the Resident's medication orders.
-There was a handwritten order on the pharmacy review to update the resident's medication orders to include a maximum daily dose of acetaminophen of 3,000mg/24 hours on 03/11/21.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 9:56am and 05/17/21 at 11:10am revealed:
-The facility had been provided with the pharmacy reviews and were responsible to relay the recommendations to the PCP, then fax any new orders or rationale from the PCP to the pharmacy.
-The pharmacy placed updated orders on the eMAR after they received the faxed order from the facility.
-They were unable to view the facility eMARs.
-The pharmacy placed orders on the eMAR after

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	HAL016018	A. BUILDING: _____ B. WING _____	R 05/17/2021

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D 406	Continued From page 80	D 406		

they received the faxed order from the facility.
-They were unable to view the facility eMARs.
-The pharmacy did not have an order on file to update or clarify Resident #2's maximum daily dose from all sources of acetaminophen.

Interview with Resident #2's PCP on 05/14/21 at 8:45am and 05/17/21 at 9:52am revealed:
-If he had been notified of pharmacy review recommendations, he would have provided a clarification order or called the pharmacy to update the order.
-He normally reviewed pharmacy reviews when on-site at a facility, but sometimes the facility would fax him the review recommendations.
-He could not recall if he had been contacted about Resident #2's pharmacy review recommendations.
-He expected the facility to follow up with him on pharmacy review recommendations.

Refer to interview with the Administrator on 05/17/21 at 3:00pm.

_____

Telephone interview with the Administrator on 05/17/21 at 3:00pm revealed:
-She could not speak about any resident pharmacy reviews or recommendations that were not implemented prior to her employment with the facility.
-Systems were currently being put into place now that the RCC position had been filled.
-When the residents' pharmacy reviews were done, she separated each residents' pharmacy reviews out and dispersed the pharmacy reviews to the residents' PCPs.
-She expected all pharmacy review recommendations to be sent to the PCP and followed up on.
-She would provide any additional information

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D 406	Continued From page 81 regarding any pharmacy reviews done in March 2021 for the residents for review if available. At the time of exit on 05/17/21 there was no additional information provided from the facility.	D 406		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 5 of 5 sampled residents (#1, #2, #3, #4, and #5) related to the omission of a referral to an endocrinologist (#1), rectal bleeding (#3), complaints of urinary discomfort, a urinalysis and laboratory orders and follow-up with a ophthalmologist (#1), not reporting blood pressures outside of parameters (#4), and not reporting fingerstick blood glucose outside of parameters (#5). [Refer to Tag D273, 10A 13F .0902(b) Health Care (Type A2 Violation)]	D912		