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WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

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D 000	Initial Comments The Adult Care Licensure Section and the Bertie County Department of Social Services conducted an annual survey on November 17, 2021 through November 18, 2021.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (#2) related to not reporting fingerstick blood sugar results greater than 250 to the resident's primary care provider as ordered. The findings are: Review of Resident #2's current FL-2 dated 04/13/21 revealed: -Diagnoses included Alzheimer's, congestive heart failure (CHF), respiratory failure, asthma, diabetes mellitus type 2 (DM), and stage 4 chronic kidney disease. -She was intermittently disoriented, semi-ambulatory, and had wandering behaviors. Review of Resident #2's primary care provider's (PCP) progress note dated 09/20/21 revealed an order to check finger stick blood sugars (FSBS) three times per day before meals and as needed with any signs or symptoms of hypo (low)/hyper (high)-glycemic (blood sugar) episodes; notify provider if under 70 or over 250.	D 273		

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D 273	Continued From page 1 Review of the facility's policy and procedure manual dated September of 2021 revealed: -The medication aide will notify the Care Coordinator of any abnormal blood glucose results. -The Care Coordinator will review any abnormal blood sugar readings and notify the provider. Review of Resident #2's September electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times daily at 7:00am, 11:00am, and 5:00pm. -There was an entry to check FSBS three times daily at needed, notify the PCP of signs or symptoms of hyper/hypo-glycemic episodes if less than 70 or over 250. -On 09/03/21 at 5:00pm, the FSBS result was 299 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 09/07/21 at 11:00am, the FSBS result was 252 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 09/20/21 at 11:00am, the FSBS result was 276 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 09/23/21 at 11:00am, the FSBS result was 258 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 09/24/21 at 11:00am, the FSBS result was 254 and there was no documentation that the PCP had been notified of the blood sugar over 250. Review of Resident #2's October 2021 eMAR revealed:	D 273		

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D 273	Continued From page 2 -There was an entry to check FSBS three times daily at 7:00am, 11:00am, and 5:00pm. -There was an entry to check FSBS three times daily at needed, notify the PCP of signs or symptoms of hyper/hypo-glycemic episodes if less than 70 or over 250. -On 10/02/21 at 11:00am, the FSBS result was 380 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 10/17/21 at 11:00am, the FSBS result was 340 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 10/25/21 at 11:00am, the FSBS result was 396 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 10/25/21 at 5:00pm, the FSBS result was 281 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 10/26/21 at 11:00am, the FSBS result was 286 and there was no documentation that the PCP had been notified of the blood sugar over 250. -On 10/27/21 at 5:00pm, the FSBS result was 304 and there was no documentation that the PCP had been notified of the blood sugar over 250. Review of Resident #2's November 2021 eMAR revealed: -There was an entry to check FSBS three times daily at 7:00am, 11:00am, and 5:00pm. -There was an entry to check FSBS three times daily at needed, notify the PCP of signs or symptoms of hyper/hypo-glycemic episodes if less than 70 or over 250. -On 11/07/21 at 5:00pm, the FSBS result was 258	D 273		

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and there was no documentation that the PCP had been notified of the blood sugar over 250.
-On 11/10/21 at 5:00pm, the FSBS result was 283 and there was no documentation that the PCP had been notified of the blood sugar over 250.
-On 11/13/21 at 11:00am, the FSBS result was 265 and there was no documentation that the PCP had been notified of the blood sugar over 250.
-On 11/14/21 at 5:00pm, the FSBS result was 258 and there was no documentation that the PCP had been notified of the blood sugar over 250.

Review of Resident #2's progress notes dated 05/17/21-11/17/21 revealed there was no documentation that the PCP had been notified of the resident's FSBS greater than 250.

Telephone interview with Resident #2's primary care provider (PCP) on 11/18/21 at 10:38am revealed:
-She began caring for Resident #2 on 09/20/21.
-The facility printed out FSBS for her when she saw the resident, but she had not been notified of FSBS greater than 250 each time it happened as ordered.
-She expected the facility to notify her of the resident's FSBS greater than 250 each time as ordered.
-If she had been notified of FSBS greater than 250, she would have seen the resident again sooner to assess her diabetes and proactively modify her plan of care to control her elevated blood sugars by changing her medications or modifying her diet.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/18/21 at 1:09pm revealed:
-Elevated blood sugars should be reported to the

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resident's PCP as ordered.
-Prolonged elevated blood sugars could cause damage to the cells and diabetic neuropathy (nerve damage causing numbness in the extremities that could lead to amputation).
-Long term elevated blood sugars that were left untreated could cause a diabetic coma or death.

Interview with a medication aide (MA) on 11/18/21 at 1:35pm revealed:
-She was expected to follow orders as written on the eMAR.
-She did not realize she was supposed to call Resident #2's PCP for FSBS greater than 250.
-She had never reported Resident #2's FSBS greater than 250 to her PCP or to the Special Care Coordinator (SCC) per facility policy.

Interview with the SCC on 11/18/21 at 10:30am and 2:05pm revealed:
-There was no documentation in Resident #2's record that her PCP had been notified of FSBS greater than 250.
-There were no FSBS greater than 250 reported to her by the MAs.
-She expected the MAs to report FSBS to her greater than 250 as ordered so she could notify the PCP.
-She or the MAs were responsible to call the PCP to notify her of the resident's FSBS greater than 250.

Interview with the Administrator on 11/18/21 at 2:42pm revealed:
-He expected the MAs to follow orders and administer medications as ordered by the resident's PCP.
-He was not aware Resident #2 was having FSBS over 250 requiring PCP notification.
-He expected the MAs to report Resident #2's

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D 273	Continued From page 5 FSBS greater than 250 to the PCP and the SCC. -He expected the SCC to follow up and ensure orders were being followed accurately. -It was concerning that Resident #2's FSBS greater than 250 had not been reported to her PCP as ordered had been overlooked.	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. 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) that needed weekly oxygen saturation, blood pressure, heart rate, and weight monitoring. The findings are: Review of the facility's policy and procedure manual dated September of 2021 revealed: -The Care Manager will fax a new medication order to the pharmacy and scan it into the computer system. -The Care Manager will wait for the order to be placed in the system and then approve the order for administration. -The medication aide will notify the Care Coordinator of any abnormal blood glucose results.	D 276		

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-The Care Coordinator will review any abnormal blood sugar readings and notify the provider.

Review of Resident #2's current FL-2 dated 04/13/21 revealed:
-Diagnoses included Alzheimer's, congestive heart failure (CHF), respiratory failure, asthma, diabetes mellitus type 2 (DM), and stage 4 chronic kidney disease.
-She was intermittently disoriented, semi-ambulatory, and had wandering behaviors.

1. Review of Resident #2's primary care provider's (PCP) progress note dated 09/20/21 revealed there was an order to check oxygen saturation (oxygen levels) every week and as needed if shortness of breath occurs, notify PCP if less than 88%.

Review of Resident #2's primary care provider's (PCP) progress note dated 11/01/21 revealed there was an order to check oxygen saturation (oxygen levels) every week and as needed if shortness of breath occurs, notify PCP if less than 88%.

Review of Resident #2's current care plan dated 06/08/21 revealed:
-The resident was short of breath.
-The resident had oxygen as needed.

Review of Resident #2's September 2021 electronic medication administration records (eMAR) revealed:
-There was an entry to obtain oxygen saturations as needed for shortness of breath; notify provider for less than 88%.
-There was not a weekly entry for oxygen saturations.
-There was no documentation of any oxygen

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D 276	Continued From page 7 saturation levels for the resident. Review of Resident #2's October 2021 eMAR revealed: -There was an entry to obtain oxygen saturations as needed for shortness of breath; notify provider for less than 88%. -There was not a weekly entry for oxygen saturations. -There was no documentation of any oxygen saturation levels for the resident. Review of Resident #2's November 2021 eMAR revealed: -There was an entry to obtain oxygen saturations as needed for shortness of breath; notify provider for less than 88%. -There was not a weekly entry for oxygen saturations. -There was no documentation of any oxygen saturation levels for the resident. Telephone interview with Resident #2's primary care provider (PCP) on 11/18/21 at 10:38am revealed: -She began caring for Resident #2 on 09/20/21. -She ordered oxygen saturation levels once per week and as needed due to the resident's oxygen dependency and to trend the resident's baseline to be able to plan her care and react appropriately as medically needed. -She was unaware that the resident's oxygen saturation was not being obtained as ordered. -She expected the facility to implement and carry out orders as written for the resident's well-being. -She expected the facility to notify her of the resident's oxygen levels less than 88%. -Being notified of the resident's low oxygen levels was the first line of defense in reacting to hypoxemia (low oxygen levels in the blood).	D 276		

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D 276	Continued From page 8 Telephone interview with a pharmacy technician on 11/18/21 at 1:09pm revealed: -Resident #2 had an order that was entered on her eMAR by the pharmacy on 09/27/21 for weekly oxygen saturations and as needed, notify the PCP if below 88%. -There was an old order dated 04/28/21 to check Resident #2's oxygen saturations as needed. -Once the order was entered onto the eMAR, it was the facility's responsibility approve new orders and discontinue old orders for accurate care. -If the new order was not on her eMAR, it meant the facility had not approved or accepted the order. Interview with the MA on 11/18/21 at 1:35pm revealed she was unaware that Resident #2 had an order for weekly oxygen saturation levels. Interview with the Special Care Coordinator (SCC) on 11/18/21 at 2:05pm revealed: -She was not sure why Resident #2's oxygen saturations were not on the eMAR as ordered or carried out as ordered. -She was not sure how the order to perform weekly oxygen saturations was missed. -The new oxygen saturation order must have been missed when she approved the orders. Refer to interview with the medication aide (MA) on 11/18/21 at 1:35pm. Refer to interview with the SCC on 11/18/21 at 2:05pm. Refer to interview with the Administrator on 11/18/21 at 2:42pm.	D 276		

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2. Review of Resident #2's primary care provider's (PCP) progress note dated 09/20/21 revealed there was an order to check blood pressure (BP), heart rate (HR), and weight once a week due to oxygen dependency.

Review of Resident #2's September 2021 electronic medication administration records (eMAR) revealed:
-There was no entry to check BP, HR, and weight once a week.
-There was no documentation of BP, HR or weight for September 2021.

Review of Resident #2's October 2021 eMAR revealed:
-There was no entry to check BP, HR, and weight once a week.
-There was no documentation of BP, HR or weight for October 2021.

Review of Resident #2's November 2021 eMAR revealed:
-There was no entry to check BP, HR, and weight once a week.
-There was no documentation of BP, HR or weight for November 2021.

Telephone interview with Resident #2's primary care provider (PCP) on 11/18/21 at 10:38am revealed:
-She began caring for Resident #2 on 09/20/21.
-She ordered BP, HR, and weight once per week due to the resident's oxygen dependency and to trend the resident's baseline to be able to plan her care and react appropriately as medically needed.
-She was unaware that the resident's BP, HR, and weight was not being obtained as ordered.
-She expected the facility to implement and carry

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out orders as written for the resident's well-being.

Telephone interview with a pharmacy technician on 11/18/21 at 1:09pm revealed there was no order on file for Resident #2 to have weekly BP, HR, and weights.

Interview with the MA on 11/18/21 at 1:35pm revealed she was unaware that Resident #2 had an order for weekly BP, HR, and weights.

Interview with the Special Care Coordinator on 11/18/21 at 2:05pm revealed:
-She was unaware that Resident #2 had an order for weekly BP, HR, and weights,
-She was unsure how the order for Resident #2's weekly BP, HR, and weights had been missed.

Refer to interview with the medication aide (MA) on 11/18/21 at 1:35pm.

Refer to interview with the SCC on 11/18/21 at 2:05pm.

Refer to interview with the Administrator on 11/18/21 at 2:42pm.

____

Interview with the MA on 11/18/21 at 1:35pm revealed:
-It was the Special Care Coordinator's (SCC) responsibility to process orders and have them entered onto the eMAR.
-If the order was not on the eMAR, she would not know to do it.

Interview with the SCC on 11/18/21 at 2:05pm revealed:
-It was her responsibility to implement, process, and approve new resident orders.
-When an order was received, it was faxed to the

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D 276	Continued From page 11 pharmacy, the pharmacy would then enter the order onto the resident's eMAR. -Once the order was on the resident's eMAR, she would compare the eMAR to the original order and approve it if accurate or clarify the order if inaccurate. -She was unsure how she missed orders for Resident #2. -It was her responsibility to follow up and ensure orders were implemented and carried out as written by the PCP. Interview with the Administrator on 11/18/21 at 2:42pm revealed: -He expected the MAs to follow orders and administer medications as ordered by the resident's PCP. -He expected the SCC to ensure orders and medications were implemented and carried out as written by the resident's PCP as soon as possible. -He was not aware Resident #2 had orders that had not been implemented or carried out as ordered. -He expected the SCC to follow up and ensure orders were being followed accurately. -It was concerning that the orders were not implemented because resident care should not get missed.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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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, record reviews, and interviews the facility failed to ensure medications were administered as ordered for 2 of 5 residents sampled (#3 and #5) for an antipsychotic medication and fingerstick blood sugar rechecks after insulin administration for blood glucose levels over 400 (#3) and fingerstick blood sugar rechecks and re-dosing of sliding scale insulin for blood glucose levels over 425 (#5).

The findings are:

Review of the facility's policy and procedure manual dated September of 2021 revealed:
-The Care Manager will fax a new medication order to the pharmacy and scan it into the computer system.
-The Care Manager will wait for the order to be placed in the system and then approve the order for administration.
-The medication aide will notify the Care Coordinator of any abnormal blood glucose results.
-The Care Coordinator will review any abnormal blood sugar readings and notify the provider.

1. Review of Resident #3's current FL-2 dated 04/05/21 revealed diagnoses included vascular dementia and diabetes.

a. Review of Resident #3's current FL-2 dated 04/05/21 revealed:
-There was an order for Seroquel 50mg, take one tablet daily (Seroquel is an antipsychotic medication).

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D 358	Continued From page 13 -There was an order for Ativan 0.5mg, take one tablet every 4 hours as needed for anxiety and agitation (Ativan is a medication used to treat anxiety and agitation). Review of Resident #3's quarterly pharmacy consultation report dated 08/04/21 revealed: -There was a recommendation to consider changing Resident #3's Seroquel order from 50mg daily to 25mg twice a day because of increased usage of the as needed Ativan dose for anxiety and agitation. -Resident #3's primary care provider (PCP) accepted the recommendation and signed the order for implementation on 08/17/21 to change the Seroquel dose from 50mg once a day, to 25mg twice a day. Observation of Resident #3's medications on hand on 10/17/21 at 3:25pm revealed Resident #3 had 7 tablets of Seroquel 50mg available for administration in a blister packet with a medication label that read Seroquel 50mg with instructions to take one tablet every day. Review of Resident #3's September 2021 electronic medication administration records (eMAR) revealed: -There was an entry for Seroquel 50mg once a day, scheduled for administration at 8:00am. -Seroquel 50mg was documented as administered on 09/01/21 through 09/30/21. -There was an entry for Ativan 0.5mg, take one tablet every 4 hours as needed for anxiety and agitation. -Ativan 0.5mg was given to Resident #3 on 18 occasions from 09/05/21 through 09/30/21. Review of Resident #3's October 2021 eMAR revealed:	D 358		

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-There was an entry for Seroquel 50mg once a day, scheduled for administration at 8:00am.
-Seroquel 50mg was documented as administered on 10/01/21 through 10/31/21.
-There was an entry for Ativan 0.5mg, take one tablet every 4 hours as needed for anxiety and agitation.
-Ativan 0.5mg was given to Resident #3 on 27 occasions from 10/02/21 through 10/31/21.

Review of Resident #3's November 2021 eMAR revealed:
-There was an entry for Seroquel 50mg once a day, scheduled for administration at 8:00am.
-Seroquel 50mg was documented as administered on 11/01/21 through 11/17/21.
-There was an entry for Ativan 0.5mg, take one tablet every 4 hours as needed for anxiety and agitation.
-Ativan 0.5mg was given to Resident #3 on 16 occasions from 11/02/21 through 11/17/21.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/18/21 at 11:20am revealed:
-The pharmacy did not receive Resident #3's order on 08/17/21 to change the Seroquel dose from 50mg once a day, to 25mg twice a day.
-The pharmacy dispensed 15 pills of Seroquel 50mg for a 15-day supply on 11/08/21.

Interview with a medication aide (MA) on 11/18/21 at 1:35pm revealed:
-The Special Care Coordinator (SCC) was responsible for entering orders into the eMAR system.
-Resident #3 tended to go into other resident rooms and go through the other resident's drawers.
-Resident #3 required the as needed dose of

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Ativan more so in the evening when she would fight back against staff redirection.

Interview with the SCC on 11/18/21 at 2:05pm revealed:
-She was responsible for faxing approved pharmacy review consultation orders to the facility's contracted pharmacy.
-The pharmacy would enter the updated orders on to the eMAR unless it was a stat order, then sometimes the SCC would update the eMAR.
-She was not sure how Resident #3's Seroquel order change was missed.
-It was her responsibility to check that the orders entered by the pharmacy matched the recommendations.
-She was not aware that Resident #3 was requiring additional as needed doses of Ativan to help with behaviors.

Interview with the Administrator on 11/18/21 at 2:40pm revealed:
-The SCC was responsible for ensuring order changes were faxed to the pharmacy.
-He expected Resident #3 to receive his medication as ordered.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/18/21 at 10:32am and 2:02pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

b. Review of Resident #3's current FL-2 dated 04/05/21 revealed:
-There was an order for Novolog insulin, with instructions to inject 3 times a day with meals per the sliding scale based on the fingerstick blood

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sugar (FSBS) results as follows: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour (Novolog is a short acting insulin used to treat high blood sugar).

Review of Resident #3's September 2021 FSBS report revealed:
-There was an entry for Novolog insulin, with instructions to inject 3 times a day with meals per the sliding scale based on the fingerstick blood sugar (FSBS) results as follows: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour.
-On 09/17/21 at 4:31pm, the residents blood sugar was 414 and it was not documented as rechecked in one hour.
-On 09/21/21 at 11:45am, the residents blood sugar was 514 and it was not documented as rechecked in one hour.
-On 09/21/21 at 4:23pm, the residents blood sugar was 454 and it was not documented as rechecked in one hour.
-On 09/24/21 at 11:02am, the residents blood sugar was 446 and it was not documented as rechecked in one hour.

Review of Resident #3's October 2021 FSBS report revealed:
-There was an entry for Novolog insulin, with instructions to inject 3 times a day with meals per the sliding scale based on the fingerstick blood sugar (FSBS) results as follows: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350,

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give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour.
-On 10/05/21 at 4:04pm, the residents blood sugar was 476 and it was not documented as rechecked in one hour.
- On 10/06/21 at 11:21am, the residents blood sugar was 459 and it was not documented as rechecked in one hour.
-On 10/07/21 at 11:15am, the residents blood sugar was 406 and it was not documented as rechecked in one hour.

Interview with a medication aide (MA) on 11/17/21 at 3:25pm revealed:
-She was not aware that Resident #3's insulin order required a FSBS recheck in one hour if the FSBS was over 400.
-If a FSBS was rechecked it would be entered into the electronic documentation system and show on the resident's FSBS report.

Interview with a second MA on 11/18/21 at 1:35pm revealed:
-She would text Resident #3's primary care provider (PCP) when there was a FSBS over 400 but did not document that she notified the provider or recheck the blood sugar.
-She was not aware that Resident #3 required a FSBS recheck when the result was over 400 because she had multiple residents that were on a sliding scale of insulin administration.
-She had not noticed that Resident #3's Novolog order on the eMAR included instructions to recheck FSBS after one hour when blood sugars were over 400.

Interview with the Special Care Coordinator (SCC) on 11/18/21 at 2:05pm revealed:
-She expected staff to recheck Resident #3's

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D 358	Continued From page 18 blood sugar if over 400 in one hour as ordered. -She expected staff to document the recheck of Resident #3's FSBS. -She faxed monthly blood sugar results to the PCP so that they were able to see FSBS trends. Interview with the Administrator on 11/18/21 at 2:40pm revealed he expected staff to follow prescribed orders for Resident #3 including rechecking the FSBS one hour after insulin administration if the FSBS was over 400 and to document the results. Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/18/21 at 10:32am and 2:02pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. 2. Review of Resident #5's current FL-2 dated 07/26/21 revealed diagnoses included diabetes. Review of Resident #5's physician's orders dated 10/29/21 revealed: -There was an order to check finger stick blood sugar (FSBS) twice daily with breakfast and supper. -There was an order for insulin lispro 100unit/ml, with instructions to inject twice daily with breakfast and supper per the sliding scale based on the FSBS results as follows: FSBS 0-175, give zero units; FSBS 176-225, give 2 units; FSBS 226-275, give 4 units; FSBS 276 to 325, give 6 units; FSBS 326 to 375, give 8 units; FSBS 376-425, give 10 units; FSBS greater than 425, give 12 units and repeat FSBS and sliding scale insulin in two hours. (Insulin lispro is a short-acting insulin used to control increased	D 358		

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blood sugars.)

Review of Resident #5's September 2021 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS twice daily with breakfast and supper at 7:00am and 4:30pm.
-There was an entry for insulin lispro 100unit/ml, with instructions to inject twice daily with breakfast and supper per the sliding scale based on the FSBS results as follows: FSBS 0-175, give zero units; FSBS 176-225, give 2 units; FSBS 226-275, give 4 units; FSBS 276 to 325, give 6 units; FSBS 326 to 375, give 8 units; FSBS 376-425, give 10 units; FSBS greater than 425, give 12 units and repeat FSBS and sliding scale insulin in two hours at 8:00am and 5:00pm.
-On 09/01/21 at 5:00pm, the FSBS result was 478, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.
-On 09/03/21 at 5:00pm, the FSBS result was 509, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.

Review of Resident #5's October 2021 eMAR revealed:
-There was an entry to check FSBS twice daily with breakfast and supper at 7:00am and 4:30pm.
-There was an entry for insulin lispro 100unit/ml, with instructions to inject twice daily with breakfast and supper per the sliding scale based on the FSBS results as follows: FSBS 0-175, give zero units; FSBS 176-225, give 2 units; FSBS 226-275, give 4 units; FSBS 276 to 325, give 6 units; FSBS 326 to 375, give 8 units; FSBS 376-425, give 10 units; FSBS greater than 425,

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give 12 units and repeat FSBS and sliding scale insulin in two hours at 8:00am and 5:00pm.
-On 10/07/21 at 5:00pm, the FSBS result was 469, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.
-On 10/19/21 at 5:00pm, the FSBS result was 435, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.
-On 10/21/21 at 5:00pm, the FSBS result was 459, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.
-On 10/22/21 at 8:00am, the FSBS result was 459, 12 units of insulin lispro was documented as administered; there was no documentation of FSBS recheck or additional sliding scale insulin administered.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/18/21 at 1:09pm revealed:
-Elevated blood sugars should be rechecked, treated, and reported to the resident's PCP as ordered.
-Prolonged elevated blood sugars could cause damage to the cells and diabetic neuropathy (nerve damage causing numbness in the extremities that could lead to amputation).
-Long term elevated blood sugars that were left untreated could cause a diabetic coma or death.

Interview with the medication aide (MA) on 11/18/21 at 1:35pm revealed:
-She was expected to follow orders as written on the eMAR.

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-She would recheck Resident #5's FSBS after 1-hour if greater than 400, but she did not document the blood sugar recheck or notification to the PCP.
-She did not realize Resident #5's order stated to re-check and re-dose the resident after 2-hours of a FSBS over 425.
-She did not re-check the FSBS or re-dose Resident #5's insulin as ordered.
-She did not notify the Special Care Coordinator (SCC) of Resident #5's FSBS greater than 400 per facility policy because the SCC reviewed them once per month.

Interview with the SCC on 11/18/21 at 2:05pm revealed:
-She expected the MAs to re-check FSBS and re-dose insulin as ordered.
-She expected all resident care to be documented in the resident's chart.
-She expected all correspondence with a resident's PCP to be documented in the resident chart.
-She expected the MAs to administer medications for increased FSBS as ordered and report them to her per facility policy.
-She was not made aware of Resident #5's increased FSBS requiring rechecks and re-dosing of insulin.
-MAs were trained upon hire to administer medications as ordered and to document all care in the resident record.

Interview with the Administrator on 11/18/21 at 2:42pm revealed:
-He expected the MAs to follow orders and administer medications as ordered by the resident's PCP.
-He was not aware Resident #5 was having FSBS over 425 requiring rechecks and re-dosing of

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D 358	Continued From page 22 insulin that were not being done. -He expected the MAs to report FSBS greater than 400 to the SCC. -He expected the SCC to follow up and ensure orders were being followed accurately. Attempted telephone interview with Resident #5's primary care provider (PCP) on 11/18/21 at 10:34am and 2:03pm was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure medication administration	D 367		

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D 367	Continued From page 23 records were complete and accurate for 2 of 5 residents sampled (#2 and #3) for sliding scale insulin administration (#3) and duplicate medication orders (#2). The findings are: Review of the facility's policy and procedure manual dated September of 2021 revealed all medications that staff members handle, store and administer will be documented on the medication administration record and in accordance with state regulations. 1. Review of Resident #3's current FL-2 dated 04/05/21 revealed: -Diagnoses included diabetes. -There was an order for Novolog insulin, with instructions to inject 3 times a day with meals per the sliding scale based on the fingerstick blood sugar (FSBS) results as follows: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour (Novolog is a short acting insulin used to treat high blood sugar). Review of Resident #3's September 2021 electronic medication administration record (eMAR) revealed: -There was an entry that began on 09/20/21 for Novolog insulin, with instructions to inject 3 times daily with meals per the sliding scale: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour; scheduled for administration at 8:00am, 12:00pm, and 5:00pm.	D 367		

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-There was a spot on the Novolog entry for the medication aide (MA) initials that they administered the medication but there was nowhere to document the amount of insulin administered or the injection site.
-There was a separate entry for FSBS three times a day.

Review of Resident #3's October 2021 eMAR revealed:
-There was an entry for Novolog insulin, with instructions to inject 3 times daily with meals per the sliding scale: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour; scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was a spot on the Novolog entry for the MA initials that they administered the medication but there was nowhere to document the amount of insulin administered or the injection site.
-There was a separate entry for FSBS three times a day.

Review of Resident #3's November 2021 eMAR revealed:
-There was an entry for Novolog insulin, with instructions to inject 3 times daily with meals per the sliding scale: FSBS 0-200, give zero units; FSBS 201-250, give 2 units; FSBS 251-300, give 4 units; FSBS 301 to 350, give 6 units; FSBS 351 to 400, give 8 units; FSBS greater than 400, give 10 units and recheck FSBS in one hour; scheduled for administration at 8:00am, 12:00pm, and 5:00pm.
-There was a spot on the Novolog entry for the MA initials that they administered the medication and a spot for the blood sugar.

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D 367	Continued From page 25 -There was nowhere to document the amount of insulin administered or the injection site. Interview with a MA on 11/18/21 at 1:35pm revealed: -She was aware there was no where to document the number of units or injection site on Resident #3's eMAR. -She made the Special Care Coordinator (SCC) aware that there were issues with the Novolog order for Resident #3. Interview with the SCC on 11/18/21 at 2:05pm revealed: -There was a lead MA that left the facility recently that was responsible for approving some orders in the computer system. -When approving insulin orders there was a box that needed to be checked so that it would create a spot for administration details including number of units and injection site. -When staff would bring insulin administration documentation issues to her attention she would try and fix them immediately. -She expected staff to documented completely and accurately on the eMAR including dosage and injection administration site. Interview with the Administrator on 11/18/21 at 2:40pm revealed: -He expected medication administration records to be complete and accurate for Resident #3's Novolog administration. -The SCC was responsible for ensuring eMAR were complete and accurate. Attempted telephone interview with Resident #3's primary care provider (PCP) on 11/18/21 at 10:32am and 2:02pm was unsuccessful.	D 367		

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D 367	Continued From page 26 Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. 2. Review of Resident #2's current FL-2 dated 04/13/21 revealed diagnoses included Alzheimer's, congestive heart failure (CHF), respiratory failure, asthma, diabetes mellitus type 2 (DM), and stage 4 chronic kidney disease. a. Review of Resident #2's current physician's orders dated 09/20/21 revealed an order for Novolog U-100 insulin (insulin aspart U-100 - generic name for Novolog U-100; used to lower elevated blood sugars), inject 4 units three times daily. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There were 22 duplicated occurrences of Novolog U-100 (insulin aspart U-100) documented as administered from 09/23/21-09/30/21. -There was an entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30am. -The Novolog U-100 (insulin aspart U-100) was documented as administered as ordered three times daily from 09/01/21-09/19/21, and on 09/20/21 at 6:30am and 11:30am. -There was a second entry for insulin aspart U-100 (Novolog U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30pm. -The insulin aspart U-100 (Novolog U-100) was documented as administered as ordered on 09/20/21 at 4:30pm and three times daily from 09/21/21-09/30/21. -There was a third entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times	D 367		

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D 367	Continued From page 27 daily at 6:30am, 11:30am, and 4:30pm. -The Novolog U-100 (insulin aspart U-100) was documented as administered three times daily from 09/23/21-09/30/21 except for being held on 09/23/21 and 09/27/21 at 4:30pm due to a duplicate order. Review of Resident #2's October 2021 eMAR revealed: -There were 66 duplicated occurrences of Novolog U-100 (insulin aspart U-100) documented as administered from 10/01/21-10/31/21. -There was an entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30am. -The Novolog U-100 (insulin aspart U-100) was documented as administered as ordered three times daily from 10/01/21-10/12/21 and on 10/13/21 at 6:30am with the exception of being held due to a duplicate order on 10/01/21 at 11:30am, 10/02/21 at 4:30pm, 10/04/21 at 6:30am, and 10/09/21 at 11:30am. -There was a second entry for insulin aspart U-100 (Novolog U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30pm. -The insulin aspart U-100 (Novolog U-100) was documented as administered three times daily from 10/01/21-10/31/21 with the exception of being held due to a duplicate order on 10/06/21 at 6:30am, 10/09/21 at 11:30am, 10/15/21 at 4:30pm, 10/18/21 at 4:30pm, 10/23/21 at 4:30pm, 10/24/21 at 11:30am, 10/24/21 at 4:30pm, and 10/25/21 at 6:30am. -There was a third entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30pm. -The Novolog U-100 (insulin aspart U-100) was documented as administered on 10/13/21 at 11:30am and 4:30pm.	D 367		

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D 367	Continued From page 28 -There was a fourth entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30pm. -The Novolog U-100 (insulin aspart U-100) was documented as administered on 10/13/21 at 4:30pm and three times daily from 10/14/21-10/31/21 with the exception of being held due to a duplicate order on 10/17/21 at 4:30pm, 10/18/21 at 6:30am and 4:30pm, 10/19/21 at 4:30pm, 10/21/21, 10/22/21 at 4:30pm, 10/23/21 at 11:30am, 10/24/21 at 6:30am, 10/25/21 at 11:30am and 4:30pm, 10/28/21 at 4:30pm, 10/30/21, and 10/31/21 at 4:30pm. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There were 2 duplicated occurrences of Novolog U-100 (insulin aspart U-100) documented as administered from 11/01/21-11/04/21. -There was an entry for Novolog U-100 (insulin aspart U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30am. -The Novolog U-100 (insulin aspart U-100) was documented as administered as ordered three times daily from 11/01/21-11/17/21, except for being held due to a duplicate order on 11/01/21 at 11:30am and 4:30pm, 11/02/21, and 11/03/21. -There was a second entry for insulin aspart U-100 (Novolog U-100), inject 4 units three times daily at 6:30am, 11:30am, and 4:30pm. -The insulin aspart U-100 (Novolog U-100) was documented as administered on 11/01/21-11/03/21 at on 11/04/21 at 6:30am. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/18/21 at 1:09pm revealed: -The pharmacy had only entered one order of the	D 367		

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Novolog U-100 (insulin aspart U-100).
-Novolog U-100 was brand name for the same generic medication brand insulin aspart U-100.
-She was not sure why duplicate orders appeared on Resident #2's eMAR but thought it could be because the facility did not discontinue an old order or entered a duplicate order after approving the order the pharmacy entered; she was unable to view the eMAR.
-Each vial of Novolog U-100 (insulin aspart U-100) contained 83 doses (less than 1-month supply) and the vial was only good for 30-days after opening.
-The resident should not have been double dosed because the facility had not tried to refill the Novolog U-100 (insulin aspart U-100) too soon; it had been filled on 07/29/21, 09/20/21, and 10/13/21.
-It was the facility's responsibility to ensure the eMAR was accurate and to call the pharmacy or primary care provider (PCP) to clarify if there were any questionable or duplicate orders.

Refer to telephone interview with Resident #2's PCP on 11/18/21 at 10:38am.

Refer to interview with the medication aide (MA) on 11/18/21 at 1:35pm.

Refer to interview with the Special Care Coordinator (SCC) on 11/18/21 at 2:05pm.

Refer to interview with the Administrator on 11/18/21 at 2:42pm.

b. Review of Resident #2's current physician's orders dated 09/20/21 revealed:
-There was an order for Vitamin D-2 (ergocalciferol) 1250mg every Monday and Thursday. (Vitamin D-2 is a supplement vitamin.)

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D 367	Continued From page 30 -There was an order for ergocalciferol (Vitamin D-2) 1250mg every Monday and Thursday. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There were 3 duplicated occurrences of the Vitamin D-2 (ergocalciferol) documented as administered on 09/16/21, 09/20/21, and 09/23/21. -There was an entry for Vitamin D-2 (ergocalciferol) 1250mg every Monday and Thursday at 8:00am. -The Vitamin D-2 was documented administered on 09/02/21, 09/06/21, 09/09/21, 09/13/21, 09/16/21, 09/20/21, and 09/23/21. -The Vitamin D-2 (ergocalciferol) was documented as held due to a duplicate order on 09/27/21 and 09/30/21. -There was a second entry for ergocalciferol (Vitamin D-2) 1250mg every Monday and Thursday at 8:00am. -The ergocalciferol was documented as held due to a duplicate order on 09/02/21, 09/06/21, 09/09/21, and 09/13/21. -The ergocalciferol was documented as administered 09/16/21, 09/20/21, 09/23/21, 09/27/21 and 09/30/21. Review of Resident #2's October 2021 eMAR revealed: -There was 1 duplicated occurrence of the Vitamin D-2 (ergocalciferol) documented as administered on 10/18/21. -There was an entry for Vitamin D-2 (ergocalciferol) 1250mg every Monday and Thursday at 8:00am. -The Vitamin D-2 (ergocalciferol) was documented as held for a duplicate order 10/04/21, 10/07/21, 10/11/21, and 10/14/21.	D 367		

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D 367	Continued From page 31 -The Vitamin D-2 (ergocalciferol) was documented administered on 10/18/21 and 10/21/21. -The Vitamin D-2 (ergocalciferol) was documented as discontinued on 10/21/21. -There was a second entry for ergocalciferol (Vitamin D-2) 1250mg every Monday and Thursday at 8:00am. -The ergocalciferol (Vitamin D-2) was documented as administered 10/04/21, 10/07/21, 10/011/21, 10/14/21, 10/18/21, 10/25/21, and 10/28/21. -The ergocalciferol (Vitamin D-2) was documented as held due to a duplicate order on 10/21/21. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/18/21 at 1:09pm revealed: -Vitamin D-2 was the brand name for the same generic medication ergocalciferol. -The pharmacy only had Vitamin D-2 as an active order on Resident #2's Resident #2's profile and she was unable to view the eMAR. -She was not sure why Resident #2 had duplicate order of the Vitamin D-2 (ergocalciferol) on her eMAR but thought it might be due to the facility forgetting to discontinue an old order of ergocalciferol. -Resident #2 could not have been double dosed because the pharmacy only dispensed a 1-month supply of 8 pills of Vitamin D-2 (ergocalciferol) on 08/27/21, 09/18/21, and 10/30/21 and the facility did not try to refill the medication too soon. -It was the facility's responsibility to ensure the eMAR was accurate and to call the pharmacy or primary care provider (PCP) to clarify if there were any questionable or duplicate orders. Refer to telephone interview with Resident #2's	D 367		

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D 367	Continued From page 32 primary care provider (PCP) on 11/18/21 at 10:38am. Refer to interview with the medication aide (MA) on 11/18/21 at 1:35pm. Refer to interview with the Special Care Coordinator (SCC) on 11/18/21 at 2:05pm. Refer to interview with the Administrator on 11/18/21 at 2:42pm. c. Review of Resident #2's current physician orders dated 09/20/21 revealed: -There was an order for famotidine 20mg, take once daily. (Famotidine is a medication used to decrease stomach acid.) -There was another order for famotidine 20mg, take once at bedtime. Review of Resident #2's September 2021 electronic medication administration record (eMAR) revealed: -There were 27 duplicate occurrences of the famotidine 20mg documented as administered. -There was an entry for famotidine 20mg, take once daily. -The famotidine 20mg once daily was documented as administered 09/01/21-09/29/21. -The famotidine 20mg once daily was documented as not administered on 09/30/21. -There was a second entry for famotidine 20mg, take once at bedtime. -The famotidine 20mg once at bedtime was documented at administered 09/01//21-09/19/21 and 09/22/21-09/30/21. -The famotidine 20mg once at bedtime was documented as held for duplicate order on 09/20/21. -The famotidine 20mg was documented at not	D 367		

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administered on 09/21/21.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/18/21 at 1:09pm revealed:
-The pharmacy only had one active order of famotidine 20mg on Resident #2's profile and she was unable to view the eMAR.
-She was unsure why duplicate orders of famotidine 20mg were showing up on Resident #2's eMAR but thought it might be due to the facility forgetting to discontinue an old order of famotidine 20mg.
-Resident #2 should not have been double dosed because the pharmacy only filled a 1-month supply of famotidine on 09/27/21 and 10/25/21 and the facility had not requested to refill the medication too soon.
-It was the facility's responsibility to ensure the eMAR was accurate and to call the pharmacy or primary care provider (PCP) to clarify if there were any questionable or duplicate orders.

Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/18/21 at 10:38am.

Refer to interview with the medication aide (MA) on 11/18/21 at 1:35pm.

Refer to interview with the Special Care Coordinator (SCC) on 11/18/21 at 2:05pm.

Refer to interview with the Administrator on 11/18/21 at 2:42pm.

Telephone interview with Resident #2's primary care provider (PCP) on 11/18/21 at 10:38am revealed:
-She expected the eMAR to be accurate for the

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D 367	Continued From page 34 resident's utmost safety. -If she had signed duplicate orders, she had not realized it, and expected the facility to notify her to clarify the order and to discontinue the duplicate order to avoid overmedicating the resident. -It was concerning that the eMAR was inaccurate because that could cause medication errors. -She expected the facility to administer medications accurately as ordered. Interview with the medication aide (MA) on 11/18/21 at 1:35pm revealed: -It was the Special Care Coordinator's (SCC) responsibility to process orders and have them entered onto the eMAR. -If she realized there were duplicate entries or errors on a resident's eMAR, she would have reported the issue to the SCC so it could be corrected. -She would document only what she administered and document "not given, duplicate order" for incorrect orders. -She must not have realized the errors on Resident #2's eMAR when she documented duplicate medications. -She did not administer Resident #2 duplicate doses of her medications; it was a documentation error due to not catching the errors on the eMAR. Interview with the SCC on 11/18/21 at 2:05pm revealed: -There should not have been duplicate or inaccurate orders on Resident #2's eMAR. -It was her responsibility to implement, process, approve, and clarify resident orders. -When an order was received, it was faxed to the pharmacy, the pharmacy would then enter the order onto the resident's eMAR. -Once the order was on the resident's eMAR, she would compare the eMAR to the original order	D 367		

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and approve it if accurate or clarify the order if inaccurate.
-She was unsure how she missed discontinuing old orders for Resident #2 resulting in duplicate orders and an inaccurate eMAR.
-It was her responsibility to follow up and ensure orders were accurate on the eMAR.
-There was no process in place to audit eMARs.

Interview with the Administrator on 11/18/21 at 2:42pm revealed:
-He expected the MAs to follow orders and administered medications as written by the resident's PCP.
-He expected the MAs to document on eMARs accurately and report any eMAR issues to the SCC.
-He expected the SCC to ensure orders and medications were implemented and carried out as written by the resident's PCP as soon as possible.
-He expected the SCC to ensure the residents' eMARs were accurate and discontinue old orders to avoid duplication.
-He was not aware Resident #2 had an inaccurate eMAR with duplicate orders.
-He expected the SCC to follow up and ensure orders were being followed accurately.
-It was concerning that Resident #2's eMAR was not accurate and the error should not have been missed.