Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032121	A. BUILDING: ____ B. WING ____	R 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE ESTATES ASSISTED LIVING	**4120 HOLT SCHOOL ROAD DURHAM, NC 27704**

Received via email 07/01/21, KHH

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on May 19, 2021 through May 20, 2021.	C 000	Prestige Estates Has implemented and updated job description form to ensure that all employees are properly trained and understand how to carry out the duties when Administrator is not available. RN Nurse Will Do routine employee file checks monthly to insure that all qualifications are being met.	6/14/21 7/1/2021
C 128	10A NCAC 13G .0402 (3) Qualifications Of Supervisor-In-Charge 10A NCAC 13G .0402 Qualifications Of Supervisor-In-Charge The supervisor-in-charge is responsible to the administrator for carrying out the program in the home in the absence of the administrator. All of the following requirements must be met: (3) The supervisor-in-charge must be willing to work with bonafide inspectors and the monitoring and licensing agencies toward meeting and maintaining the rules of this Subchapter and other legal requirements; This Rule is not met as evidenced by: Based on observations and interviews, the Supervisor-In-Charge (SIC) failed to carry out the program in the home to meet and maintain rules and requirements when the Administrator was not available. The findings are: Observations on 05/19/21 between 12:30pm and 6:00pm revealed: -Surveyors entered the facility at 12:30pm at which time the SIC notified the Administrator via telephone. -At 2:40pm the SIC provided a weekly menu and substitute menu for 05/19/21.	C 128		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Reviewed and Accepted 07/01/21 KHH

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C 128	Continued From page 1 -At 4:00pm the SIC provided the fire drill and inspection record and 2 employee records for review. -At 4:32pm the SIC walked out the front door and immediately returned with a key to the medication closet. -The SIC opened the medication closet and stated she did not know where any one resident's medications were and could not identify medications for the residents. -The SIC was informed that surveyors would not go through the medication closet and a staff member must pull out the resident's medications and stay present while surveyors recorded resident medications. -At 4:40pm the SIC retrieved medications for two sampled residents requested by the surveyors. -At 4:45pm the Administrator reentered the facility and provided additional medications for residents for two sampled residents the medications the SIC pulled out were extra medications. At this time surveyor asked for Resident #2's medications on hand. -At 5:15pm the Administrator locked the medication closet and left the facility to find other facility records, medications for two sampled residents (metoprolol) and (magnesium and nicotine patches), not in medications on hand. Interview with the SIC on 05/19/21 at 12:30pm and 6:00pm revealed: -The SIC verbalized she did not have access to resident records and medication administration records (MARs). -She did not know about the activity calendar. -She did not know about the menus for the meals. -At 4:20pm the SIC said she called and left a message for the Administrator to see how far away she was with records and MARs.	C 128		

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C 128	Continued From page 2 -At 4:27pm the Administrator returned a call to the SIC and spoke to surveyor. -The Administrator was again informed that surveyors still needed March 2021 and April 2021 MARs for the residents as well as other records and to record resident medications on hand in the facility. -The Administrator asked to speak to the SIC again to tell her how to access the resident medications. -When the Administrator left at 5:15pm she did not leave the key to the medication closet with her. Interview with the Administrator on 05/19/21 at 1:30pm revealed: -She had an activities calendar and records for the 4 current residents. -Residents medication administration records (MARs) for March 2021, April 2021 and May 2021 were not available in the facility. -She brought the May 2021 MARs for the residents with her but did not bring the March and April 2021 MARs. -At 1:50pm the Administrator stated she was leaving the facility to go to her office, which was "across town" to retrieve MARs for the residents. Attempted interview with the Administrator on 05/19/21 at 5:50pm was unsuccessful.	C 128		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted	C 202	Chart audits will be done the Rn. Nurse monthly to ensure that all residents charts are updated with all needed information inside each chart 7/1/2021	

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C 202	Continued From page 3 by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #3) received a test for tuberculosis (TB) upon admission. The findings are: Review of Resident #3's current FL2 dated 08/25/20 revealed diagnoses included a bloodborne pathogen infectious disease, diabetes mellitus type I, hypertension, pancreatitis and acute encephalopathy. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 09/14/19. Review of Resident #3's immunization records revealed: -There was documentation a TB skin test was placed on 08/23/19, and a negative TB skin test read on 08/25/19. -There was no documentation for a second TB skin test available for review. Interview with Resident #3 on 05/19/21 at 3:15pm revealed: -She had one TB skin test done when she was in the hospital prior to coming to the facility.	C 202	Pre admissions forms are now in place to ensure that all required information are inside each resident chart All Pre admissions will be conducted by the RN to ensure that each resident have their step 1 and step 2 in each file. Rn nurse will conduct preadmission audits at the time of admission to ensure that all requirement are met for each resident.	6/28/21 6/28/21

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C 202	Continued From page 4 -She did not have another TB skin test after her admission to the facility. Interview with the Administrator on 05/19/21 at 2:31pm revealed: -She was not aware Resident #3 did not have a second TB skin test. -She thought Resident #3 had both TB skin tests done. -She was responsible for ensuring TB skin tests were completed on residents upon admission. -She did not know what happened with Resident #3 and why the second TB skin test was not completed. Telephone interview with the nurse manager at Resident #3's Primary Care Provider's (PCP) office on 05/20/21 at 10:45am revealed: -Resident #3 had a TB skin test done on 08/23/19 that was read on 08/25/19. The results were negative. -The resident nor the facility made the PCP aware Resident #3 needed a second TB skin test done.	C 202		
C 205	10A NCAC 13G .0702(c)(2) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the	C 205		

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C 205	Continued From page 5 administrator or supervisor-in-charge before admission except for emergency admissions. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) had a FL-2 completed which documented the medical examination prior to admission. The findings are: Review of Resident #1's record on 05/19/21 revealed: -There was no current FL2 available. -There was no physician's order sheet that listed the resident's current medications. -There was no current Resident Register available. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for nicotine 14mg patch place 1 patch on the skin every day at 8:00am. -There was no documentation nicotine 14mg patch was administered 05/11/21-05/18/21. -There was an entry for Advair diskus 250-50 1 puff every 12 hours at 8:00am and 8:00pm. -There was no documentation Advair diskus 250-50 was administered at 8:00am from 05/11/21-05/19/21. -There was an entry for Eliquis 5mg 1 tablet every 12 hours at 8:00am and 8:00pm. -There was no documentation Eliquis 5mg 1 tablet was administered at 8:00am from 05/11/21-05/19/21. -There was an entry for Entresto 24mg-26mg 1 tablet 2 times a day at 8:00am and 8:00pm. -There was no documentation Entresto 24mg-26mg 1 tablet was administered at 8:00am	C 205	The Facility has implemented the following Policy and Procedure to ensure that all paperwork appointments have needed information back to facility with 24 hours giving Physicians 24 hours to complete paperwork requiring them to fax back to Facility with 24 hours To ensure that all medications and FL-2, medications are inside of the facility at all times. RN Nurse will do chart audits at the time of admissions to ensure all required documents are inside each resident file at the time of each admission or re eval.,or re-admit. RN Nurse will monthly chart audits as well to ensure all files and medication orders are maintained in facility	7/1/2021. 7/1/21

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from 05/11/21-/05/19/21.
-There was an entry for pregabalin 150mg 1 capsule 2 times a day at 8:00am and 8:00pm.
-There was no documentation pregabalin 150mg was administered at 8:00am from 05/11/21-05/19/21.

Review of Resident #'1's medications on hand 05/19/21 revealed:
-There were no nicotine 14mg patches available to administer.
-There were 3 boxes labeled Advair diskus 250-50 1 puff every 12 hours and dispensed on 04/14/21.
-There were 2 bubble pack card labeled Eliquis 5mg 1 tablet every 12 hours and last dispensed on 04/14/21 for 60 tablets with 54 tablets left.
-There were 2 bubble pack card labeled Entresto 24mg-26mg 1 tablet 2 times a day and last dispensed on 08/13/20 for 60 tablets with 43 tablets left.
-There was a bubble pack card labeled pregabalin 150mg 1 capsule 2 times a day and dispensed on 03/29/21 for 60 tablets with 30 capsules left and one bubble pack card labeled pregabalin 150mg 1 capsule 2 times a day wrapped in a pharmacy return form and dispensed on 04/26/21 containing 60 capsules.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

Interview with the Administrator on 05/19/21 at 1:35pm revealed:
-Resident #1 was readmitted on 05/10/21.
-She did not have a current FL2 for the 05/10/21 admission.
-She took him to an appointment on 05/18/21 to complete an exam for an FL2, but did not have

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C 205	Continued From page 7 the completed FL2 because it was still with the resident's physician. Attempted interview with the Administrator on 05/19/21 at 5:15pm was unsuccessful. Telephone interview with a representative from Resident #1's Primary Care Providers' (PCP) office on 05/20/21 at 3:42pm revealed the PCP had an FL2 that was completed on 05/18/21, that was not picked up by the facility until 05/20/21.	C 205		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .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 observations, record reviews, and interviews, the facility failed to ensure implementation of physician's orders for 2 of 3 sampled residents (Residents #2 and #3) with orders for daily blood pressure (#2) and orders for daily weights (#3). The findings are: 1. Review of Resident #3's current FL2 dated 08/25/20 revealed diagnoses included a bloodborne pathogen infectious disease, diabetes mellitus type I, hypertension, pancreatitis and	C 249	Daily Progress notes form have been updated and put in Mar for the Administrator to ensure that daily needed vitals and are charted All Chart Audits will be reviewed by RN on a monthly base to ensure all treatment and orders are implemented and carried out daily by staff.	6/28/21 7/2721

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acute encephalopathy.

Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed Discharge to outside facility orders included an order from the Nephrologist for daily weights and to notify the provider of weight gain greater than 2 pounds in one day or 5 pounds in one week.

Review of Resident #3's medication administration records (MARs) revealed there were no March and April 2021 MARs available for review.

Review of Resident #3's May 2021 MAR revealed there was no entry for daily weights.

Review of Resident #3's record and progress notes revealed there was no documentation of daily weights.

Interview with Resident #3 on 05/19/21 at 3:40pm revealed:
-She used to be weighed weekly but had not been weighed for several weeks because the facility's scale was broken.
-She was weighed once per week by the Supervisor-In-Charge (SIC) but she was not told what her weight was.
-She did not know there was an order to weigh her daily.
-She was not weighed daily at the facility.
-She was not sure if her weight fluctuated up and down, she felt the same all the time.
-The Administrator received her paperwork when she returned from the hospital.
-She depended on the Administrator to tell when there were orders that she needed to follow.

Interview with the SIC on 05/19/21 at 3:55pm

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revealed:
-She did not know Resident #3 had an order for daily weights.
-When Resident #3 returned from the hospital on 03/13/21 the Administrator reviewed the paperwork.
-If there was an order for daily weights the Administrator should have told her.
-Sometimes she weighed Resident #3 once a week, but not consistently weekly.
-It had been over one week, since Resident #3 was weighed because the facility's scale was broken.
-After the scale broke it was removed from the facility and Resident #3 was no longer weighed.
-She did not call the Primary Care Provider (PCP) it was done by the Administrator.

Telephone interview with the Administrator on 05/19/21 at 4:45pm revealed:
-When Resident #3 returned from the hospital on 03/13/21 she reviewed the hospital discharge paperwork.
-She did not realize there was an order for daily weights.
-Resident #3 was not currently being weighed daily.

Attempted telephone interview with Resident #3's Nephrologist on 05/20/21 at 11:54am was unsuccessful.

2. Review of Resident #2's current FL2 dated 04/05/21 revealed:
-Diagnoses included hypertension, hyperlipidemia and chronic kidney disease.
-There was an order for daily blood pressure (BP).

Review of Resident #2's March, April and May

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2021 medication administration record (MAR) revealed there was no entry for daily BP.

Review of Resident #2's record and progress notes revealed there was no documentation of Resident #2's BP readings recorded daily.

Interview with the Supervisor-In-Charge (SIC) on 05/19/21 at 5:40pm revealed:
-She did never taken Resident #2's BP at all.
-The Administrator took care of residents' medications and orders from the Primary Care Provider (PCP).

Interview with the Administrator on 05/19/21 at 1:30pm revealed:
-She documented Resident #2's BP daily.
-The BP documentation was in her office "across town".

Telephone interview with the Administrator on 05/20/21 at 8:40am revealed she would fax Resident #2's BP records.

Based on observation and record review it was determined that Resident #2 was not interviewable.

Attempted second interview with the Administrator on 05/19/21 at 6:00pm was unsuccessful.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 05/20/21 at 3:42pm was unsuccessful.

A request was made for Resident #2's BP readings but was not provided prior to exit on 05/20/21.

Provider's plan of correction:

Daily Progress Notes booklet has been created to log and ensure all residents daily vitals are recorded in one place this will be conducted by Administrator — 7/1/2021

Weekly Checks for documentation are done by ADMN to ensure that all daily vital sign orders are carried out — 6/29/21.

RN Will do monthly Checks to ensure that all orders are in guidelines with resident current orders and correctly documented. — 7/14/21

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C 270	Continued From page 11	C 270		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to ensure matching therapeutic diets menus were available for 2 of 3 residents who were ordered low carbohydrate diet (#2) and no concentrated sweets and carbohydrate diet (#3). The findings are: 1. Review of Resident #2's current FL2 dated 04/05/21 revealed: -Diagnosis including prediabetes. -There was an order for a low carbohydrate diet. Observation of the facility kitchen and dining room on 05/19/21 at 12:40pm revealed there was no menu or therapeutic diet list posted. Interview with a personal care aide (PCA) on 05/19/21 at 12:42pm revealed: -The Administrator prepared the weekly menu. -She did not have access to a menu. -She did not have a list of residents on therapeutic diets. -She prepared the same meals for all residents. -She did not know of any residents on therapeutic diets.	C 270	Diet and nutrition in-service has been completed to ensure that staff are following all diet orders for all residents Nutrition Form has been implemented to offer Physician a ability to select best diet for each resident. Nutritionist will provide a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance for food service staff. Rn Nurse will do routine monthly checks to ensure that menus are posted daily. Rn Nurse do audits to ensure that diets match current standing orders.	6/28/2021 7/1/21 7/1/21

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Review of the facility's daily menu at a glance titled "Week 2, Wednesday" provided on 05/19/21 at 2:40pm by the Administrator revealed there was no low carbohydrate diet listed on the menu.

Observation of the dinner meal on 05/19/21 from 4:00pm to 4:30pm revealed:
-There were 4 residents present for the meal.
-All residents were served barbeque chicken leg quarter, canned peas/carrots and mashed potatoes with a glass of fruit punch and a glass of water.
-Resident #2 ate 100% of his meal.

Without a therapeutic diet menu it could not be determined if Resident #2 was served the appropriate meal.

Based on observation, record review and interview, it was determined Resident #2 was not interviewable.

Attempted interview with the Administrator on 05/19/21 at 2:40pm was unsuccessful.

Attempted telephone interview on 05/20/21 at 3:42pm with Resident #2's PCP was unsuccessful.

2. Review of Resident #3's current FL2 dated 08/25/20 revealed:
-Diagnoses included diabetes mellitus type I.
-There was a diet order for a no concentrated sweets diet

Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed a diet order for a carbohydrate diet.

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PRESTIGE ESTATES ASSISTED LIVING	4120 HOLT SCHOOL ROAD DURHAM, NC 27704

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C 270	Continued From page 13	C 270		

Observation of the facility kitchen and dining room on 05/19/21 at 12:40pm revealed there was no therapeutic diet menu or diet list posted.

Review of the facility's daily menu at a glance titled "Week 2, Wednesday" provided by the Administrator on 05/19/21 at 2:40pm revealed there was carbohydrate diet listed on the menu.

Observation of the dinner meal on 05/19/21 from 4:00pm to 4:30pm revealed:
-Resident #3's dinner meal consisted of a barbeque chicken leg quarter, canned peas/carrots and mashed potatoes with a glass of fruit punch and a glass of water.
-Resident #3 consumed 100% of her meal.

Without a therapeutic diet menu it could not be determined if Resident #3 was served the appropriate meal.

Interview with Resident #3 on 05/19/21 at 4:58pm revealed:
-She had diabetes and was administered insulin to help control her diabetes.
-She did not know if she was ordered a special diet.
-She knew not to eat sweets because of her diabetes.
-When she was in the hospital she was served a carbohydrate-controlled diet.
-At the facility she was served the same meal as other residents.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/20/21 at 10:45am revealed:
-The last diet order for Resident #3 was the FL2 dated 08/25/20 with an order for a no concentrated sweets diet.

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C 270	Continued From page 14 -Resident #3 was a diabetic and was on medications to help control her diabetes. -It was not uncommon for the hospital to order a carb-controlled for most discharge patients. -The facility should serve Resident #3's diet as ordered. -If there was a problems with the diet order the PCP should be notified. -Resident #3's glycated hemoglobin (A1C) on 02/27/21 was 7.4. A normal range for A1C should be 5.6 or lower.	C 270		
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to	C 291		

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C 291	Continued From page 15 enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to prepare a monthly calendar of planned group activities for the residents to encourage participation, socialization, mental stimulation, physical exercise and creativity. The findings are: Observation of the facility on 05/19/21 at 12:30pm revealed: -There was no activity calendar posted. -There were no activity supplies, such as cards, games or crafts available in the facility. Interview with a resident on 05/19/21 at 12:45pm revealed they do not do any activities, just watch television. Interview with a second resident on 05/19/21 at 12:47pm revealed they only sit outside at the table in the yard and watch television. Interview with a personal care aide (PCA) on 05/19/21 at 12:50pm revealed: -She did not have an activities calendar. -She did not do scheduled activities with the residents, they just did what they wanted such as	C 291	Activity Director has updated and created an interest form indicating a interest for each resident, in order to encourage participation. activity calendar will be posted throughout facility Monthly Calendar will be posted by Admin. Activity Coordinator will create calendar on a monthly base	7/1/2021

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C 291	Continued From page 16 watch television and walk outside. Review of the May 2021 activity calendar provided by the Administrator on 05/19/21 at 1:30pm revealed: -The activity calendar for May 2021 documented 13 hours of activities per week. -On 05/16/21 from 9:00am -1:00pm Sunday School was scheduled. -On 05/17/21 from 10:00am-11:00am newsgroup was scheduled. -On 05/18/21 from 10:00am -12:00pm balloon Zumba was scheduled. -On 05/19/21 from 10:00am -11:00am aerobics and slow movements was scheduled. -On 05/20/21 from 10:00am -12:00am cutting stars was scheduled. -On 05/21/21 from 10:00am-12:00am coffee time was scheduled. -On 05/22/21 from 2:00pm-3:00pm movie matinee was scheduled. Interview with the Administrator on 05/19/21 at 1:35 pm revealed: -She prepared the activity calendar. -There was no Activities Director. -She expected the staff to post the monthly activity calendar. -She expected staff to perform activities with the residents. Attempted telephone interview with the Administrator on 05/19/21 at 1:50pm was unsuccessful.	C 291		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with	C 315		

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C 315	Continued From page 17 the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to contact the physician for 1 of 3 sampled residents related to medication order clarification for a antihypertensive medication (Resident #3). The findings are: Review of Resident #3's current FL2 dated 08/25/20 revealed: -Diagnoses included diabetes mellitus type I, hypertension, bloodborne pathogen infectious disease, pancreatitis and acute encephalopathy. Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed an order for metolazone 2.5mg once daily (diuretic used to treat high blood pressure). Review of Resident #3's medication administration records (MARs) revealed there were no March and April 2021 MARs for review.	C 315	Chart Audit will be done for each resident to ensure that all medication clarification orders are in place by conducting audits on all residents by Routine Monthly Checks will be conducted by RN Nurse.	7/1/2021

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C 315	Continued From page 18 Review of Resident #3's May 2021 MAR revealed there was no entry for metolazone 2.5mg once daily. Observation of Resident #3's medications on hand at the facility on 05/19/21 at 4:15pm revealed metolazone 2.5mg was not available for administration. Telephone interview with the facility's contracted pharmacy on 05/20/21 at 12:05pm revealed: -Metolazone did not have a discontinuation order and there was no specific stop date for the medication. -The medication was filled on 03/12/21 for a quantity of 30 tablets was dispensed to the facility. -There were no refills on the metolazone order. -Metolazone was used to treat blood pressure and without it there could be complications if the blood pressure was high. -The physician who ordered the medication needed to be contacted to clarify if the medication should continue. Interview with Resident #3 on 05/19/21 at 3:40pm revealed: -She was aware she had high blood pressure. -She was not aware of medications ordered to treat her high blood pressure. -She depended on the Administrator to make sure she got the correct medications. Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed: -When Resident #3 returned from the hospital on 03/13/21 the resident had a lot of new orders. -Some of Resident #3's medication orders specified a specific stop date. -She was unable to recall what happened with	C 315	verification or clarification of orders for medications and treatments will be completed by the RN Nurse monthly RN Nurse will review Admissions also readmissions as well as discharge summaries Clarification policy and Procedure put in place to ensure that all orders for each resident are dated and signed within 24 hours by Physician	7/14/21 7/14/21 7/14/21

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C 315	Continued From page 19 Resident #3's metolazone and why it was not on the May MAR. -She was unable to locate Resident #3's March and April 2021 and could not validate when metolazone was out. -She had not contacted the pharmacy regarding the metolazone because she did not know the medication was out. -She had not contacted Resident #3's PCP to clarify if Resident #3 should continue taking metolazone because she did not realize the medication was no longer dispensed by the pharmacy. Telephone interview with the nurse manager at Resident #3's PCP office on 05/20/21 at 10:45am revealed: -No one from the facility had called to clarify if they needed to continue administering metolazone 2.5mg once daily. -The PCP had not seen or reviewed Resident #3's hospital discharge summary dated 03/13/21. -Their records showed the PCP did not order metolazone 2.5mg once daily. -Metolazone 2.5mg once daily was ordered by the Nephrologist. Attempted telephone interview with Resident #3's Nephrologist on 05/20/21 at 11:54am was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:	C 330		

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C 330	Continued From page 20 (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 administer medications as ordered by a licensed prescribing practitioner for 3 of 3 sampled residents (Residents #1, #2 and #3) related to a medication used to thin the blood, heart failure, neuropathic pain, shortness of breath, and nicotine withdrawal (#1) an anti-anxiety medication, medication used to treat diabetes and vitamin D3 supplement (#2) Finger Stick Blood Sugar (FSBS) and sliding scale insulin, a medication for high blood pressure and antidepressant medications (#3). The findings are: 1. Review of Resident #3's current FL2 dated 08/25/20 revealed: -Diagnoses included diabetes mellitus type I, hypertension, a bloodborne pathogen infectious disease, pancreatitis and acute encephalopathy. -There was documentation on the FL2 Resident #3 may inject her own insulin and check blood sugars. -There were no orders for FSBS and frequency on the current FL2. a. Review of Resident #3's previous hospital discharge summary report dated 10/20/20 revealed: -There was an order for FSBS four times daily before meal and at bedtime. -There was no order for the resident to obtain her own FSBS.	C 330	Prestige Estates RN nurse shall assure that the all resident files are in preparation and administration of medications, prescriptions and non-prescription and treatments by staff are in accordance with the DHSR Rule and Regulation by updating Policy and Procedures for Medication Orders and Managing Clarification orders at the time of Discharge form a outside facility.	7/14/21

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Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed:
-Resident #3 was admitted to the hospital on 02/27/21 for hyperglycemia.
-Resident #3 was discharged from the hospital on 03/13/21 with orders for FSBS four times daily before meals and at bedtime.
-There was no order for the resident to check her own FSBS.

Review of Resident #3's medication administration records (MARs) revealed there was no March and April 2021 MARs available for review.

Review of Resident #3's May 2021 MAR revealed:
-There was no entry for FSBS four times daily on the MAR.
-There was an entry for accu-check lancets four times daily before meals and nightly to check blood sugar.
-There was no documentation FSBS were obtained.
-There was an entry for accu-check plus test strips check blood sugar four times daily before meals and at bedtime.
-There was no documentation FSBS were obtained.

Review of Resident #3's notebook for FSBS documentation for March, April and May 2021 revealed:
-The resident checked and recorded FSBS three times daily, not four times daily as ordered.
-In March 2021 Resident #3's FSBS ranged between 46 and 484.
-In April 2021 Resident #3's FSBS ranged between 73 and 358.

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-In May 2021 Resident #3's FSBS ranged between 48 and 264.

Review of Resident #3's records revealed:
-There was no documentation the Primary Care Provider (PCP) had been contacted to clarify the order for FSBS four times daily.
-There was no documentation the PCP had been contacted to clarify if Resident #3 should continue to check her own FSBS.

Interview with Resident #3 on 05/19/21 at 2:30pm revealed:
-In February 2021, she was hospitalized due high blood sugar.
-When she returned from the hospital on 03/13/21, she did not read the hospital discharge paperwork; she gave all her paperwork to the Administrator.
-She was not aware her FSBS were ordered four times daily.
-She expected the Administrator to inform her of her orders, especially FSBS four times daily.

Telephone interview with Resident #3's PCP on 05/20/21 at 10:45am revealed:
-The PCP was not aware Resident #3 did not check her FSBS four times daily as ordered.
-The PCP saw Resident #3 via tele-a-visits.
-The last visit was in March 2021 following the resident's discharge from the hospital.
-The PCP did not ask to see Resident #3's FSBS readings and was not aware Resident #3's FSBS were not checked four times daily as ordered.
-She expected Resident #3's FSBS to checked four times daily.
-If the resident or the facility staff were not sure about checking FSBS four times daily, then they should have contacted the PCP to clarify the order.

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-Resident #3 was allowed to self-administer her own insulin and check her own FSBS because the PCP thought the resident could follow the orders for FSBS four times daily.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-She was responsible for reviewing Resident #3's hospital discharge summary report and all orders for the residents.
-She reviewed the hospital discharge summary reports from 10/20/20 and 03/13/21 and did not realize Resident #3 had orders to check her FSBS four times daily.
-She had not contacted Resident #3's PCP because she missed seeing the order for FSBS four times daily.

Telephone interview with the facility's contacted pharmacy on 05/20/21 at 12:09pm revealed:
-Resident #3 FSBS were ordered four times daily since September 2019.
-FSBS was not printed on the MAR but the test strips and lancets were printed on the MARs for facility staff to document they tested the resident's FSBS.
-The pharmacy did not have an order for Resident #3 to obtain her own FSBS.

b. Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed:
-There was an order for Humalog insulin 15 units at breakfast, 12 units at lunch and 15 units at supper.
-There was an order for Humalog sliding scale insulin for blood sugars 251-300 administer an additional 1 unit of Humalog insulin; blood sugars 301-350 administer an additional 2 units; and blood sugars greater than 350 administer 3 units of Humalog.

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-Under the section "Additional instructions from your provider" there were orders if the resident ate a bedtime snack, then administer an additional 5 units of Humalog insulin.

Review of Resident #3's medication administration records (MARs) revealed there were no March and April 2021 MARs for review.

Review of Resident #3's May 2021 MAR revealed:
-There was an entry for Humalog insulin with sliding scale.
-There was no entry for the additional 5 units of Humalog after bedtime snack.
-There was no documentation Humalog was administered.

Review of Resident #3's records revealed there was no documentation the Primary Care Provider (PCP) had been contacted to clarify the order for an additional 5 units of Humalog after a bedtime snack.

Interview with Resident #3 on 05/19/21 at 2:30pm revealed:
-The facility offered three snacks daily.
-The last snack she received was around 8:00pm.
-She also had her own food that she kept in the refrigerator and ate at night when she was hungry.
-When she returned from the hospital on 03/13/21, the Administrator wrote out the sliding scale on a piece of paper but did not include any other insulin orders.
-If there was an order an additional 5 units of Humalog was to be administered after a bedtime snack, the Administrator did not tell her about the order.

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-She did not read the hospital discharge paperwork; she depended on the Administrator to inform her of the medication ordered.

Telephone interview with Resident #3's PCP on 05/20/21 at 10:45am revealed:
-The PCP was not aware when Resident #3 was discharged from the hospital on 03/13/21 the resident was ordered an additional 5 units of Humalog if the resident had a bedtime snack.
-If the Resident #3 or the facility were not sure to administer the insulin, they should have contacted the PCP to clarify the order.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-She was responsible for reviewing Resident #3's hospital discharge summary report.
-If there were discrepancies or she was not sure about orders then she contacted the PCP or physician that wrote the order.
-She had not contacted Resident #3's PCP regarding the additional 5 units of Humalog because she did not see the order on the discharge summary report.

Telephone interview with the facility's contacted pharmacy on 05/20/21 at 12:09pm revealed:
-The pharmacy received orders from the 03/13/21 hospital discharge summary.
-The pharmacy had not received the order for the additional 5 units of Humalog after a bedtime snack.
-If the facility had made the pharmacy aware of the order then the pharmacy would have clarified the order with the PCP.

c. Review of Resident #3's hospital discharge summary report dated 10/20/20 revealed an order

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for losartan 50mg once daily (used to treat high blood pressure).

Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed an order to discontinue losartan 50mg once daily.

Review of Resident #3's medication administration records (MARs) revealed there were no March and April 2021 MARs available for review.

Review of Resident #3's May 2021 MAR revealed:
-There was an entry for losartan 50mg once daily scheduled for administration at 8:00am.
-There was documentation losartan 50mg was administered at 8:00am from 05/01/21 through 05/19/21.

Observation of the Resident #3's medications on hand on 05/19/21 at 4:15pm revealed:
-There were two bubble packed cards of losartan 50mg.
-One bubble packed card of losartan was dispensed on 03/03/21 for 30 tablets, there were 5 tablets of losartan left.
-The second bubble packed card of losartan was dispensed on 02/04/21 for 30 tablets, there were 30 losartan tablets left.

Telephone interview with a representative from the facility's contracted pharmacy on 05/20/21 at 12:05pm revealed:
-On 08/20/20, the pharmacy received an order for losartan 50mg once daily.
-Losartan 50mg was filled and dispensed on 08/28/20 for a quantity of 30 tablets.
-Losartan 50mg was filled again and dispensed on 09/25/20.

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C 330	Continued From page 27 -Losartan 50mg was not filled in the months of October, November and December 2020, he was not sure why the medication was not refilled. -Losartan 50mg was filled on 01/08/21, 02/04/21 and 03/03/21 each time a quantity 30 tablets were dispensed. -Losartan 50mg was discontinued on 03/15/21. -When the pharmacy received the discontinue order for losartan 50mg the medication should have been removed from the MAR. -Sometimes the medication was not removed from the MAR, then the facility should contact the pharmacy to make sure the medication was removed from the MAR. Interview with Resident #3 on 05/19/21 at 3:40pm revealed: -The Administrator administered her medications daily at 8:00am, 12:00pm and 8:00pm. -She had a diagnosis of hypertension, but did not know the names of the medications ordered to treat her hypertension. -She did not know the names of the medications administered by the Administrator. -She did not know if her blood pressure was high or low because her blood pressure was not checked at the facility. Telephone interview with Resident #3's Primary Care Provider (PCP) revealed Resident #3 should not be administered losartan because the medication was discontinued on 03/15/21. Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed: -She did not know Resident #3's losartan was discontinued because the medication was still printed on the MAR. -She had the medication in the facility, so she administered the medication to Resident #3.	C 330	Monthly Mar Reviews are completed by the RN NURSE to ensure that all orders are correct and matched with current standing orders. Physician Medication update form has been created to update Pharmacy with any new standing orders	7/1/21 7/14/21

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C 330	Continued From page 28 -She was unable to recall what happened to Resident #3's March and April 2021 MARs. -She was not certain that she administered losartan in the months March and April 2021. -There was no system of auditing to compare orders with the MARs. d. Review of Resident #3's hospital discharge summary report dated 10/20/20 revealed an order for seroquel 100mg at bedtime (used to treat bipolar/depression). Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed an order that changed seroquel to 200mg at bedtime. Review of Resident #3's medication administration records (MARs) revealed there were no March and April 2021 MARs available for review. Review of Resident #3's May 2021 MAR revealed: -There was an entry for seroquel 200mg at once daily scheduled for administration at 8:00am. -There was documentation seroquel 200mg was administered daily at 8:00am from 05/01/21 through 05/19/21. -There was an entry for seroquel 100mg scheduled for administration at 8:00pm. -There was documentation seroquel 100mg was administered daily at 8:00pm from 05/01/21 through 05/18/21. Observation of Resident #3's medications on hand at the facility on 05/19/21 at 4:15pm revealed: -Seroquel 200mg was available for administration. The medication was dispensed on 05/17/21 for a quantity of 30 tablets and there	C 330		

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were 28 tablets of seroquel 200mg remaining.
-Seroquel 100mg was available for administration. The medication was dispensed on 05/18/21 for a quantity of 30 tablets, there were 29 tablets of seroquel 100mg remaining.

Interview with Resident #3 on 05/20/21 at 4:17pm revealed:
-She was not aware of the dose of seroquel administered.
-She depended on the Administrator to give her the correct medication ordered.
-She could not say that she felt different or had any unusual feelings since her last hospitalization in March 2021.

Telephone interview with a representative from the facility's contracted pharmacy on 05/20/21 at 12:05pm revealed:
-Resident #3 had an order for seroquel 200mg in the morning that was written on 04/12/21.
-Seroquel 200mg was last filled and dispensed on 05/17/21.
-Resident #3 had an order for seroquel 100mg at bedtime that was written on 04/22/21.
-The order was a reduction in the seroquel dose.
-The pharmacy was not sure if the reduction discontinued for 100mg at bedtime or the 200mg in the morning.
-The pharmacy did not contact the physician who ordered the seroquel because he just realized the order was printed incorrectly on the MAR.
-The pharmacy dispensed both medications to the facility and both seroquel 200mg and 100mg were documented on the MAR.
-Administering seroquel 300mg could possibly cause the resident side effects such as drowsiness and low blood pressure.
-The worse case scenario it could be fatal, but the side effects depended on the individual getting

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the medication.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/20/21 at 10:45am revealed:
-On 02/27/21, Resident #3's mental health provider increased seroquel 100mg to 200mg at bedtime.
-Resident #3 should currently be administered 200mg of seroquel only at bedtime.

Telephone interview with Resident #3's mental health provider on 05/20/21 at 11:07am revealed:
-Resident #3 should currently be administered seroquel 200mg at bedtime.
-Resident #3 was previously ordered 200mg of seroquel in the morning and 100mg at bedtime, then that order was changed to 200mg at bedtime.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-She did not know Resident #3's order for seroquel had changed.
-The pharmacy put both medications on the May 2021 MAR, so she administered both medications.
-She did not think there was a problem administering both seroquel 200mg and 100mg.

2. Review of Resident #2's current FL2 dated 04/05/21 revealed:
-Diagnoses included neurocognitive disorder, insomnia, hypertension and chronic kidney disease.
-There was no order for trazadone listed on the FL2.

a. Review of Resident #2's after visit summary from the Primary Care Provider (PCP) dated

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04/05/21 revealed there was an order to discontinue trazadone 50mg one half tablet at bed time (used to treat anxiety).

Review of Resident #2's care plan dated 04/05/21 revealed there was a line drawn through trazadone and documentation to "D/C 4/5/21" written on the line beside it.

Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for trazadone 50mg one half tablet (25mg) at bedtime at 8:00pm.
-There was documentation trazadone 50mg one half tablet (25mg) was administered at 8:00pm from 04/05/21 through 04/30/21.

Review of Resident #2's May 2021 MAR revealed:
-There was an entry for trazadone 50mg one half tablet (25mg) at bedtime at 8:00pm.
-There was documentation trazadone 50mg one half tablet (25mg) was administered at 8:00pm from 05/01/21 through 05/18/21.

Review of medications on hand 05/20/21 at 10:30am revealed:
-The Administrator provided a picture of the trazadone 50mg bubble pack label on 05/20/21 due to her unavailability during survey on 05/19/21.
-There was a bubble pack card labeled trazadone 50mg one half tablet (25mg) at bedtime dispensed on 04/05/21 for 15 tablets (30 half tablets).
-It could not be undetermined how many tablets were left in the bubble pack.

Telephone interview with a pharmacy representative on 05/20/21 at 2:15pm revealed:

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-Trazadone 50mg one half tablet (25mg) at bedtime was dispensed on 04/05/21 for a 30 day supply.
-The pharmacy did not know to discontinue trazadone unless the facility or PCP informed them.
-As of 05/20/21 at 2:15pm the pharmacy had not been notified to discontinue the trazadone for Resident #2.

Based on observation, record review and interview, it was determined Resident #2 was not interviewable.

Attempted interview with the Administrator on 05/19/21 at 6:00pm was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 05/20/21 at 3:42pm was unsuccessful.

b. Review of Resident #2's current FL2 dated 04/05/21 revealed:
-Diagnoses included neurocognitive disorder, insomnia, hypertension and chronic kidney disease.
-There was an order for metformin 1000mg two times a day (used to treat diabetes).

Review of Resident #2's March 2021 medication administration record (MAR) revealed:
-There was an entry for metformin 1000mg twice daily scheduled for administration at 8:00am and 5:00pm.
-There was no documentation metformin 1000mg was administered at 5:00pm from 03/01/21 through 03/31/21.

Review of Resident #2's April 2021 MAR revealed:
-There was an entry for metformin 1000mg twice

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C 330	Continued From page 33 daily scheduled for administration at 8:00am and 5:00pm. -There was no documentation metformin 1000mg was administered at 5:00pm from 04/01/21 through 04/30/21. Review of Resident #2's May 2021 MAR revealed: -There was an entry for metformin 1000mg twice daily scheduled for administration at 8:00am and 5:00pm. -There was no documentation metformin 1000mg was administered at 5:00pm from 05/01/21 through 05/18/21. Observation of Resident #2's medications on hand on 05/19/21 at 4:45pm revealed: -The Administrator was not available and the residents medications were accessible. Observation of Resident #2's medications on hand on 05/20/21 at 8:52am revealed: -The Administrator took a picture of Resident #2's medications and sent via text. -There were two bubble cards labeled metformin 1000mg take 1 tablet two times a day was available for administration. -The Administrator refused to send a complete picture of the full medication card. Based on observation, record review and interview, it was determined Resident #2 was not interviewable. Attempted interview with the Administrator on 05/19/21 at 5:50pm was unsuccessful. Attempted telephone interview with Resident #2's PCP on 05/20/21 at 3:42pm was unsuccessful.	C 330		

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c. Review of Resident #2's current FL2 dated 04/05/21 revealed there was an order for vitamin D3 25mcg once a day.

Review of Resident #2's April 2021 medication administration record (MAR) revealed:
-There was an entry for vitamin D3 25mcg once daily scheduled for administration at 8:00am.
-There was documentation vitamin D3 25mcg once daily was administered at 8:00am from 04/05/21 through 04/30/21.

Review of Resident #2's May 2021 MAR revealed:
-There was an entry for vitamin D3 25mcg once daily scheduled for administration at 8:00am.
-There was documentation vitamin D3 25mcg once daily was administered once daily at 8:00am from 05/01/21 through 05/19/21.

Review of Resident #2's medications on hand at the facility 05/20/21 at 10:30am revealed:
-There was a bubble pack card labeled vitamin D3 25 mcg one tablet once a day dispensed on 04/05/21.
-It could not be determined how many tablets were left in the bubble pack.

Telephone interview with a pharmacy representative on 05/20/21 at 2:15pm revealed:
-Vitamin D3 25 mcg take once daily was dispensed 05/03//21 with a 30 day supply.
-The pharmacy did not know to discontinue vitamin D3 unless the facility or PCP informed them.
-As of 05/20/21 at 2:15pm, the pharmacy had not been notified to discontinue the vitamin D3 for Resident #2.

Based on observation, record review and

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interview, it was determined Resident #2 was not interviewable.

Attempted interview with the Administrator on 05/19/21 at 6:00pm was unsuccessful.

Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 05/20/21 at 3:42pm.

3. Review of Resident #1's record revealed there was no FL2 or physician's order sheet available.

Review of Resident #1's May 2021 medication administration record (MAR) revealed:
-There was an entry for nicotine 14mg patch place 1 patch on the skin every day at 8:00am.
-There was no documentation nicotine 14mg patch was administered from 05/11/21-05/18/21.
-There was an entry for Advair diskus 250-50 1 puff every 12 hours at 8:00am and 8:00pm.
-There was no documentation Advair diskus 250-50 was administered at 8:00am from 05/11/21-05/19/21.
-There was an entry for Eliquis 5mg 1 tablet every 12 hours at 8:00am and 8:00pm.
-There was no documentation Eliquis 5mg 1 tablet was administered at 8:00am from 05/11/21-05/19/21.
-There was an entry for Entresto 24mg-26mg 1 tablet 2 times a day at 8:00am and 8:00pm.
-There was no documentation Entresto 24mg-26mg 1 tablet was administered at 8:00am from 05/11/21-/05/19/21.
-There was an entry for pregabalin 150mg 1 capsule 2 times a day at 8:00am and 8:00pm.
-There was no documentation pregabalin 150mg was administered at 8:00am from 05/11/21-05/19/21.

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C 330	Continued From page 36 Review of medications on hand 05/19/21 revealed: -There were no nicotine 14mg patches available to administer. -There were 3 boxes labeled Advair diskus 250-50 1 puff every 12 hours dispensed on 04/14/21. -There were two bubble pack cards labeled Eliquis 5mg 1 tablet every 12 hours. -There were 60 tablets of Eliquis 5mg dispensed on 04/14/21 with 54 tablets left. -There were two bubble pack cards labeled Entresto 24mg-26mg 1 tablet 2 times a day. -There were 60 tablets of Entresto 24mg-26mg dispensed on 08/13/20 with 43 tablets left. -A bubble pack card labeled pregabalin 150mg 1 capsule 2 times a day was dispensed on 03/29/21 for 60 tablets with 30 capsules left and one bubble pack card labeled pregabalin 150mg 1 capsule 2 times a day was wrapped in a pharmacy return form dispensed on 04/26/21 containing 60 capsules. Based on observation, record review and interview, it was determined Resident #1 was not interviewable. Attempted interview with the Administrator on 05/19/21 at 5:50pm was unsuccessful. Attempted telephone interview with Resident #1's PCP on 05/20/21 at 3:42pm was unsuccessful.	C 330		
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medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed ensure documentation of medications administered occurred after the administration of a resident's medication and prior to the administration of the next resident's medication for 1 of 3 sampled residents (#3).

The findings are:

Review of Resident #3's current FL2 dated 08/25/20 revealed:
-Diagnoses included a bloodborne pathogen infectious disease, diabetes mellitus type I, hypertension, pancreatitis and acute encephalopathy.
-The FL2 included medication orders for: genvoya 150-150-200-10 once daily (used to treat bloodborne pathogen), atorvastatin 20mg daily (used to lower bad cholesterol), amlodipine 5mg once daily (used to treat high blood pressure), multi-vitamin once daily (used to treat vitamin deficiency), creon 24,000 units three times daily (used to treat pancreatitis), Humalog 24 units for breakfast, 18 units for lunch, and 8 units bedtime (fast-acting insulin used to treat diabetes mellitus), and lantus 40 units at bedtime (long-acting insulin used to lower blood glucose).

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Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed medication orders included genvoya 150-150-200-10 once daily; atorvastatin 20mg daily; amlodipine 5mg once daily; multi-vitamin once daily; creon 24,000 units three times daily with meal; Humalog 15 units for breakfast, 12 units for lunch, and 15 units supper, Humalog sliding scale insulin 251-300=1 unit, 301-350=2 units, greater than 350=3 units, lantus 40 units at bedtime; torsemide 100mg once daily (diuretic used to treat hypertension); clonazepam 0.5mg nightly (used to treat panic disorder); mirtazapine 30mg nightly (used to treat depressive order); quetiapine 200mg nightly (used to treat depression) and sertraline 50mg once daily (used to treat depressive disorder).

Review of Resident #3's medication administration records (MAR) revealed there was no March and April 2021 MARs.

Interview with Resident #3 on 05/19/21 at 2:30pm revealed:
-The Administrator administered her medications daily at 8:00am, 12:00pm and 8:00pm.
-In March 2021 she was in the hospital from 03/01/21 through 03/12/21.
-When she returned to the facility on 03/13/21 the Administrator administered her medications through the end of the month 03/31/21.
-The Administrator administered her medication the entire month of April 2021 from 04/01/21 through 04/30/21.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-She administered Resident #3's medications three times daily.
-She did not keep Resident #3's MARs at the

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PRESTIGE ESTATES ASSISTED LIVING	4120 HOLT SCHOOL ROAD DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 341	Continued From page 39 facility. -The MARs were at another office, which was located across town. -She used the other office as a storage area for paperwork. -She administered all the residents' medications then documented on the MARs that she kept at another location. -She did not know where Resident #3's March and April 2021 MARs were located. -She would provide the March and April 2021 MARs by the exit of the survey. A request was made for a copy of Resident #3's March and April 2021 MARs on 05/19/21 at 1:16pm, 3:58pm, 5:48pm and on 05/20/21 at 8:41am, 10:20am, 12:48pm, 3:16pm, 4:09pm, and 5:05pm. The Administrator did not provide the March and April 2021 MARs prior to exit on 05/20/21. Attempted telephone interview with the Administration on 05/20/21 at 5:35pm and 6:25pm was unsuccessful.	C 341	off site storage is no longer used at this time all Resident Records are maintain at the facility at this time.	6/29/21
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of	C 350	The facility will preform evaluations done by RN to ensure that assessments comply with current MD order allowing residents who are competent and physically able to self-administer their medications. a Self Administering Form will be completed by Rn and remain in File.	7/14/21

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C 350	Continued From page 40 prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 1 sampled resident (#3) who obtained their own fingerstick blood sugar checks (FSBS), and self-administered a long acting insulin, and a fast-acting insulin had orders to self-administer prescription medications including specific instructions for administering sliding scale insulin. The findings are: Review of Resident #3's current FL2 dated 08/25/20 revealed diagnoses included diabetes mellitus type I, hypertension, pancreatitis and acute encephalopathy. a. Resident #3's current FL2 dated 08/25/20 revealed: -Medication orders for Humalog 24 units for breakfast, 18 units for lunch and 8 units at bedtime. -There was an order lantus 40 units at bedtime. -There were instructions Resident #3 "may inject her own insulin and check her own blood sugar."	C 350	RN nurse will monitor monthly and maintain facility Policy and Procedures to ensure that each resident has the following orders and cross referencing orders for each fl-2 and medication orders for each resident.	7/1/21.

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Review of Resident #3's hospital discharge summary report dated 10/20/20 revealed:
-An order for Humalog sliding scale for FSBS 201-250= 1 unit, 251-300= 2 units, 301-350= 3 units, greater than 350 give 4 units and call the physician.
-There were no orders for Resident #3 to inject her own insulin.

Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed:
-There was an order for Humalog 15 units for breakfast, 12 units for lunch and 15 units for dinner along with a sliding scale 251-300=1 unit, 301-350=2 units and greater 350 give 3 units.
-There was an order to administer an additional 5 units of Humalog if a snack was eaten prior to bedtime.
-There were no orders for Resident #3 to self-administer her own insulin.

Review of Resident #3's March and April 2021 medication administration records (MARs) revealed the March and April 2021 MARs were not available for review.

Review of Resident #3's May 2021 MAR revealed:
-There was an entry for Humalog 15 units for breakfast, 12 units for lunch and 15 units for dinner.
-There was no documentation Humalog was administered from 05/01/21 through 05/19/21.
-There was an entry for Humalog sliding scale 251-300=1 unit, 301-350=2 units and greater 350 give 3 units.
-There was no documentation Humalog sliding scale was administered.
-There was no documentation Resident #3

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C 350	Continued From page 42 self-administered Humalog. Observation of Resident #3's room and medication storage area on 05/19/21 at 1:45pm revealed: -Resident #3 had a small bedroom sized refrigerator in her room. -Resident #3's lantus and Humalog were in the door of the refrigerator. -There were two boxes of lantus pens. -One box had three Lantus pens, the second box had two pens. -There was a third Lantus pen loose in the door of the refrigerator. -There were three vials of Humalog in boxes in the door of the refrigerator. -Two of the boxes were sealed and unopened, the third box was open. -Resident #3 had glucometer strips, lancets, and syringes with needle caps kept in a nightstand drawer. Interview with Resident #3 on 05/19/21 at 2:30pm revealed: -She checked her FSBS three times daily and administered 15 units of insulin for breakfast, 12 units for lunch and 15 units for dinner. -She administered additional insulin during the breakfast, lunch and dinner meal according to the sliding scale that was written down by the Administrator. -An example of how she administered her insulin: for FSBS-484 she administered herself 25 units of Humalog. -She did not write the units of insulin administered down. -She was unable to explain how she knew to administer 25 units of Humalog for a FSBS of 484. -She had snacks at the facility in the evening but	C 350		

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was not aware she was supposed to administer an additional 5 units of Humalog.
-The Administrator did not write that down for her.
-When her FSBS was low, 60 or less she did not administer herself Humalog.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 05/20/21 at 10:45am revealed:
-On the 08/25/20 FL2 the PCP allowed Resident #3 to self-administer her own insulin because the resident had done it when she lived on her own.
-The PCP thought Resident #3 could understand the orders and follow the instructions for the insulin.
-The PCP physically saw Resident #3 prior to COVID-19.
-Now visits were done via tele-a-communications with no in-person visits.
-The PCP expected the facility staff to ensure Resident #3 administered medications as ordered.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-Resident #3 had orders to self-administer her own insulin and check her own FSBS.
-When Resident #3 returned from the hospital she was responsible for ensuring the resident was aware of the medication orders.
-She observed Resident #3 check her FSBS and take insulin.
-If Resident #3 administered insulin incorrectly she was not aware.

b. Review of Resident #3's hospital discharge summary report dated 10/20/20 revealed:
-There was an order for FSBS four times daily before meals and at bedtime.
-There was no order for Resident #3 to check her

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own FSBS.

Review of Resident #3's hospital discharge summary report dated 03/13/21 revealed:
-There was an order for FSBS four times daily before meal and at bedtime.
-There was no order for Resident #3 to check her own FSBS.

Review of Resident #3's documented FSBS on 05/19/21 at 1:50pm revealed:
-Resident #3 had a thin 8 x 11-inch spiral note pad with lines.
-Resident #3 documented her FSBS results in the note pad.
-Resident #3 documented FSBS three times daily.

Review of Resident #3's handwritten logs for FSBS values documented in her notebook revealed:
-In March 2021, Resident #3's FSBS results ranged from 46 to 484. There was no documentation for the amount the units of Humalog administered.
-In April 2021, Resident #3's FSBS results ranged from 86 to 356. There was no documentation for the amount the units of Humalog administered.
-In May 2021, Resident #3's FSBS results ranged from 48 to 264.
-There was no documentation for the amount the units of Humalog administered.

Interview with Resident #3 on 05/19/21 at 2:30pm revealed:
-She checked her own FSBS three times daily.
-She had checked her own FSBS since her admission to the facility.
-She was not aware that she was supposed to check her FSBS four times daily.

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-She expected the Administrator to inform when orders had changed.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-Resident #3 had always checked her own FSBS.
-She thought once there was an order for the resident to check her own FSBS the order did not need to be renewed.
-She reviewed Resident #3's hospital discharge summary reports dated 10/20/20 and 03/13/21 and did not realize there were orders for FSBS four times daily.

Telephone interview with a representative at the facility's contracted pharmacy on 05/20/21 at 12:05pm revealed:
-Administering Humalog insulin at the incorrect dose could cause excess use of sliding scale insulin to lower elevated FSBS results.
-Not properly treating elevated FSBS results could lead to damage to the kidneys and eyes in the long term.

C 415 | 10A NCAC 13G .1201 (a) Resident Records | C 415

10A NCAC 13G .1201 Resident Records

(a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Facility Services and county departments of social services:
(1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable;
(2) Resident Register;
(3) receipt for the following as required in Rule

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.0704 of this Subchapter:
(A) contract for services, accommodations and rates;
(B) house rules as specified in Rule .0704(a)(2) of this Subchapter;
(C) Declaration of Residents' Rights (G.S. 131D-21);
(D) the home's grievance procedures; and
(E) civil rights statement;
(4) resident assessment and care plan;
(5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;
(6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;
(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and
(8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged.
When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to maintain resident records in an orderly manner at the facility for 2 of 3 (#1 and #3) sampled residents.

The findings are:

1. Review of Resident #1's record revealed:

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-There was no documentation of a pneumonia or influenza vaccine in the resident's record.
-There was no FL2 in Resident #1's record.
-There was no documentation of a physician's order sheet that listed the resident's curernt medications.
-There was no Resident Register documenting Resident #1's admission to the facility.

Based on observation, record review and interview, it was determined Resident #1 was not interviewable.

Interview with the Supervisor-In-Charge (SIC) on 05/19/21 at 12:40pm revealed:
-The Administrator was responsible for the resident records.
-She did not have access to Resident #1's record.

Interview with the Administrator on 05/19/21 at 1:35pm revealed:
-Resident #1 was readmitted on 05/10/21.
-She did not have a current FL2 for the 05/10/21 admission.
-She took Resident #1 to an appointment on 05/18/21 to complete an exam for an FL2, but did not have the completed FL2 because it was still with the resident's physician office.

2. Review of Resident #3's record revealed the following documents were not readily available for Resident #3: March and April 2021 medication administration records (MARs).

A request was made for a copy of Resident #3's March and April 2021 MARs on 05/19/21 at 1:16pm, 3:58pm, 5:48pm and on 05/20/21 at 8:41am, 10:20am, 12:48pm, 3:16pm, 4:09pm, and 5:05pm. The Administrator did not provide March and April 2021 MARs prior to exit on

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C 415	Continued From page 48 05/20/21. Interview with Resident #3 on 05/19/21 at 2:30pm revealed: -The Administrator administered her medications daily at 8:00am, 12:00pm and 8:00pm. -She received medications daily in March 2021 from 03/13/21 through 03/31/21 and daily in April 2021 from 04/01/21 through 04/30/21. Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed: -She administered Resident #3's medications three times daily. -She did not know where Resident #3's March and April 2021 MARs were located. -She would provide the March and April 2021 MARs by the exit of the survey. Attempted telephone interview with the Administrator on 05/20/21 at 5:35pm and 6:25pm was unsuccessful.	C 415		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health	C 612		

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C 612	Continued From page 49 department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection of respiratory illness as related to the facility screening staff and visitors for fever and signs and symptoms of respiratory illness. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility revealed staff should be screened for fever and signs and symptoms of illness before they began work. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities 03/31/21 revealed: -LTC facilities must screen every individual each	C 612	Policies And Procedures were implemented and maintained to provide protection to the residents during the(COVID-19) pandemic and to To reduce transmission and infection screening staff and visitors for fever and signs and symptoms of respiratory illness. Keeping Visitor log and sign in sheet listing all temp checks done by staff on duty Infection Control In-services are done by the RN Nurse to ensure that staff are complying with facility Policy and Procedures 7/14/21	6/29/21 6/29/21

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and every time they are wishing to enter the facility.
-Ensure the facility policies comply with the latest guidance and educate staff about any policy changes.
-Facility should screen healthcare providers at the beginning of their shift for fever or respiratory symptoms.

Review of the facility's policies revealed there was no written Infection Control Policy available at the time of this survey.

Observation upon entrance to the facility on 05/19/21 at 12:30pm revealed:
-The Supervisor-In-Charge (SIC) came to the front door of the facility and greeted the surveyors.
-The SIC asked the surveyors to enter the facility without having been screened for fever and signs and symptoms of illness.
-Surveyors were wearing facemasks.
-The SIC told the surveyors to follow her to another room.
-The surveyors asked to be screened by the SIC by taking temperatures and asking a series of questions regarding COVID-19 exposure before entering the facility.
-The SIC stated she had never screened visitors entering the facility.
-When asked about checking the surveyors' temperature the SIC left the front room area and returned with a hand-held no contact digital thermometer and handed it to the surveyor.
-When asked where to write down temperature the SIC shrugged her shoulders in an upward motion and stated she did not know.

Interview with the SIC on 05/19/21 at 12:38pm revealed:

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PRESTIGE ESTATES ASSISTED LIVING	4120 HOLT SCHOOL ROAD DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-She did not know where the Infection Control Policy was located.
-The facility had never screened visitors since he started working at the facility.
-She did not screen when coming to work 11/04/20.
-Four residents lived at the facility and only one resident had received her first COVID-19 vaccine.

Based on observation, record review and interview, it was determined that three of the four residents residing in the facility were not interviewable.

Telephone interview with the Administrator on 05/20/21 at 12:55pm revealed:
-She had an Infection Control Policy in her office.
-She was unable to provide the Infection Control Policy by the exit of the survey.
-The SIC had been trained that she needed to screen all outside visitors.
-Only one resident at the facility had received her first COVID-19 vaccine.
-The SIC was not required to screen herself, but she knew to screen outside visitors.