STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLADEN ASSISTED LIVING	**714 BLADEN STREET BLADENBORO, NC 28320**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 02/09/22 - 02/10/22.	{D 000}		
{D 269}	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provider personal care assistance according to the care plans for 1 of 5 sampled residents (#1) who required assistance with dressing. The findings are: Review of Resident #1's current FL-2 dated 10/11/21 revealed: -Diagnoses included Alzheimer's dementia with behavioral disturbance. -The recommended level of care was documented as a memory care unit. -The resident was ambulatory, intermittently disoriented, wandered, and incontinent of urine. -The resident was verbally able to communicate his needs. -The resident required staff assistance with bathing and dressing.	{D 269}		

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{D 269}	Continued From page 1	{D 269}		

Review of Resident #1's current care plan dated 10/16/21 revealed:
-The resident was oriented but forgetful and needed reminders.
-The resident's speech and communication method was normal.
-The resident was independent with ambulation, transfers, and eating.
-The resident required limited staff assistance with toileting.
-The resident required extensive staff assistance with bathing, dressing, and grooming.

Review of Resident #1's resident care plan and profile for the Special Care Unit (SCU) dated 10/04/21 revealed:
-The resident was confused to person, time, and place.
-The resident was able to follow instructions and communicate his wants, needs, likes, and dislikes.

Observation of Resident #1 on 02/09/22 at 8:55am revealed:
-The resident was sitting at dining room table located in the SCU.
-The resident was wearing a long sleeve green plaid shirt and gray plaid pants.
-The resident was confused, did not respond when spoken to, and both hands were contracted.
-There was a hospital band on his left wrist.

Second observation of Resident #1 on 02/09/22 at 12:09pm revealed the resident was sitting in a wheelchair at the second dining room table wearing the same long sleeve green plaid shirt and gray plaid pants.

Interview with the MA on 02/09/22 at 12:17pm

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{D 269}	Continued From page 2	{D 269}		

revealed:
-The hospital band on Resident #1's left wrist was from a hospital visit one month ago.
-Resident #1 would not let staff remove the hospital band from his wrist.

Observation of Resident #1 on 02/10/22 at 7:35am revealed:
-The resident was sitting in a chair located in the hallway leaning forward and fiddling with his bedroom shoe.
-He was wearing the same long sleeve green plaid shirt and gray plaid pants as on 02/09/22.
-The shirts left upper chest and sleeve was soiled.
-The personal care aide (PCA) removed Resident #1's green plaid shirt and under the shirt was a white t-shirt.
-There were electrocardiogram (EKG) pads (sticky pads that are stuck to the skin used to measure the heart's electrical activity) stuck to the resident's chest.
-The PCA placed a clean shirt on the resident.
-The PCA did not attempt to remove the EKG pads from the resident.

Interview with the SCU shift coordinator on 02/10/22 at 3:00pm revealed:
-She did not know if Resident #1 had received a bath or shower today.
-She did not notice Resident #1 was wearing the same clothes today as he had on yesterday.
-She expected staff to change resident clothing every day or when soiled.
-She expected staff to assist the residents with changing into pajamas at bedtime.
-She expected the second shift PCA to change Resident #1's clothes to pajamas before he went to bed on 02/09/22.
-She expected facility staff to remove the EKG

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{D 269}	Continued From page 3 pads from Resident #1's chest when he returned from the ED on 02/09/22. Interview with a PCA on 02/10/22 at 3:10pm revealed: -She changed residents to their pajamas before the first shift ended at 7:00pm when she worked. -When she arrived to work this morning, she noticed Resident #1 was wearing the same clothes today as yesterday. -Staff were not supposed to change a resident's clothing unless it was on their shower days. -She did not know why. -Soiled clothes were supposed to be changed regardless if it was not the resident's shower days. Interview with the Administrator on 02/10/22 at 4:00pm revealed: -He expected the hospital staff to have removed the EKG pads from Resident #1 prior to sending him back to the facility. -He did not respond when asked his expectation for facility staff removing the EKG pads on Resident #1's chest. -Residents were showered after breakfast on their shower days, and he expected their clothes changed with each shower to ensure they did not wear soiled clothing. -He did not respond when asked his expectations for changing resident clothing when it was not their shower days. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	{D 269}		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

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{D 273}	Continued From page 4	{D 273}		

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 observations, interviews, and record reviews the facility failed to ensure the acute health care needs were met for 1 of 5 sampled residents (#2) who needed a podiatry appointment.

The findings are:

1. Review of Resident #2's current FL-2 dated 10/13/21 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, adult failure to thrive, anemia, and severe protein calorie malnutrition.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #2's current care plan dated 10/13/21 revealed:
-The resident required limited staff assistance with bathing, dressing, grooming, and toileting.
-The resident was independent with ambulation and transfers.

Observation of Resident #2 on 02/09/22 at 2:05pm revealed:
-The resident's shoes and socks were removed by the medication aide (MA).
- The resident's left first toenail was thick, yellow and jagged. The left edge of the nail at the cuticle was darker in color and a shade of gray. Under the nail was a thick yellow debris.
- The resident's left second toenail was curved, extended past the toe one centimeter, and was thick and jagged.

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{D 273}	Continued From page 5 - The resident's left third toenail was jagged, elevated and grew curved into and up the side of her second toe. The toenail was touching the skin of the second toe. -The skin of the second toe next to the nail of the toe was red. - The resident's left fourth toenail was thick, elevated above the nail bed and grew up over the nailbed towards the cuticle of her fourth toe. -There were two dark plum colored areas approximately one to two centimeters located to the pad of her left foot between the third and fourth toes, -The top and bottom of her feet were flaking with skin. - The right first toenail was thick and striated (striations can indicate nail bed injury and protein and vitamin deficiencies). -The right second toenail was thick, yellow, and jagged. -The right third toenail was thick, yellow, extended past the toe two to three centimeters and grew to the inside of the second toe. -The inside of the right second toe where the third toenail contacted the skin was red. -The right fourth toenail was yellow to light gray in color, extended past the toe two to three centimeters and was curved to the inside. -The right fifth toenail grew up approximately one centimeter. -The skin on the right foot was flaking. Interview with the Special Care Unit (SCU) Shift Coordinator on 02/09/22 at 2:8pm revealed: -The facility had a contracted podiatrist that visited the facility every three months who was last at the facility in December 2021. -Usually, the contracted podiatrist would see all the residents in the facility. -She did not know if Resident #2 had been seen	{D 273}		

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{D 273}	Continued From page 6 by the contracted podiatrist. -The personal care aides (PCA) should notice jagged, yellow, overgrown toenails and any foot abnormalities when bathing or provider personal care to the residents. -She expected the PCAs to report to her or the Resident Care Director (RCD) when they notice a resident with long jagged, thick toenails or foot abnormalities so the resident could be referred to podiatry. -PCAs were to document long or curling toenails on the resident bath skin assessment sheets. -She and the RCD reviewed the bath skin assessment sheets daily and signed once reviewed. -She did not know Resident #2's toenails were thick, jagged, extended past the toes and into adjoining toes. -She did not know there were two dark spots on the bottom of Resident #2's left foot. Telephone interview with the office manager for the facility's contracted podiatrist on 02/10/22 at 1:30pm revealed: -Resident #2 had never been treated by the podiatrist. -The facility did not need a medical referral to schedule an appointment for Resident #2. -The facility could have referred Resident #2 to the podiatrist at any time. -If the podiatrist knew Resident #2 needed to be treated by podiatry, the resident could have been seen by the podiatrist. -The podiatrist would have worked in any resident who needed to be seen when last in the facility in December 2021. Telephone interview with the Nurse Practitioner for the facility's contracted podiatrist on 02/10/22 at 1:50pm revealed:	{D 273}		

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{D 273}	Continued From page 7	{D 273}		

-Resident #2's overgrown and curved nails could cause discomfort and possibly infection if the nails were to cut into the resident's skin.
-Resident #2 needed to be treated by podiatry.
-Normally facility staff referred residents to podiatry for nail care as the staff did not cut resident nails because they could accidentally cause trauma.

Second interview with the SCU Shift Coordinator on 02/10/22 at 3:00pm revealed she had tried to cut Resident #2's toenails with the nail trimmers on 02/09/22 but could not because they were too thick.

Interview with a PCA on 02/10/22 at 3:10pm revealed:
-Foot and nail care were expected to be performed by staff on resident shower days.
-Normally resident toenails were trimmed by podiatry.
-PCAs should observe resident's toenails every day because they put on the resident's socks.
-She last saw Resident #2's toenails on 02/08/22 and they were not very long.
-She did not see any curved toenails for Resident #2 on 02/08/22.
-She did not see any dark spots on the bottom of Resident #2's feet on 02/08/22.
-It was the responsibility of the PCA to tell the SCU Coordinator when a resident's toenails were long or thick, the SCU shift coordinator would tell the Resident Care Director (RCD), and the RCD would schedule an appointment with the podiatrist.
-She did not tell the SCU shift coordinator Resident #2's toenails were long because the resident didn't report pain.
-She would have told the SCU shift coordinator Resident #2's nails were long if the resident

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{D 273}	Continued From page 8	{D 273}		

reported pain.
-PCAs were expected to look at the resident's feet when bathing and document on the bath skin assessment sheet if toenails were long, jagged, thick, or curved.
-She did not complete a body skin assessment sheet for Resident #2 when she last provided her with a shower/bath on 02/08/22.

Interview with the Administrator on 02/10/22 at 5:20pm revealed:
-Resident's did not need an order for a referral for the podiatrist.
-He expected the RCD to ensure staff performed their jobs as expected.

Interview with the RCD on 02/10/22 at 5:20pm revealed:
-Staff were expected to do a head to toe assessment on residents with every shower.
-Staff were expected to look at resident's feet and toes to for sores, redness, and/or skin integrity issues.
-Staff were expected to notice if resident's toenails were long, extended past, or curved into their toes.
-She expected the PCAs to tell the medication aides (MAs) or SCU shift coordinator when they saw a resident's toenails were long, jagged, extended past or curved into their toes.
-The MA or SCU shift coordinator was responsible to notify the RCD so she could schedule the resident an appointment with the podiatrist.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

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{D 358} 10A NCAC 13F .1004(a) Medication Administration {D 358}

10A NCAC 13F .1004 Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 8 residents (#6, #7) observed during the medication pass including errors with a medication to lower blood pressure, treat anemia, low potassium levels, and idiopathic thrombocytopenia (#6); and medications to treat rashes; and for 1 of 5 residents sampled for record review including errors to treat high blood sugar (#4).

The findings are:

Review of the facility's medication policy on 02/10/22 revealed the purpose was to ensure staff who had demonstrated competency according to state rules prepare and administer prescription medications and treatments in accordance with the prescribing practitioner's orders.

1. The medication error rate was 16% as evidenced by the observation of 6 errors out of 36

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{D 358}	Continued From page 10 opportunities during the 9:30am medication pass on 02/10/22. a. Review of Resident #6's current FL-2 dated 06/01/21 revealed: -Diagnoses included Alzheimer's, hypertension (HTN), chronic idiopathic thrombocytopenia (abnormally low levels of blood cells that control bleeding), hypokalemia, Vitamin B12 deficiency, and anemia. -There was an order for Norvasc 5 milligrams (mg) take one tablet daily (Norvasc is used to treat high blood pressure). Review of Resident #6's electronic physicians order sheet dated 09/07/21 revealed: -There was an entry for Norvasc 5mg take one tablet daily. Review of Resident #6's physician visit note dated 01/26/22 revealed there was an entry for Norvasc 5mg take one tablet daily. Observation of the 9:30am medication pass on 02/10/22 revealed: -The medication aide (MA) prepared Resident #6's medications. -The MA did not prepare Norvasc for administration to the resident. -The MA entered the resident's room and administered Resident #6's medications. -Norvasc 5 mg was not administered to Resident #6. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Norvasc 5mg take one tablet daily at 9:30am. -There was documentation Norvasc was not	{D 358}		

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{D 358}	Continued From page 11 administered to the resident at 9:30am on 02/10/22 because the facility was waiting on the pharmacy. Observation of Resident #6's medications on hand on 02/10/22 at 12:35pm revealed Norvasc 5mg was not available on the medication cart for the resident. Interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 2:45pm revealed: -She did not know Resident #6 did not have Norvasc available on the medication cart until she attempted to administer the medication during the 9:30am medication pass today, 02/10/22. -The SCU shift coordinator and the Resident Care Director (RCD) both shared the responsibility to reorder resident medications. -It was the ultimate responsibility of the SCU shift coordinator to reorder the resident's medications. -Her first day as SCU shift coordinator was 02/09/22 and she did not know what the process was prior to 02/09/22 to ensure resident's ordered medications were always available. -The current process was to reorder resident medications 25 days after the dispense date leaving five days of medications remaining. -The medications would arrive to the facility during third shift if ordered before 5:00pm. -The medications would arrive to the facility during third shift the following night if ordered after 5:00pm. -She did not remember if she faxed a request to the facility's contracted pharmacy for a refill of Resident #6's Norvasc on 09/09/22. -She and the RCD completed cart audits to ensure resident medications were always available. -The last cart audit was completed on 02/09/22	{D 358}		

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but it did not include Resident #6's medications.

Interview with the RCD on 02/10/22 at 5:30pm revealed:
-She expected the resident medications to always be available on the medication cart for administration.
-The last medication cart audit for Resident #6 was one week ago.
-There were no medications missing.
-It was the responsibility of the MA to verbally tell her or the SCU shift coordinator when a resident had three to four doses remaining on the shift discovered.
-It was the responsibility of the SCU shift coordinator to be certain resident medications were always available for administration.
-The current SCU Coordinator started her position on 02/09/22.
-There was no reason why a resident's medications would not be available for administration.
-She expected the MAs to administer medications as ordered.

Review of a handwritten document provided on 02/10/22 by the RCD revealed:
-There was documentation to call Norvasc 5mg to the back-up pharmacy. There was no date.
-Attached to the document was a fax transaction report dated 02/10/22 at 9:48am with the facility's contracted pharmacy as the receiver.

Review of a medication order form dated 02/09/22 revealed there was no documentation of a refill request for Resident #6's Norvasc 5mg.

Interview with the Administrator on 02/10/22 at 5:35pm revealed:
-He expected the MA to do a shift to shift report

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 13 when three to four doses of resident medications were remaining if the RCD or SCU shift unit coordinator were not in the building. -Medications ordered before 5:00pm were delivered during third shift between midnight to 6:00am. -The facility contracted with a back-up pharmacy for medications that needed to be ordered after 5:00pm. -The back-up pharmacy was available 24 hours a day, seven days a week. -He expected medications administered as ordered. Telephone interview with the facility's contracted pharmacy on 02/10/22 at 5:45pm revealed: -Norvasc was used to control elevated blood pressure and missing a dose could cause the blood pressure to increase. -The facility faxed a refill request for Resident #6's Norvasc 5mg on 01/06/22 and 02/10/22. -Norvasc 5mg was dispensed for Resident #6 on 01/06/22 and 02/10/22 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 02/10/22 at 1:00pm was unsuccessful. b. Review of Resident #6's current FL-2 dated 06/01/21 revealed: -There was an order for Prednisone 5mg daily (Prednisone is a steroid used to treat many conditions such as low platelet levels in Idiopathic thrombocytopenia purpura, arthritis, and breathing problems). Review of Resident #6's pharmacy medication	{D 358}		

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WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

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{D 358}	Continued From page 14	{D 358}		

issue communication form dated 01/26/22 revealed:
-There was a clarification request regarding the resident's Prednisone.
-There was a physician's order to administer Prednisone 40mg daily for seven days then resume Prednisone 20mg daily.
-There was no diagnosis.
-The order was signed by the resident's oncologist.

Observation of the 9:30am medication pass on 02/10/22 revealed:
-The medication aide (MA) prepared Resident #6's medications.
-The MA did not prepare Prednisone for administration to Resident #6.
-The MA entered the resident's room and administered Resident #6's medications.
-Prednisone 20mg was not administered to Resident #6.

Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Prednisone 20mg daily to be administered at 9:30am.
-There was documentation Prednisone was not administered to the resident at 9:30am on 02/10/22 because the facility was waiting on the pharmacy.

Observation of Resident #6's medications on hand on 02/10/22 at 12:35pm revealed Prednisone 20mg was not available on the medication cart for the resident.

Interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 2:45pm revealed:

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{D 358}	Continued From page 15 -She did not know Resident #6 did not have Prednisone available for administration on the medication cart until she attempted to administer the medication during the 9:30am medication pass today, 02/10/22. -The SCU shift coordinator and the Resident Care Director (RCD) both shared the responsibility to reorder resident medications. -It was the ultimate responsibility of the SCU shift coordinator to reorder the resident's medications. -Her first day as SCU shift coordinator was 02/09/22 and she did not know what the process was prior to 02/09/22 to ensure resident's ordered medications were always available. -The current process was to reorder resident medications 25 days after the dispense date leaving five days of medications remaining. -The medications would arrive to the facility during third shift if ordered before 5:00pm. -The medications would arrive to the facility during third shift the following night if ordered after 5:00pm. -She did not remember if she faxed a request to the facility's contracted pharmacy for a refill of Resident #6's Prednisone on 09/09/22. -She and the RCD completed cart audits to ensure resident medications were always available. -The last cart audit was performed on 02/09/22 but it did not include Resident #6's medications. Interview with the RCD on 02/10/22 at 5:30pm revealed: -She expected the resident medications to always be available on the medication cart for administration. -The last medication cart audit for Resident #6 was one week ago. -There were no medications missing. -It was the responsibility of the MA to verbally tell	{D 358}		

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{D 358}	Continued From page 16 her or the SCU shift coordinator when a resident had three to four doses remaining on the shift discovered. -It was the responsibility of the SCU shift coordinator to be certain resident medications were always available for administration. -The current SCU Coordinator started her position on 02/09/22. -There was no reason why a resident's medications would not be available for administration. -She expected the MAs to administer medications as ordered. Review of a document provided on 02/10/22 by the RCD revealed: -There was handwritten documentation to call Prednisone to the back-up pharmacy. -There was no date. -Attached to the document was a fax transaction report dated 02/10/22 at 9:48am with the facility's contracted pharmacy as the receiver. Review of a medication order form dated 02/09/22 revealed there was no documentation of a refill request for Resident #6's Prednisone 20mg. Interview with the Administrator on 02/10/22 at 5:35pm revealed: -He expected the MA to do a shift to shift report when three to four doses of resident medications were remaining if the RCD or SCU shift unit coordinator were not in the building. -Medications ordered before 5:00pm were delivered during third shift between midnight to 6:00am. -The facility contracted with a back-up pharmacy for medications that needed to be ordered after 5:00pm.	{D 358}		

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{D 358}	Continued From page 17 -The back-up pharmacy was available 24 hours a day, seven days a week. -He expected medications administered as ordered. Telephone interview with the facility's contracted pharmacy on 02/10/22 at 5:45pm revealed: -Prednisone 5mg was last dispensed for Resident #6 on 01/12/22. -Resident #6 had an active order for Prednisone 20mg daily. -The facility requested a refill for Resident #6's Prednisone on 02/10/22. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 02/10/22 at 1:00pm was unsuccessful. c. Review of Resident #6's current FL-2 dated 06/01/21 revealed there was an order for Potassium Chloride (KCL) Extended Release (ER) 10 milliequivalent (meq) daily (KCL ER is a mineral supplement used to prevent or treat low amounts of potassium in the blood and released slowly into the blood stream). Review of Resident #6's physician order sheet dated 09/07/21 revealed there was an order for KCL ER 10meq daily. Review of Resident #6's physician visit note dated 01/26/22 revealed: -There was an order for KCL ER 10meq daily. Observation of the 9:30am medication pass on 02/10/22 revealed: -The medication aide (MA) prepared Resident	{D 358}		

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{D 358}	Continued From page 18 #6's medications. -The MA did not prepare KLC ER for administration to the resident. -The MA entered the resident's room and administered Resident #6's medications. -KCL ER 10meq was not administered to Resident #6. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for KCL ER 10meq daily to be administered at 9:30am. -There was documentation KCL ER was not administered to the resident at 9:30am on 02/10/22 because the facility was waiting on pharmacy. Observation of Resident #6's medications on hand on 02/10/22 at 12:35pm revealed KCL ER 10 meq was not available for administration on the medication cart for the resident. Interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 2:45pm revealed: -She did not know Resident #6 did not have KCL ER available for administration on the medication cart until she attempted to administer the medication during the 9:30am medication pass today, 02/10/22. -The SCU shift coordinator and the Resident Care Director (RCD) both shared the responsibility to reorder resident medications. -It was the ultimate responsibility of the SCU shift coordinator to reorder the resident's medications. -Her first day as SCU shift coordinator was 02/09/22 and she did not know what the process was prior to 02/09/22 to ensure resident's ordered medications were always available.	{D 358}		

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{D 358}	Continued From page 19 -The current process was to reorder resident medications 25 days after the dispense date leaving five days of medications remaining. -The medications would arrive to the facility during third shift if ordered before 5:00pm. -The medications would arrive to the facility during third shift the following night if ordered after 5:00pm. -She did not remember if she faxed a request to the facility's contracted pharmacy for a refill of Resident #6's KCL ER on 09/09/22. -She and the RCD completed cart audits to ensure resident medications were always available. -The last cart audit was performed on 02/09/22 but it did not include Resident #6's medications. Interview with the RCD on 02/10/22 at 5:30pm revealed: -She expected the resident medications to always be available on the medication cart for administration. -The last medication cart audit for Resident #6 was one week ago. -There were no medications missing. -It was the responsibility of the MA to verbally tell her or the SCU shift coordinator when a resident had three to four doses remaining on the shift discovered. -She did not respond when asked what the process was for notifying the RCD or SCU shift coordinator if they were not in the building. -It was the responsibility of the previous SCU shift coordinator to be certain resident medications were always available for administration. -The current SCU Coordinator started her position on 02/09/22. -There was no reason why a resident's medications would not be available for administration.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 20 -She expected the MAs to administer medications as ordered. Review of a document provided on 02/10/22 by the RCD revealed: -There was handwritten documentation to call KCL to the back-up pharmacy. There was no date. -Attached to the document was a fax transaction report dated 02/10/22 at 9:48am with the facility's contracted pharmacy as the receiver. Review of a medication order form dated 02/09/22 revealed there was no documentation of a refill request for Resident #6's KCL ER 10meq. Interview with the Administrator on 02/10/22 at 5:35pm revealed: -He expected the MA to do a shift to shift report when three to four doses of resident medications were remaining if the RCD or SCU shift unit coordinator were not in the building. -Medications ordered before 5:00pm were delivered during third shift between midnight to 6:00am. -The facility contracted with a back-up pharmacy for medications that needed to be ordered after 5:00pm. -The back-up pharmacy was available 24 hours a day, seven days a week. -He expected medications administered as ordered. Telephone interview with the facility's contracted pharmacy on 02/10/22 at 5:45pm revealed: -The facility last ordered KCL ER 10meq for Resident #6 on 02/10/22. -KCL ER was dispensed for Resident #6 on 01/06/22 and 02/10/22. -KCL ER was used to treat low potassium.	{D 358}		

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{D 358}	Continued From page 21 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 02/10/22 at 1:00pm was unsuccessful. d. Review of Resident #6's current FL-2 dated 06/01/21 revealed there was an order for Iron 325mg daily (a medication used to treat anemia). Review of Resident #6's physician order sheet dated 09/07/21 revealed there was an order for Iron 325mg daily. Review of Resident #6's physician visit note dated 01/26/22 revealed: -There was an order for Iron 325mg daily. -The visit note was electronically signed by the PCP. Observation of the 9:30am medication pass on 02/10/22 revealed: -The medication aide (MA) prepared Resident #6's medications. -The MA did not prepare Iron for administration to the resident. -The MA entered the resident's room and administered Resident #6's medications. -Iron was not administered to Resident #6. Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Iron 325mg daily. -There was documentation Iron was not administered to the resident at 9:30am on 02/10/22 because the facility was waiting on	{D 358}		

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{D 358}	Continued From page 22 pharmacy. Observation of Resident #6's medications on hand on 02/10/22 at 12:35pm revealed: -Iron 325mg was available on the medication cart as house stock for the resident. -There was approximately one-half a bottle of the Iron remaining. Interview with the RCD on 02/10/22 at 12:35am revealed: -The facility had house stock of Iron 325mg kept in the bottom drawer of the medication cart. -The SCU shift coordinator/MA should have administered Resident #6 the house stock of Iron during the 9:30am medication pass today. Interview with the SCU shift coordinator/MA on 02/10/22 at 12:36am revealed she did not know the facility had house stock of Iron for administration. Second interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 2:45pm revealed: -She did not know Resident #6 did not have Iron for administration on the medication cart until she went to administer during the 9:30am medication pass today, 02/10/22. -The SCU shift coordinator and the Resident Care Director (RCD) both shared the responsibility to reorder resident medications. -It was the ultimate responsibility of the SCU shift coordinator to reorder the resident's medications. -Her first day as SCU shift coordinator was 02/09/22 and she did not know what the process was prior to 02/09/22 to ensure resident's ordered medications were always available. -The current process was to reorder resident medications 25 days after the dispense date	{D 358}		

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{D 358}	Continued From page 23	{D 358}		

leaving five days of medications remaining.
-The medications would arrive to the facility during third shift if ordered before 5:00pm.
-The medications would arrive to the facility during third shift the following night if ordered after 5:00pm.
-She did not remember if she faxed a request to the facility's contracted pharmacy for a refill of Resident #6's Iron on 02/09/22.
-She and the RCD completed cart audits to ensure resident medications were always available.
-The last cart audit was completed on 02/09/22 but it did not include Resident #6's medications.

Second interview with the RCD on 02/10/22 at 5:30pm revealed:
-She expected the resident medications to always be available on the medication cart for administration.
-The last medication cart audit for Resident #6 was one week ago.
-There were no medications missing.
-It was the responsibility of the MA to verbally tell her or the SCU shift coordinator when a resident had three to four doses remaining on the shift discovered.
-It was the responsibility of the previous SCU shift coordinator to be certain resident medications were always available for administration.
-The current SCU Coordinator started her position on 02/09/22.
-There was no reason why a resident's medications would not be available for administration.
-She expected the MAs to administer medications as ordered.

Review of a medication order form dated 02/09/22 revealed there was no documentation of

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{D 358}	Continued From page 24 a refill request for Resident #6's Iron 325mg. Interview with the Administrator on 02/10/22 at 5:35pm revealed: -He expected the MA to do a shift to shift report when three to four doses of resident medications were remaining if the RCD or SCU shift unit coordinator were not in the building. -Medications ordered before 5:00pm were delivered during third shift between midnight to 6:00am. -The facility contracted with a back-up pharmacy for medications that needed to be ordered after 5:00pm. -The back-up pharmacy was available 24 hours a day, seven days a week. -He expected medications administered as ordered. Telephone interview with the facility's contracted pharmacy on 02/10/22 at 5:45pm revealed: -The facility ordered Iron 325mg for Resident #6 on 02/10/22. -Iron was last dispensed for Resident #6 on 02/10/22. -Iron was used to treat anemia and low iron levels. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Attempted telephone interview with Resident #6's PCP on 02/10/22 at 1:00pm was unsuccessful. e. Review of resident #7's current FL-2 dated 10/20/21 revealed: -Diagnoses included dementia, mild mental retardation, diabetes, and anxiety. -There was an order for Nyamyc powder 100000	{D 358}		

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{D 358}	Continued From page 25 apply to abdominal rash twice daily (used to treat rashes and fungal infections). Observation of the 9:30am medication pass on 02/10/22 revealed: -The medication aide (MA) prepared Resident #7's medications. -The MA did not prepare Nyamyc powder for administration to the resident. -The MA entered the resident's room and administered Resident #7's medications. -Nyamyc powder was not administered to Resident #6. Interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 9:00am revealed she had administered to Resident #7 all medications due for the 9:30am medication pass. Review of Resident #7's February 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Nyamyc powder 100000 apply to abdominal rash twice daily to be administered at 9:30am and 9:30pm. -There was documentation Nyamyc powder was administered by the MA on 02/10/22 at 9:30am. Second interview with the SCU shift coordinator/MA on 02/10/22 at 2:45pm revealed: -Resident #7's Nyacin order populated as due on the eMAR after the 9:30am medication pass observation. She did not know why. -She administered Nyacin to Resident #7 after the 9:30am medication pass observation. -It was not uncommon for medications to populate due to be administered after the scheduled time.	{D 358}		

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Interview with the RCD on 02/10/22 at 5:30pm revealed:
-She expected the MAs to administer medications as ordered.
-Every two weeks she randomly followed the MAs during medication passes to be certain medications were administered as ordered.
-Her last random medication pass observation was two weeks ago.
-There were no problems observed during that medication pass.

Interview with the Administrator on 02/10/22 at 5:35pm revealed he expected medications to be administered as ordered.

f. Review of resident #7's current FL-2 dated 10/20/21 revealed there was an order for Clotrim/Beta cream apply to legs and back twice daily (a combination medication used to treat fungal infections).

Observation of the 9:30am medication pass on 02/10/22 revealed:
-The medication aide (MA) prepared Resident #7's medications.
-The MA did not prepare Clotrim/Beta cream for administration to the resident.
-The MA entered the resident's room and administered Resident #7's medications.
-Clotrim/Beta cream was not administered to Resident #6.

Interview with the Special Care Unit (SCU) shift coordinator/medication aide (MA) on 02/10/22 at 9:00am revealed she had administered to Resident #7 all medications due for the 9:30am medication pass.

Review of Resident #7's February 2022 electronic

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WEST BLADEN ASSISTED LIVING	**714 BLADEN STREET BLADENBORO, NC 28320**

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medication administration record (eMAR) revealed:
-There was an electronic entry for Clotrim/Beta cream apply to rash on legs and back twice daily until clear to be administered at 9:30am and 9:30pm.
-There was documentation Clotrim/Beta cream was administered by the MA on 02/10/22 at 9:30am.

Second interview with the SCU shift coordinator/MA on 02/10/22 at 2:45pm revealed:
-Resident #7's Clotrim/Beta cream order populated as due on the eMAR after the 9:30am medication pass observation. She did not know why.
-She administered Clotrim/Beta cream to Resident #7 after the 9:30am medication pass observation.
-It was not uncommon for medications to populate as due to be administered after the scheduled time.

Interview with the RCD on 02/10/22 at 5:30pm revealed:
-She expected the MAs to administer medications as ordered.
-Every two weeks she randomly followed the MAs during medication passes to be certain medications were administered as ordered.
-Her last random medication pass observation was two weeks ago.
-There were no problems observed during that medication pass.

Interview with the Administrator on 02/10/22 at 5:35pm revealed he expected medications to be administered as ordered.

Based on observations, interviews, and record

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{D 358}	Continued From page 28 reviews it was determined Resident #7 was not interviewable. Attempted telephone interview with Resident #7's PCP on 02/10/22 at 1:00pm was unsuccessful. 2. Review of Resident #4's FL-2 dated 10/20/21 revealed: -Diagnoses included diabetes and dementia. -There was an order to take blood sugar levels twice a day, for Lantus 18 units at bedtime (Lantus is a long acting insulin used to help control blood sugar) and Novolog with sliding scale twice a day with instructions 0-150-0 units, 151-200-2 units, 201-250-3 units, 251-300-4 units, 301-350-5 units, 351-400-6 units, 401-450-7 units, above (>) 450-8 units. (Novolog is a short acting insulin used to help control blood sugars). Review of Resident #4's December 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check the resident's blood sugar twice a day at 6am and 8pm with Novolog sliding scale 0-150-0 units, 151-200-2 units, 201-250-3 units, 251-300-4 units, 301-350-5 units, 351-400-6 units, 401-450-7 units, >450-8 units. Review of Resident #4's blood sugars documented on the December 2021 eMAR revealed: -The 6:00am blood sugar readings were: 12/04/21=160; 12/05/21=169; 12/08/21=220; 12/09/21=220; 12/11/21=210; 12/12/21=271; 12/13/21=170; 12/16/21=210; 12/17/21=200; 12/19/21=187; 12/20/21=178; 12/21/21=209; 12/23/21=154, 12/24/21=174; 12/25/21=170; 12/26/21=172; 12/28/21=167; 12/29/21=154; and	{D 358}		

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{D 358}	Continued From page 29 there was no documentation Novolog was administered. -At 8:00pm, elevated blood sugar readings were: 12/01/21=300; 12/02/21=210; 12/03/21=210; 12/04/21=167; 12/05/21=167; 12/06/21=320; 12/07/21=201; 12/10/21=201; 12/11/21=262; 12/12/21=210; 12/14/21=166; 12/15/21=267; 12/16/21=259; 12/17/21=198; 12/19/21=176; 12/20/21=179; 12/21/21=189; 12/24/21=210; 12/26/21=173; 12/27/21=190; 12/28/21=188; 12/30/21=156; 12/31/21=169; and there was no documentation that Novolog was administered. Review of Resident #4's primary care provider (PCP) visit note dated 12/01/21 revealed: -The chief complaint was to follow-up on diabetes. -The PCP documented Resident #4's Lantus dosage was increased during the last visit to 23 units at bedtime. -The PCP documented he reviewed the glucose log and increased the Lantus dosage to 25 units at bedtime. Review of physician's orders for Resident #4 revealed an order dated 12/01/21 for Lantus 25 units at bedtime. Review of Resident #4's PCP visit note dated 12/22/2021 revealed: -The chief complaint was to follow-up on diabetes. -The PCP documented Resident #4's Lantus dosage was increased during the last visit to 25 units at bedtime. -The PCP documented he reviewed the glucose log and Resident #4's fasting blood sugar levels were 130-200. -He increased the Lantus dosage to 28 units at bedtime.	{D 358}		

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{D 358}	Continued From page 30 Review of physician's orders for Resident #4 revealed an order dated 12/22/21 for Lantus 28 units at bedtime. Review of Resident #4's January 2022 eMAR revealed: -There was an order entry to take the resident's blood sugar twice a day at 6am and 8pm. -There was an order entry for Novolog sliding scale 0-150-0 units, 151-200-2 units, 201-250-3 units, 251-300-4 units, 301-350-5 units, 351-400-6 units, 401-450-7 units, > 450-8 units. Review of Resident #4's blood sugars documented on the January 2022 eMAR revealed: -The 6:00am blood sugar level readings were: 01/01/22=160; 01/02/22=160; 01/03/22=197; 01/06/22=194; 01/07/22=188; 01/09/22=151; 01/12/22=178; 01/15/22=153; 01/16/22=151; 01/17/22=204; 01/18/22=151; 01/22/22=167; 01/23/22=200; 01/25/22= 176; 01/26/22= 156; 01/29/22= 157; 01/30/22=186; and there was no documentation that Novolog was administered as ordered. -The 8:00pm blood sugar level readings were: 01/01/22=178; 01/02/22= 156; 01/05/22=189; 01/06/22=213; 01/10/22=163; 01/14/22=161; 01/15/22=161; 01/16/22=151; 01/19/22=165; 01/24/22=165; 01/25/22=161; 01/26/22=200; 01/29/22=249; 01/31/22=151; and there was no documentation that Novolog was administered as ordered. Review of Resident #4's PCP visit note dated 01/12/22 revealed: -The chief complaint was follow-up on diabetes. -The PCP documented Resident #4's Lantus dosage was increased during the last visit to 28	{D 358}		

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{D 358}	Continued From page 31 units at bedtime. -He ordered to have her Hemoglobin A1C checked (HbA1c, a laboratory test used to measure blood sugar levels over the past 2-3 months). Review of Resident #4's laboratory results dated 01/26/22 revealed her HbA1c level was 7.6 (normal range was 4.8-5.6). Review of Resident #4's February 2022 eMAR revealed: - There was an entry to take the resident's blood sugar twice a day at 6am and 8pm with Novolog sliding scale 0-150-0 units, 151-200-2 units, 201-250-3 units, 251-300-4 units, 301-350-5 units, 351-400-6 units, 401-450-7 units, above > 450-8 units. Review of Resident #4's blood sugars documented on the February 2022 eMAR revealed: -The 6:00am blood sugar levels were: 02/03/22=154; 02/09/22=151; and there was no documentation that Novolog was administered as ordered. -The 8:00pm blood sugar levels were: 02/03/22=165 and there was no documentation that Novolog was administered as ordered. Observation on 02/10/22 at 7:52am of Resident #4's medications on hand revealed: -There was a Novolog insulin pen in a clear plastic bag labeled with Resident #4's name. -The Novolog pen chamber was full. -The pharmacy label indicated the pen was last refilled on 01/18/22. Interview on 02/10/22 at 9:39am with the SCU Shift Supervisor revealed:	{D 358}		

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-She was the medication aide for the 7:00am-7:00pm shift that day (02/10/22).
-She became the SCU Shift Supervisor the day before.
-Resident #4 had not received any Novolog in February 2022.
-Resident #4 did not need any Novolog according to the sliding scale in February because her blood sugar levels were normal.
-Resident #4 did not need Novolog unless her blood sugars were over 150.
-Resident #4 needed Novolog on 01/29/2022 according to the sliding scale but there was no documentation it was administered.
-The computer MAR did not trigger Novolog was needed because it was classified as an "as needed" medication.
-Novolog classification was changed on the eMAR on 02/10/22 from an "as needed" medication to a "routine" medication so that the computer would trigger Novolog was needed.

Interview on 02/10/22 at 8:41am with a pharmacy technician from the facility contracted pharmacy revealed:
-The Novolog pen was last refilled 01/18/22 and one pen was sent on that date.
-The pen lasted approximately 15 days.
-The pharmacy had refilled the Novolog pen on 01/07/22 and 11/24/21.
-The pharmacy sent only 30 days' worth of medication at a time.
-The facility initiated requests for medication refills.
-Resident #4 did not have any medications that were automatically refilled.

Interview on 02/10/22 at 6:07pm with the Resident Care Director (RCD) revealed:
-Staff had not been documenting Novolog in

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December 2021, January 2022, and February 2022.
-She believed the medication aides did not administer the Novolog because the eMAR did not trigger them to when a blood sugar level was elevated.
-RCD confirmed the Novolog pen was full and the dispense date was 01/18/2022.
-The RCD expected staff to provide Novolog as ordered by the provider.

Interview on 02/10/22 at 6:13pm with the Administrator revealed:
-He spoke with another medication aide who said she had been giving the Novolog.
-He confirmed no documentation of Novolog administration in December 2021, January 2022, and February 2022.
-He confirmed the Novolog pen was full and the dispense date was 01/18/2022.
-He confirmed there were blood sugar readings in that time period that needed Novolog coverage.

Attempted interview with Resident #4's PCP on 2/10/22 at 1:00pm was unsuccessful.

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The facility failed to assure medications were administered as ordered for a diabetic resident who was ordered insulin sliding scale coverage and whose blood sugar was elevated and did not receive the ordered insulin for 41 occurrences out of 31 days in December 2021 ranging from 154 to 271, 31 occurrences out of 31 days in January 2022 ranging from 151 to 300, and 3 occurrences out of 10 days in February 2022 ranging from 151 to 165 (#4) requiring titrations in the resident's regular scheduled insulin. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation.

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{D 358}	Continued From page 34 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 27, 2022	{D 358}		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and health care. The findings are: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 8 residents (#6, #7) observed during the medication pass including errors with a medication to lower blood pressure, treat anemia, low potassium levels, and idiopathic thrombocytopenia (#6); and medications to treat rashes; and for 1 of 5 residents sampled for record review including errors to treat high blood sugar (#4). [Refer to Tag 358 10A NCAC 13F	{D912}		

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{D912}	Continued From page 35 .1004(a) Medication Administration (Type B Violation)].	{D912}		