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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 04/05/22 to 04/07/22.	{D 000}		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff A), who obtained fingerstick blood	D 164		

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sugars (FSBS) and administered insulin to residents, completed training on the care of diabetic residents.

The findings are:

Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A was hired on 11/14/21.
-There was no documentation Staff A completed training on the care of diabetic residents.

Review of a diabetic resident's February electronic medication administration record (eMAR) revealed Staff A checked FSBS and administered insulin 4 times from 02/12/22 through 02/28/22.

Review of a diabetic resident's March eMAR revealed Staff A checked FSBS and administered insulin 7 times from 03/01/22 through 03/31/22.

Interview with Staff A on 03/07/22 at 5:24pm revealed:
-She was hired at the facility in November 2021 as a MA.
-She checked FSBSs and administered insulin to residents.
-She remembered having diabetic care training at a previous facility, but she did not remember having diabetic care training at the current facility unless it was when she was checked off by a nurse on the medication cart.

Interview with the Business Office Manager (BOM) on 04/07/22 at 5:54pm revealed:
-She was responsible for ensuring staff completed diabetic care training and filing the documentation of the training in the personnel file.

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D 164	Continued From page 2 -She did not know Staff A did not have documentation of diabetic care training in her personnel file. -She had not had a chance to audit all personnel records to ensure all required staff trainings were completed including training on the care of diabetic residents. Interview with the Administrator on 04/07/22 at 6:08pm revealed: -The BOM was responsible for maintaining staff personnel records and ensuring required staff trainings were completed. -He did not know Staff A did not have documentation of having completed training on the care of diabetic residents.	D 164		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 5 residents sampled (#1 and #2) related to episodes of elopement and self injurious behaviors (#1) and a missed appointment and medication refusals (#2). The findings are: 1. Review of Resident #1's FL-2 dated 03/14/22 revealed: -Diagnoses included short term memory loss, and	D 273		

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depression.
-She was intermittently disoriented.
-She was semi-ambulatory, and an assistive device was not indicated.

Review of Resident #1's Resident Register revealed an admission date of 03/23/22.

Review of Resident #1's Care Plan revealed there was no Care Plan available for review.

Review of Resident #'1's Care Notes revealed:
-On 03/29/22 at 6:00pm, Resident #1 tried numerous times to leave out the door, but staff had always been there to catch her, will continue to monitor the resident throughout the shift (second shift).
-On 03/30/22 at 2:00pm, the resident had tried to escape all day from running out the side exits to running out the front entrance without her walker.
-On 03/31/22 at 6:00pm, Resident #1 slept all morning, was fine for a while, then started trying to escape again. The resident had started harming herself by biting her arms (both arms are bruised).
-On 04/01/22 no time indicated, the resident was harming herself by making her arms bleed and 911 was called to send the resident to the hospital and EMS came to the facility. Resident #1 was screaming and fussing with EMS and all staff when she left the facility with EMS.
-On 04/03/22 at 3:15pm, Resident #1 returned to the facility from the hospital by a family member.
-On 04/03/22 at 4:35pm, Resident #1 tried twice to leave the facility. Staff took the resident back to her room where she snatched the blinds off the window, and emptied clothes all over the floor.
-On 04/03/22 at 5:45pm, Resident #1 went out the side door and staff went out to get her. She was sitting on the ground. Staff helped her up and

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back to her room. Resident #1 continued to cry and pull at her skin causing it to bleed with staff telling her to stop. Will continue to monitor.
-On 04/03/22 at 10:05pm, Resident #1 was lying in bed. Will continue to monitor.
-On 04/04/22 at 2:30pm, Resident #1 broke her window and made exit through the window, she ran towards the street stopping traffic. She began banging on the window of a van begging the driver to let her in. Staff attempted to redirect Resident #1 back into the facility. Resident #1 was screaming and crying when she was returned to the facility. EMS was called at 2:30pm and arrived at 6:30pm to transport Resident #1 to a local hospital.
-There was no documentation the PCP was notified of elopements on 04/03/22, and 04/04/22 and attempts to hurt herself on 03/31/22, 04/01/22.
-There was no documentation the resident was receiving mental health services.

Review of Resident #1's Incident and Accident reports revealed:
-On 03/31/22 at 6:00pm, Resident #1 was agitated and wanted to be left alone, when a resident insisted on coming over to talk to her and Resident #1 lifted her foot up and kicked another resident (not very hard). Resident #1 apologized. Resident #1 was disoriented. Resident #1 was not sent out to hospital. PCP notified verbally was documented but no time or date of notification was documented.
-On 04/01/22 at 6:45pm, Resident #1 was emotional and combative. The resident was biting her arms till they were bleeding. Resident was sent out to a local hospital. The PCP was notified via phone message left at 7:00pm on 04/01/22 was documented.
-On 04/04/22 at 2:30pm, Resident #1 was in her

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room lying down on her bed, after taking all her clothes and putting them on the floor, the resident raised her window and got out of the facility and was trying to get into a vehicle and traffic was stopped. There was a right arm skin tear noted. Resident #1 was sent to a local hospital. There was no documentation for the PCP notified.

Interviews with the Resident Care Coordinator (RCC) on 04/05/22 at 2:33pm and 3:33pm revealed:
-She contacted Resident #1's PCP for crying and depressive behaviors on 03/25/22 and an order for an antidepressant was sent for the resident.
-She contacted the resident's family and received approval for placing a special arm/ankle bracelet alarm that activated to warn the staff when Resident #1 was too close to the exit doors at the facility.
-She contacted Resident #1's PCP for exit seeking behaviors on 03/30/22 and a prn medication order for anxiety/agitation was sent for the resident.
-On 04/01/22, Resident #1 had been sent out to the hospital for biting herself, picking her arms and trying to hurt herself.
-On 04/03/22, Resident #1's family member brought her back to the facility and told staff at the facility that Resident #1 had tried to jump out of the moving car and needed something to calm her down. Later, Resident #1 threw a book at the window in her room and tried to take down the window blinds.
-On 04/04/22, Resident #1 had been sent out to the hospital for eloping from the facility into the street.
-She had not contacted the facility's contracted mental health provider (MHP) because the resident's family member wanted Resident #1's PCP to handle her behaviors due to being her

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PCP for many years.
-She met with Resident #1's family member this morning (04/05/22) to obtain consent to contact the facility's contracted MHP for evaluation and treatment for the inappropriate behaviors
-She had not contacted the resident's PCP for the incidents on 04/01/22, 04/03/22, because she thought the resident should have gotten treatment or a referral for mental health evaluation or medication adjustments and notes sent to the PCP by the hospitals.
-The facility's contracted mental health provider (MHP) was contacted today (04/05/22) after the RCC contacted Resident #1's family member earlier on 04/05/22 to provide an authorization to switch to the facility's contracted MHP.
-The MHP arranged for an emergency video conference evaluation for Resident #1 since it was after 5:00pm before the evaluation was arranged.

Telephone interview with Resident #1's family member on 04/05/22 at 3:40pm revealed:
-He was Resident #1's Responsible Party/Power of Attorney.
-Resident #1 came to the facility about 3 weeks ago from an independent living facility.
-Resident #1 had been having difficulty adjusting to the transition to the facility.
-Resident #1 wanted to leave the facility to find her spouse (who was deceased).
-Resident #1 was very emotional and cried a lot.
-The facility had called him several times regarding Resident #1 going out the exit doors of the facility.
-He wanted Resident #1's PCP to handle her behaviors due to being her PCP for many years and knowing her declining mental status.
-He came to the facility this morning (04/05/22) to sign paperwork for the facility to start mental

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health services from the contracted mental health provider (MHP).
-He was aware the facility placed a special arm/ankle bracelet alarm that activated to warn the staff when Resident #1 was too close to the exit doors.

Interview with the Administrator on 04/06/22 at 4:00pm revealed:
-He knew about Resident #1's inappropriate behaviors of biting herself, exit seeking, emotional outburst of crying that had been escalating since she came to the facility 3 weeks ago (03/24/22).
-Resident #1's family member had been reluctant to switch from her long time PCP (not the facility's contracted PCP) because he felt the PCP that had provided care for several years would know her best and be able to treat her best.
-The Administrator had spoken to the family member a few times (no exact dates provided) regarding the facility's need to get a mental health evaluation by the facilty's contracted MHP.
-The RCC was responsible for ensuring health care providers were informed of any changes in residents' conditions, behaviors, or acute health care needs in a timely manner.
-Resident #1's family member came to the facility early yesterday to approve switching to the facility's contracted PCP and mental health provider (MHP) but Resident #1 had already eloped to the road and endangered herself.

Telephone interview with Resident #1's PCP from a return telephone call on 04/07 at 11:47am revealed:
-There was no documentation the facility had notified the PCP regarding continued emotional and combative behaviors or the elopement on 04/05/22.

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D 273	Continued From page 8 -The PCP recommended sending Resident #1 to a local hospital with a geriatric psychiatric unit for evaluation and suggested treatment. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #2's current FL2 dated 08/27/22 revealed diagnoses included allergies and asthma, gastroesophageal reflux disease, gastrointestinal bleeding, and colon polyp. a. Review of Resident #2's physician's orders dated 03/29/22 revealed an order to hold antihistamines from 03/29/22 until after her appointment with the allergist on 04/05/22. Interview with Resident #2 on 04/06/22 at 4:24pm revealed: -She missed her appointment with her allergist yesterday on 04/05/22. -Her original appointment was in March 2022, but it had to be rescheduled because she had another appointment on the same date. -The Scheduling/Transportation Coordinator rescheduled her appointment for 04/05/22. -She did not know she had an appointment on 04/05/22 until the Scheduling Coordinator told her she missed the appointment. -She needed to keep her appointments with the allergist because she had allergies that were affecting her hearing. -She usually made her own appointments, but she was told that she could not make appointments for herself anymore because there was sometimes a conflict with other residents' appointments. Interview with the Scheduling/Transportation	D 273		

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D 273	Continued From page 9 Coordinator on 04/06/22 at 4:46pm revealed: -Resident #2 made her own appointments and gave her a long list of upcoming appointments to place in her appointment book. -Resident #2 had an appointment with her allergist in March 2022, but the appointment was rescheduled because she (Resident #2) had another appointment on the same date. -She did not remember whether she rescheduled the appointment with the allergist or if Resident #2 rescheduled the appointment. -Resident #2 missed her appointment with the allergist on 04/05/22 because she (Resident #2) forgot she had an appointment. -She usually reminded residents of their appointments by writing the appointment date and time on a sticky note and giving it to the resident. -She did not remind Resident #2 of her appointments with a sticky note because Resident #2 made and kept track of her own appointments. -Resident #2 usually came to her office to remind her of any appointments she had. -She took other residents to appointments on 04/05/22, and she did not realize Resident #2 had an appointment on 04/05/22 until she returned to the facility and looked at her appointment book. -She had not rescheduled the appointment for Resident #2 with her allergist. Interview with a nurse at Resident #2's allergist's office on 04/07/22 at 8:47am revealed: -Resident #2 was on antihistamines for her allergies. -There was an order dated 03/29/22 to hold Resident #2's antihistamines until her appointment on 04/05/22 due to testing. -Resident #2 was a "no show" for her appointment on 04/05/22 and the appointment had not been rescheduled.	D 273		

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-Resident #2 should have restarted her antihistamines on 04/06/22 although she did not show up for her appointment.
-She would have to stop taking the antihistamines again 7 days prior to her next appointment once it was scheduled.

Interview with the Administrator on 04/07/22 at 6:08pm revealed:
-Resident #2 made most of her appointments herself and some of them conflicted with the appointments previously scheduled for other residents.
-He had spoken to Resident #2 and she agreed to hand over scheduling her appointments to staff.
-The Scheduling/Transportation Coordinator was responsible for ensuring residents made it to scheduled appointments.
-The Scheduling/Transportation Coordinator was responsible for reminding residents of their appointments before it was time to leave for their appointments.
-The Scheduling/Transportation Coordinator was responsible for rescheduling appointments for residents.

b. Review of Resident #2's physician's orders dated 12/30/21 revealed there was an order for lactulose 10gm/15 mL, 30 mL twice daily (used to treat constipation).

Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lactulose 10 gm/15 mL solution 30 mL (20 gm dose) twice daily scheduled for administration at 8:00am and 8:00pm.
-Lactulose was documented as refused for 9 of

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31 opportunities at 8:00am and for 5 of 31 opportunities at 8:00pm between 01/01/22 and 01/31/22.

Review of Resident #2's February 2022 eMAR revealed:
-There was an entry for lactulose 10 gm/15 mL solution 30 mL (20 gm dose) twice daily scheduled for administration at 8:00am and 8:00pm.
-Lactulose was documented as resident refused for 21 of 28 opportunities at 8:00am and for 25 of 28 opportunities at 8:00pm between 02/01/22 and 02/28/22.

Review of Resident #2's March 2022 eMAR revealed:
-There was an entry for lactulose 10 gm/15 mL solution 30 mL (20 gm dose) twice daily scheduled for administration at 8:00am and 8:00pm.
-Lactulose was documented as resident refused for 6 of 31 opportunities at 8:00am and for 16 of 31 opportunities at 8:00pm between 03/01/22 and 03/31/22.

Review of Resident #2's April 2022 eMAR revealed:
-There was an entry for lactulose 10 gm/15 mL solution 30 mL (20 gm dose) twice daily scheduled for administration at 8:00am and 8:00pm.
-Lactulose was documented as resident refused for 2 of 6 opportunities at 8:00am between 04/01/22 and 04/06/22.

Interview with Resident #2 on 04/07/22 at 5:54pm revealed:
-She took lactulose for constipation.
-She refused lactulose sometimes because it

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caused her stomach to be in knots and she felt a burning sensation.
-She took lactulose when she needed to have a bowel movement, although it hurt her stomach.
-She had bowel movements 2 to 3 times a week.

Interview with a medication aide (MA) on 04/07/22 at 12:12pm revealed:
-Resident #2 took lactulose when she wanted to.
-Resident #2 refused lactulose often, but she wanted to stay on it.
-She had not followed up with Resident #2's primary care provider (PCP) because she had an outside PCP and she had never followed up with any outside PCPs.

Telephone interview with a nurse from Resident #2's PCP's office on 04/07/22 at 3:59pm revealed:
-Resident #2 had an order for lactulose 30 mL twice daily for constipation.
-The PCP made a referral to a gastroenterologist and Resident #2 was seen by the gastroenterologist on 12/30/21 with diagnoses of nausea and dizziness.
-The facility used to send notifications to the PCP's office at least 3 times a week, but there had been no recent correspondence.
-Resident #2 was seen in the PCP's office in January 2022 and the facility sent a copy of Resident #2's eMAR, but there had not been any proper notification Resident #2 refused lactulose or any other medications.
-The PCP would have expected the facility to contact their office to let them know Resident #2 had been consistently refusing lactulose, because the PCP may have switched the medication or referred Resident #2 back to the gastroenterologist.
-A possible outcome of not taking lactulose as

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D 273	Continued From page 13 ordered could have been bowel obstruction. Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm revealed: -She knew Resident #2 refused lactulose, but she did not know she refused lactulose as frequently as she did. -Resident #2 "fired" the facility's PCP, and she would not tell her who her new PCP was. -She had not contacted any physician about Resident #2 refusing lactulose. Interview with the Administrator on 04/07/22 at 6:08pm revealed: -He was not aware Resident #2 was consistently refusing lactulose. -MAs or the RCC should have contacted Resident #2's PCP after 3 refusals per the facility's policy. The facility failed to contact the primary care provider (PCP) or arrange for a psychiatric evaluation for a resident who was intermittently disoriented with a diagnoses of short-term memory loss and depression, exhibited increased behavior of anxiety and self-harming tendencies, and multiple elopement attempts with one elopement resulting in the resident wandering into a busy street and stopping traffic (Resident #1); and a resident who had diagnoses of allergies and asthma and missed an appointment with an allergist after being off of antihistamines for 7 days as ordered by the allergist, and the resident refused a medication for constipation for 43 of 90 opportunities and the PCP was not notified which could have resulted in a bowel obstruction (Resident #2). This failure resulted in substantial risk for serious physical harm, and neglect to the resident and constitutes a Type A2 Violation .	D 273		

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D 273	Continued From page 14 The facility provided a plan of protection in accordance with G.S. 131D-34 on April 06, 2022 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 07, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#2 and #6) observed during the medication pass including errors with insulin (#2) and a medication to treat ulcers (#6); and for 2 of 5 residents (#1 and #2) sampled for record review including errors with checking fingerstick blood sugar (FSBS) and administering insulin (#1 and #2). The findings are: 1. The medication error rate was 7% as evidenced by the observation of 2 errors out of 26 opportunities during the 11:00am, 2:00pm, and	D 358		

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D 358	Continued From page 15 5:00pm medication passes on 04/06/22. a. Review of Resident #2's current FL2 dated 08/27/21 revealed: -Diagnoses included bipolar disorder, diabetes mellitus, hypertension, and anxiety. -There was an order for Humalog (a rapid acting insulin) 100 units per ml (100u/ml) inject 25 units subcutaneously (SQ) 3 times a day, if FSBS greater than 300 give an extra 5 units SQ for a total of 30 units. Review of Resident #2's physician's orders revealed a subsequent physician's orders dated 01/28/22 for Humalog insulin 100u/ml inject 20 units SQ 3 times a day before meals, if FSBS greater than 300 give an extra 5 units SQ for a total of 25 units. Review of the manufacturer's recommendation for Admelog insulin (substituted for Humalog insulin) revealed administer Admelog insulin within 15 minutes before a meal or immediately after a meal. Observation of the medication pass for Resident #2 on 04/06/22 revealed: -At 11:00am, the morning medication aide (MA) used a glucometer labeled with the resident's name to obtain a FSBS; the FSBS was 213 on the glucometer. -The MA consulted the electronic medication record (eMAR) to determine the amount of Admelog to administer to Resident #2. -The MA added a needle cap to the Admelog insulin pen dialed up 2 units, did air shot and dialed up 20 units on the pen's dial. -The MA administered 20 units of Admelog to Resident #2's right deltoid.	D 358		

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D 358	Continued From page 16 Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Admelog insulin 100units/ml inject 20units SQ 3 times daily, scheduled for administration at 6:30am, 11:30am, and 4:30pm. -Admelog insulin 20 units was documented as administered on 04/06/22 at 11:30am. Interview with the MA on 04/06/22 at 11:00am revealed: -Resident #2's FSBS and insulin administration was scheduled for administration at 11:30am. -The medications scheduled for 11:30am started appearing on the eMAR for MAs to administer one hour before (10:30am) and stayed on the eMAR for up to one hour after the scheduled time of administration. -She started obtaining FSBS and administering insulin around 11:00am each day. -Residents were served lunch from 11:30am to 12:15pm depending on the cook of the day. -Resident #2's FSBS was always high. -She administered Humalog insulin according to the one hour before or 1 hour after the scheduled time parameters. -Resident #2's eMAR listed Admelog insulin 3 times a day with no information regarding meals. -She knew some of the types of insulin should be administered close to meals but she did not recall the name of all the types. Interview with Resident #2 on 04/06/22 at 12:00pm revealed: -Resident #2 had been seated in the dining room for about 15 minutes. -She knew the insulin she received before meals worked quickly. -Most days she was administered her lunch time Admelog insulin around 11:00am to 11:45am.	D 358		

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-She could tell when her blood sugar started getting low because she started feeling weak and sweaty.
-She was fine right now, and the staff were serving plates so she should get hers soon.

Observation of Resident #2's lunch meal on 04/06/22 revealed she received her plate at 12:08am (68 minutes after receiving Admelog rapid acting insulin) and immediately took a bite of her roll.

Telephone interview with the order entry technician at the facility's contracted pharmacy on 04/06/22 at 10:17am revealed:
-Resident #2's Admelog insulin was entered from the order received on 12/17/21 for 20 units SQ 3 times a day, if FSBS greater than 300 give an extra 5 units SQ for a total of 25 units of Humalog insulin.
-The time for administration was entered by the contracted pharmacy staff as 11:30am.

Telephone interview with Resident #2's previous primary care provider (PCP) on 04/06/21 at 2:59pm revealed:
-She would expect the facility to administer rapid acting insulin closer to the time the resident was going to eat the meal.
-Administering Admelog insulin more than 15 to 20 minutes before a resident ate could cause the blood sugar to drop too low and the resident could experience, weakness, sweating, and potential loss of consciousness.
-The insulin was scheduled for 11:30am when she reviewed the eMAR.
-The facility should have more training for the correct time to administer the rapid acting insulin.

Interview with the Administrator on 04/06/22 at

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3:00pm revealed:
-The MAs received training on medication administration.
-The MAs should use their training for administering insulin according to how quickly the insulin works and the manufacturer's recommended times for administration.
-The MAs should be administering insulin closer to meals if the insulin was rapid acting.
-He would expect the MAs to know how to administer insulin.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 5:40pm revealed:
-She expected the MAs to administer medications as ordered.
-She was available to assist with orders that were not clear or if staff needed assistance with medication orders.
-She had not reviewed the eMARs compared to the orders for Resident #2 and did not know MAs were routinely administering rapid acting insulins more than 30 minutes before a meal.

b. Review of Resident #6's current FL2 dated 10/22/21 revealed diagnoses included dementia, hypertension, and diabetes mellitus.

Review of Resident #6's after visit summary from a local emergency department (ED) dated 01/03/22 revealed:
-Diagnoses included dysphagia, nausea and vomiting.
-There was an order to start sucralfate (used to treat stomach ulcers) 1 gram (gm) 30 minutes before meals and at bedtime.

Observation of the 2:00pm medication pass on 04/06/22 at 1:57pm revealed the medication aide (MA) prepared 3 oral medications, including one

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D 358	Continued From page 19 sucralfate 1gm tablet. Review of Resident #6' April 2022 electronic medication administration record revealed: -There was an entry for sucralfate 1gm one tablet before meals and at bedtime scheduled for administration at 8:00am, 12:00pm, 2:00pm and 8:00pm. -There was documentation sucralfate 1gm was administered at 8:00am, 12:00pm, 2:00pm and 8:00pm daily from 04/01/22 to 04/06/22 at 2:00pm. Interview with the MA on 04/06/22 at 2:00pm revealed: -She administered Resident #6's sucralfate 1gm according to the administration time appearing on the screen for the eMAR. -Resident #6 was supposed to receive a snack at 2:00pm; she considered the snack as a meal and administered sucralfate 1gm. -She did not know if the order was supposed to omit the supper dose even though it was a meal. -She did not have access to the original physicians' orders and did not enter orders on the eMAR system. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/06/22 at 2:27pm revealed: -There was an order dated 03/08/22 to change the sucralfate 1gm before meals and at bedtime from a liquid to tablet dose but no change to the order 30 minutes before meals and bedtime. -The pharmacy staff entered the sucralfate order as before meals and at bedtime as ordered without entering 30 minutes before meals and at bedtime. -The pharmacy staff chose incorrect times of day to schedule administration.	D 358		

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-The facility was responsible to review and approve orders entered by the pharmacy staff prior to the order appearing on the eMAR screen for the MA to administer.
-There was no documentation the facility's staff had contacted the pharmacy for correcting the time of administration.

Telephone interview with Resident #6's primary care provider (PCP) on 04/06/22 at 2:59pm revealed:
-The PCP expected the facility's MAs to administer medications as ordered.
-The MAs should review the medications orders compared to the eMAR to ensure residents were receiving medications as ordered.
-Sucralfate 1gm should have been given before the breakfast, lunch, and supper meals and at bedtime for the medication to work properly.
-The facility should have corrected the 2:00pm time to reflect supper time around 5:00pm.

Interview with the Administrator on 04/06/22 at 3:00pm revealed:
-The MAs should administer medications as ordered by the physician.
-If the orders printed in the directions did not match the times of administration scheduled, the MA should call the pharmacy for assistance with correcting the eMAR.

Interview with the Resident Care Coordinator (RCC) on 04/06/22 at 5:40pm revealed:
-She expected the MAs to administer medications as ordered.
-She was available to assist with orders that were not clear or if staff needed assistance with medication orders.
-She had not reviewed the eMARs compared to the orders for Resident #6 and did not know the

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pharmacy had entered the 2:00pm time for a meal time.

Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable.

2. Review of Resident #1's current FL2 dated 03/14/22 revealed:
-Diagnoses included hypertension, Type II diabetes mellitus, depression, history of stroke, short term memory loss.
-The resident was intermittently disoriented and semi-ambulatory.
-There was an order for Humalog insulin inject subcutaneously (SQ) 3 times a day with meals per sliding scale as directed. (Humalog insulin is a rapid acting insulin) (According to the manufacturer's guideline a rapid acting insulin should not be administered more than 30 minutes prior to a meal or immediately after a meal.).

Review of Resident #1's Resident Register revealed an admission date of 03/23/22.

Review of Resident #1's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog insulin 100u/ml inject SQ 3 times a day per sliding scale: 131-180 give 4 units, 181-240 give 8 units, 241-300 give 10 units, 301-360 give 12 units, 361-400 give 15 units, over 401 give 20 units.
-Humalog insulin was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-There was no space on the eMAR to document the fingerstick blood sugar (FSBS) value or the amount of Humalog insulin administered.
-Humalog insulin was documented for administration at 8:00am, 2:00pm and 8:00pm

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D 358	Continued From page 22 daily from 03/23/22 at 8:00am to 03/31/2022 at 8:00pm except on 03/26/22 at 8:00pm. Review of Resident #1's medication pass notes documented on the March 2022 eMAR from 03/23/22 to 03/31/22 revealed: -There were 25 opportunities from 03/23/22 to 03/31/22 for obtaining FSBS readings as ordered before meals. -At 8:00am, there were 6 of 8 opportunities for FSBS with values not documented in the medication pass notes. -There were 4 of 8 FSBS values documented and it could not be determined if the correct dose of Humalog was administered before the breakfast meal. -There were 16 of 16 opportunities from 03/23/22 to 03/31/22 for obtaining FSBS readings before the lunch and supper meals not documented as ordered. -At 2:00pm, there were 7 of 8 days with FSBS values documented at 2:00pm and no Humalog insulin administered. -At 8:00pm, there were 4 of 8 days with FSBS values documented and 6 of 8 days when Humalog insulin was documented as administered with no order. -At 12:00pm, there were 8 of 8 days with no documentation for FSBS obtained or Humalog insulin administered before the lunch meal. -At 5:00pm (supper), there were 8 of 8 days with no documentation for FSBS values obtained or Humalog insulin administered before the supper meal. Review of Resident #1's April 2022 eMAR revealed: -There was an entry for Humalog insulin 100u/ml inject SQ 3 times a day per sliding scale: 131-180 give 4 units, 181-240 give 8 units, 241-300 give	D 358		

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10 units, 301-360 give 12 units, 361-400 give 15 units, over 401 give 20 units.
-Humalog insulin was scheduled for administration at 8:00am, 2:00pm, and 8:00pm.
-There was no space on the eMAR to document the FSBS value or the amount of Humalog insulin administered.
-Humalog insulin was documented for administration at 8:00am, 2:00pm and 8:00pm as follows:
-On 04/01/22 at 8:00am and 2:00pm, Humalog was documented as administered.
-On 04/01/22 at 8:00pm to 04/03/22 at 2:00pm, Humalog was not documented as administered for resident in the hospital.
-On 04/03/22 at 8:00pm and 04/04/22 at 8:00am, and 2:00pm, Humalog was documented as administered.
-On 04/04/22 at 8:00pm and 04/05/22 at 8:00am, Humalog was not documented as administered for resident in the hospital.
-On 04/05/22 at 2:00pm and 8:00pm, and 04/06/22 at 8:00am, Humalog was documented as administered.

Review of Resident #1's medication pass notes documented on the April 2022 eMAR from 04/01/22 to 04/06/22 revealed:
-There were 9 opportunities when Resident #1 was in the facility from 04/01/22 to 04/06/22 for obtaining FSBS readings as ordered before meals.
-There were 0 of 9 opportunities with the FSBS value and the amount of Humalog insulin administered documented correctly from 04/01/22 to 04/06/22.
-There were 3 of 3 days (doses) when Resident #1 was in the facility with missing FSBS values and it could not be determined if the correct dose of Humalog was administered before the

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breakfast meal (04/01/22, 04/04/22, and 04/06/22).
-There were 3 of 3 days (doses) when Resident #1 was in the facility with missing FSBS values and no Humalog was administered before the lunch meal (04/04/22, 04/05/22, and 04/06/22).
-There were 2 of 2 days (doses) when Resident #1 was in the facility with missing FSBS values and no Humalog was administered before the supper meal (04/03/22 and 04/05/22).

Telephone interview with a pharmacist on 04/06/22 at 10:17am revealed:
-On 03/22/22, the facility sent the FL2 with "see attached list" handwritten in the medications section of the FL2.
-There was a pre-printed list of medications with an encounter date of 02/09/22 that included Humalog insulin inject subcutaneously (SQ) 3 times a day with meals per sliding scale as directed.
-The facility also sent sliding scale insulin (SSI) parameters of 131-180 give 4 units, 181-240 give 8 units, 241-300 give 10 units, 301-360 give 12 units, 361-400 give 15 units, over 401 give 20 units that were handwritten on a small card brought to the facility by the resident's family member.
-The pharmacy staff entered the medications on the electronic medication administration record (eMAR) system with an note at the pharmacy regarding the pharmacy staff contacting the primary care provider for verification of the SSI parameters.
-When the pharmacy staff entered the Humalog insulin order, it was entered as 3 times a day, which populated onto the eMAR with administration of 8:00am, 2:00pm, and 8:00pm unless modified.
-The 8:00am, 2:00pm, and 8:00pm administration

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should have been changed by the pharmacy staff.
-The pharmacy finally received verification on 03/29/22 that the SSI parameters were correct.
-The pharmacy should have entered the Humalog insulin as a SSI medications using one of the embedded pharmacy eMAR codes which would have listed the Humalog on the eMAR with times of day (set by pharmacy), FSBS value, amount of insulin administered, site of injection and staff who administered but did not.
-Part of the directions related to administering with meals was omitted from the directions.
-The facility was responsible to review orders entered by the pharmacy staff and accept the order prior to the orders appearing in the eMAR system for administration.
-There was no documentation the facility contacted the contracted pharmacy to correct the times of administration or no place to document FSBS value, amount of insulin administered, site of injection and staff who administered.

Interview with a medication aide (MA) on 04/07/22 at 12:15pm revealed:
-She administered medications, including Resident #1's Humalog insulin, according to the time the medication appeared on the eMAR.
-Medications appeared on the eMAR system one hour before up to one hour after scheduled times of administration.
-The Resident Care Coordinator (RCC) routinely reviewed medication orders entered by the contracted pharmacy and approved (released) the orders which then appeared on the eMAR for administration.
-She did not know Resident #1's Humalog insulin was ordered with meals since the eMAR did not say with meals.
-She was knew the eMAR did not have a place to document the FSBS value, amount of Humalog

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administered per SSI parameters, or the site of administration.
-She used the medication pass notes section of the eMAR to document the FSBS value and SSI administered.
-She had not questioned why Resident #1 was receiving SSI in the middle of the afternoon.

Interview with the RCC on 04/07/22 at 1:00pm revealed:
-She routinely reviewed and approved medication orders in the eMAR system.
-Resident #1 was the only resident at the facility with sliding scale insulin orders.
-Since she was not familiar with documenting SSI, she overlooked the contracted pharmacy's incorrect entry for Resident #1's Humalog insulin that was missing "with meals", the incorrect hours of administration based on "with meals", no place to document the FSBS value, the amount of Humalog administered, or the site of administration.
-The MAs had not informed her of the missing areas for documentation.

Interview with the Administrator on 04/07/22 at 5:00pm revealed:
-The RCC was responsible to assure medications were administered as ordered.
-She reviewed medication orders for accuracy and completeness, approved the orders and released the orders to appear on the eMAR for administration.
-He did not know Resident #1's Humalog insulin was administered incorrectly for the 3 weeks she had been at the facility.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

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D 358	Continued From page 27 3. Review of Resident #2's current FL2 dated 08/27/21 revealed diagnoses included diabetes. -There was an order for finger stick blood sugar (FSBS) 3 times daily -There was an order for Humalog (a fast-acting insulin) 100 units/mL inject 25 units 3 times daily, if FSBS greater than 300 give an extra 5 units for a total of 30 units. Review of Resident #2's physician's orders dated 12/17/21 revealed: -There was an order for Humalog 100 units/mL kwikpen inject 20 units 3 times daily. -There was an order for Humalog 100 units/mL kwikpen give an extra 5 units 3 times daily if FSBS greater than 300. Review of Resident #2's January 2022 electronic medication administration record (eMAR) revealed: -There was an order to check FSBS 3 times daily and record on the eMAR scheduled for 6:30am, 11:30am, and 4:30pm. -There was an entry for Humalog inject 20 units 3 times daily scheduled for administration at 6:30am, 11:30am, and 4:30pm. -There was an entry for Humalog give an extra 5 units 3 times daily if FSBS greater than 300. -There was documentation 20 units of Humalog were not administered on 01/01/22 at 4:30pm due to withheld per doctor's orders; there were blank spaces with no documentation of administration on 01/08/22 at 6:30am, on 01/14/22 at 11:30am, and on 01/18/22 at 6:30am. -There was documentation an extra 5 units were administered when Resident #2's FSBS was less than 300 on 01/02/22 at 6:30am (FSBS was 224), on 01/05/22 at 6:30am (FSBS was 187), on 01/15/22 at 6:30am (FSBS was 290), on 01/16/22	D 358		

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at 6:30am (FSBS was 161), on 01/16/22 at 11:30am (FSBS was 155), on 01/16/22 at 4:30pm (FSBS was 217).
-There were blank spaces with no documentation of FSBS or administration on 01/08/22 at 6:30am, on 01/14/22 at 11:30am, and on 01/18/22 at 6:30am.

Review of Resident #2's February 2022 eMAR revealed:
-There was an order to check FSBS 3 times daily and record on eMAR scheduled for 6:30am, 11:30am, and 4:30pm.
-There was an entry for Humalog inject 20 units 3 times daily scheduled for administration at 6:30am, 11:30am, and 4:30pm.
-There was an entry for Humalog give an extra 5 units 3 times daily if FSBS greater than 300.
-There was documentation 20 units of Humalog were not administered on 02/02/22 at 11:30am due to withheld per doctor's orders, on 02/26/22 at 4:30pm due to withheld per doctor's orders, and on 02/07/22 at 4:30pm due to withheld per doctor's orders.
-There was documentation an extra 5 units were not administered on 02/02/22 at 11:30am due to withheld per doctor's orders and there was no documentation of FSBS.
-There was no documentation an extra 5 units were administered on 02/09/22 at 11:30am (FSBS was 344), on 02/10/22 at 4:30pm (FSBS was 344), on 02/12/22 at 4:30pm (FSBS was 450), on 02/26/22 at 4:30pm (FSBS was 328), and on 02/27/22 at 4:30pm (FSBS was 309).

Review of Resident #2's March 2022 eMAR revealed:
-There was an order to check FSBS 3 times daily and record on eMAR scheduled for 6:30am, 11:30am, and 4:30pm.

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D 358	Continued From page 29 -There was an entry for Humalog inject 20 units 3 times daily scheduled for administration at 6:30am, 11:30am, and 4:30pm. -There was an entry for Humalog give an extra 5 units 3 times daily if FSBS greater than 300. -There was documentation 20 units of Humalog were not administered on 03/122/22 at 4:30pm due to withheld per doctor's orders, on 03/13/22 at 4:30pm due to withheld per doctor's orders, and on 03/21/22 at 11:30am due to withheld per doctor's orders. -There was no documentation an extra 5 units were administered on 03/31/22 at 11:30am (FSBS was 306). Review of Resident #2's April 2022 eMAR revealed: -There was an order to check FSBS 3 times daily and record on eMAR scheduled for 6:30am, 11:30am, and 4:30pm. -There was an entry for Humalog inject 20 units 3 times daily scheduled for administration at 6:30am, 11:30am, and 4:30pm. -There was an entry for Humalog give an extra 5 units 3 times daily if FSBS greater than 300. -There was no documentation an extra 5 units were administered between 04/01/22 and 04/06/22 on 04/02/22 at 6:30am (FSBS was 313). Observation of Resident #2's medication available for administration on 04/07/22 at 10:45am revealed: -There was 1 Humalog pen on the medication cart. -There was no opened or dispensed date on the Humalog pen. Interview with a pharmacist from the facilty's contracted pharmacy on 04/07/22 at 3:00pm revealed:	D 358		

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-Resident #2 had an order for Humalog 100 units/mL 20 units 3 times daily, give an extra 5 units if FSBS greater than 300.
-There was 1 box of 5 Humalog pens dispensed to the facility on 11/30/21, 12/23/21, 03/06/22, and 03/25/22.
-Each box should have lasted 25 days if only given the 20-unit dose 3 times daily.

Interview with Resident #2 on 04/07/22 at 5:45pm revealed:
-She had a diagnosis of diabetes and was administered Humalog 3 times daily.
-She was administered 20 units of Humalog plus an additional 5 units if her FSBS was over 300.
-There had been times when she did not receive her Humalog, but she did not remember when or how often.

Interview with a medication aide (MA) on 04/07/22 at 11:02am revealed:
-Resident #2 had an order for Humalog 20 units 3 times daily and if her FSBS was greater than 300, Resident #2 was administered an extra 5 units.
-On the days when she did not give an extra 5 units to Resident #2 when her FSBS was over 300, it was because she confused Resident #2 with another resident who had orders to give an extra 5 units when her FSBS was over 350.

Interview with a second MA on 04/07/22 at 12:12pm revealed:
-She did not administer Humalog 20 units on 03/21/22 because it was not available in the facility.
-She did not know why she documented withheld per doctor's orders in 04/02/22.

Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm revealed:

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D 358	Continued From page 31 -She did not know MAs documented insulin was administered when it should not have been administered, and that insulin was not administered when it should have been administered. -The pharmacy reviewed the eMARs during their quarterly pharmacy reviews. -She did not know if the pharmacy looked for errors with insulin administration. -There was no one at the facility who looked at the eMARs regularly to ensure accurate insulin administration. Telephone interview with a nurse at Resident #2's endocrinologist's office on 04/07/22 at 3:31pm revealed: -Resident #2 had an order for Humalog due to a diagnosis of type 2 diabetes with hyperglycemia. -The facility had not contacted the endocrinologist to report any issues with insulin administration. -If Resident #2 was administered the extra 5 units of Humalog when her FSBS was greater than 300, it could cause elevated blood sugar levels. -If Resident #2 was not administered the extra 5 units of Humalog when her FSBS were less than 300, it could cause her blood sugar levels to drop too low. Interview with the Administrator on 04/07/22 at 6:08pm revealed: -He did not know about the errors with the administration of Humalog. -He expected Resident #2's medications to be administered as ordered. _____ The facility failed to ensure medications were administered as ordered for 2 of 7 sampled residents observed during the medication pass including a resident who had a diagnosis of diabetes mellitus and was not administered a	D 358		

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D 358	Continued From page 32 rapid acting insulin as ordered, no more than 15 minutes before meals (#2) and a resident who had diagnoses of dysphagia, nausea, and vomiting was not administered a medication to treat ulcers before the dinner meal (#6); and for 2 of 5 sampled residents for record review including a resident who was not administered an additional dose of a rapid acting insulin 7 times when her blood sugars were above 300 or was administered an additional dose of a rapid acting insulin 6 times when her blood sugars were below 300 (#2) which could have resulted in hypoglycemia or hyperglycemia; and another resident who was not administered a rapid acting insulin as ordered which could have possibly resulted in hypoglycemia (#1). The facility's failure to administer medication as ordered was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on April 7, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 22, 2022.	D 358		
{D 392}	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.	{D 392}		

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{D 392}	Continued From page 33 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of controlled substances was maintained for 3 of 5 sampled residents related to pain medication (#2, #3), a medication for anxiety (#1), and a medication for sleep (#2). The findings are: Review of the facility's policy for the proper handling and tracking of controlled substances dated July 2007 revealed: -Log all controlled medications on a Controlled Substance Count Sheet (CSCS) with the resident's name, quantity received, and date received. -Prepare controlled medications for administration from the electronic medication administration record (eMAR) first logging entry on the CSCS, and then on the eMAR. -At change of shift, the controlled medications should be counted by the on-coming and out-going staff persons for accuracy prior to the out-going staff person leaving. -Documentation of the counts should be done on the Narcotic Count at Shift Change form. -If there is a discrepancy, the Administrator or designee in charge (Resident Care Coordinator) should be notified. 1. Review of Resident #3's current FL2 dated 07/09/21 revealed: -Diagnoses included diabetes mellitus, heart failure, atrial fibrillation, and peripheral	{D 392}		

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neuropathy.
-There was an order for Norco (used to treat pain) 5/325mg 1 tablet every 6 hours as needed for pain.

Review of a signed physician's order for Resident #3 dated 01/07/22 revealed an order for Norco 5/325mg one tablet twice daily for pain.

Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Norco 5/325mg 1 tablet twice daily.
-There was documentation Norco was administered 10 times from 02/12/22 through 02/16/22.

Review of Resident #3's CSCS dated 02/11/22 revealed:
-There were 51 tablets of Norco dispensed from the pharmacy on 02/14/22.
-The first tablet was signed out on 02/16/22 and the last tablet was signed out on 03/24/22 leaving a balance of 0.
-There was no documentation of Norco being signed out from the 8:00am dose on 02/12/22 through the 8:00am dose on 02/16/22 for a total of 9 times.

Telephone interview with a representative from the facility's contracted pharmacy on 04/07/22 at 11:02am revealed:
-Resident #3 had an order for Norco 5-325mg one tablet twice daily.
-Norco was dispensed from the pharmacy on 01/07/22, 02/11/22, 02/14/22, and 03/11/22.
-There was a quantity of 60 tablets dispensed on 01/07/22 and 03/11/22.
-There was a quantity of 9 tablets dispensed on

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02/11/22 due to a stock shortage of Norco.
-There was an additional 51 tablets dispensed on 02/14/22 once the pharmacy had more Norco in stock.
-Two separate CSCSs were sent to the facility.
-The pharmacy crossed out "60" for the number of tablets on the second CSCS and wrote "payback 51" to indicate that only 51 doses of Norco were dispensed on 02/14/22.

Interview with Resident #3 on 04/07/22 at 11:37am revealed:
-He received all his medication on time, including Norco.
-He did not recall missing any scheduled doses of Norco.

Interview with a second shift medication aide (MA) on 04/07/22 at 5:08pm revealed:
-She documented administration on the eMAR for Norco from 02/12/22 through 02/14/22.
-She remembered signing the CSCS for Norco from 02/12/22 through 02/14/22 for Resident #3.

Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 3:11pm revealed:
-She was not aware that there were nine doses of Norco that were not documented on the CSCS for Resident #3.
-She searched for the first CSCS where the medication aides (MAs) documented administration of Norco from 02/12/22 through 02/16/22 but was unable to locate it.
-She expected the MAs to document on the eMAR and the CSCS.
-She expected the MAs to document as they administer medication to ensure accuracy.
-She had not audited or compared the eMARs to the CSCS prior to 04/05/22.
-The MAs were responsible for documenting

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medications as administered.
-The RCC was responsible for checking behind the MAs to ensure that the eMAR matched the CSCS.

Refer to interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm.

Refer to interview with the Administrator on 04/07/22 at 4:53pm.

2. Review of Resident #2's current FL2 dated 08/27/21 revealed diagnoses included bipolar disorder, diabetes mellitus, chronic obstructive pulmonary disease, depression, hypertension, asthma, anxiety, fibromyalgia, and arthritis.

a. Review of Resident #2's current FL2 dated 08/27/21 revealed there was an order for Ambien (a medication used to treat insomnia) 10mg 1 tablet at bedtime as needed (prn) for sleep.

Review of Resident #2's March 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Ambien 10mg 1 tablet at bedtime as needed for sleep.
-There was no documentation Ambien was administered on 03/12/22 or on 03/13/22.

Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 02/15/22 revealed:
-Thirty tablets of Ambien were dispensed from the pharmacy on 02/15/22; the first tablet was signed out on 02/17/22 and the last tablet was signed out on 04/04/22.
-There was 1 tablet of Ambien signed out on 03/12/22 and 1 tablet signed out on 03/13/22.

Review of Resident #2's April 2022 eMAR

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{D 392}	Continued From page 37 revealed: -There was an entry for Ambien 10mg 1 tablet at bedtime as needed for sleep. -There was no documentation Ambien was administered from 04/04/22 through 04/06/22. Review of Resident #2's CSCS dated 02/15/22 revealed: -There was 1 tablet of Ambien signed out on 04/04/22 leaving a balance of 2. -There was 1 tablet of Ambient signed out on 04/05/22, but there was a line drawn through leaving a balance of 2. Observation of medications available for Resident #2 on 04/07/22 at 10:56am revealed: -There was a bubble pack of 30 tablets of Ambien dispensed from the pharmacy on 02/15/22 and there were 3 tablets remaining. (There were 2 tablets remaining on the CSCS.) -There was 1 unopened bubble pack of 30 tablets dispensed from the pharmacy on 04/04/22. Interview with a pharmacist from the facility's contracted pharmacy on 04/07/22 at 9:20am revealed: -Resident #2 had an order for Ambien 10mg 1 tablet at bedtime as needed. -Ambien was dispensed from the pharmacy on 02/15/22 and 04/04/22 with a quantity of 30 tablets each time. Interview with Resident #2 on 04/07/22 at 5:45pm revealed: -She had an order for Ambien due to having trouble sleeping. -She received Ambien when she needed it a few times a week. Interview with a first shift medication aide (MA) on	{D 392}		

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THE BRADFORD VILLAGE OF KERNERSVILLE	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

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{D 392}	Continued From page 38	{D 392}		

04/07/22 at 11:07am revealed:
-All MAs were responsible for making sure that controlled substances matched the CSCSs.
-The MAs counted and signed off that the counts were correct at the beginning of each shift.
-She signed off that Resident #2's CSCS was accurate for Ambien on 04/07/22, but she did not notice the tablet count for Ambien was off because she did not administer Ambien during her shift.
-Another MA must have forgotten to administer Ambien after it was signed out.

Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm revealed she did not know there were discrepancies between the eMAR and Resident #2's CSCS for Ambien or that the count for Ambien, as of 04/07/22, was off because no MA had reported any discrepancies.

Refer to interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm.

Refer to interview with the Administrator on 04/07/22 at 6:08pm.

b. Review of Resident #2's current FL2 dated 08/27/21 revealed there was an order for Norco (used to treat pain) 10/325mg 1 tablet every 8 hours as needed for pain.

Review of Resident #2's February 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Norco 10/325mg 1 tablet every 8 hours as needed.
-There was no documentation Norco was administered on 02/26/22 or on 02/27/22.

Review of Resident #2's Controlled Substance

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{D 392}	Continued From page 39 Count Sheet (CSCS) dated 08/09/21 revealed: -Thirty tablets of Norco were dispensed from the pharmacy on 08/09/21; the first tablet was signed out on 01/14/22 and the last tablet was signed out on 03/25/22 leaving a balance of 0. -There was 1 tablet of Norco signed out on 02/26/22 and 1 tablet signed out on 02/27/22. Review of Resident #2's March 2022 eMAR revealed: -There was an entry for Norco 10/325mg 1 tablet every 8 hours as needed. -There was no documentation Norco was administered on 03/12/22 or on 03/13/22. Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 08/09/21 revealed: -Thirty tablets of Norco were dispensed from the pharmacy on 08/09/21; the first tablet was signed out on 01/14/22 and the last tablet was signed out on 03/25/22 leaving a balance of 0. -There was 1 tablet of Norco signed out on 03/12/22 and 1 tablet signed out on 03/13/22. Review of Resident #2's April 2022 eMAR revealed: -There was an entry for Norco 10/325mg 1 tablet every 8 hours as needed. -There was no documentation Norco was administered on 04/06/22. Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 01/31/22 revealed: -Thirty tablets of Norco were dispensed from the pharmacy on 01/31/22; the first tablet was signed out on 03/25/22 and the last tablet was signed out on 04/07/22 leaving a balance of 73. -There was 1 tablet of Norco signed out on 04/06/22.	{D 392}		

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{D 392}	Continued From page 40 Observation of medications available for Resident #2 on 04/07/22 at 10:56am revealed there were 3 bubble packs of 30 tablets of Norco, totaling 90 tablets, dispensed from the pharmacy on 02/15/22 and there were 72 tablets remaining. (There were 73 tablets remaining according to the CSCS.) Interview with a pharmacist from the facility's contracted pharmacy on 04/07/22 at 9:20am revealed: -Resident #2 had an order for Norco 10/325mg 1 tablet every 8 hours as needed. -Norco was dispensed from the pharmacy on 08/09/21, 09/10/21, 11/17/21, and 01/31/22 with a quantity of 90 tablets each time. Interview with Resident #2 on 04/07/22 at 5:45pm revealed: -She had an order for Norco 3 times daily as needed due to having pain in her arm, legs, and sometimes her back. -She received Norco when she needed it and usually took 1 tablet every night. Interview with a first shift medication aide (MA) on 04/07/22 at 11:07am revealed: -All MAs were responsible for making sure that controlled substances matched the CSCSs. -The MAs counted and signed off that the counts were correct at the beginning of each shift. -She signed off that Resident #2's controlled substance count and the CSCS were accurate, but she did notice the tablet count for Norco was off by 1. -She told the third shift MA about the discrepancy and the MA told her she would look at it. -She did not report the discrepancy to the Resident Care Coordinator (RCC) because she had been busy.	{D 392}		

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{D 392}	Continued From page 41 Interview with a third shift MA on 04/07/22 at 12:12pm revealed: -Her process for administering controlled substances was to pull the medication, sign her name on the CSCS, administer the medication and then sign the eMAR. -The number of controlled substance tablets on the medication cart should match the eMAR and the CSCS. -She counted Resident #2's Norco with the second shift MA, but she did not notice the count was off by 1 until after the second shift MA left the facility. -She did not report the number of Norco tablets on the medication cart did not match the CSCS to the RCC. Interview with the RCC on 04/07/22 at 4:53pm revealed she did not know there were discrepancies between the eMAR and Resident #2's CSCS for Norco or that the count for Norco, as of 04/07/22, was off because no MA had reported any discrepancies. Refer to interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm. Refer to interview with the Administrator on 04/07/22 at 6:08pm. 3. Review of Resident #1's current FL2 dated 03/14/22 revealed diagnoses included hypertension, type II diabetes mellitus, depression, history of stroke, and short term memory loss. Review of Resident #1's physician's orders revealed: -There was an electronic order dated 03/30/22 for	{D 392}		

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{D 392}	Continued From page 42	{D 392}		

lorazepam 0.5mg (used to treat anxiety and agitation) take (½) to 1 tablet twice daily as needed (prn).
-There was an order dated 04/05/22 for lorazepam 0.5mg one tablet twice a day.

Review of Resident #1's April 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg (used to treat anxiety and agitation) ½ to 1 tablet twice daily as needed (prn) from 04/01/22 to 04/06/22 (discontinued).
-Lorazepam 0.5mg one tablet was documented as administered prn on 04/01/22, on 04/03/22, on 04/04/22, on 04/05/22, and on 04/06/22.
-There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm.
-Lorazepam 0.5mg twice a day was documented as administered scheduled on 04/06/22 at 8:00am and 8:00pm, and on 04/07/22 at 8:00am.

Review of Resident #1's handwritten CSCS dated 03/30/22 revealed:
-There was a beginning balance of 57 lorazepam 0.5mg tablets.
-There was 1 tablet of lorazepam 0.5mg signed out on 04/01/22 at 11:48am, on 04/03/22 at 3:40pm, on 04/04/22 at 2:36pm one tablet was wasted, on 04/04/22 at 2:38pm, on 04/05/22 at 11:26am, and on 04/06/22 at 8:30am leaving a balance of 52 tablets.
-On 04/06/22 at 8:00am and 04/07/22 at 8:00am, lorazepam 0.5mg not signed out on the CSCS and documented as administered on the April 2022 eMAR.

Observation of medications available for Resident #1 on 04/07/22 at 3:50pm revealed there were 50 tablets of lorazepam 0.5mg available for

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{D 392}	Continued From page 43 administration for Resident #1. Interview with a first shift medication aide (MA) on 04/07/22 at 3:00pm revealed: -All MAs were responsible for making sure that controlled substances matched the CSCS. -The MAs counted and signed off that the counts were correct at the beginning of each shift. -Resident #1's lorazepam 0.5mg was in a bottle dispensed from a pharmacy other than the facility's contracted pharmacy. -There was no counting tray or easy way to count loose tablets in a bottle, so she assumed the count was correct. -She signed off that Resident #1's controlled substance count and the CSCS were accurate, but she did not actually count the tablets in the bottle and did not know the tablet count for lorazepam 0.5mg was off by 1. -She had not signed out on the CSCS for the lorazepam 0.5mg she administered this morning to Resident #1. -She knew she was supposed to sign out on the CSCS at the time she prepared the medication for administration according to the facility policy. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm. Refer to interview with the Administrator on 04/07/22 at 6:08pm. _____ Interview with the Resident Care Coordinator (RCC) on 04/07/22 at 4:53pm revealed: -When administering controlled substances, MAs were to pop the pill from the bubble pack, sign the	{D 392}		

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{D 392}	Continued From page 44 pill out on the CSCS, administer the pill to the resident and watch the resident take it, and then click administered on the eMAR. -The MA on each shift was supposed to count off each controlled substance on the medication cart with the oncoming MA to ensure the pill count matched the number on the CSCS. -If the count on the CSCS did not match the number of pills in the medication bubble cards, the oncoming MA should not have taken the keys to the medication cart. -If the controlled substances counts were off, the MA should have told her, and if she was not in the facility, MAs were to call her to let her know. -She was responsible for reviewing the CSCS, but she had not compared the CSCS to the eMAR to ensure an accurate accounting of the controlled substances. Interview with the Administrator on 04/07/22 at 4:53pm revealed: -He expected MAs to pull the medication, deduct the number of tablets pulled from the CSCS, administer the medication, and then document administration on eMAR. -The CSCS should match the number of tablets available on the medication cart. -The RCC was responsible for reviewing the CSCS, but he did not know how often. -He did not know about any discrepancies between the medication available for residents, the CSCS, and the eMAR. -If there were any discrepancies with controlled substances, the MAs should report the discrepancies to the RCC.	{D 392}		
{D 612}	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)	{D 612}		

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{D 612}	Continued From page 45 10A NCAC 13F .1801 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 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 established 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 residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and the proper use of source control. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) during the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP.	{D 612}		

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{D 612}	Continued From page 46 -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCP. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting facemasks to cover a person's mouth and nose. -Cloth masks were not considered PPE and should not be worn by staff. Review of the facility's Infection Prevention and Control policy dated 10/26/20 revealed: -The facility followed federal CDC guidelines as a part of their Infection Prevention and Control program. -Staff were to comply with standard and transmission-based precautions for respiratory hygiene. Observation upon entering the facility on 04/05/22 from 9:27am to 9:36am revealed: -There was a visitor putting out phones who was not wearing a mask. -The Resident Care Coordinator (RCC) was not wearing a mask. -There were no signs on the entrance door about wearing a mask. -The Business Office Manager (BOM) was not wearing a mask.	{D 612}		

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{D 612}	Continued From page 47 Interview with the Resident Care Coordinator (RCC) on 04/05/22 at 9:27am revealed that facility staff did not have to wear masks or check-in anymore. Interview with a medication aide (MA) on 04/05/22 at 9:39am revealed: -She wore her mask in order to protect herself. -She did not recall when staff were told that they did not have to wear a mask. Observation on 04/05/22 at 9:50am revealed that two staff members standing next to a medication cart in the hallway were not wearing masks. Observation on 04/05/22 at 10:57am revealed that the Administrator was not wearing a mask in the hallway. Observation on 04/05/22 at 11:14am revealed that a MA who was not wearing a mask administered medication to a resident in the resident's room. Interview with a resident on 04/05/22 at 2:36pm revealed: -Staff stopped wearing masks a couple of weeks ago. -It seemed like the staff were given an option to wear a mask. -The residents were not told why staff were not wearing masks. Interview with a second resident on 04/05/22 at 2:48pm revealed: -Staff stopped wearing masks a few weeks ago. -Some staff wore masks, but others did not. -The residents were not told why staff were not wearing masks.	{D 612}		

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{D 612}	Continued From page 48 Interview with the Activity Director on 04/05/22 at 3:14pm revealed there was an e-mail sent out by the Administrator about a month ago saying that staff did not have to wear masks. Review of an e-mail chain dated from 03/03/22 to 03/07/22 revealed: -The North Carolina Department of Labor (NCDOL) repealed the COVID-19 Emergency Temporary Standard (ETS) on 03/04/22. -The Administrator sent an email to all staff on 03/07/22 saying no more masks were required unless the facility had a positive COVID-19 case in the building. Interview with the Administrator on 04/05/22 at 3:23pm revealed: -He was not aware that staff were still required to wear masks. -He thought that the announcement by the NCDOL meant that staff were no longer required to wear masks. -He was not aware of any other guidance for wearing masks. -He thought that staff only had to wear masks for positive COVID-19 cases in the facility. -He had not received any recent guidance from the NCDHHS. -Neither staff nor residents had any recent cases of COVID-19. -The facility was not routinely testing for COVID-19.	{D 612}		
{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	{D912}		

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{D912}	Continued From page 49 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 health care and medication administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 5 residents sampled (#1 and #2) related to episodes of elopement and self injurious behaviors (#1) and a missed appointment and medication refusals (#2).[Refer to Tag 0273 10A NCAC 13F. 0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 7 residents (#2 and #6) observed during the medication pass including errors with insulin (#2) and a medication to treat ulcers (#6); and for 2 of 5 residents (#1 and #2) sampled for record review including errors with checking fingerstick blood sugar (FSBS) and administering insulin (#1 and #2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	{D912}		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		

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THE BRADFORD VILLAGE OF KERNERSVILLE	602 PINEY GROVE ROAD KERNERSVILLE, NC 27284

(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
D935	Continued From page 50 G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034069	A. BUILDING: _____ B. WING _____	R 04/07/2022

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D935	Continued From page 51 accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) who administered medications completed the state approved 5, 10 or 15 hour medication aide training course or had verification of prior employment as a medication aide within the previous 24 months. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 11/14/21. -Staff A passed the written MA exam on 10/19/04. -Staff A completed the Medication Administration Clinical Skills Validation Checklist on 12/01/21. -There was no documentation of completion of a 5, 10 or 15 hour MA training course. -There was no documentation of employment verifications for Staff A. Review of residents' February 2022 electronic medication administration record (eMAR) revealed there was documentation Staff A administered medications for 15 days from 02/08/22 to 02/28/22. Review of residents' March 2022 eMAR revealed there was documentation Staff A administered medications 17 days from 3/2/22 to 03/31/22. Review of residents' April 2022 eMAR revealed there was documentation Staff A administered medications on 04/01/22 and on 04/04/22. Interview with Staff A on 03/07/22 at 5:24pm revealed:	D935		

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D935	Continued From page 52 -She was hired at the facility in November 2021 as a MA and administered medications to residents. -She did not remember completing the 5, 10 or 15 hour MA training at the facility. -She did not remember if she completed the 5, 10 or the 15 hour training at another facility, but she had worked as a MA since 1994. Interview with the Business Office Manager (BOM) on 04/07/22 at 5:54pm revealed: -She was responsible for ensuring staff completed the 5, 10 or 15 hour MA training and filing the documentation of the training in the personnel record. -She did not know Staff A did not have documentation of her 5, 10 or 15 hour MA training in her personnel record. -She started working as BOM in November of 2021 and she had not had a chance to audit all personnel records to ensure all required trainings were completed including the 5, 10 or 15 hours of MA training. Interview with the Administrator on 04/07/22 at 6:08pm revealed: -The BOM was responsible for maintaining staff personnel records and ensuring required trainings were completed. -He did not know Staff A did not have documentation of having completed the 5, 10 or 15 hour MA training.	D935		