STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018036	A. BUILDING: _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

(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 and the Catawba County DSS conducted an annual and follow-up survey on 04/20/22 to 04/22/22.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 6 sampled staff (Staff B and E) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff B's, medication aide (MA) personnel record revealed: -Staff B was hired on 01/19/22. -She was full-time staff. -There was no documentation a HCPR was completed prior to hire. Review of Staff B's HCPR check dated 04/22/22 revealed there were no substantiated findings. Telephone interview on 04/22/22 at 3:45pm revealed: -She had worked at the facility as a MA. -She could not remember if the facility staff completed a HCPR.	D 137		

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D 137	Continued From page 1 Refer to the interview with the Special Care Director (SCD) on 04/20/22 at 4:11pm. Refer to interview with the Business Office Manager (BOM) on 04/22/22 at 3:33pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/22/22 at 3:45pm. Refer to interview with Administrator 04/22/22 at 3:35pm. 2. Review of Staff E's, MA, personnel record revealed: -There was no record of the date of hire at the agency or at the facility. -He was an agency staff member. -There was no documentation a HCPR check was completed upon hire. -There was no documentation provided by the staffing agency a HCPR check had been completed prior to 04/22/22. Review of Staff E's HCPR check dated 04/22/22 revealed there were no substantiated findings. Refer to interview with the Special Care Director (SCD) on 04/20/22 at 4:11pm. Refer to interview with the Business Office Manager (BOM) on 04/22/22 at 3:33pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/22/22 at 3:45pm. Refer to interview with Administrator 04/22/22 at 3:35pm. Attempted telephone interview with Staff E on	D 137		

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D 137	Continued From page 2 04/22/22 at 3:40pm was unsuccessful. _____ Interview with the SCD on 04/20/22 at 4:11pm revealed: -She was the current scheduler for staff in the facility. -She was the liaison between the facility and the staffing agencies. -She created a template each month and determined the days and shifts she would need to supplement with agency staff. -She worked with 5 different agencies for staffing to fill the staffing needs. -She was not responsible for documentation of staff qualifications. -She would orient the agency staff to the community if she was in the building during their shift and assign them a MA as a mentor. -She did not review the HCPR for agency staff. Interview with the BOM on 04/22/22 at 3:33pm revealed: -She was responsible for putting the pre-employment packet together which included the HCPR and bring it to the RCC for processing. -She was not aware she needed to have proof of the HCPR for the agency MAs. Interview with the RCC on 04/22/22 at 3:45pm revealed: -The BOM was responsible for giving her the MA staff records for processing including the HCPR verification. -She was not aware the staff needed the HCPR verification upon hire. -There were no agency staff records located in the facility because the agency maintained all of those records. -She was not aware she needed the same documentation required for regular facility staff as	D 137		

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D 137	Continued From page 3 the agency staff. Interview with the Administrator on 04/22/22 at 3:35pm revealed: -The BOM was responsible for giving the staff records to the RCC. -The BOM was responsible for collecting agency staff records from the agency upon hire. -She did not know the agency had to provide HCPR verification to the facility upon hire.	D 137		
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.	D 164		

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D 164	Continued From page 4	D 164		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 6 of 6 sampled medication aides (Staff A, B, C, D, E, and F), who obtained fingerstick blood sugars (FSBS) for residents, completed training on the care of diabetic residents.

The findings are:

1. Review of Staff A's, medication aide (MA) personnel record revealed:
-Staff A was hired on 02/24/22.
-She was full-time staff.
-There was no documentation she completed the training on the care of diabetic residents.

Review of a diabetic resident's February 2022 eMAR revealed Staff A did not check a FSBS and administered insulin 02/01/22-02/28/22.

Review of a diabetic resident's March 2022 eMAR revealed Staff A checked FSBS and administered insulin 1 time from 03/01/22-03/31/22.

Review of a diabetic resident's April 2022 eMAR revealed Staff A checked FSBS and administered insulin 6 times from 04/10/22-04/20/22.

Attempted telephone interview on 04/22/22 at 3:41pm was unsuccessful.

Refer to interview with the Special Care Director (SCD) on 04/20/22 at 4:11pm.

Refer to interview with the Business Office

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D 164	Continued From page 5	D 164		

Manager (BOM) on 04/22/22 at 3:33pm.

Refer to interview with the Resident Care Coordinator (RCC) on 04/22/22 at 3:45pm.

Refer to interview with the Administrator on 04/22/22 at 3:35pm.

2. Review of Staff B's, medication aide (MA) personnel record revealed:
-Staff B was hired on 01/19/22.
-She was full-time staff.
-There was no documentation she completed the training on the care of diabetic residents.

Review of a diabetic resident's February 2022 eMAR revealed Staff B checked a FSBS but did not administer insulin 02/01/22-02/28/22.

Review of a diabetic resident's March 2022 eMAR revealed Staff B did not check a FSBS or administered insulin from 03/01/22-03/31/22.

Review of a diabetic resident's April 2022 eMAR revealed Staff B did not check a FSBS or administered insulin from 04/10/22-04/20/22.

Telephone interview on 04/22/22 at 3:45pm revealed:
-She had worked at the facility as a MA and had administered insulin and checked FSBS.
-She did not receive any diabetic training at the facility.

Refer to interview with the SCD on 04/20/22 at 4:11pm.

Refer to interview with the BOM on 04/22/22 at 3:33pm.

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D 164	Continued From page 6 Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 3. Review of Staff C's, medication aide (MA) personnel record revealed: -Staff C was hired on 03/03/22. -She was full-time staff. -There was no documentation she completed the training on the care of diabetic residents. Review of a diabetic resident's February 2022 eMAR revealed Staff C did not check a FSBS and did not administer insulin 02/01/22-02/28/22. Review of a diabetic resident's March 2022 eMAR revealed Staff C did not check a FSBS or administered insulin from 03/01/22-03/31/22. Review of a diabetic resident's April 2022 eMAR revealed Staff C checked a FSBS and administered insulin 1 time from 04/10/22-04/20/22. Telephone interview with Staff C on 04/22/22 at 3:30pm revealed: -She was hired in March 2022. -She checked FSBS and administered insulin to residents at the facility. -She thought she had diabetic training from the facility, but was not sure. Refer to interview with the SCD on 04/20/22 at 4:11pm. Refer to interview with the BOM on 04/22/22 at 3:33pm.	D 164		

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D 164	Continued From page 7 Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 4. Review of Staff D's, MA, personnel record revealed: -There was no hire date provide by the agency or facility for Staff D. -There was no documentation Staff D completed training on the care of diabetic residents. Review of a diabetic resident's February 2022 eMAR revealed Staff D checked FSBS and administered insulin 14 times from 02/01/22-02/28/22. Review of a diabetic resident's March 2022 eMAR revealed Staff D checked FSBS and administered insulin 17 times from 03/01/22-03/31/22. Review of a diabetic resident's April 2022 eMAR revealed Staff D checked FSBS and administered insulin 9 times from 04/10/22-04/20/22. Interview with Staff D on 04/22/22 at 4:20pm revealed: -She was hired by the agency in 2019. -She worked at the facility since November 2021. -She checked FSBS and administered insulin to residents at the facility. -She thought she had diabetic training at the staffing agency, but was not sure. Refer to interview with the SCD on 04/20/22 at 4:11pm. Refer to interview with the BOM on 04/22/22 at 3:33pm.	D 164		

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D 164	Continued From page 8 Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 5. Review of Staff E's, MA, personnel record revealed: -There was no hire date provide by the agency or facility for Staff E. -There was no documentation Staff E completed training on the care of diabetic residents. Review of a diabetic resident's February 2022 eMAR revealed Staff E checked FSBS and administered insulin one time. Review of a diabetic resident's March 2022 eMAR revealed Staff E checked FSBS and administered insulin 5 times from 03/05/22-03/27/22. Attempted telephone interview with staff E on 04/22/22 at 3:07pm was unsuccessful. Refer to interview with the MCM on 04/20/22 at 4:11pm. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 6. Review of Staff F's, MA, personnel record revealed: -Her hire date was documented as 12/01/22.	D 164		

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D 164	Continued From page 9 -There was no documentation Staff F completed training on the care of diabetic residents. Review of a diabetic resident's March 2022 eMAR revealed Staff F checked FSBS and administered insulin 3 times from 03/12/22-03/20/22. Telephone interview with Staff F on 04/22/22 at 3:23pm revealed: -She had worked at the facility as a MA and had administered insulin and checked FSBS. -She did not receive any diabetic training at the facility. -She did not remember if she had diabetic training at the agency. Refer to interview with the MCM with the Memory Care Manager (MCM) on 04/20/22 at 4:11pm. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. _____ Interview with the SCD on 04/20/22 at 4:11pm revealed: -She was the current scheduler for staff in the facility. -She was the liaison between the facility and the staffing agencies. -She created a template each month and determined the days and shifts she would need to supplement with agency staff. -She worked with 5 different agencies for staffing. -She was not responsible for agency staff training or documentation of staff qualifications.	D 164		

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D 164	Continued From page 10 -She would orient the agency staff to the community if she was in the building during their shift and assign them a medication aide (MA) as a mentor. -She did not know who was responsible for obtaining agency staff qualifications. -She did not know of training agency staff received at the facility. Interview with the BOM on 04/22/22 at 3:33pm revealed: -She was responsible for putting the pre-employment packet together and to bring them to the RCC for processing. -She was not aware she needed to have proof of diabetic training for the agency MAs. Interview with the RCC on 04/22/22 at 3:45pm revealed: -The BOM was responsible for giving her the agency staff records. -She was not aware the agency MAs needed verification of diabetic training. -There were no agency staff records located in the facility because the agency maintained all of those records. -She was not aware she was required to have a personnel file with the same documentation required for agency staff as their facility staff. Interview with the Administrator on 04/22/22 at 3:35pm revealed: -The BOM was responsible for giving the staff records to the RCC. -The BOM was responsible for collecting agency staff records from the agency upon hire. -She did not know the agency had to provide verification of diabetic training for the MAs to the facility upon hire.	D 164		

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D 260	Continued From page 11	D 260		
D 260	10A NCAC 13F .0802(b) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the resident's care plan due to a change in condition for 1 out of 6 sampled residents (#1). The findings are: Review of Resident #1's current FL2 dated 02/24/22 revealed: -Diagnoses included dementia, . -The recommended level of care was the special care unit (SCU). Review of Resident #1's Resident Register revealed she was admitted to the SCU on 03/24/10. Observation of Resident #1 on 04/20/22 at 8:45am revealed: -She was wearing a left leg knee immobilizer and socks. -Her left lower leg was edematous including her foot and there was an indention from her socks. Review of Resident #1's Resident Profile revealed there was no Resident Profile. Review of Resident #1's current Care Plan dated 03/02/22 revealed:	D 260		

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-She was independent with transfers.
-She required supervision with eating.
-She required limited assistance with toileting.
-She required extensive assistance with bathing, dressing and grooming.
-There was no documentation of Resident #1's knee immobilizer.

Review of Resident #1's Emergency Room (ER) discharge dated 02/28/22 revealed:
-An Xray of Resident #1's left knee noted a left tibia plateau fracture.
-Discharge instructions included Resident #1 to maintain non-weight bearing to the left leg until seen by orthopedics.

Review of Resident #1's orthopedic provider's order dated 03/03/22 revealed Resident #1 was to maintain non-weight bearing to left leg.

Interview with the Resident Care Coordinator (RCC) on 04/22/22 at 11:25am revealed:
-The Health and Wellness Director (HWD) was responsible for completing the residents' care plans.
-The HWD position had been vacant since November 2021 and on 04/18/22 a new HWD started working at the facility.
-From November 2021, she was responsible for completing the care plans but she did not know a care plan was to be completed with in 10 days once a significant change happened.

Interview with the HWD on 04/22/22 at 11:45 revealed:
-The HWD was responsible for the Care Plan and was to be completed within 30 days of admission, within 10 days following a significant change in the resident's condition.
-The HWD position had been vacant since

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D 260	Continued From page 13 November 2021 and on 04/18/22 she started working at the facility. -She was informed by the Administrator the RCC was responsible for completion of the Care Plans after November 2021 until she started work at the facility. -She did not know the Care Plans were not completed correctly. Interview with the Administrator on 04/22/22 at 12:16pm revealed: -A nurse or the HWD was responsible for completion of the care plan with in 30 days of admission and with in 10 days of a significant change in a resident's condition. -After November 2021 the RCC was responsible for completion of the care plan with in 10 days of a significant change. -Since there was no HWD/Nurse at the facility, the RCC was responsible for contacting the Regional Nurse for guidance with completion of the care plans. -She was not aware the RCC did not contact the Regional Nurse for Resident #1 care plan and the change in condition.	D 260		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 270		

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D 270	Continued From page 14 Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' current symptoms for 1 of 5 sampled residents who was assigned to the Special Care Unit (SCU) that had a history of a fall requiring the resident to be non-weight bearing after a left tibia plateau fracture (the upper part of the shin involving the knee joint). The findings are: Review of the facility's undated Falls Policy, Communication and Follow up revealed: -There was no date on the policy. -A fall was defined as an unintentionally coming to rest on the ground, floor or other lower level surface. -If a resident was found on the floor, a fall was considered to have occurred. -When a fall was noted, the staff would contact the Nurse and available care managers. -The care manager would document in the resident's communication log the fall and any significant change noted. -The Health Wellness Director (HWD) who is a Nurse/designee will notify the physician after the resident was assessed and stable. -The HWD/designee will document the resident's status in the resident's 24-hour Communication Log. -The HWD/designee will communicate the event to all staff at the start of the next shifts. -The HWD/designee will complete an Incident/Accident Report. -The HWD will update the care plan with a Fall Intervention Plan. -The HWD will complete a Fall Management Program-Internal Investigation for Falls form. -The HWD will review the forms and make the	D 270		

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appropriate changes to the resident's assessment internally.
-The HWD will suggest the appropriate changes identified in the completion of the form to the resident or responsible party.

Review of Resident #1's current FL-2 dated 02/24/22 revealed:
-Diagnoses included vascular dementia, left femur fracture, hypertension, epilepsy, heart failure, and anemia.
-She was semi-ambulatory, and an assistive device was not indicated.

Review of Resident #1's Nursing Home Transfer/Discharge Summary dated 02/24/22 revealed:
-Resident #1 was discharged from a Nursing Home back to the facility.
-Diagnoses included status post-operative partial left hip replacement.
-Resident #1's level of care was the SCU.
-Continue with physical therapy (PT), monitor for signs of infection, deep vein thrombosis (DVT) or other complications.
-Assistance was needed for transfers for safety and to prevent falls.
-There were hip precautions to continue for 6 more weeks with assistance needed for clothing management below the knees and to avoid crossing legs.
-Resident #1 was diagnosed as a high risk for falls, fractures, and other complication due to dementia.
-Resident #1 was a high risk for complications and needed frequent follow-up with orthopedics and primary care provider to minimize complications and rehospitalization risk.

Review of Resident #1's care plan dated 03/02/22

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revealed:
-She required supervision with eating.
-She required limited assistance with toileting.
-She required extensive assistance with bathing, dressing and grooming.
-She was independent with transfers.

Observation of Resident #1 on 04/20/22 at 10:15am revealed:
-Resident #1 was lying in bed, wearing an incontinent brief.
-She was wearing a left leg knee immobilizer (used to prevent the left leg from bending) and socks.
-Her left lower leg was edematous including her foot and there was an indention from her socks.
-Her room was approximately 50 feet down the hall from the Nurses Station, around the corner and the second room on the right.
-There was no direct visualization of the room from the Nurses station, main hallway, dining room or day room.

a. There was no significant change to the care plan after Resident #1's left tibia plateau fracture on 02/28/22.

There was no Incident/Accident Report dated 02/28/22 documenting a fall.

Review of Resident #1's Resident's Care Notes dated 02/28/22 revealed:
-Resident #1 was in severe pain, could not walk, barely stand or move.
-Resident #1 received an Xray earlier in the day.
-Resident #1's family member requested Resident #1 was transported to the ER for evaluation.
-Resident #1 was transported to the ER at 8:30pm.

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D 270	Continued From page 17 Review of the Emergency Room (ER) visit discharge summary dated 02/28/22 revealed: -Resident #1 was diagnosed with a fracture of the left tibia plateau (the upper part of the shin involving the knee joint). -Resident #1 was to not bear any weight on the left leg until evaluated by orthopedics. -Follow-up with orthopedics. -A referral was initiated on 02/28/22 for orthopedics follow-up. -A knee immobilizer was placed on Resident #1's left leg. Review of Resident #1's Resident Care Notes dated 03/01/22 revealed: -Resident #1 was diagnosed with a fracture of the left tibia plateau. -Resident #1 was to not bear any weight on the left leg until evaluated by orthopedics. -An agency medication aide (MA) notified the Resident Care Coordinator (RCC) that Resident #1 fell on 02/28/22 at 5:45am. -On 02/28/22, the MA found Resident #1 on the floor, lying on her back at the bathroom door and Resident #1's left leg was under the dresser. Review of Resident #1's Orthopedic follow-up visit notes dated 03/03/22 revealed: -She was diagnosed with a left tibia plateau fracture on 02/28/22. -Resident #1 was considered an extremely poor surgical candidate so continue treatment for the left tibia plateau fracture using the knee immobilizer and strict non-weight bearing to the left leg. Review of Resident #1's orthopedic specialist orders dated 03/03/22 revealed: -There was an order for a knee immobilizer to the	D 270		

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left leg and daily neurovascular and skin checks.
-There was an order to keep a close eye/checks on skin to include posterior thigh and distal leg (the back and lower part of the leg).
-There was an order for strict non-weight bearing to the left leg.

Interview with the Special Care Director (SCD) on 04/20/22 at 9:25am revealed:
-The staff were to check on Resident #1 every hour.
-She was not aware of how often the staff were checking on Resident #1 because the staff did not document the increased safety checks and she did not check to see how often the staff were completing the safety checks.

Interview with the Special Care Coordinator (SCC) on 04/20/22 at 9:30am revealed the staff were to check on Resident #1 as often as possible.

Refer to interview with a SCD on 04/20/22 at 9:25am.

Refer to interview with the SCC on 04/20/22 at 9:30am.

Refer to interview with the RCC on 04/20/22 at 12:11pm.

Refer to interview with the Health Wellness Director (HWD) on 04/20/22 at 12:17pm.

Refer to interview with a medication aide (MA) on 04/22/22 at 11:36am.

Refer to interview with a personal care aide (PCA) on 04/22/23 at 1:12pm.

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D 270	Continued From page 19 Refer to interview with a second PCA on 04/22/22 at 1:26pm. Refer to telephone interview with Resident #1's primary care physician (PCP) on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm. Refer to interview with the Administrator on 04/22/22 at 12:16pm. b. Review of Resident #1's Incident/Accident Report dated 03/07/22 at 10:55am revealed: -Resident #1 was found sitting on the floor. -There were no injuries documented. -There were no interventions documented to prevent future falls or increased checks. Review of Resident #1's Resident Care Notes dated 03/07/22 revealed there was no documentation of incidents/accidents. Refer to interview with a SCD on 04/20/22 at 9:25am. Refer to interview with the SCC on 04/20/22 at 9:30am. Refer to interview with the RCC on 04/20/22 at 12:11pm. Refer to interview with the HWD on 04/20/22 at 12:17pm. Refer to interview with a MA on 04/22/22 at 11:36am. Refer to interview with a PCA on 04/22/23 at	D 270		

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D 270	Continued From page 20 1:12pm. Refer to interview with a second PCA on 04/22/22 at 1:26pm. Refer to telephone interview with Resident #1's PCP on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm. Refer to interview with the Administrator on 04/22/22 at 12:16pm. c. Review of Resident #1's Incident/Accident Report dated 03/28/22 at 6:32am revealed: -Resident #1 was found sitting on the floor. -There were no injuries documented. -There were no interventions documented to prevent future falls or increased checks. Review of Resident #1's Resident Care Notes dated 03/28/22 revealed there was no documentation of incidents/accidents. Review of Resident #1's orthopedics physician orders dated 03/31/22 revealed: -There was an order for daily skin checks under knee immobilizer. -There was an order for strict non-weight bearing to the left leg. Refer to interview with a SCD on 04/20/22 at 9:25am. Refer to interview with the SCC on 04/20/22 at 9:30am. Refer to interview with the RCC on 04/20/22 at 12:11pm.	D 270		

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D 270	Continued From page 21 Refer to interview with the HWD on 04/20/22 at 12:17pm. Refer to interview with a MA on 04/22/22 at 11:36am. Refer to interview with a PCA on 04/22/23 at 1:12pm. Refer to interview with a second PCA on 04/22/22 at 1:26pm. Refer to telephone interview with Resident #1's PCP on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm. Refer to interview with the Administrator on 04/22/22 at 12:16pm. d. Review of Resident #1's Incident/Accident Report dated 04/06/22 at 4:25pm revealed: -Resident #1 was found sitting on the floor. -There were no injuries documented. -There were no interventions documented to prevent future falls or increased checks. Review of Resident #1's Resident Care Notes revealed on 04/06/22, there was no time stamp documented, the personal care aide (PCA) noticed Resident #1's left foot was swollen, edematous, bruised and PCA notified RCC. Refer to interview with a SCD on 04/20/22 at 9:25am. Refer to interview with the SCC on 04/20/22 at 9:30am.	D 270		

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D 270	Continued From page 22 Refer to interview with the RCC on 04/20/22 at 12:11pm. Refer to interview with the HWD on 04/20/22 at 12:17pm. Refer to interview with a MA on 04/22/22 at 11:36am. Refer to interview with a PCA on 04/22/23 at 1:12pm. Refer to interview with a second PCA on 04/22/22 at 1:26pm. Refer to telephone interview with Resident #1's PCP on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm. Refer to interview with the Administrator on 04/22/22 at 12:16pm. e. Review of Resident #1's Incident/Accident Report dated 04/15/22 at 2:40am revealed: -Resident #1 was found lying on the floor. -Bruises were documented to Resident #1's back, both arms and right hip. -Resident #1 complained of left leg pain. -There were no interventions documented to prevent future falls or increased checks. Review of Resident #1's Resident Care Notes revealed; -On 04/15/22, at 2:40am, Resident #1 rolled out of the bed and is ok. -On 04/17/22, at 12:00pm, Resident #1 complained of right-hand pain and there were no	D 270		

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D 270	Continued From page 23 visible signs of injury. -On 04/18/22, at 9:00am, staff observed Resident #1's right hand was swollen and bruised around the last 2 fingers and palm of hand. -On 04/18/22, an Xray was taken of Resident #1's right hand and revealed an acute fracture of the fifth proximal phalanx (a fracture of the pinky finger). Review of Resident #1's Right hand Xray dated 04/18/22 revealed an acute fracture of the fifth proximal phalanx. Refer to interview with a SCD on 04/20/22 at 9:25am. Refer to interview with the SCC on 04/20/22 at 9:30am. Refer to interview with the RCC on 04/20/22 at 12:11pm. Refer to interview with the HWD on 04/20/22 at 12:17pm. Refer to interview with a MA on 04/22/22 at 11:36am. Refer to interview with a PCA on 04/22/23 at 1:12pm. Refer to interview with a second PCA on 04/22/22 at 1:26pm. Refer to telephone interview with Resident #1's PCP on 04/21/22 at 8:47am. Refer to telephone interview with Resident #1's orthopedic specialist on 04/21/22 at 3:41pm.	D 270		

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D 270	Continued From page 24 Refer to interview with the Administrator on 04/22/22 at 12:16pm. _____ Interview with a SCD on 04/20/22 at 9:25am revealed: -She considered Resident #1 a fall risk because in February 2022 Resident #1 fell and broke her left hip. -Resident #1 returned from rehab the end of February 2022 and fell fracturing her left leg. -After the second fall, Resident #1 was considered non-weight bearing on her left leg. -Resident #1 fell a couple more times after that because Resident #1 could not remember to ask for assistance and would get up on her own and fall. -Resident #1 developed a DVT in the left lower leg and fell a few more times causing injury to her left foot and a fracture to her right hand. -The staff were to check on Resident #1 every hour because of Resident #1's injury to her left leg. -After a fall, the staff were to complete an incident/accident report, document the fall and injuries in the 24-hour book, report it to her, the SCD, or to the Resident Care Coordinator (RCC). -There was no direction from the RCC on how often to complete safety check of Resident #1 after every fall. -There were no fall management recommendations initiated after each fall. Interview with the SCC on 04/20/22 at 9:30am revealed: -Resident #1 fell about 4-5 times since February 2022 after coming back from rehab with a left hip replacement after one of the falls. -After a fall, the staff were to complete an incident/accident report, document the fall and	D 270		

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injuries in the 24-hour book, report it to her, the SCD, or to the RCC.
-The Nurse, who was a Registered Nurse (RN) was to review the incident/accident reports and make recommendations according to the Fall Management Policy.
-There was not a Nurse in the facility since November 2021, so she did not know who was responsible for making the recommendations.
-The recommendations were for fall mats, non-skid socks, and increased supervision up to 1 on 1 supervision and she did not ask for those interventions.
-The normal safety checks were every 2 hours in the Special Care Unit (SCU).
-Resident #1 was considered a high fall risk because Resident #1 forgot what she was told, and because she was non-weight bearing due to left leg fracture and DVT.
-There were no fall management recommendations initiated after each of Resident #1's falls and staff were to check on Resident #1 as often as possible.

Interview with the Resident Care Coordinator (RCC) on 04/20/22 at 12:11pm revealed:
-The HWD who was a RN and began work on 04/20/22.
-The HWD was responsible for reviewing the incident/accident reports and made recommendations of what to do in the case of a resident who had more than one fall.
-When a fall happened, it was the responsibility of the MA to notify her and she would assist in completing the report.
-The MA was responsible for documenting the falls, injuries and procedures put in place such as increased supervision in the 24-hour book located in her office.
-The MA was to notify the SCC, SCD, HWD or

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her after a resident fell.
-After the incident/accident report was completed, it was the responsibility of the HWD to initiate the fall management program which included recommendations of fall mats, non-skid socks and increased supervision.
-Since the nurse or HWD position was vacant at the facility, she received all the incident/accident reports and would call the Regional Nurse for recommendations.
-She did not know why she did not contact the Regional Nurse for recommendations.
-The staff were to complete frequent checks every 15- 30 minutes on Resident #1.
-She did not know why the facility did not move Resident #1 closer to the Nurse's Station.
-On 04/19/22, she and the Administrator talked about Resident #1 needing a higher level of care, but nothing was put into motion.
-She could have called home health and inquired about other interventions to assist with recommendations for Resident #1, but she did not and did not know why.
-There should have been a care conference with the Administrator, SCD and herself after Resident #1 came back to the facility on 02/24/22 to discuss interventions to help prevent falls and increased supervision because of Resident #1's dementia, but there was not one.

Interview with the HWD on 04/20/22 at 12:17 revealed:
-On 04/18/22, she began orientation at the facility.
-It was the responsibility of the MA to fill out the incident/accident report and submit it to her or the RCC.
-If the incident report was related to a fall the RCC and she would discuss the incident and recommendations in the next stand up meeting with the staff.

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D 270	Continued From page 27 -She was responsible for recommendations such as, fall mat, gripper socks, physical therapy suggestion to the physician and increased supervision/safety checks. -It was her responsibility to review the incident/accident reports and implement the fall management program but since the position was vacant at the facility until now it would have been the responsibility of the RCC to review the incident/accident reports and contact the Regional Nurse for recommendations. -Since Resident #1's dementia was at the point she could not remember to not stand up on a broken leg, Resident #1 could have used the 1:1 supervision. -After the first fall the Regional Nurse should have implemented a fall mat and gripper socks to help prevent falls as well as increased supervision from every 2 hours to every 15 minutes, 30 minutes or 1-hour safety checks. -She was not aware of any increased supervision in place for Resident #1. Interview with a MA on 04/22/22 at 11:36am revealed: -She witnessed Resident #1 on 2 occasions in the past 2 weeks, out of her bed and standing by her dresser which was 5-6 feet away. -Resident #1 was known to have fallen frequently. -Staff were constantly redirecting Resident #1 to sit back down in her chair or lay back down in her bed. -She had not been instructed to increase frequency of supervision or to document any increased supervision. -Resident #1 sustained no immediate visible injuries with each fall within 1 to 2 days after each fall. -She was informed about the falls and injuries from report from the last shift MA.	D 270		

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D 270	Continued From page 28 -There were no instructions from the RCC, SCC, SCD or the Administrator related to increased supervision. -She tried to check in on Resident #1 every 30 minutes to an hour if she could. -Resident #1 could not remember to ask for assistance. -All the falls reported to her were Resident #1 was found on the floor, never witnessed how she got there. -Resident #1 was a two person assist because of the non-weight bearing on the left leg. Interview with a PCA on 04/22/23 at 1:12pm revealed: -Resident #1 needed constant reminders to stay off her leg, stay in the chair or bed and do not get up without assistance. -She found Resident #1 up and out of her bed or chair when she was to be non-weight bearing and at risk for falls. -Resident #1's dementia made it hard for her to remember to not get up without assistance. -She had not been instructed to increase frequency of supervision or to document any increased supervision. Interview with a second PCA on 04/22/22 at 1:26pm revealed: -Resident #1 would not stay in her chair or bed and she would find her standing in her room without staff present. -Resident #1 could not remember what to do. -Resident #1 fell many times and sustained many injuries. -The normal checks on the residents were every 2 hours. -She was not instructed to increase supervision on Resident #1. -There was not the implementation of a fall mat,	D 270		

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non-skid socks, or increased supervision for Resident #1.

Telephone interview with Resident #1's PCP on 04/21/22 at 8:47am revealed:
-On 02/07/22, Resident #1 received a partial left hip replacement due to a fall.
-On 02/28/22, the physical therapy assistant called reporting Resident #1 could not straighten her left leg and was in a lot of pain.
-Resident #1 was most recently seen on 03/08/22.
-On 03/09/22 and 03/28/22 he received a fax from the facility Resident #1 fell and there were no injuries.
-On 04/06/22, the on-call physician received a call from the facility Resident #1 fell and there were no injuries.
-On 04/18/22, he received a fax from the facility Resident #1 fell and sustained bruises and an Xray of Resident #1 right hand was requested.
-Resident #1 was at risk for falls due to dementia which caused her to not remember minutes after direction/instructions were provided and an even greater risk for falls since Resident #1 broke her leg on 02/28/22 and was non-weight bearing on her left leg.
-It was the facility's responsibility to call and inform him of the falls as soon as they happened, and the type of injuries for him to make appropriate and informative decisions about the care of Resident #1.
-Due to Resident #1's dementia, and the partial left hip replacement, left leg fracture, and the non-weight bearing on the left leg, Resident #1 required increased supervision of at least every 15 minutes to even 1:1 supervision to decrease the amount of falls and injuries.

Telephone interview with Resident #1's

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orthopedic specialist on 04/21/22 at 3:41pm revealed:
-On 02/07/22, Resident #1 received a partial left hip replacement due to a fall.
-On 02/28/22, an Xray indicated a left tibial plateau fracture after a fall.
-On 04/08/22, a venous doppler ultrasound indicated a blood clot in Resident #1's left leg.
-On 04/18/22, a right hand Xray indicated a fracture of the pinky finger after a fall.
-There were 3 falls reported between 02/28/22 and 04/18/22.
-On 03/03/22, he saw Resident #1 in his office for a follow-up appointment related to the left leg tibia plateau fracture and informed the staff member present, the importance of Resident #1 maintaining non-weight bearing on the left leg, because of Resident #1's dementia and lack of remembering instructions, the staff must keep an eye on Resident #1, every 15 minutes to 1:1 if necessary to help prevent more falls, more injuries and dislodgement of the blood clot in her left leg.
-He considered Resident #1 an increased fall risk leading to more injuries after returning to the facility on 02/24/22 from her partial left hip replacement, and more of an increased fall risk with injuries requiring more supervision on 02/28/22 because of Resident #1's dementia, strict non-weight bearing of her left leg, and increased risk of fall leading to dislodgement and causing vascular compromise (partial or complete interruption of the blood flow).

Interview with the Administrator on 04/22/22 at 12:16pm revealed:
-The required safety checks in the SCU were every 2 hours and were to be increased based on a resident's care needs.
-An incident/accident report was to be completed

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after every fall and given to the RCC.
-It was the responsibility of the HWD to review all incident/accident reports and implement a fall management program and after every fall, make recommendations such as; a fall mat, non-skid socks, increase the supervision of the resident based on their care needs and/or notification to the physician and ask for physical therapy.
-The HWD did not require an order for fall mats, non-skid socks or increased supervision.
-Since the facility did not have an HWD on duty, the RCC was responsible for receiving the incident/accident reports and notifying the Regional Nurse for assistance in implementation of the fall management program and recommendations.
-Based on Resident #1's fall history, injuries such as a hip fracture, left leg fracture, right hand fracture, a blood clot in the left leg and Resident #1's dementia causing Resident #1 to forget instruction within 1-2 minutes after being told, she expected the staff to be checking on Resident #1 every 15 to 30 minutes up to even 1:1 supervision.
-She did not check to ensure the increased supervision was implemented because the RCC did not inform her of any concerns.
-She was not aware the fall management program was not implemented.

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

_____

The facility failed to provide supervision in accordance with the resident's current symptoms for 1 of 5 sampled residents (#1) who after returning from rehab with a partial left hip placement, fell 5 more times in 53 days resulting in a left tibia plateau fracture, a fractured right

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D 270	Continued From page 32 hand and the risk of dislodgment of the blood clot in her left leg. This failure resulted in serious physical harm and neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on April 20, 2022 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 22, 2022.	D 270		
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 interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 5 sampled residents (#3, and #6) related to a fasting blood sugar (FSBS) greater than 400 (#6) and missed doses of a blood thinner medication and mood stabilizer (#3). The findings are: 1. Review of Resident #6's FL2 dated 01/24/22 revealed diagnoses including type II diabetes mellitus Review of a physician's order for Resident #6	D 273		

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dated 03/16/22 revealed to monitor FSBS before meals and at bedtime, and to notify physician if the FSBS were less than 120 or greater than 400.

Review of Resident #6's March 2022 electronic Medication Administration Records (eMAR) revealed:
-There was an entry to monitor FSBS before meals and at bedtime and to notify provider if blood sugar less than 120 or greater than 400 documented at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-FSBS were documented on 03/16/22, at 4:30pm as 408, 03/18/22, at 4:30pm as 407, 03/19/22, at 4:30pm as 438, 03/20/22, at 4:30pm as 488, 03/20/22, at 8:00pm as 495, 03/21/22, at 11:30am as 446, 03/22/22, at 11:30am as 426, 03/22/22, at 4:30pm as 426, 03/23/22, at 11:30am as 416, 03/24/22, at 4:30pm as 416, 03/24/22, at 8:00pm as 529, 03/26/22, at 7:30am as 410, 03/26/22, at 11:30am as 419, 03/26/22, at 4:30pm as 490, 03/26/22, at 8:00pm as 571, 03/27/22, at 4:30pm as 432, 03/27/22, at 8:00pm as 445, 03/28/22, at 11:30am as 436, 03/29/22, at 4:30pm as 457, 03/29/22, at 8:00pm as 491, 03/30/22, at 7:30am as 436, and 03/30/22, at 4:30pm as 505.
-There was no documentation on the exception note page the physician was notified when the FSBS was greater than 400.

Review of Resident #6's April 2022 eMAR revealed:
-There was an entry to monitor FSBS before meals and at bedtime and to notify provider if blood sugar less than 120 or greater than 400 documented at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-FSBS were documented on 04/1/22 at 4:30pm as 461, 04/1/22 at 8:00pm as 472, 04/2/22 at

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7:30am as 493, 04/3/22 at 11:30am as 466, 04/3/22 at 8:00pm as 435, 04/4/22 at 11:30am as 427, 04/6/22 at 8:00pm as 455, 04/7/22 at 4:30pm as 431, 04/9/22 at 4:30pm as 453, 04/13/22 at 11:30am as 402, 04/14/22 at 7:30am as 451, 04/15/22 at 8:00pm as 480, 04/16/22 at 8:00pm as 537, 04/17/22 at 8:00pm as 416, 04/18/22 at 8:00pm as 407, and 04/19/22 at 8:00pm as 421.
-There was no documentation on the exception note page the physician was notified when the FSBS was greater than 400.

Review of progress notes for Resident #6 revealed there was no documentation the physician was notified about the elevated FSBS greater than 400 on 03/16/22, 03/18/22, 03/19/22, 03/20/22, 03/21/22, 03/22/22, 03/23/22, 03/24/22, 03/26/22, 03/27/22, 03/28/22, 03/29/22, 03/30/22, 04/1/22, 04/2/22, 04/3/22, 04/4/22, 04/6/22, 04/7/22, 04/9/22, 04/13/22, 04/14/22, 04/15/22, 04/16/22, 04/17/22, 04/18/22, or 04/19/22.

Interview with Resident Care Coordinator (RCC) on 4/21/22 at 11:30am revealed:
-It was the responsibility of the MA to notify the physician when a FSBS was greater than 400.
-It was the responsibility of the MA to document the greater than 400 FSBS and the notification to the physician in the 24-hour log.
-She was not aware Resident #6's FSBS were greater than 400.
-She was responsible for weekly medication cart and 24 hour logs audits, but since the Health and Wellness Director (HWD) left, she had not audited the medication carts and 24 hour logs on a regular basis.
-As far as the eMARs were concerned, she was responsible for running a report of the eMARs which did not include documentation of FSBS

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greater than 400 and physician notification.
-It was her expectation the MA would contact the physician for a FSBS greater than 400 to receive further orders.
-It was her expectation the MA inform the nurse or HWD, RCC, and Administrator with concerns about the order and when the physician was notified.

Interview with the Primary Care Provider on 4/21/22 at 4:00pm revealed:
-Resident #6 was new to her.
-Resident #6 was last seen on 03/28/22 to reassess Resident #6's FSBS.
-Notification of Resident #6's FSBS greater than 400 was a way for her to manage his diabetes/medication.
-There was documentation in Resident #6's office record dated 03/23/22, Resident #6's FSBS was 594 and insulin was ordered and a recheck in 1 hour was also ordered.
-The facility staff was responsible for notifying her if Resident #6's FSBS was great than 400 because she would order a one time dose of insulin, a recheck in 1 hour and to send out to the emergency room (ER) for evaluation if the FSBS was still high.
-A FSBS greater than 400 that was not improving with the one-time dose of insulin put Resident #6 at risk of a diabetic coma.

Interview with the Administrator on 04/21/22 at 11:45am revealed:
-The MA was responsible for notifying the physician for a FSBS greater than 400 and follow the physician's recommendations at that point.
-The MA was responsible for notifying the calling 911 for a FSBS greater than 500.
-The MA was responsible for documentation in the 24-hour log when the FSBS was greater than

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400 and when the physician was notified related to a FSBS greater than 400.
-The MA was responsible for documentation in the 24-hour log when 911 was called related to a FSBS greater than 500.
-The HWD and the RCC were responsible for auditing the 24-hour logs, medication carts and the eMARs for completion of the orders to notify the physician for the FSBS greater than 400.
-It was her expectation the MAs follow the order as written by the physician.

2. Review of Resident #3's FL2 dated 11/19/21 revealed diagnoses included a history of a pulmonary embolism and anxiety.

Review of Resident #3' resident register revealed an admission date of 04/07/07.

a. Review of Resident #3's physician order on 01/13/22 revealed:
-There was no documentation of an International Normalized Ratio (INR), used to determine the time it takes for one's blood to clot.
-There was an order sent to the pharmacy for warfarin 6mg to be administered daily on Monday through Friday, and 4mg to be administered on Saturday and Sunday.

Review of Resident #3's physician order dated 01/24/22 revealed:
-Resident #3's INR on 01/24/22 was 4.6.
-Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and warfarin 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday.

Review of Resident #3's physician order dated 02/07/22 revealed:
-The INR results on 02/07/22 was 1.7.

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-The warfarin dosing continued at 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday.

Review of Resident #3's physician order dated 03/31/22 revealed:
-INR drawn on 03/31/22 was 1.7.
-Based on the INR, the warfarin dosage ordered by the physician was 2mg on Monday and Friday and 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday.

Review of Resident #3's physician order dated 04/11/22 revealed:
-INR results on 04/11/22 was 1.6.
-Based on the INR, the warfarin dosage ordered by the physician was 4mg daily.

Review of Resident #3's coumadin (warfarin) worksheet dated 01/24/22 revealed:
-Resident #3's coumadin worksheet documented the date the INR was drawn, the INR results, the current coumadin dosage, the coumadin adjustment and the next date the INR was scheduled to be drawn.
-INR results on 01/24/22 were documented as 4.6.
-There was an entry for warfarin 6mg to be administered Monday through Friday.

Review of Resident #3's record revealed there was no documentation of INR results on 01/24/22 or a physician's order for warfarin 6mg to be administered daily Monday through Friday.

Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed :
-There was an entry for warfarin 4mg one tablet to be administered daily on Saturday and Sunday

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at 8:00pm.
-There was an entry for warfarin 6mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm.
-There was documentation Resident #3 was not administered warfarin on 02/04/22, 02/06/22, 02/07/22, 02/22/22, 02/23/22 and 02/28/22.
-Resident #3 missed warfarin dosing 6 of 28 possible opportunities.

Review of Resident #3's March 2022 eMAR revealed :
-There was an entry for warfarin 4mg one tablet to be administered daily on Saturday and Sunday at 8:00pm.
-There was an entry for warfarin 6mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm.
-There was documentation Resident #3 was not administered warfarin on 03/10/22- 03/11/22, 03/13/22, 03/19/22-3/23/22, 03/25/22, and 03/28/22-03/31/22.
-Resident #3 missed warfarin dosing 13 out of 31 possible opportunities.

Observation Resident #3's medications on hand on 04/21/22 at 3:05pm revealed:
-There was a bubble card of warfarin 2mg administer 1 tablet on Monday and Friday.
-There was a bubble card of warfarin 4mg administer 1 tablet on Sunday, Tuesday, Wednesday, Thursday and Saturday.

Interview with the second shift medication aide on 04/22/22 at 4:32pm revealed:
-There were 2 medication carts in the SCU and she did not administer Resident #3's medications on her shift.
-If a resident was on warfarin and it was not available for administration, she would contact

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the pharmacy and the RCC.
-It was not her responsibility to notify the physician if a resident missed medications.
-She did not know who was responsible to notify the physician.

Interview with a another second shift MA on 04/22/22 at 4:40 pm revealed:
-She administered medications to the residents on the Assisted Living community and the Special Care Unit (SCU).
-If there was a medication that was not available to administer for a resident she would contact the pharmacy to order in backup to be received that evening.
-She would let the RCC know if a medication needed a refill or a prescription so the RCC could follow up in the morning with the physician.
-She did not contact the physicians.
-She thought there were times Resident #4's warfarin was not available for administration.
-She documented on the eMAR notes when a medication was unavailable.

Review of the 24 hour progress note binder revealed no documentation from 02/01/22 through 04/01/22 of Resident #3 missing medications due to not having them available for administration.

Telephone interview with the Medical Assistant at the primary care physician's (PCP) office on 04/22/22 at 11:20am revealed:
-The PCP reviewed Resident #3's INR results sent from the home health nurse (HHN) and prescribed the warfarin dosing.
-The warfarin dosing was communicated to the HHN, who contacted the RCC with the new warfarin orders.
-The physician's office did not contact the

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TERRABELLA NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

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pharmacy with the new orders unless the facility requested a new prescription for refills.
-The last prescription that was sent from this office for Resident #3's warfarin was 01-04/22 for warfarin 4mg sixty tablets with 11 refills and warfarin 6mg ten tablets with 11 refills.
-The facility staff had not requested any additional prescriptions, and they had not been notified of any missed doses of warfarin.
-If they had been notified of missed doses of warfarin or incorrect doses, a new blood draw would have been ordered to determine the INR.
-The prescribing physician, as relayed by the Medical Assistant, stated possible outcomes to not receiving proper warfarin dosing were blood clots, an internal bleed or a stroke.

Telephone interview with the Administrative Specialist at the Home Health agency on 04/22/22 at 11:45am revealed:
-The HHN contacted the RCC at the facility and reported the INR results and the warfarin dosing ordered by the PCP.
-If there were any new prescriptions, the facility staff was responsible for forwarding them to the pharmacy.
-She had not been informed by facility staff Resident #3 had missed several doses of warfarin in February 2022 and March 2022.
-If the facility reported Resident #3 missed warfarin doses, she would have informed the PCP.

Interview with the RCC on 04/22/22 at 3:20pm revealed:
-She was responsible for tracking Resident #3's INR and warfarin dosing.
-She kept a record of the date of the last INR, the lab values of the INR, and the date the next INR was scheduled on a Coumadin (Warfarin)"Hot

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List".
-She received the results of the INR blood draw and new warfarin orders from the HHRN.
-The HHN usually contacted her by telephone and she recorded the order on the coumadin hot list documentation.
-She did not know why the orders she had written on the coumadin hot list did not match the orders documented by the physician's office.
-She did not receive any new prescriptions from the physician's off ice for warfarin 2 mg.
-It was the responsibility of the MAs to report when a medication was not administered and the reason why
-It was the responsibility of the MAs to document a missed medication or a medication error in the 24 hour progress note binder.
-She reviewed the binder every morning.
-She did not review the eMAR for medications not administered.
-The Missed Medication report she ran daily did not capture medications documented as not administered.
-She did not know Resident #3 had 6 missed doses of warfarin in February 2022 and 13 missed doses of warfarin in March 2022.
-She would have reported the missed doses to the physician if she had been notified.

Interview with the Administrator on 04/21/22 at 3:10pm revealed:
-It was the responsibility of the HWD to oversee medication orders and eMAR reviews.
-The HWD position had been vacant from 11/01/22 until 04/18/22 and the RCC tried to do both jobs during that time.
-The cart audits and medication reviews suffered with the absence of a nurse.
-When a resident 's medication was not available for administration, the MAs were instructed to

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order through the back up pharmacy, notify the RCC and document in the 24 hour progress note binder..
-She did not know Resident #3 missed 6 doses of warfarin in February 2022 and missed 13 doses in March 2022 of the warfarin.
-It was the responsibility of the MAs to inform the RCC when a medication was not available for administration and when a medications was missed.
-It was the responsibility of the RCC to notify the physician if a resident missed medications.
-She did not know the physician had not been notified Resident #3's warfarin had 6 missed doses in February 2022 and 13 missed doses in March 2022.

b. Review of a physician's order dated 11/19/21 revealed an order for latuda 60mg take one tablet daily.

Review of Resident #3's April 2022 eMAR, from 04/01/22 - 04/20/22 revealed:
-There was an entry for Latuda take 1 tablet by mouth once daily at 8:00pm.
-On 04/02/22 - 04/04/22 Latuda 60mg was documented as not administered.
-On 04/07/22 - 04/09/22 Latuda 60mg was documented as not administered.
-Latuda was documented as not administered due to the 'medication was unavailable' or 'waiting for a prescription'.
-Latuda was documented as not administered 6 of 20 possible opportunities in April 2022.

Observation of Resident #3's medications available for administration on 04/21/22 at 3:05pm revealed there was a bubble card of Latuda 30 tablets, filled on 04/11/22, with 21 tablets remaining.

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D 273	Continued From page 43 Telephone interview with the PCP on 04/22/22 at 10:30am revealed: -Resident #3 was prescribed Latuda 60 mg for behaviors and agitation by the another physician. -If a resident did not receive Latuda for 2 or more consecutive days there could be withdrawal symptoms, gastrointestinal symptoms, suicidal ideation or an increase in behaviors. -She had not been informed by staff Resident #3 had missed Latuda 6 of 20 possible opportunities in April 2022. Interview with the RCC on 04/22/22 at 3:20pm revealed: -The resident's medications that were sent to the facility for April's cycle fill were checked by the RCC and lead MA before placing them in the medication carts. -The process was to compare the label on the bubble card with the eMAR order and if they were correct, the medication was placed in the cart. -Resident #3's Latuda was checked as sent from pharmacy and placed in the medication cart. -She did not know Latuda was not administered 6 of 20 opportunities in April 2022. -She did not notify the physician and there was no documentation any of the MAs notified the physician of Resident #3's missed medications. -She was responsible for weekly cart audits, but since the Health and Wellness Director (HWD) left, she had not been audited the medication carts on a regular basis. Interview with the Administrator on 04/21/22 at 3:10pm revealed: -It was the responsibility of the RCC or designee to perform weekly cart audits. -It was the responsibility of the MAs to inform the RCC when a medication was not available for	D 273		

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administration and when a medications was missed.
-It was the responsibility of the RCC to notify the physician if a resident missed medications.
-She did not know the physician had not been notified Resident #3's Latuda had been missed 6 of 20 possible opportunities in April 2022.

Attempted telephone interview with the prescribing physician on 04/22/22 at 2:50pm was unsuccessful.

3. Review of Resident #2's FL2 dated 03/07/22 revealed:
-Diagnoses included dementia and neuromuscular disorder of the bladder.
-The level of care was documented as the Special Care Unit (SCU).

Review of Resident #2's primary care physician's (PCP) visit summary note dated 03/15/22 revealed:
-Resident #2 had reddened patches on both sides of his inner cheeks and a white coating over his tongue.
-There was an order for Nystatin suspension, swish inside the oral cavity and spit out three times a day for 14 days.

Review of Resident #2's March electronic medication administration record (eMAR) from 03/16/22 -03/30/22 revealed:
-There was an entry for nystatin suspension swish and spit three times a day for 14 days, to be administered at 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin was not administered on 03/16/22 at 8:00am, 03/18/22 at 8:00pm, 03/19/22-03/20/22 at 2:00pm and 8:00pm, and 03/22/22 at 8:00pm.
-There was documentation Resident #2 was not

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administered nystatin suspension 7 of 42 possible opportunities.
-Nystatin was documented as not administered due to 'medication not on the cart.'

Observation of Resident #2 on 04/22/22 at 10:25am revealed the inner cheek on the right side had a reddened raised area and his tongue was pink with no signs of white coating.

Interview with the pharmacist at the facility's contracted pharmacy on 04/22/22 at 11:35am revealed:
-Resident #2's nystatin suspension 630ml (a 14 day supply) was filled on 03/15/22 and sent to the facility.
-The nystatin suspension was returned when the suspension was discontinued after 14 days with 150ml remaining in the bottle.
-If the resident did not receive the full prescribed dosage of nystatin, the oral yeast infection may return.
-The yeast infection causes discomfort when eating or drinking, so the resident may refuse to eat or drink while the infection was active.

Interview with a medication aide (MA) on 04/22/22 at 4:20pm revealed:
-Resident #2 had an order for nystatin suspension three times a day in March 2022.
-Staff supervised Resident #2 when he was administered nystatin suspension, prompting him to swish and spit.
-She did not know why there was 150ml remaining in the suspension bottle when it was returned to the pharmacy.
-She did not notify the physician of the remaining nystatin suspension.

Interview with the Resident Care Coordinator

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D 273	Continued From page 46 (RCC) on 04/22/22 at 3:20pm revealed: -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection for 14 days. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. -It was the responsibility of the MAs to contact her if they could not locate a medication on the cart. -She did not know 150ml of nystatin suspension was returned to the pharmacy at the end of the 14 days. Interview with the Administrator on 04/21/22 at 3:10pm revealed: -It was the responsibility of the MAs to contact the pharmacy and the RCC when they could not locate a medication on the cart. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. Attempted interview with Resident #2 on 04/22/22 at 10::25am was unsuccessful. _____ The facility failed to ensure the primary care provider was notified a resident's FSBS was greater than 400, for 38 times over 34 days that increased a risk for diabetic coma (Resident #6), and a blood thinning medication was missed 19 times over 7 weeks which put the resident at risk for a blood clot or stroke (Resident #3), and 7 missed doses of a suspension to treat a yeast infection in the mouth which could lead to a loss of appetite and weight loss due to discomfort (Resident #2). This failure placed the residents at a substantial risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 273		

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D 273	Continued From page 47 accordance with G.S. 131D-34 on April 21, 2022 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 22, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 1 of 5 sampled residents related to blood pressure checks prior to the administration of a medication if the blood pressure was too low and the administration of an as needed (PRN) medication if the systolic blood pressure was above parameters set by the provider (Resident #4). Review of Resident #4's current FL2 dated 03/15/22 revealed diagnoses included vascular dementia, dysphagia, coronary artery disease (CAD), acute kidney failure and anxiety disorder. a. Review of Resident #4's primary care provider's (PCP) order dated 03/17/22 revealed there was an order for hydralazine 100mg administer one tablet three times daily. Hold if	D 276		

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D 276	Continued From page 48 systolic blood pressure was less than 120. Review of Resident #4's March 2022 electronic medication administration record (eMAR) from 03/17/22 to 03/31/22 revealed: -There was an entry for hydralazine 100mg to be administered three times daily, at 8:00am, 2:00pm and 8:00pm, hold for systolic blood pressure less than 120. -There was documentation hydralazine 100mg was administered 32 out of 42 opportunities in March 2022 with no recording of a blood pressure reading before administration. A request was made for documentation Resident #4's blood pressure readings from 03/17/22 to 03/31/22 and was not provided prior to survey exit. Review of Resident #4's April 2022 eMAR from 04/01/22-04/20/22 revealed: -There was an entry for hydralazine 100mg to be administered three times daily, at 8:00am, 2:00pm and 8:00pm, hold for systolic blood pressure less than 120. -There was documentation hydralazine was administered 27 out of 58 possible opportunities in April 2022 with no recording of a blood pressure reading before administration. Interview with the first shift medication aide (MA) on 04/20/22 at 10:05am revealed: -She administered hydralazine 100mg to Resident #4 during the morning medication pass. -There was no entry on the eMAR to document blood pressure reading, so she did not check it prior to administering the hydralazine. -If there was no entry to document the readings she did not take the blood pressure. -She did not report this to the Resident Care	D 276		

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D 276	Continued From page 49 Coordinator (RCC). Interview with the second shift MA on 04/22/22 at 3:50pm revealed: -She administered Resident #4's medications on second shift. -She administered the hydralazine 100mg at 8:00pm. -The dashboard highlighted the medications and the tasks required during the medication pass. -There was no drop down menu on the hydralazine order to enter a blood pressure reading. -There was no stand alone task to take Resident #4's blood pressure before hydralazine was administered. -She did not report this to the RCC. Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/22/22 at 11:35am revealed: -When an order for a medication was written to include a blood pressure to be taken before administration of the medication, the facility staff enter the drop down menu for the blood pressure readings. -The pharmacy staff only enter blood pressure orders if they were separate from the medication order. -The hydralazine medication order was written to include the blood pressure parameters, so the drop down menu for blood pressure reading was the responsibility of the facility staff. Telephone interview with the PCP on 04/22/22 at 10:30am revealed: -Resident #4's prior PCP had ordered 2 blood pressure medications to be administered daily for hypertension. -Without hydralazine or blood pressure checks	D 276		

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prior to administering the medication, this placed her at an increased risk of an adverse event such as a stroke.
-She had not had any recent blood pressure readings so it was unclear as to the effect of this error.

Interview with the RCC on 04/22/22 at 04/20/22 at 2:45pm revealed:
-She did not know it was the facility's responsibility to add blood pressure readings to the eMAR.
-She did not know the MAs were not taking Resident #4's blood pressure before administering hydralazine three times a day.

Interview with the Health and Wellness Director (HWD) on 04/22/22 at 4:50pm revealed:
-She expected the MAs to take a blood pressure before administration of a medication with blood pressure parameters.
-The MAs should have brought that to the attention of the RCC.
-She took Resident 4's blood pressure earlier today and the systolic reading was above 180.
-Clonidine 0.1mg was prescribed as a PRN medication twice daily for systolic blood pressure greater than 180, and notify the physician.
-She administered the clonidine 0.1mg and contacted the physician.

Interview with the Administrator on 04/22/22 at 3:40pm revealed she did not know the MAs were not taking Resident #4's blood pressure reading before administration of a medication with blood pressure parameters and a medication for systolic blood pressure readings greater than 180.

A request was made for documentation Resident

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#4's blood pressure readings from 04/01/22 to 04/20/22 and was not provided prior to survey exit.

b. Review of Resident 4's PCP's order dated 03/17/22 revealed there was an order for clonidine 0.1mg take one tablet twice daily for systolic pressure greater than 180 and call the physician.

Review of Resident #4's March 2022 eMAR from 03/17/22 to 03/31/22 revealed:
-There was an entry for clonidine 0.1mg take one tablet twice daily for systolic pressure greater than 180 and call the physician.
-There was no documentation of Resident #4's blood pressure readings.
-There was no documentation clonidine was administered from 03/17/22 to 03/31/22.

Review of Resident #4's April 2022 eMAR from 04/01/22 to 04/20/22 revealed:
There was an entry for clonidine 0.1mg take one tablet twice daily for systolic pressure greater than 180 and call the physician.
-There was no documentation of Resident #4's blood pressure readings.
-There was no documentation clonidine was administered from 04/01/22 to 04/20/22.

Interview with the first shift medication aide on 04/20/22 at 10:05am revealed:
-She did not administer Resident #4's clonidine 0.1mg as needed for systolic blood pressure over 180.
-There was no order to take Resident #4's blood pressure.

Interview with the second shift MA on 04/22/22 at 3:50pm revealed:

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D 276	Continued From page 52 -Resident #4's clonidine was an as needed medication and was not highlighted during the medication pass on the computer dashboard. -She was not triggered to take Resident #4's blood pressure since it was not on the eMAR as an order. Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/22/22 at 11:35am revealed the clonidine 0.1mg order was written to include the blood pressure parameters, so the drop down menu for blood pressure readings was the responsibility of the facility staff to enter on the eMAR.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify orders with the provider for 1 of 5 sampled residents, related to an order for an antidepressant (Resident #4).	D 344		

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The findings are:

Review of Resident #4's FL2 dated 11/19/21 revealed diagnoses included a history of a pulmonary embolism and anxiety.

Review of Resident #4's physician orders dated 02/23/22 revealed there was an order for sertraline 100mg daily (used to treat depression).

Observation of the Special Care Unit (SCU) medication pass on 04/20/22 at 9:15am revealed:
-The medication aide (MA) prepared 7 oral medications for Resident #4.
-There was a bubble card of sertraline 25mg, take one half tablet (12.5mg) in the morning.
-Sertraline 25mg, one half tab, was not administered.
-Sertraline 100mg was not administered to Resident #4.

Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed:
-There was a bubble card of 90 tablets with a computer generated label 'sertraline 25mg take one half tablet in the morning' and a fill date of 02/21/22 .
-There were 82 tablets remaining in the bubble card.
-There were no other bubble cards for sertraline 100mg on the medication cart or with the medication supplies.

Review of Resident #4's February 2022 eMAR from 02/23/22-02/28/22 revealed:
-There was an entry for sertraline 25mg take one half tablet (12.5mg) every morning at 8:00am.
-There was documentation Resident #4 was on a

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leave of absence from 02/24/22 to 02/28/22.

Review of Resident #4's March 2022 eMAR from 03/09/22 to 03/31/22 revealed:
-There was an entry for sertraline 100mg take one tablet every morning at 8:00am.
-There was documentation sertraline 100mg was administered from 03/09/22 to 03/31/22.

Review of Resident #4's April 2022 eMAR from 04/01/22 to 04/20/22 revealed:
There was an entry for sertraline 100mg take one tablet every morning at 8:00am.
-There was documentation sertraline 100mg was administered from 04/01/22 to 04/20/22.

Telephone interview with the pharmacist at the facility's contracted pharmacy on 04/22/22 at 11:35am revealed Resident #4's Sertraline 100mg prescription was never filled by the facility's contracted pharmacy.

Telephone interview with Resident #4's preferred pharmacy technician on 04/22/22 at 12:01pm revealed:
-Sertraline 25mg take one half tablet in the morning was filled and a 90 day supply was sent to the facility on 02/21/22.
-No other sertraline prescriptions were filled for Resident #4 since January 2022.
-Resident #4's sertraline 100mg prescription was not sent to this pharmacy.

Interview with the MA on 04/20/22 at 9:50am revealed:
-She thought Resident #4's sertraline 12.5mg tablets had been changed from a morning dose to an evening dose.
-She did not review the eMAR entry and observe the dosage difference.

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D 344	Continued From page 55 Telephone interview with Resident #4's primary care provider (PCP) on 04/22/22 at 10:30am revealed: -She expected the staff to administer medications as prescribed by the physician. -She did not know Resident #4's sertraline was not administered as prescribed. Interview with the RCC on 04/20/22 at 2:45pm revealed: -It was her responsibility to conduct weekly cart audits. -In the absence of a Health and Wellness Director, she has delegated the completion of cart audits to the MAs. -The process to be followed was to print the eMARs for each resident and ensure the medication was on the cart and was the correct dosage. -The MAs did not document the results of the cart audit, they would communicate verbally to her they were completed. -She did not go behind the MAs to ensure the cart audits were done correctly. -The MAs, the RCC or HWD could fax an order to the pharmacy but Resident #4 does not receive her medications from the facility contracted pharmacy, the pharmacy technicians only profile her medications. -She thought whomever sent the prescription with the new order to the facility contracted pharmacy did not send a copy to the resident's preferred pharmacy and the new sertraline dosage was never sent. -It was the responsibility of the MAs administering the medication to do their 3 checks, comparing the medication entered on the eMAR and the label of the bubble card. -She expected the MAs to report to her if there	D 344		

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D 344	Continued From page 56 needs to be a clarification of orders with the physician or pharmacy. -She did not know Resident #4's sertraline had not been clarified with the physician and she continued to receive the incorrect dosage. Interview with the HWD on 04/22/22 at 4:50pm revealed she expected the MAs to clarify a medication order for any resident whose label on the bubble card of a medication and the entry on the eMAR did not match.. Interview with the Administrator on 04/20/22 at 2:40pm revealed: -Ongoing, it would be the responsibility of the HWD to oversee medications, eMAR review, liaison with physicians and training of the staff, amongst other clinical responsibilities. -The cart audits and medication reviews were not completed as scheduled with the absence of an HWD. -It was the responsibility of the MAs to report to the HWD or RCC that a medication label did not match an order entered on the eMAR for the same medication. -She did not know Resident #4's sertraline order had not been clarified with the prescribing physician.	D 344		
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	D 358		

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D 358	Continued From page 57 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents observed during the medication pass as related to a medication used to thin the blood, two medications to control high blood pressure, and medications to control high cholesterol and increase low iron in the blood and an anti-depressant (#4), and medications not available as ordered for 3 of 5 sampled residents (#2, #3, and #4), including a medication for anxiety (#4), medications used to prevent blood clots and treat depression (#3), and a medication used to treat mouth sores (#2). The medication error rate was 12.9% as evidenced by the observation of 4 errors out of 31 opportunities during the 8:00am medication pass on 04/20/22. 1. Review of Resident #4's current FL2 dated 03/15/22 revealed diagnoses included vascular dementia, dysphagia, coronary artery disease (CAD), acute kidney failure and anxiety disorder. a. Review of Resident #4's current FL2 dated 03/15/22 revealed there was an order for clopidogrel 75mg, (an anticoagulant used to thin the blood and prevent clots), to be administered daily. Observation of the Special Care Unit (SCU) medication pass on 04/20/22 at 9:15am revealed: -The medication aide (MA) prepared 7 oral	D 358		

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medications for Resident #4.
-Clopidogrel was not administered to Resident #4.

Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed clopidogrel was not available for administration.

Review of Resident #4's April 2022 electronic medication administration record (eMAR), from 04/01/22 to 04/20/22, revealed:
-There was an entry for clopidogrel 75mg to be administered daily at 8:00am.
-Clopidogrel was not administered 18 of 20 opportunities in April 2022 due to the "medication was unavailable" or "waiting on a prescription".

Interview with the MA on 04/20/22 at 9:50am revealed:
-She had informed the Resident Care Coordinator (RCC) on 04/18/22 that Resident #4 did not have clopidogrel 75mg on the medication cart.
-She documented on the eMAR the medication was not available to administer.
-She was not given any further directives regarding the medication from the Resident Care Coordinator (RCC).

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed:
-Resident #4's primary care provider (PCP) faxed her prescriptions to the pharmacy and the clopidogrel 75mg order was filled for a 90 day supply of tablets and sent on 01/31/22.
-There was a prescription received on 04/20/22 for a 7 day supply filled the same day.

Telephone interview with Resident $4's PCP on

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04/22/22 at 10:30am revealed:
-Resident #4 was a new client as of April 2022.
-She had a prosthetic heart valve and clopidogrel was prescribed to prevent bloods clots due to possible complications.
-She did not know Resident #4 had missed her clopidogrel dosage for 18 of 20 days in April 2022.

Interview with the RCC on 04/20/22 at 2:45pm revealed:
-She knew Resident #4 did not have clopidogrel 75mg available to be administered.
-The MA had informed her the medication was not on the cart earlier this week.
-She did not know it was unavailable for 18 of 20 days in April 2022.
-The Administrator was working with the family to have the medication sent to the facility.

b. Review of Resident #4's current FL2 dated 03/15/22 revealed there was an order for amlodipine 10mg, (a medication used to control blood pressure), to be administered daily.

Observation of the SCU medication pass on 04/20/22 at 9:15am revealed:
-The MA prepared 7 oral medications for Resident #4.
-Amlodipine was not administered to Resident #4.

Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed amlodipine 10mg was not on the medication cart or in the back up medication supplies.

Review of Resident #4's April 2022 eMAR, from 04/01/22 to 04/20/22, revealed:
-There was an entry for amlodipine 10mg to be

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administered daily at 8:00am.
-There was documentation that amlodipine was not administered 16 out of 20 opportunities in April 2022 due to the "medication was unavailable" or "waiting on a prescription".

Interview with the SCU MA on 04/20/22 at 9:50am revealed:
-She had informed the RCC on 04/18/22 that Resident #4 did not have amlodipine 10mg on the medication cart.
-She documented on the eMAR the medication was' not available to administer'.

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 12:01pm revealed:
-Amlodipine 10mg was filled 04/15/22 for 90 tablets.
-That was the only time amlodipine had been filled for Resident #4 since January 2022.

Telephone interview with Resident #4's PCP on 04/22/22 at 10:30am revealed:
-Resident #4's prior PCP had ordered 2 blood pressure medications to be administered daily for hypertension.
-Without these medications, this would place her at an increased risk of an adverse event such as a stroke.
-She had not had any recent blood pressure readings so it was unclear as to the effect of this error.
-She had not been notified the resident was not administered amlodipine 10mg, 16 out of 20 possible opportunities in April 2022.

Interview with the RCC on 04/20/22 at 2:45pm revealed:
-She knew Resident #4 did not have amlodipine

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10mg available to be administered.
-The MA had informed her the medication was not on the cart earlier this week.
-She did not know it had not been available for 16 of 20 days in April 2022.

c. Review of Resident #4's current FL2 order dated 03/15/22 revealed an order for hydralazine 100mg, (a medication used to control high blood pressure), to be administered three times daily.

Observation of the SCU medication pass on 04/20/22 at 9:15am revealed:
-The MA prepared 7 oral medications for Resident #4.
-Hydralazine 100mg was not administered to Resident #4.

Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed hydralazine was not on the medication cart or in the back up medication supplies.

Review of Resident #4's April 2022 eMAR from 04/01/22 - 04/20/22 revealed:
-There was an entry for hydralazine 100mg to be administered three times daily, at 8:00am, 2:00pm and 8:00pm.
-There was documentation hydralazine was not administered 27 out of 58 opportunities in April 2022 due to the "medication was unavailable" or "waiting on a prescription".

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed:
-Hydralazine was filled 03/2/22 for 360 tablets (90 day supply).
-That was the only time hydralazine was filled for

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D 358	Continued From page 62 Resident #4 since January 2022. Interview with the MA on 04/20/22 at 9:50am revealed: -She did not know how long Resident #4's hydralazine was not available to be administered. -She had contacted the RCC and informed her the medication was not on the cart on 04/18/22. Telephone interview with Resident #4's PCP on 04/22/22 at 10:30am revealed: -There was no documentation of recent blood pressure readings, so it was unclear as to the effect of this error. -She was not notified the resident had not been administered Hydralazine 100mg 27 out of 58 opportunities in April 2022. Interview with the RCC on 04/20/22 at 2:45pm revealed: -She knew Resident #4 did not have hydralazine 100mg available to be administered. -The MA had informed her the medication was not on the cart earlier this week. -She did not know it was unavailable for 27 out of 58 opportunities in April 2022. d. Review of Resident #4's current FL2 dated 03/15/22 revealed there was an order for atorvastatin 40mg, (a medication used for high cholesterol), to be administered daily. Observation of the SCU medication pass on 04/20/22 at 9:15am revealed: -The MA prepared 7 oral medications for Resident #4. -Atorvastatin 10mg was not administered to Resident #4. Observation of Resident #4's medications	D 358		

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available for administration on 04/20/22 at 10:05 am revealed atorvastatin was not on the medication cart or in the back up medication supplies.

Review of Resident #4's April 2022 eMAR, from 04/01/22 to 04/20/22, revealed:
-There was an entry for atorvastatin 40mg to be administered daily at 8:00am.
-There was documentation atorvastatin was not administered 16 out of 20 possible opportunities in April 2022 due to the "medication was unavailable".

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed:
-Atorvastatin 40mg was filled on 04/15/22 for 90 tablets.
-That was the only time atorvastatin has been filled for Resident #4 since January 2022.

Interview with the MA on 04/20/22 at 9:50am revealed:
-She did not know how long Resident #4's atorvastatin was unavailable to be administered.
-She had contacted the RCC and informed her the medication was not on the cart.

Telephone interview with Resident #4's PCP on 04/22/22 at 10:30am revealed:
-Resident #4 had an elevated cholesterol level.
-This placed her at an increased risk of an adverse event such as a stroke.
-She did not know Resident #4 had not been administered atorvastatin as ordered.

e. Review of Resident #4's physician's orders dated 03/15/22 revealed an order for ferrous sulfate 325mg, (a medication used for low blood

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D 358	Continued From page 64 iron), to be administered daily. Observation of the SCU medication pass on 04/20/22 at 9:15am revealed: -The MA prepared 7 oral medications for Resident #4. -Ferrous sulfate 325mg was not administered to Resident #4. Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed there was no ferrous sulfate on the medication cart or in the back up medication supplies. Review of Resident #4's April 2022 eMAR from 04/01/22 to 04/20/22 revealed: -There was an entry for ferrous sulfate 325mg to be administered daily at 8:00am -There was documentation that ferrous sulfate was not administered 14 out of 20 opportunities due to the "medication was unavailable" or "waiting on a prescription". Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed there was no record ferrous sulfate was filled since January of 2020. Interview with the MA on 04/20/22 at 9:50am revealed: -She did not know how long Resident #4's ferrous sulfate was not available to be administered. -She could not remember if she informed the RCC ferrous sulfate was not available for administration. Telephone interview with Resident #4's PCP 04/22/22 at 10:30am revealed she expected the facility to administer medications as prescribed by	D 358		

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the physician.

Interview with the RCC on 04/20/22 at 2:45pm revealed she did not know Resident #4's ferrous sulfate 325mg had not been available for administration 20 out of 20 possible opportunities in April 2022.

f. Review of Resident #4's physician order dated 02/23/22 revealed there was an order for sertraline 100mg daily (used to treat depression).

Observation of the SCU medication pass on 04/20/22 at 9:15am revealed:
-The MA prepared 7 oral medications for Resident #4.
-Sertraline 100mg was not administered to Resident #4.

Observation of Resident #4's medications available for administration on 04/20/22 at 10:05am revealed:
-There was a bubble card of 90 tablets with a computer generated label 'Sertraline 25mg take one half tablet in the morning' and a fill date of 02/21/22 .
-There were 82 tablets remaining in the bubble card.
-There were no other bubble cards for Sertraline 100mg on the medication cart or with the medication supplies.

Review of Resident #4's February 2022 eMAR from 02/23/22 to 02/28/22 revealed:
-There was an entry for sertraline 25mg take one half tablet (12.5mg) every morning at 8:00am.
-There was documentation Resident #4 was on a leave of absence from 02/24/22 to 02/28/22.

Review of Resident #4's March 2022 eMAR from

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TERRABELLA NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

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03/09/22 - 03/31/22 revealed:
-There was an entry for sertraline 100mg take one tablet every morning at 8:00am.
-There was documentation Sertraline 100mg was administered from 03/09/22 to 03/31/22.

Review of Resident #4's April 2022 eMAR from 04/01/22 - 04/20/22 revealed:
There was an entry for sertraline 100mg take one tablet every morning at 8:00am.
-There was documentation Sertraline 100mg was administered from 04/01/22-04/20/22.

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed:
-Sertraline 25mg take one half tablet in the morning was filled and a 90 day supply was sent to the facility on 02/21/22.
-No other sertraline prescriptions were filled for Resident #4 since January 2022.
-Resident #4's physician order for sertraline 100mg daily was not sent to this pharmacy.

Interview with the MA on 04/20/22 at 9:50am revealed:
-She did not administer Resident #4's sertraline 12.5mg tablets because she thought the time had changed from morning to evening administration.
-She did not compare the dosage on the label of the bubble card with the dosage on the eMAR.
-She did not observe the dosage on the bubble card was 12.5mg and the dosage on the eMAR was 100mg.

Telephone interview with Resident #4's PCP 04/22/22 at 10:30am revealed:
-She expected the staff to administer medications as prescribed by the physician.
-The condition for which it was prescribed, panic

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disorder or generalized anxiety disorder, may increase with incorrect dosing or missed doses.
-She did not know Resident #4's sertraline was not administered as prescribed.

g. Review of Resident #4's physician's orders dated 03/17/22 revealed an order for lorazepam 0.5mg, (a medication used to treat anxiety and agitation), one half tablet to be administered at bedtime.

Observation of Resident #4's medications available for administration on 04/20/22 at 4:15pm revealed lorazepam 0.25mg was not on the medication cart or in the back up medication supplies.

Review of Resident #4's March 2022 eMAR, from 03/17/22 to 03/31/22 revealed:
-There was an entry for lorazepam 0.5mg take one half tablet (0.25mg) to be administered at 8:00pm.
-There was documentation that lorazepam was not administered 14 out 14 possible opportunities in March 2022 due to the "medication was unavailable" or "not on the cart".

Review of Resident #4's April 2022 eMAR, from 04/01/22 to 04/20/22, revealed:
-There was an entry for lorazepam 0.5mg take one half tablet (0.25mg) to be administered daily at 8:00pm.
-There was documentation lorazepam was not administered 20 out of 20 possible opportunities in April 2022 due to the "medication was unavailable" or "not on the cart".

Telephone interview with Resident #4's contracted pharmacy technician on 04/22/22 at 12:01pm revealed a prescription for lorazepam

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D 358	Continued From page 68 0.25mg was not filled by their pharmacy. Telephone interview with Resident #4's PCP 04/22/22 at 10:30am revealed: -Resident #4 was prescribed lorazepam by the previous PCP for anxiety and agitation at night. -She was not informed by the facility the resident was not receiving the medication. -She had not had any reports from the facility the resident experienced increased agitation at night. -She would expect to observe increased agitation and anxiety in the evening if the resident missed several doses of Lorazepam. -She expected the facility to administer medications as prescribed by the physician. Interview with the RCC on 04/20/22 at 2:45pm revealed: -Resident #4's prescription for lorazepam dated 03/17/22 was sent to the facility's contracted pharmacy. -The pharmacy technician entered the order, but they did not fill her medications. -The prescription was never sent to the resident's preferred pharmacy. -She did not know Resident #4's lorazepam 0.25mg had not been available for administration from 03/17/22 through 04/20/22. Interview with the SCU MA on 04/20/22 at 9:50am revealed: -The residents' medications were delivered by the facility contracted pharmacy on a monthly cycle fill, unless the family delivered the resident's medications. -If a resident was low on a medication before the next fill date, or had a new medication ordered, the MA contacted the pharmacy and the medication would be sent from the local backup pharmacy.	D 358		

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-The MA contacted the responsible family member if they provided the resident's medications.
-If the medication was not delivered within the next day or two, the MA would inform the RCC again and the RCC would contact the family member, or the pharmacy.
-Resident #4 did not receive her medications from the facility contracted pharmacy.
-A family member ordered Resident #4's medications from a mail order company.
-The medications were delivered with a 90 day supply to the facility.
-When Resident #4 had less than a 10 day supply, the MA contacted the family member and informed the RCC.
-There were times Resident #4 did not have medications.
-She was not sure how long Resident #4 was out of some of her medications.
-The MAs were instructed not to order Resident #4's medications from the back up pharmacy per the family's request.
-She documented on the eMAR that the medication was not available to be administered when there was no medication on the cart.
-The medication does not record as a missed medication in the eMAR program, but she did not know why.
-She was not directed by the RCC to do anything further.

Interview with a second SCU MA on 04/21/22 at 8:25am revealed:
-It was the responsibility of the MA to contact the pharmacy or family member and the RCC when a medication had 7 tablets remaining.
-The pharmacy would send the medication through back up by the following day.
-There was a problem at times getting family

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members to bring in medications on time that were not filled by the pharmacy.
-A second call was made if the medication had only a 4 day supply and was still not on the cart.
-If a resident's medication was not available to administer, she informed the RCC and documented the medication on the eMAR as 'not administered'.
-The RCC had not instructed her to do anything else.

Telephone interview with Resident #4's responsible family member on 04/22/22 at 12:55pm revealed:
-She was responsible for providing Resident #4's medications to the facility, and contracted with a mail order pharmacy.
-She had requested Resident #4's physician to send the prescriptions to this pharmacy in quantities of a 90 day supply.
-When the medication was shipped from the preferred pharmacy to the facility, the family member received notification.
-She was contacted last week by facility staff and was told Resident #4 was out of 5 medications.
-According to her records, there should be enough medication until the next 90 day fill.
-Resident #4 had a history of a stroke and hypertension.
-She does not want the facility to order more medication, she wants them to find the medication they should have for the resident.

Interview with the RCC on 04/20/22 at 2:45pm revealed:
-The facility was on a monthly cycle fill for most of the residents' medications.
-Some residents filled their medication prescriptions through an outside pharmacy and family members bring to the facility.

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D 358	Continued From page 71 -It was the responsibility of the MAs to contact the back up pharmacy or the family if a medications was not in the building. -The MA should also contact the physician if a new prescription was needed. -The MAs should be contacting the pharmacy or family as well as the RCC when there was a 10 day supply of the medication remaining. -The MAs should contact the RCC if the medication continued to be unavailable with a 7 day supply. -The RCC followed up with the family or pharmacy at that time. -If a family member refused to supply the medication she referred them them to the Administrator. -The MA should also document in the 24 hour progress book so the following shift can follow up. -She communicated to her staff the process for medication refills, but it was challenging to communicate to all the agency staff. -It was her responsibility to complete cart audits weekly. -In the absence of a Health and Wellness Director (HWD), she assumed additional responsibilities and delegated cart audits to the MAs. -The MAs do not document the results of the cart audits, they communicate verbally with her. -She reviewed the missed medication reports daily, but did not know medications documented as 'not administered' were not captured in that report. -She did not review the eMARs unless alerted to an issue. That was the responsibility of the HWD. -If a family member would not allow us to order medications through back up if there was none available for administration, she refer red them to the Administrator. -If she was not able to order medications for a	D 358		

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resident due to family not approving, she notified the physician and tried to get a hold or discontinue order from the physician.
-She did not document these physician notifications.

Interview with the HWD on 04/22/22 at 4:50pm revealed:
-She started in her position as HWD on 04/18/22.
-She did not know Resident #4 did not have medications available for administration.
-It would be her responsibility ongoing to review the eMARs for missed medications and medications not available for administration.
-She expected the MAs to contact the pharmacy when a resident needed a refill medication and contact the physician if a new prescription was needed.
-She expected the MAs to inform the RCC and HWD when medications were unavailable.
-She would contact the physician and order the medications through the backup pharmacy until the issue was resolved so the resident did not miss any medications.

Interview with the Administrator on 04/20/22 at 2:40pm revealed:
-It was the responsibility of the HWD to oversee medications, eMAR review, liaison with physicians and training of the staff, amongst other clinical responsibilities.
-The HWD position had been vacant from 11/01/22 until 04/18/22.
-The RCC tried to do both jobs during that time, with assistance from the regional clinical support staff available for questions.
-The cart audits and medication reviews suffered with the absence of a nurse.
-When a resident 's medication was not available for administration, the staff has been instructed to

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order through the back up pharmacy.
-There were challenges with medications available for administration when a family provided the resident's medications.
-Resident #4's family member had instructed the facility not to order medications from the backup pharmacy when needed.
-She has been trying to work with family members on this issue.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

2. Review of Resident #3's current FL2 dated 11/19/21 revealed diagnoses included a history of a pulmonary embolism and anxiety.

a. Review of Resident #3's physician order dated 01/24/22 revealed:
-Resident #3 had an order for a blood draw to determine the effectiveness of her anticoagulation treatment (for the risk of bleeding or blood clotting) while taking warfarin medication.
-The laboratory results of the blood draw were expressed in an International Normalized Ratio (INR), with the therapeutic range between 2.0 - 3.0.
-Resident #3's INR on 01/24/22 was 4.6.
-Based on the INR, 2mg of warfarin on Monday and Friday and 4mg of warfarin on Tuesday, Wednesday, Thursday, Saturday and Sunday was ordered.

Review of Resident #3's physician order dated 02/07/22 revealed:
-The INR results on 02/07/22 was 1.7.
-Warfarin 2mg on Monday and Friday and warfarin 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday was continued.

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D 358	Continued From page 74 Review of Resident #3's physician order dated 03/31/22 revealed: -INR drawn on 03/31/22 was 1.7. -Based on the INR, warfarin 2mg on Monday and Friday and warfarin 4mg on Tuesday, Wednesday, Thursday, Saturday and Sunday was ordered. Review of Resident #3's physician order dated 04/11/22 revealed: -INR results on 04/11/22 was 1.6. -Based on the INR, warfarin 4mg daily was ordered. Review of Resident #3's February 2022 electronic medication administration record (eMAR) revealed : -There was an entry for warfarin 4mg one tablet to be administered daily on Saturday and Sunday at 8:00pm. -There was an entry for warfarin 6mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm. -There was no entry for warfarin 2mg one tablet to be administered daily on Monday and Friday. -There was no entry for warfarin 4mg to be administered on Tuesday, Wednesday, Thursday, Saturday and Sunday. -There was documentation Resident #3 was not administered warfarin on 02/04/22, 02/06/22, 02/07/22, 02/22/22, 02/23/22 and 02/28/22. -There was documentation Resident #3 received the incorrect dosage of warfarin (6mg) on 02/01/22-02/03/22, 02/08/22-02/11/22, 02/15/22-02/18/22, 02/21/22, and 02/24/22-02/25/22. -Resident #3 missed warfarin dosing 6 of 28 possible opportunities. -Resident #3 was administered the incorrect	D 358		

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dosage of warfarin 14 of 28 possible opportunities.

Review of Resident #3's March 2022 eMAR revealed :
-There was an entry for warfarin 4mg one tablet to be administered daily on Saturday and Sunday at 8:00pm.
-There was an entry for warfarin 6mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm.
-There was no entry for warfarin 2mg one tablet to be administered daily on Monday and Friday.
-There was no entry for warfarin 4mg to be administered on Tuesday, Wednesday, Thursday, Saturday and Sunday.
-There was documentation Resident #3 was not administered warfarin on 03/10/22- 03/11/22, 03/13/22, 03/19/22-3/23/22, 03/25/22, and 03/28/22-03/31/22.
-There was documentation Resident #3 received the incorrect dosage of warfarin (6mg) on 03/01/22-03/04/22, 03/07/22-03/09/22, 03/14/22-03/18/22, and 03/24/22.
-Resident #3 missed warfarin dosing 13 out of 31 possible opportunities.
-Resident #3 was administered the incorrect dosage of warfarin 13 of 31 possible opportunities.

Review of Resident #3's April 2022 eMAR, from 04/01/22-04/20/22 revealed :
-There was an entry on 04/01/22 for warfarin 4mg one tablet to be administered daily on Saturday and Sunday at 8:00pm.
-There was an entry on 04/01/22 for warfarin 2mg one tablet to be administered daily on Monday, Tuesday, Wednesday, Thursday and Friday at 8:00pm.
-There was no entry on 04/11/22 for warfarin 4mg

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to be administered daily.
-There was documentation Resident #3 received the incorrect dosage of warfarin (2mg) on 04/11/22-04/15/22 and 04/18/22-04/19/22.
-Resident #3 was administered the incorrect dosage of warfarin 9 of 9 possible opportunities.

Interview with the second shift medication aide on 04/22/22 at 4:32pm revealed:
-She administered medications to the residents on the Assisted Living community and the Special Care Unit (SCU).
-If there was a medication that was not available to administer for a resident she would contact the pharmacy to order in backup to be received that evening.
-If she could not get the medication in that evening, she would contact the Resident Care Coordinator (RCC) and document in the 24 hour book.
-There were 2 medication carts in the SCU and she did not administer Resident #3's medications on her shift.
-If a resident was on warfarin and it was not on the cart, she would contact the pharmacy and the RCC and contact the on call physician if she could not get the medication in that evening.

Interview with a another second shift MA on 04/22/22 at 4:40 pm revealed:
-She administered medications to the residents on the Assisted Living community and the Special Care Unit (SCU).
-If there was a medication that was not available to administer for a resident she would contact the pharmacy to order in backup to be received that evening.
-She would let the RCC know if a medication needed a refill or a prescription so the RCC could follow up in the morning with the physician.

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-She did not contact the physicians.
-Warfarin tablets were available to be administered on the cart the evenings she worked in the SCU.

Telephone interview with the Medical Assistant at Resident #3's primary care provider's (PCP) office on 04/22/22 at 11:20am revealed:
-The PCP reviewed Resident #3's INR results sent from the home health nurse (HHN) and prescribed the warfarin dosing.
-The warfarin dosing was communicated to the HHN, who contacted the RCC with the new warfarin orders.
-The physician's office did not contact the pharmacy with the new orders unless the facility requested a new prescription for refills.
-The last prescription that was sent from this office for Resident #3's warfarin was January 4, 2022 for warfarin 4mg sixty tablets with 11 refills and warfarin 6mg ten tablets with 11 refills.
-The facility staff had not requested any additional prescriptions, and we have not been notified of any missed doses of warfarin.
.The last INR recorded was on 04/11/22 and was 1.6.
-The new dosing ordered by the physician on 04/11/22 was 4mg every day and re-check on 04/28/22.
-This was communicated to the HHN on 04/11/22.

Telephone interview with the Office Manager at Resident #3's Home Health (HH) agency on 04/22/22 at 11:45am revealed:
-Resident #3's PCP would send orders for her INR to be tested and subsequent warfarin orders based on the results..
-She scheduled a HHN to visit the facility and draw Resident 3's blood for INR testing.

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-She forwarded Resident #3's INR results to the PCP and received new orders from their Medical Assistant .
-She communicates the new warfarin orders to the HHN.
-The HHN contacts the facility (RCC) and reports th result and the dosing ordered by the PCP.
-If there were any new prescriptions, the facility staff was responsible for forwarding them to the pharmacy.
-She did not know Resident #3 had missed several doses of warfarin in February 2022 and March 2022, or that incorrect doses were administered.

Interview with the RCC on 04/22/22 at 3:20pm revealed:
-She was responsible for tracking Resident #3's INR and warfarin dosing.
-She kept a record of the date of the last INR, the lab values of the INR, and the date the next INR was scheduled on a Coumadin (Warfarin)"Hot List".
-She usually received a verbal order from the HHN for the current warfarin order from the PCP.
-She documented the current warfarin dosage on an INR Log and sent the log to the pharmacy.
-She did not know why the HH agency and the PCP's office had different warfarin orders than she had transcribed.
-It was the responsibility of the MAs to contact the pharmacy for refills or if a new prescription was needed to contact the physician's office.
-The MAs should also contact her when a medication was not available and document in the 24 hour progress note binder.
-She reviewed the progress notes every morning and there was no documentation regarding Resident #3's warfarin.
-She did not review the eMAR for medications not

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administered.
-The Missed Medication report she ran daily did not capture medications documented as not administered.
-She did not know Resident #3 had 6 missed doses of warfarin in February 2022 and 13 missed doses of warfarin in March 2022.

Review of the INR Log on 04/22/22 revealed:
-On 01/24/22 the RCC documented the warfarin dosage as 6mg Monday through Friday and 4mg Saturday and Sunday, per verbal orders from the HHN.
-On 01/25/22 she sent this order to the pharmacy and it was entered into the eMAR.
-On 02/07/22 the RCC documented the warfarin dosage as 6mg Monday through Friday and 4 mg Saturday and Sunday, per verbal orders from the HHN.
-On 02/09/22 she sent this order to the pharmacy and it remained on the eMAR with no changes.
-On 03/31/22, the RCC documented the warfarin dosage as 2mg on Monday through Friday and 4mg all other days, per verbal order from the HHN.
-On 03/31/22, she sent this order to the pharmacy to be entered on the eMAR.
-On 04/11/22, the RCC documented the warfarin dosage as 2mg on Monday through Friday and 4mg all other days.
-On 04/12/22, she sent the new order to the pharmacy to be entered on the eMAR.

Interview with the Administrator on 04/21/22 at 3:10pm revealed:
-It was the responsibility of the Health and Wellness Director (HWD) to oversee medication orders and eMAR reviews.
-The HWD position had been vacant from 11/01/22 until 04/18/22 and the RCC tried to do

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both jobs during that time.
-The cart audits and medication reviews suffered with the absence of a nurse.
-When a resident 's medication was not available for administration, the MAs were instructed to order through the back up pharmacy and notify the RCC.
-She did not know Resident #3 had 6 missed doses of warfarin in February 2022 and 13 missed doses of warfarin in March 2022.
She did not know Resident #3 had received the incorrect warfarin dosage 14 times in February 2022, 13 times in March 2022 and 9 times in April 2022.

b. Review of a physician's order dated 11/19/21 revealed an order for Latuda 60mg take one tablet daily.

Review of Resident #3's April 2022 eMAR, from 04/01/22 to 04/20/22 revealed:
-There was an entry for Latuda take 1 tablet by mouth once daily at 8:00pm.
-On 04/02/22 to 04/04/22 Latuda 60mg was documented as not administered due to the "medication was unavailable" or "waiting for a prescription".
-On 04/07/22 to 04/09/22 Latuda 60mg was documented as not administered due to the "medication was unavailable" or "waiting for a prescription".
-Latuda was documented as not administered 6 of 20 opportunities in April 202.

Observation of medications available for administration revealed there was a bubble card of 30 tablets, filled on 04/11/22, with 21 tablets remaining.

Telephone interview with Resident #3's PCP on

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04/22/22 at 10:30am revealed:
-Resident #3 had been prescribed Latuda 60 mg for behaviors and agitation.
-If a resident does not receive the Latuda 2 or more consecutive days there could withdrawal symptoms, gastrointestinal symptoms, suicidal ideation or an increase in behaviors.

Interview with the RCC on 04/22/22 at 3:20pm revealed:
-The medications that were sent to the facility for April's cycle fill were accounted for before placing them on the medication carts.
The process was to compare the label on the medication with the eMAR order and if they match, the medication was placed on the cart.
-Resident #3's Latuda was checked as sent from pharmacy and placed on the medication cart.
-She did not know why the medication was not administered 6 of 20 opportunities in April 2022.

Interview with the Administrator on 04/21/22 at 3:10pm revealed:
-It was the responsibility of the RCC or designee to perform weekly cart audits.
-She did not know Resident #3's Latuda medication was documented as not administered 6 of 20 opportunities in April 2022.

3. Review of Resident #2's current FL2 dated 03/07/22 revealed:
-Diagnoses included dementia and neuromuscular disorder of the bladder.
-The level of care was documented as Special Care Unit (SCU).

Review of Resident #2's primary care provider 's (PCP) visit summary note dated 03/15/22 revealed:
-Resident #2 had reddened patches in the inner

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cheeks with a white coating over his tongue.
-There was an order for Nystatin suspension, swish inside the oral cavity and spit out three times a day for 14 days.

Review of Resident #2's March 2022 electronic medication administration record (eMAR) from 03/16/22 to 03/30/22 revealed:
-There was an entry for nystatin suspension swish and spit three times a day for 14 days, to be administered at 8:00am, 2:00pm and 8:00pm.
-There was documentation nystatin was not administered on 03/16/22 at 8:00am, 03/18/22 at 8:00pm, 03/19/22 to 03/20/22 at 2:00pm and 8:00pm, and 03/22/22 at 8:00pm.
-There was documentation Resident #2 was not administered nystatin suspension 7 of 42 opportunities due to"'medication not on the cart".

Interview with the pharmacist at the facility contracted pharmacy on 04/22/22 at 11:35am revealed:
-Resident #2's nystatin suspension 630ml was filled on 03/15/22 and sent to the facility.
-The nystatin suspension was returned when the suspension was discontinued after 14 days with 150ml remaining in the bottle.
-If the resident did not receive the full prescribed dosage of nystatin, the oral yeast infection may return.
-The yeast infection causes discomfort when eating or drinking, so the resident may refuse to eat or drink while the infection was active.

Interview with the a medication aide (MA) on 04/22/22 at 4:20pm revealed:
-He was very compliant with his medications.
-He had an order for nystatin suspension three times a day in March 2022.
-Staff had to stay with him and direct him to swish

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D 358	Continued From page 83 and spit. -He did not eat very much but she did not know if that was due to his mouth sores. Interview with the Resident Care Coordinator (RCC) on 04/22/22 at 3:20pm revealed: -She knew Resident #2 had an order for nystatin suspension for a possible yeast infection, swish and spit three times a day for 14 days. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. -She thought agency MAs may not have been familiar with the placement of bottled medications on the cart. -It was the responsibility of the MAs to contact her if they can not locate a medication on the cart. Interview with the Administrator on 04/21/22 at 3:10pm revealed: -It was the responsibility of the MAs to contact the pharmacy and the RCC when they could not locate a medication on the cart. -She did not know Resident #2 was not administered nystatin suspension 7 of 42 possible opportunities. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. _____ The facility failed to ensure medications were administered as ordered for 1 of 5 residents during the medication pass, who had a history of stroke and hypertension, including a blood thinner used to prevent a blood clot and blood pressure medications used to control high blood pressure which could lead to another stroke, and did not have medications available for administration used for high cholesterol, depression and anemia	D 358		

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D 358	Continued From page 84 (Resident #4) and an antifungal oral suspension that was not completed. This failure placed residents at substantial risk of serious physical harm and constitutes and Type A2 Violation. _____ The facility provided a plan of protection on 04/22/22 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 22, 2022.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.	D 464		

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D 464	Continued From page 85 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed was completed within 30 days of admission, quarterly and within 10 days following a significant change in the resident's condition for 2 of 5 sampled residents (Resident #1) with recurrent falls, injuries and becoming non-weight bearing and (Resident #4) who did not have documentation of a care plan within 30 days of admission, quarterly profiles or a significant change care plan after a stroke. The findings are: Review of the facility's current license effective revealed the facility was licensed with a special care unit (SCU) with a capacity of beds. 1. Review of Resident #1's current FL2 dated 02/24/22 revealed: -Diagnoses included dementia, . -The recommended level of care was the SCU. Review of Resident #1's Resident Register revealed she was admitted to the SCU on 03/24/10. Observation of Resident #1 on 04/20/22 at 8:45am revealed: -Resident #1 was lying in the bed, wearing an incontinent brief. -She was wearing a left leg knee immobilizer and socks. Review of Resident #1's Resident Profile revealed there was no SCU resident care plan and profile completed with in 30 days of admission to the SCU.	D 464		

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D 464	Continued From page 86 Review of Resident #1's current Care Plan dated 03/02/22 revealed: -She was independent with transfers. -She required supervision with eating. -She required limited assistance with toileting. -She required extensive assistance with bathing, dressing and grooming. Review of Resident #1 transfer form dated 02/24/22 revealed Resident #1 was transferred from a skilled nursing facility post op a left partial hip replacement on 02/07/22. Review of Resident #1's Emergency Room (ER) discharge dated 02/28/22 revealed: -An Xray of Resident #1's left knee noted a left tibia plateau fracture. -Discharge instructions included Resident #1 to maintain non-weight bearing to the left leg until seen by orthopedics. Review of Resident #1's orthopedic provider's order dated 03/03/22 revealed Resident #1 was to maintain non-weight bearing to left leg. Refer to interview with the Resident Care Coordinator (RCC) on on 04/22/22 at 11:25am Refer to interview with the Health and Wellness Director (HWD) on 04/22/22 at 11:45am. Refer to interview with the Administrator on 04/22/22 at 12:16pm Based on interviews, observations and record review Resident #1 was not interviewable. Resident #1's SCU care plan and profile was requested prior to exit on 04/22/22.	D 464		

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D 464	Continued From page 87 2. Review of Resident #4's current FL2 dated 11/24/21 revealed: -Diagnoses included dementia, hypertension, right sided hemiplegia due to a stroke, acute kidney failure, anxiety and coronary artery disease . -The recommended level of care was the SCU. Review of Resident #4's Resident Register revealed she was admitted to the SCU on 06/24/20. Review of Resident #4's record revealed: -There was no documented SCU Resident Profile and Care Plan completed within 30 days of admission. -There were no Quarterly profiles. Review of Resident #4's record revealed; -There was one care plan dated 09/13/21. -Activities of daily living were documented as; supervision with ambulation and eating; cues and prompts with some staff assistance for toileting,bathing, dressing, grooming and transfers. Review of a progress note entry on 03/17/22 revealed: -Resident #4 returned from rehabilitation facility after her stroke on 02/23/22. -Resident has an order for a wheelchair and physical therapy and occupational therapy. Review of Resident #4's record revealed there was no documented Care Plan upon return of the resident from rehabilitation. Telephone interview with the primary care physician (PCP) on 04/13/22 at 1:25pm revealed:	D 464		

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D 464	Continued From page 88 -Resident #4 was a new client since April 2022. -The facility had not sent a care plan for her to review. Refer to interview with the RCC on on 04/22/22 at 11:25am Refer to interview with the HWD on 04/22/22 at 11:45am. Refer to interview with the Administrator on 04/22/22 at 12:16pm Based on interviews, observations and record review Resident #4 was not interviewable. Resident #4's SCU care plan and profile was requested prior to exit on 04/22/22. _____ Interview with the RCC on 04/22/22 at 11:25am revealed: -The HWD was responsible for completing the residents' care plans. -The HWD position had been vacant since November 2021 and on 04/18/22 a new HWD started working at the facility. -From November 2021, she was responsible for completing the care plans but she did not know a care plan was to be completed with in 10 days once a significant change happened. Interview with the HWD on 04/22/22 at 11:45 revealed: -The HWD was responsible for the SCU Resident Profile and Care Plan and was to be completed within 30 days of admission, quarterly and within 10 days following a significant change in the resident's condition. -The HWD position had been vacant since November 2021 and on 04/18/22 she started	D 464		

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D 464	Continued From page 89 working at the facility. -She was informed by the Administrator the RCC was responsible for completion of the Special Care Unit Resident Profile and Care Plans after November 2021 until she started work at the facility. -She did not know the Special Care Unit Resident Profile and Care Plans were not completed correctly. Interview with the Administrator on 04/22/22 at 12:16pm revealed: -A nurse or the HWD was responsible for completion of the care plan with in 30 days of admission and with in 10 days of a significant change in a resident's condition. -The Special Care Director (SCD) was responsible for completion of the SCU Resident Profile before admission and quarterly there after. -The SCD was new to her position and she was aware the quarterly profiles were not completed.	D 464		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication aide training	D912		

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D912	Continued From page 90 and competency. The findings are: 1. Based on interviews, and record reviews the facility failed to ensure 6 of 6 sampled staff (Staff A, B, C, D, E and F) who administered medications had completed the Medication Aide Training and 2 of 6 sampled staff (Staff A and F) had completed the clinical skills checklist prior to administering medications. [Refer to tag 0935, G.S. 131D-4.5B(b) ACH Medication Aide; Training and Competency (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all residents were free from neglect related to Personal Care and Supervision, Health Care and Medication Administration. The finding are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' current symptoms for 1 of 5 sampled residents who was assigned to the Special Care Unit (SCU) that had a history of a fall requiring the resident to be non-weight	D914		

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D914	Continued From page 91 bearing after a left tibia plateau fracture (the upper part of the shin involving the knee joint). [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 2 of 5 sampled residents (#3, and #6) related to a fasting blood sugar (FSBS) greater than 400 (#6) and missed doses of a blood thinner medication and mood stabilizer (#3). [Refer to Tag D0273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 3. Based on observation, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 residents observed during the medication pass as related to a medication used to thin the blood, two medications to control high blood pressure, and medications to control high cholesterol and increase low iron in the blood and an anti-depressant (#4), and medications not available as ordered for 3 of 5 sampled residents (#2, #3, and #4), including a medication for anxiety (#4), medications used to prevent blood clots and treat depression (#3), and a medication used to treat mouth sores (#2). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

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	HAL018036	A. BUILDING: _____ B. WING _____	04/22/2022

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D935	Continued From page 92 (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 accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION	D935		

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D935	Continued From page 93 Based on interviews, and record reviews the facility failed to ensure 6 of 6 sampled staff (Staff A, B, C, D, E and F) who administered medications had completed the Medication Aide Training and 2 of 6 sampled staff (Staff A and F) had completed the clinical skills checklist prior to administering medications. The findings are: 1. Review of Staff A's, medication aide (MA) personnel record revealed: -Staff A was hired on 02/24/22. -There was documentation she passed the written MA exam on 04/28/21. -There was no documentation she completed the 5/10/15 hour training. -There was no documentation Staff A completed the medication clinical skills competency validation. Review of a resident's February 2022 electronic medication administration record (eMAR) revealed Staff A did not administer medications. Review of a resident's March 2022 eMAR revealed Staff A documented administering medications on 03/12/22, 03/13/22, 03/23/22, 03/24/22, 03/25/22, 03/26/22, and 03/31/22. Review of a resident's April 2022 eMAR revealed Staff A documented administering medications on 04/15/22. Refer to interview with the Business Office Manager (BOM) on 04/22/22 at 3:33pm. Refer to interview with the Resident Care Coordinator (RCC) on 04/22/22 at 3:45pm.	D935		

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D935	Continued From page 94 Refer to interview with the Administrator on 04/22/22 at 3:35pm. 2. Review of Staff B's, MA personnel record revealed: -Staff B was hired on 01/19/22. -There was documentation she passed the written MA exam on 12/30/21. -There was no documentation she completed the 5/10/15 hour training. -There was documentation Staff B completed the medication clinical skills competency validation on 02/10/22. Review of a resident's February 2022 eMAR revealed Staff B documented administering medications on 02/28/22. Review of a resident's March 2022 eMAR revealed Staff B documented administering medications on 03/01/22, 03/03/22, 03/07/22, 03/08/22, 03/09/22, 03/13/22, 03/16/22, 03/17/22, 03/21/22, 03/22/22, 03/23/22, 03/24/22, 03/27/22, 03/29/22, 03/30/22 and 03/31/22. Review of a resident's April 2022 eMAR revealed Staff B documented administering medications on 04/05/22, 04/06/22, 04/08/22, 04/10/22, 04/12/22 and 04/19/22. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm.	D935		

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D935	Continued From page 95 3. Review of Staff C's, MA personnel record revealed: -Staff C was hired on 03/03/22. -There was documentation she passed the written MA exam on 10/23/18. -There was no documentation she completed the 5/10/15 hour training. -There was documentation Staff C completed the medication clinical skills competency validation on 03/22/22. Review of a resident's February 2022 eMAR revealed Staff C did not administer medications. Review of a resident's March 2022 eMAR revealed Staff C documented administering medications on 03/26/22. Review of a resident's April 2022 eMAR revealed Staff C documented administering medications on 04/01/22, 04/02/22, 04/04/22, 04/07/22, 04/09/22, 04/13/22, 04/14/22 and 04/19/22. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 4. Review of Staff D's, MA personnel record revealed: -There was no hire date documented for Staff D. -Staff D was agency staff hired as a MA. -There was documentation she passed the written MA exam on 01/10/22. -There was no documentation she completed the 5/10/15 hour training.	D935		

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D935	Continued From page 96 -There was documentation Staff D completed the medication clinical skills competency validation on 01/10/22. Review of a resident's February 2022 eMAR revealed there was documentation Staff D administered medications for 17 days from 02/08/22 to 02/28/22. Review of a resident's March 2022 eMAR revealed there was documentation Staff D administered medications for 19 days from 03/01/22 through 03/31/22. Review of a resident's April 2022 eMAR revealed there was documentation Staff D administered medications for 10 days from 04/01/22 through 04/20/11. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 5. Review of Staff E's, MA personnel record revealed: -There was no hire date documented for Staff E. -Staff E was agency staff hired as a MA. -There was documentation she passed the written MA exam on 12/03/15. -There was no documentation she completed the 5/10/15 hour training. -There was documentation Staff E completed the medication clinical skills competency validation on 10/07/21.	D935		

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D935	Continued From page 97 Review of a resident's February 2022 eMAR revealed there was documentation Staff E administered medications one day 02/01/22 to 02/28/22. Review of a resident's March 2022 eMAR revealed there was documentation Staff E administered medications for four days from 03/01/22 through 03/31/22. Review of a resident's April 2022 eMAR revealed there was no documentation Staff E administered medications from 04/01/22 through 04/20/22. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. 6. Review of Staff F's, MA personnel record revealed: -Staff F was hired on 12/01/21. -Staff F was agency staff hired as a MA. -There was documentation she passed the written MA exam on 05/31/17. -There was no documentation she completed the 5/10/15 hour training. -There was no documentation Staff F completed the medication clinical skills competency validation. Review of a resident's February 2022 eMAR revealed there was no documentation Staff F administered medications from 02/01/22 through 02/28/22.	D935		

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D935	Continued From page 98 Review of a resident's March 2022 eMAR revealed there was no documentation Staff F administered medications from 03/01/22 through 03/31/22. Review of a resident's April 2022 eMAR revealed there was no documentation Staff F administered medications from 04/01/22 through 04/20/22. Refer to interview with the BOM on 04/22/22 at 3:33pm. Refer to interview with the RCC on 04/22/22 at 3:45pm. Refer to interview with the Administrator on 04/22/22 at 3:35pm. _____ Interview with the BOM on 04/22/22 at 3:33pm revealed: -She was aware the MAs required the 5/10/15 hour MA training and clinical skill check off to be completed prior to administering medications. -She was responsible for putting the pre-employment packet together which included the staff's 5/10/15 hour MA training and give to the RCC for processing. -The RCC was responsible for getting the MAs clinical skills check off completed by a nurse. -After the 5/10/15 hour training and clinical skills were verified and completed then the RCC was to give her the staff file back for the final hiring process. -She was not aware she needed to have proof of the 5/10/15 hour MA training for the agency MAs or that the agency MA were required to have the clinical skills check off prior to administering medications. Interview with the RCC on 04/22/22 at 3:45pm	D935		

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D935	Continued From page 99 revealed: -The BOM was responsible for giving her the MA staff records for processing the 5/10/15 hour MA training and the clinical skills check off. -Previously, until November 2021, she would contact the facility contracted nurse for completion of the 5/10/15 hour MA training and or the clinical skills check off prior to a MA administering medications. -Since November 2021, the facility did not have a nurse to complete the clinical skills check off. -Since November 2021, if a MA was listed on the registry as passing the MA test, then the MA's were cleared to pass medications. -She was not aware the MAs needed the clinical skills check off prior to administering medications. -There were no agency staff records located in the facility because the agency maintained all of those records. -She was not aware she needed the same documentation required for regular facility staff as the agency staff. Interview with the Administrator on 04/22/22 at 3:35pm revealed: -The BOM was responsible for giving the MA staff records to the RCC for processing the 5/10/15 hour MA training and the clinical skills check off. -The Health Wellness Director (HWD) who was a nurse was responsible for all MA training and the clinical skills check off to show profiency. -A MA could not administer medications until completion/verification of the 5/10/15 hour MA training and the clinical skill check off. -The BOM was responsible for collecting agency staff records to show proof of MA training and clinical skills check off from the agency prior to administering medications. -She did not know the agency MAs needed to have a nurse complete the clinical skill check off	D935		

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D935	Continued From page 100 at the facility prior to administering medications. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). Refer to Tag D0344 10A NCAC 13F .1002(a) Medication Orders (Type B Violation). Refer to Tag D0164 10A NCAC 13F .0505 Training on Care of Diabetic Resident (Type SD Violation). _____ The facility failed to ensure 6 of 6 sampled staff (Staff A, B, C, D, E and F) who administered medications had completed the Medication Aide Training and 2 of the 6 sampled staff (Staff A and F) had completed the clinical skills checklist prior to administering medications resulting in MAs who failed to re-order medications used to treat high blood pressure, cholesterol, anxiety, depression, and pain and medications used to thin the blood, and failed to clarify orders to complete neurovascular checks resulting in a resident developing a blood clot and check blood pressures prior to administering a blood pressure medication with parameters. The facility's failure to ensure MAs met training requirements prior to the administration of medications resulted in medication errors which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on April 22, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 7, 2022.	D935		

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