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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from June 1, 2022 to June 3, 2022.	D 000		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3	D 164		

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sampled medication aides (Staff A) who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin.

The findings are:

Review of Staff A's personnel record revealed:
-There was a hire date of 02/09/22.
-The Medication Clinical Skills Validation checklist was completed and dated 04/12/22.
-The 5-hour and 10-hour Medication Trainings were completed and dated 04/12/22.
-There was no documentation Staff A had completed training on the care of diabetic residents.

Observation of the 11:00am/12:00am medication pass on 06/02/22 revealed:
-Staff A performed fingerstick blood sugars (FSBS) on two residents.
-Staff A administered insulin to two residents.

Review of a resident's April 2022 electronic medication administration record (eMAR) revealed Staff A checked FSBS 24 times and administered insulin 26 times from 04/12/22-04/30/22.

Review of a resident's May 2022 eMAR revealed Staff A checked FSBS 38 times and administered insulin 36 times from 05/01/22-05/31/22.

Telephone interview with Staff A on 06/03/22 at 11:10am revealed:
-She had worked at the facility as a MA since April 2022 and administered insulin and checked FSBS.
-The Clinical Director (CD) trained her on the medication cart and showed her how to give

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insulin a few times.
-She learned how to check FSBS and administer insulin by observing other MAs at the facility as well.
-Other than observing other facility staff she did not receive any other diabetic training from the facility.

Interview with the Administrator on 06/03/22 at 10:45am revealed:
-Diabetic training was usually offered by the facility once a year.
-Diabetic training was last offered by the facility July 2021.
-She was not aware that MAs needed diabetic training before administering insulin.
-She thought if MAs had received their Medication Clinical Skills Validation checklist, they were then able to check FSBS and administer insulin to residents.

Interview with the facility's contracted nurse on 06/03/22 at 11:21am revealed:
-She provided training to staff at the facility.
-She validated MAs on competency of checking FSBS and administering insulin, but they did not receive diabetic training before administering insulin to residents.
-She was unaware that MAs needed diabetic training before administering insulin to residents.

D 269 — 10A NCAC 13F .0901(a) Personal Care and Supervision — D 269

10A NCAC 13F .0901 Personal Care and Supervision
(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care

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needs residents may be unable to attend to for themselves.

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

Based on observations, interviews, and record reviews, the facility failed to provide personal assistance for 1 of 5 sampled residents (#2) related toenails that were long, jagged, and curled; dry, flakey skin on his feet, dirt under his fingernails, hair that was growing over his ears and not clean shaven.

The findings are:

Review of a primary care physician (PCP) progress note dated 01/10/22 revealed Resident #2 had a diagnosis of prediabetes (prediabetes means an individual has higher than normal blood sugar levels).

Review of Resident #2's current FL-2 dated 12/21/21 revealed:
-Diagnoses of muscle weakness, abnormal gait, hypertension, and arthritis.
-He was intermittently disoriented and used a wheelchair to ambulate.

Review of Resident #2's previous care plan dated 04/25/22 revealed:
-His skin was extremely dry.
-He was oriented, and his memory was adequate.
-He required extensive hands on assistance daily for bathing.
-He required extensive hands on assistance for shaving and nail care of feet and hands as needed.

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Review of Resident #2's care plan dated 05/19/21 revealed:
-He required extensive hands on assistance daily for bathing.
-He required verbal prompts with extensive hands on assistance for shaving.
-He required verbal prompts with extensive hands on assistance for nail care of feet and hands as needed.

Review of a facility progress note dated 03/29/22 revealed Resident #2 allowed a medication aide (MA) to trim and file his fingernails.

Review of a facility progress note dated 12/27/21 revealed:
-The Administrator met with Resident #2's family member about concerns related to the residents care.
-The Administrator documented that staff were to encourage and assist Resident #2 with his activities of daily living (ADL's).
-If Resident #2 refused care staff were expected to report his refusal to the Resident Care Coordinator (RCC) or Administrator.

Interview with Resident #2 on 06/01/22 at 10:05am revealed:
-He bathed himself, but he needed help washing his back and feet.
-Staff had not helped him wash his back and feet "since last year".
-The last time staff was supposed to help him (the resident could not recall the date), staff went to get a towel but never came back to assist him.
-His feet/toenails were "real terrible".

Observation of Resident #2 on 06/01/22 at 1:40pm revealed:

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-He was in his room seated in his wheelchair.
-He had socks on that came to his mid-calf and was wearing loafers.
-When he removed his socks flakes of dry skin were visible on the floor.
-The resident's toenails on both feet were long, yellowish brown and had thick clumps of a yellow substance underneath the nails.
-Both feet had thick areas of skin patches that were dry and flaking onto the floor when he removed his socks.
-The left foot had overgrown nails that had curved together.
-The great toe on his left foot was curved to the right past the end of his toe and about 1 inch long with clumps of yellow at the cuticle.
-The second and third toenail on his left foot were about ¾ of an inch long and curved on both sides of the nails.
-The fourth and fifth toenail on his left foot were about ½ in long and curved.
-The great toe on the right foot was about ¾ inch long with clumps of yellow at the cuticle.
-The second and third toe on the resident's right foot was about 1 inch long and jagged.
-The fourth toe on his right foot was about ½ inch long and curved upward and was angled toward the left.
-The fifth toe on his right foot was ½ inch long, angled to the left and was jagged.
-His hair had grown past his ears and was not clean shaven.

Interview with a personal care aide (PCA) on 06/01/22 at 1:53pm revealed Resident #2 required extensive assistance with bathing, skincare, haircare and footcare on Mondays, Wednesdays and Fridays on second shift.

Interview with a second PCA on 06/01/22 at

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5:45pm revealed:
-She worked second shift and was responsible for providing personal care to Resident #2 based on his plan of service.
-She would check on Resident #2 every few minutes to see if he needed any assistance with his bath.
-She had never washed or applied lotion to his feet unless he asked for assistance.
-When he asked for lotion for his feet, she would give him the lotion so he could apply it to his feet.
-She observed his feet three weeks ago and did not notice any problems with his feet or toenails; they looked clean and she did not notice the long toenails.
-She was not aware that Resident #2's toenails were long and that his feet were dry because she did not provide him assistance with his bath.
-She was expected to report any concerns to the medication aide (MA), RCC or the Clinical Director (CD).
-She laughed and did not know why she had not reported any concerns to the MA, RCC or the CD.

Interview with the RCC on 06/01/22 at 2:17pm revealed:
-PCAs used a plan of service to provide personal care to residents based on their needs.
-PCAs were expected to wash Resident #2's feet and back on Mondays, Wednesdays and Fridays and he required extensive assistance.
-She provided nailcare to non-diabetic residents and PCAs washed resident toenails and fingernails.
-She was not aware that the PCP had written in a progress note on 01/10/22 that Resident #2 had a diagnosis of prediabetes.
-She soaked residents' feet, cut their toenails and applied lotion.
-She washed his feet and back 2 weeks ago

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when he requested assistance with his bath, and she did not notice that his toenails were long and curved.
-She was concerned that Resident #2's toenails were so long and "knew they were hurting him."
-She did not notice that Resident #2's toenails were long and curved until she observed them with the state surveyor on 06/01/22.
-She did not realize his toenails were if they were and did not understand why the PCAs or MAs had not reported it to her.
-She expected PCAs to provide residents with care based on their plan of service in the activities of daily living (ADL) binder.
-PCAs were expected to document an "R" if a resident refused personal care services.
-Resident #2 would refuse assistance with personal care from PCAs at times.
-PCAs were expected to report any refusal of care to the MA, CD or the RCC.

Interview with the Administrator on 06/01/22 at 2:40pm revealed:
-She was not aware that Resident #2's toenails were unkept and long.
-PCAs were expected to provide residents with care based on their plan of service.
-PCAs should have provided Resident #2 assistance with bathing his feet and applying lotion to his feet.
-Resident #2 often refused care but that was no excuse for his feet to be so dry and his toenails so long.
-When a resident refused care the PCAs were expected to report the refusal to the MA, CD or the RCC.
-The RCC and CD were responsible for completing a quality assurance log once a month on resident skin and nailcare.
-She was not able to provide documentation of

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the quality assurance long on resident skin and nailcare.
-She reviewed the quality assurance log after the RCC, and CD completed their review of the log.
-Resident #2's feet and toenails should not have been neglected.
-When the RCC provided him with bathing assistance last week, she should have applied lotion to his feet, trimmed his toenails and contacted his PCP for a referral to the podiatrist.

Attempted telephone interview with Resident #2's family member on 06/02/22 at 11:19am and 06/03/22 at 10:17am were unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/02/22 at 2:23pm and 06/03/22 at 10:07am were unsuccessful.

____

The facility failed to ensure the personal care needs were met for 1 of 5 sampled residents. Resident #2 had long, thick yellowed toenails, extremely dry, thick flaky skin on his feet, resulting in difficulty with walking and discomfort. The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/01/22 for this violation.

CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 18, 2022.

D 273	10A NCAC 13F .0902(b) Health Care	D 273		

10A NCAC 13F .0902 Health Care

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(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 A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 5 sampled residents (#2, #3, #4) related to not obtaining podiatry care for a diabetic resident with long, thick toenails and open wounds on his feet, not notifying the primary care provider (PCP) of elevated blood sugars, and not notifying the mental health provider (MHP) of side effects of an antipsychotic medication (#3); not notifying the PCP of a resident's swollen legs and obtaining podiatry care for the resident's long, thick toenails (#2); and not obtaining an abdominal computed tomography (CT) scan for a resident (#4).

The findings are:

1. Review of Resident #3's current FL-2 dated 11/30/21 revealed diagnoses included early stage dementia, type 2 diabetes mellitus, schizoaffective disorder, depression, protein calorie malnutrition, and absence of right great toe.

a. Review of Resident #3's current assessment and care plan dated 11/30/21 revealed:
-The resident was ambulatory.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision by staff with bathing, dressing, eating, ambulation, transferring, and toileting.

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D 273	Continued From page 10 -The resident required extensive assistance by staff with nail care. -The resident's medical history included right great toe amputation. Review of Resident #3's licensed health professional support (LHPS) evaluation dated 04/12/22 revealed: -The resident was diabetic and received oral diabetes medication and insulin at bedtime. -The resident had right great toe amputation (no date provided). -The resident refused nail care on 04/05/22. Review of Resident #3's facility progress note dated 04/05/22 revealed the resident refused to allow the podiatrist to look at his feet or trim his toenails today. Observation of Resident #3 on 06/02/22 at 11:33am revealed: -The resident's toenails on both feet were yellowish brown, long, and thick with clumps of a yellow substance underneath the nail. -The second and fourth toenails on the left foot were long, thick, yellow and curved over the top of the toes. -The third and fifth toenails were about ½ inch long, thick, yellow, and jagged. -There was a quarter sized black scabbed area on the side of his left foot near the fifth toe with some redness around the area. -The great toe on his right foot had been amputated. -The second toenail on his right foot was about 1 inch long, thick and curved over the top of the toe and pressed into the skin under the toe. -The top of his second toe on his right foot was red and swollen with two small open areas in the center of the swelling and redness.	D 273		

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-The third toenail on the right foot was about ½ inch long, thick, jagged and curved over the top of the toe.
-The fifth toenail on the right foot was about 1 inch long, thick, and yellow.

Interview with Resident #3 on 06/02/22 at 11:33am revealed:
-The scabbed area on his left foot had been there a couple of months.
-It started as a blister that he "popped" open.
-The two open areas on his right second toe also started as blisters a couple of months ago.
-His toenails needed trimming and his left foot was the worst.
-He did not know when he last saw a podiatrist.
-No one had offered to help with his toenails.

Interview with a personal care aide (PCA) on 06/02/22 at 11:54am revealed:
-She assisted Resident #3 with a shower yesterday, 06/01/22, and she did not notice any issue with his skin or body.
-The resident's toenails were "real long" and needed cutting.
-The PCAs were not allowed to cut any residents' toenails.
-The scab on the resident's left foot had been there a couple of weeks.
-She reported the scab on the resident's left foot to the Resident Care Coordinator (RCC) when she saw it a couple of weeks ago.
-The RCC stated she would take care of it.

Interview with the RCC on 06/02/22 at 11:42am revealed:
-Resident #3 required extensive assistance with nail care.
-She thought a PCA reported concerns about Resident #3's feet yesterday, 06/01/22, and that

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may be the reason the resident was seen by the primary care provider (PCP) yesterday.
-The PCAs should have reported the condition of Resident #3's feet and toenails sooner.

Interview with the Clinical Director (CD) on 06/02/22 at 1:23pm revealed:
-She was unaware of the condition of Resident #3's feet and toenails until the PCP notified her yesterday, 06/01/22.
-Resident #3 was being seen yesterday, 06/01/22, for falls when the PCP noticed the wounds on the resident's feet.
-The PCAs and medication aides (MAs) were supposed to let her or the RCC know about any change in a resident's condition.
-No facility staff had reported any issues with Resident #3's feet or toenails.
-A podiatrist usually came to the facility every 3 months.
-Resident #3 refused to see the podiatrist on the last visit to the facility in April 2022.
-The PCAs should be assisting the resident with washing his feet and putting lotion on his feet.
-If she had known the resident's feet and toenails were in that condition, she would have contacted the facility's contracted podiatry provider to come back sooner or set up an appointment with an outside podiatry provider.

Interview with the Administrator on 06/03/22 at 4:43pm revealed:
-The PCAs should notify the MAs of any concerns with residents' feet or toenails.
-The MAs should notify the RCC or the CD, who would be responsible for contacting the provider and getting care for the resident.

Review of Resident #3's PCP visit note dated 06/01/22 revealed:

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-The resident was being seen for a follow up to a fall.
-The resident had uncontrolled diabetes mellitus, his right great toe had been amputated, and he had a wound to his left lateral foot.
-The resident's left lateral foot had a wound covered with eschar (dead tissue), with callous formation underneath the foot.
-The resident's right foot had two small open areas and swelling on the second toe and a callous under the right lateral aspect of his foot.
-There was possibly a fungus infection under the left great toenail.
-The resident had decreased sensation of his feet.
-The wound to the left foot was covered with dead tissue and unable to see base.
-Podiatry consult for diabetic foot care was ordered.

Telephone interview with Resident #3's PCP on 06/02/22 at 2:55pm revealed:
-She saw Resident #3 for a visit yesterday, 06/01/22, due to a recent fall.
-The resident mentioned his feet problems to her.
-The facility staff had not reported any concerns about the resident's feet.
-The resident had some wounds on his feet and she needed to know about the wounds so she could try to mitigate (lessen the severity of) any problems from the wounds.
-She was concerned about the resident's foot wounds because the resident was diabetic and his right great toe had been amputated.
-The resident had a quarter-sized eschar (dead tissue) on his lateral left foot.
-The resident had 2 open wounds on top of his second toe on the right foot.
-She wrote an order for a consult with podiatry for diabetic foot care.

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-A wound could worsen "pretty rapidly" especially for diabetics and needed to be treated.
-The wound on the left lateral foot was likely initially a blister and would need to be debrided.
-The resident would probably have to be seen by a wound care clinic because more extensive treatment would be needed since it was not taken care of sooner.
-The facility staff should have notified her of any changes in the resident's condition immediately.

b. Review of Resident #3's primary care provider (PCP) order dated 02/01/22 revealed an order to check fingerstick blood sugar (FSBS) twice a day, notify the provider if the FSBS was less than (<) 60 or greater than (>) 250.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS twice a day, notify PCP if <60 or >250.
-FSBS were scheduled to be checked at 7:00am and 7:00pm.
-The resident's FSBS was documented as >250 on 11 occasions ranging from 251 - 428 on those 11 occasions.
-The FSBS was 266 at 7:00am on 04/25/22.
-The FSBS at 7:00pm included: 261 on 04/01/22, 266 on 04/06/22 and 04/26/22, 258 on 04/07/22, 278 on 04/23/22, 262 on 04/24/22, 293 on 04/25/22, 251 on 04/27/22, 274 on 04/28/22, and 428 on 04/29/22.
-There was no documentation the resident's PCP was notified of any of the 11 FSBS >250 as ordered.

Review of Resident #3's May 2022 eMAR revealed:
-There was an entry to check FSBS twice a day,

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notify PCP if <60 or >250.
-FSBS were scheduled to be checked at 7:00am and 7:00pm.
-The resident's FSBS was documented as >250 on 15 occasions ranging from 251 - 526 on those 15 occasions.
-The FSBS at 7:00am included: 310 on 05/30/22 and 269 on 05/31/22.
-The FSBS at 7:00pm included: 292 on 05/01/22, 290 on 05/02/22, 251 on 05/03/22, 311 on 05/05/22, 526 on 05/07/22, 328 on 05/10/22, 268 on 05/14/22, 263 on 05/17/22 and 05/29/22, 294 on 05/24/22, 273 on 05/25/22, 279 on 05/26/22, and 275 on 05/27/22.
-There was no documentation the resident's PCP was notified of any of the 15 FSBS >250 as ordered.

Review of Resident #3's facility progress notes and provider notification forms revealed no documentation the PCP was notified of 26 of 26 FSBS >250 in April 2022 and May 2022.

Interview with Resident #3 on 06/02/22 at 11:33am revealed:
-He took an oral diabetic medication.
-He did not remember if he received insulin or how often his FSBS was checked.

Interview with a medication aide (MA) on 06/02/22 at 12:10pm revealed:
-She had not contacted Resident #3's PCP when his FSBS was >250 because the PCP came to the facility every week.
-She would have documented in the resident's record if she had notified the PCP.

Interview with a second MA on 06/02/22 at 4:47pm revealed:
-She did not contact Resident #3's PCP when his

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FSBS was >250 when she checked it because she overlooked the instructions to do that on the eMAR.
-If she had noticed the instructions, she would have called the PCP to get further instructions and documented it in the facility progress notes in the resident's record.

Interview with the Clinical Director (CD) on 06/02/22 at 1:23pm revealed:
-The MAs were responsible for contacting the PCP for any FSBS >250 as ordered.
-The MAs should document notification of FSBS >250 on the facility's provider notification form or in the facility progress notes.
-The PCP should be faxed or called at the time the FSBS was >250.

Interview with the Resident Care Coordinator (RCC) on 06/02/22 at 1:45pm revealed:
-The MAs were responsible for notifying the PCP of any FSBS over the ordered parameters.
-The MAs should notify the PCP of the high FSBS because the resident could go into a diabetic coma if the FSBS went too high.

Interview with the Administrator on 06/03/22 at 4:43pm revealed the MAs should call Resident #3's PCP immediately for any FSBS >250 and document it on the eMAR and the facility progress notes.

Telephone interview with Resident #3's PCP on 06/02/22 at 2:55pm revealed:
-She had not been notified of any FSBS >250 for Resident #3 since she started providing care services at the facility on 04/11/22.
-Resident #3's FSBS were not well controlled and she needed to know if the resident's FSBS was high so the medication dosage could be adjusted.

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c. Review of Resident #3's mental health provider (MHP) visit note dated 04/27/22 revealed:
-There was an order to start Seroquel 25mg 1 tablet twice a day at 8:00am and 2:00pm for behaviors. (Seroquel is an antipsychotic used to treat schizophrenia and mood disorders.)
-Staff to monitor for sedation falls or gait disturbance, and contact MHP immediately for further instructions.

Review of Resident #3's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Seroquel 25mg 1 tablet twice a day for behaviors at 8:00am and 2:00pm.
-Seroquel 25mg was documented as administered from 04/28/22 - 04/30/22.

Review of Resident #3's May 2022 and June 2022 eMARs revealed:
-There was an entry on each eMAR for Seroquel 25mg 1 tablet twice a day for behaviors at 8:00am and 2:00pm.
-Seroquel 25mg was documented as administered from 05/01/22 - 06/01/22.

Review of Resident #3's facility progress note dated 05/01/22 revealed the resident was found on the floor in the hallway outside of the café.

Review of Resident #3's emergency department (ED) after visit summary dated 05/01/22 revealed:
-The resident's reason for visit was a fall.
-The resident's diagnoses included fall and bilateral elbow joint pain.

Review of Resident #3's facility progress note dated 05/15/22 revealed the resident stated he

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fell out of bed and he had a large swollen area on his forehead.

Review of Resident #3's ED after visit summary dated 05/15/22 revealed:
-The resident's reason for visit was a fall.
-The resident's diagnoses included fall, head injury, and contusion of forehead.
-The head scan showed no signs of fracture or acute abnormality.

Review of Resident #3's facility progress note dated 05/31/22 revealed the resident fell in the hallway and was sent to the ED.

Review of Resident #3's ED after visit summary dated 05/31/22 revealed:
-The resident's reason for visit and diagnosis was fall.
-The resident's head scan was negative.

Review of Resident #3's facility progress notes revealed no documentation the MHP was notified of the resident's 3 falls that occurred after the resident started taking Seroquel.

Interview with the Clinical Director (CD) on 06/02/22 at 1:23pm revealed:
-She was not aware Resident #3's Seroquel order included notifying the MHP of side effects including falls.
-She was aware Resident #3 had some recent falls but she did not notify the MHP because she was not aware of the order.
-She or the Resident Care Coordinator (RCC) would have been responsible for ensuring the medication aides (MAs) were aware of the order to notify the MHP of side effects of the Seroquel.
-The order was overlooked.

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Interview with the RCC on 06/02/22 at 1:45pm revealed:
-She or the CD would have been responsible for ensuring the MAs were aware of the order to notify the MHP of side effects of the Seroquel.
-The order was overlooked.
-If the MHP was notified, it would have been documented in the facility progress notes.

Interview with the Administrator on 06/03/22 at 4:43pm revealed:
-The MAs were responsible for notifying a provider of side effects of medications.
-The MHP should have been notified of Resident #3's falls after he started taking Seroquel.

Telephone interview with Resident #3's MHP on 06/02/22 at 2:33pm revealed:
-She prescribed Seroquel for the resident on 04/27/22 for behaviors.
-She last saw the resident during a visit on 05/20/22.
-Staff reported during the visit on 05/20/22 that the resident had falls on 05/01/22 and 05/15/22.
-The resident's falls should have been reported to her on the same day they occurred so she could have assessed at that time whether the Seroquel contributed to those falls.
-She was not aware Resident #3 had a third fall on 05/31/22.
-Staff should have reported the fall when it occurred on 05/31/22.
-If she had been notified of the third fall on 05/31/22 since Seroquel was started, she would have decreased the dose.
-Seroquel could cause gait instability, leading to the falls.

2. Review of Resident #2's current FL-2 dated 12/21/21 revealed:

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-Diagnoses of muscle weakness, abnormal gait, hypertension, and arthritis.
-He was intermittently disoriented and used a wheelchair to ambulate.

Review of Resident #2's current care plan dated 04/25/22 revealed:
-He had a history of mental illness and received medications for mental illness.
-He had a history of anxiety and agitation.
-His skin was extremely dry.
-He was oriented, and his memory was adequate.

a. Observation of Resident #2 on 06/01/22 at 1:34pm revealed:
-He was in his room seated in his wheelchair.
-He had socks on that came to his mid-calf and was wearing loafers.
-He removed the sock from his left foot.
-There was an imprint of ridges from the sock and a large amount of swelling above the imprint of ridges.

Interview with Resident #2 on 06/01/22 at 10:05am revealed:
-His legs had been swollen for over a week and he propped them up in bed, but the swelling did not go down.
-It was "hard to stand up" because of his swollen legs.
-A staff person (could not recall who) told him yesterday that they would make an appointment for him to see the doctor.

A second interview with Resident #2 on 06/01/22 at 1:34pm revealed he informed the Resident Care Coordinator (RCC) on 05/31/22 that he needed to see his doctor because his left leg was swollen.

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Interview with a personal care aide (PCA) on 06/01/22 at 5:45pm revealed that she had not noticed any swelling of Resident #2's legs.

Interview with the RCC on 06/01/22 at 2:17pm revealed:
-Resident #2 spoke with her on 05/31/22 about his left leg being swollen and he requested that she make him an appointment with his primary care provider (PCP).
-She contacted his PCP on 05/31/22 and left a message for the PCP to call her back regarding the swelling of his left leg but had not heard back from the PCP.

Interview with the Administrator on 06/01/22 at 2:40pm revealed:
-The RCC should have already made an appointment with Resident #2's PCP for his swelling at his left calf.
-She was concerned that an appointment had not been scheduled and if an appointment could not be made for this week; he would need to be sent out for an emergency evaluation.

Attempted telephone interview with Resident #2's family member on 06/02/22 at 11:19am and 06/03/22 at 10:17am was unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/02/22 at 2:23pm and 06/03/22 at 10:07am were unsuccessful.

b. Review of a physician's order request dated 04/27/22 revealed:
-The Clinical Manager (CM) requested medication for agitation, resident refused to see in house psychiatrist, he yelled and cursed at staff and other residents and slammed doors.
-The primary care provider (PCP) ordered on

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04/29/22 that Resident #2 needed to be attended by someone who can answer questions about behavior and medications and needed to be referred to a psychiatrist.

Interview with the Clinical Director (CD) on 06/03/22 at 8:40am revealed:
-When the primary care provider (PCP) wrote a progress note or communication note that a resident needed a referral to another provider; she was responsible for contacting the provider and coordinating the appointment.
-Occasionally she would inform the transportation coordinator that the PCP wanted a resident referred to another provider for services and the transportation coordinator would contact the provider and schedule the appointment.
-She knew that Resident #2 would refuse to see a psychiatrist, but it was her responsibility to follow the PCP order to refer him to a psychiatrist.
-She should have contacted the PCP for a clarification order.
-It was her responsibility to make the referral to a psychiatrist even though Resident #2 refused the service.
-She was expected to follow PCP orders and should have contacted the psychiatrist to make an appointment.

Interview with the RCC on 06/03/22 at 8:53am revealed:
-She did not realize that Resident #2 had not been referred to a psychiatrist as ordered by the PCP.
-Resident #2 had refused to see a psychiatrist but he had not been referred to a psychiatrist for an assessment.
-She did not know exactly when Resident #2 had refused to see a psychiatrist.
-She and the CD should have followed the PCP's

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order to refer Resident #2 to a psychiatrist.
-She and the CD were responsible for not completing the referral to a psychiatrist for Resident #2.
-Resident #2 could have benefited from mental health services to decrease his anxiety and agitation he experienced at times.

Attempted telephone interview with Resident #2's family member on 06/02/22 at 11:19am and 06/03/22 at 10:17am were unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/02/22 at 2:23pm and 06/03/22 at 10:07am were unsuccessful.

c. Review of a primary care physician (PCP) progress note dated 01/10/22 revealed Resident #2 had a diagnosis of prediabetes.

Observation of Resident #2 on 06/01/22 at 1:40pm revealed:
-He was in his room seated in his wheelchair.
-He had socks on that came to his mid-calf and was wearing loafers.
-When he removed his socks flakes of dry skin were visible on the floor.
-The resident's toenails on both feet were long, yellowish brown and had thick clumps of a yellow substance underneath the nails.
-Both feet had thick areas of skin patches that were dry and flaking onto the floor when he removed his socks.
-The left foot had overgrown nails that had curved together.
-The great toe on his left foot was curved to the right past the end of his toe and about 1 inch long with clumps of yellow at the cuticle.
-The second and third toenail on his left foot were about ¾ of an inch long and curved on both sides

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of the nails.
-The fourth and fifth toenail on his left foot were about ½ in long and curved.
-The great toe on the right foot was about ¾ inch long with clumps of yellow at the cuticle.
-The second and third toe on the resident's right foot was about 1 inch long and jagged.
-The fourth toe on his right foot was about ½ inch long and curved upward and was angled toward the left.
-The fifth toe on his right foot was ½ inch long, angled to the left and was jagged.

Interview with a personal care aide (PCA) on 06/01/22 at 1:53pm revealed she provided bathing and footcare to Resident #2 on Mondays, Wednesdays and Fridays on second shift but had not noticed how long his toenails were.

Interview with a second PCA on 06/01/22 at 5:45pm revealed:
-She worked second shift and was responsible for providing personal care to Resident #2 based on his plan of service.
-She observed his feet three weeks ago and did not notice how long his toenails had grown.

Interview with the RCC on 06/01/22 at 2:17pm revealed:
-Resident #2 had asked her for toenail clippers several times.
-She was not aware that his toenails were long and curved.
-He was diagnosed as prediabetic by his PCP and his toenails would need to be cut by a podiatrist.
-She should have updated the PCP that he needed to be seen by a podiatrist to have his toenails trimmed since he was prediabetic.
-She was concerned that Resident #2's toenails

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were so long and "knew they were hurting him."

Interview with the Administrator on 06/01/22 at 2:40pm revealed:
-She was not aware that Resident #2's toenails were unkept and so long.
-When the RCC provided him with bathing assistance last week she should have contacted his PCP for a referral to the podiatrist.
-Resident #2's feet and toenails should not have been neglected.

Attempted telephone interview with Resident #2's family member on 06/02/22 at 11:19am and 06/03/22 at 10:17am were unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/02/22 at 2:23pm and 06/03/22 at 10:07am were unsuccessful.

3. Review of Resident #4's current FL-2 dated 09/07/21 revealed diagnoses of diabetes and thrombophlebitis of his left arm (a blood clot in a vein that causes inflammation and pain).

Review of Resident #4's current care plan dated 04/26/22 revealed:
-He used a wheelchair to ambulate and had limited range of motion of his left shoulder and arm.
-He was oriented but forgetful at times and needed reminders.

Review of Resident #4's a physician order dated 03/02/22 revealed the primary care provider (PCP) wrote a new order referring the resident for a CT (computed tomography) scan of his abdomen with contrast to rule out an intestinal obstruction.

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D 273	Continued From page 26 Review of Resident #4's physician order request dated 02/19/22 revealed: -The Clinical Director (CD) informed the PCP that the resident refused all morning medications because it made him sick to his stomach. -The PCP documented on 03/22/22 on the form that an abdominal CT scan had been previously ordered and that the resident needed to be scheduled for the scan. Review of a facility fax dated 03/04/22 revealed the transportation coordinator at the facility sent a fax to a local radiologist to request an appointment for Resident #4 sometime in April 2022 on a Tuesday or Thursday. Record review revealed there was no documentation that Resident #4 had a CT scan with contrast as ordered by the PCP. Interview with the CD on 06/03/22 at 1:08pm revealed: -She did not know if Resident #4 had a CT scan as ordered. -Sometimes she gave PCP orders to the transportation coordinator to schedule appointments for residents. -She was unable to find documentation that a CT scan had been completed. Interview with the RCC on 06/03/22 at 12:59pm revealed: -Resident #4 was ordered an abdominal CT scan on 03/02/22. -She was unable to locate documentation that the CT scan had been completed. -She had contacted the radiologist on 06/03/22 to obtain the results but had not received them. -The CD should have followed up to ensure the CT scan was completed and to request	D 273		

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documentation of the scan.
-She did not know how she had missed the results not being in his chart and should have followed up with the radiologist to ensure the CT scan was completed.

Interview with the Administrator on 06/03/22 at 4:00pm revealed:
-She was not aware that the CD and RCC were unable to locate documentation that Resident #4 had an abdominal CT scan.
-The CD and RCC should have followed up with the radiologist to ensure the appointment was made and the facility received documentation of the report.
-The CD and RCC should have sent the report to his PCP.
-She was concerned that Resident #4 was refusing medications due to stomach pain and that a CT scan should have been completed to make a proper diagnosis.

Attempted telephone interview with Resident #4's PCP on 06/03/22 at 3:50pm was unsuccessful.

____

The facility failed to ensure the acute and routine health care needs were met for 3 sampled residents. Resident #3 had diabetes and had long thick toenails that were jagged with some curving over the top of the toes and a quarter-sized wound on his left foot and two open areas on his second right toe. Resident #3's PCP was not notified of 26 FSBS >250 preventing the PCP from making changes in the resident's medication regimen resulting in uncontrolled FSBS. Resident #3's MHP was not notified of side effects of an antipsychotic resulting in 3 falls requiring evaluation at the emergency room, with one fall resulting in a closed head injury. Resident #2 had long, thick yellowed toenails,

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D 273	Continued From page 28 extremely dry, thick flaky skin on his feet, and swelling in the lower legs resulting in difficulty with walking and discomfort. Resident #4 did not have a CT scan for symptoms related to stomach issues. The facility's failure resulted in serious physical harm and serious neglect and constitutes a Type A1 Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/02/22 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 3, 2022.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 4 residents (#4, #6, #7, #8) observed during the medication passes including errors with insulin (#4, #8), medication for diabetes and constipation (#6), inhaled medications used to treat asthma (#6, #7); and	D 358		

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for 4 of 5 residents sampled (#1, #2, #4, #5) for record review including errors with a medication for ear wax removal (#1), a medication for moderate to severe pain (#2), insulin (#4), and medications for inflammation and acid reflux (#5).

The findings are:

1. The medication error rate was 24% as evidenced by the observation of 5 errors out of 25 opportunities during the 9:00am medication pass on 06/01/22 and the 11:00am/12:00pm medication pass on 06/02/22.

a. Review of Resident #8's current FL-2 dated 01/04/22 revealed:
-Diagnoses included type 2 diabetes mellitus with hyperglycemia. (Hyperglycemia is high blood sugar.)
-There was an order for Humalog inject 3 units three times a day before meals. (Humalog is a rapid-acting insulin used to lower blood sugar. The manufacturer recommends taking Humalog 15 minutes before or immediately after a meal.)

Observation of the 11:00am/12:00pm medication pass on 06/02/22 revealed:
-The medication aide (MA) checked Resident #8's blood sugar, which was 124 at 11:18am.
-The MA administered Humalog 3 units into Resident #8's left lower abdomen at 11:19am.

Interview with Resident #8 on 06/02/22 at 11:51am revealed:
-He received his lunchtime insulin anywhere between 11:00am and 12:00pm.
-He usually ate lunch at 12:00pm.
-When his blood sugar was low, he had symptoms such as feeling dizzy and weak.
-He did not currently feel like his blood sugar was

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low.

Observation on 06/02/22 revealed Resident #8 received his lunch and at 12:16pm starting eating 57 minutes after being administered Humalog, a rapid-acting insulin.

Review of Resident #8's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog inject 3 units three times a day before meals.
-Humalog was scheduled for administration at 7:00am, 11:00am, and 4:00pm.
-The 11:00am dosage of Humalog was documented as administered on 06/01/22 and 06/02/22.
-The resident's blood sugar ranged from 104-178 on 06/01/22-06/02/22.

Interview with the MA on 06/02/22 at 2:27pm revealed:
-Insulin should be given 30 minutes or less before a meal.
-If rapid-acting insulin was administered too long before a meal it could cause the resident to have a low blood sugar which could cause them to sweat or pass out.
-She went by the eMAR for what time to administer insulin to residents.
-If the insulin was on the eMAR to be administered at 11:45am she could administer it as early as 11:15am because that was 30 minutes before the scheduled administration time.

Interview with the Clinical Director (CD) on 06/02/22 at 1:56pm revealed:
-Residents should receive rapid-acting insulin within 30 minutes of eating a meal.

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-Administering a rapid-acting insulin more than 30 minutes before eating a meal could cause the resident's blood sugar to drop.
-The MAs were trained regarding the timing of giving insulin in accordance with meals.

Interview with the Resident Care Coordinator (RCC) on 06/02/22 at 1:22pm revealed:
-Rapid-acting insulin should be administered 10-15 minutes before a resident started eating.
-If rapid-acting insulin was administered too long before a resident started eating it could affect their blood sugar by making it drop.
-The MAs were trained to administer rapid-acting insulin right before meals which was 10-15 minutes prior to eating.

Interview with the Administrator on 06/02/22 at 1:29pm revealed:
-Rapid-acting insulin should be administered 10-15 minutes prior to meals.
-A resident's blood sugar could become too low if rapid-acting insulin was administered too far in advance of a meal.
-The MAs should have been trained regarding administering insulin in relation to mealtimes.

Telephone interview with Resident #8's primary care provider (PCP) on 06/02/22 at 2:55pm revealed:
-Residents should be administered rapid-acting insulin no more than 15-30 minutes prior to eating.
-Administering a rapid-acting insulin more than 30 minutes before eating could cause a resident to become hypoglycemic. (Hypoglycemia is a low blood sugar.)

b. Review of Resident #4's current FL-2 dated 09/07/21 revealed:

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-Diagnoses included diabetes mellitus.
-There was an order for NovoLog inject 4 units before meals, hold if blood sugar was less than 150. (NovoLog is rapid-acting insulin used to lower blood sugar. The manufacturer recommends taking NovoLog within 5-10 minutes before the start of a meal.)

Observation of the 11:00am/12:00pm medication pass on 06/02/22 revealed:
-The medication aide (MA) checked Resident #4's blood sugar which was 193 at 11:29am.
-The MA administered 4 units of NovoLog into Resident #4's left upper arm at 11:30am.

Interview with Resident #4 on 06/02/22 at 11:48am revealed:
-He received insulin at different times before lunch.
-When his blood sugar was low, he had symptoms such as the room spinning around.
-He did not currently feel like his blood sugar was low.

Observation on 06/02/22 revealed Resident #4 received his lunch and at 12:18pm started eating 48 minutes after being administered 4 units of NovoLog, a rapid-acting insulin.

Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for NovoLog inject 4 units before meals, hold for fingerstick blood sugar (FSBS) less than 150.
-NovoLog was scheduled to be administered at 6:50am, 11:50am, and 4:50pm.
-The 11:50am dose was documented as administered on 06/01/22 and 06/02/22.
-The resident's blood sugar ranged from 149-296

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from 06/01/22-06/02/22.

Interview with the MA on 06/02/22 at 2:27pm revealed:
-Insulin should be given 30 minutes or less before a meal.
-If rapid-acting insulin was administered too long before a meal it could cause the resident to have a low blood sugar which could cause them to sweat or pass out.
-She went by the eMAR for what time to administer insulin to residents.
-If the insulin was on the eMAR to be administered at 11:45am she could administer it as early as 11:15am because that was 30 minutes before the scheduled administration time.

Interview with the Clinical Director (CD) on 06/02/22 at 1:56pm revealed:
-Residents should receive rapid-acting insulin within 30 minutes of eating a meal.
-Administering a rapid-acting insulin more than 30 minutes before eating a meal could cause the resident's blood sugar to drop.
-The MAs were trained regarding the timing of giving insulin in accordance with meals.

Interview with the Resident Care Coordinator (RCC) on 06/02/22 at 1:22pm revealed:
-Rapid-acting insulin should be administered 10-15 minutes before a resident started eating.
-If rapid-acting insulin was administered too long before a resident started eating it could affect their blood sugar by making it drop.
-The MAs were trained to administer rapid-acting insulin right before meals which was 10-15 minutes prior to eating.

Interview with the Administrator on 06/02/22 at

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1:29pm revealed:
-Rapid-acting insulin should be administered 10-15 minutes prior to meals.
-A resident's blood sugar could become too low if rapid-acting insulin was administered too far in advance of a meal.
-The MAs should have been trained regarding administering insulin in relation to mealtimes.

Telephone interview with Resident #8's primary care provider (PCP) on 06/02/22 at 2:55pm revealed:
-Residents should be administered rapid-acting insulin no more than 15-30 minutes prior to eating.
-Administering a rapid-acting insulin more than 30 minutes before eating could cause a resident to become hypoglycemic. (Hypoglycemia is a low blood sugar.)

c. Review of Resident #6's current FL-2 dated 03/15/22 revealed:
-Diagnoses included type 2 diabetes mellitus (DM) and gastro-esophageal reflux disease (GERD). (GERD is a digestive disease in which stomach acid or bile irritates the food pipe lining.)
-There was an order for Metformin 500mg 2 tablets twice a day with meals for DM. (Metformin lowers blood sugar.)

Observation of the 9:00am medication pass on 06/01/22 revealed the medication aide (MA) administered 2 tablets of Metformin 500mg to Resident #6 at 9:32am.

Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Metformin 500mg take 2 tablets twice a day with meals for DM.

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D 358	Continued From page 35 -The Metformin was scheduled for administration at 9:00am and 5:00pm. -The 9:00am dose of Metformin was documented as administered on 06/01/22. Interview with Resident #6 on 06/01/22 at 10:33am revealed: -She did not like breakfast and only ate breakfast 1-2 times a year. -She did not eat breakfast this morning. -She was not currently having any stomach upset or feelings of low blood sugar. Interview with the MA on 06/01/22 at 1:39pm revealed: -Medications could be administered one hour before and one hour after the scheduled administration time. -If a medication was scheduled for administration at 9:00am the earliest she would administer it was 8:00am. -She administered medication whenever it "popped up" on the eMAR to be administered. -If a medication was ordered to be administered with meals it should be administered once a resident started eating. -Resident #6 sometimes ate breakfast but she did not know if Resident #6 ate breakfast on 06/01/22 or not. Interview with the Resident Care Coordinator (RCC) on 06/01/22 at 1:56pm revealed: -Medications could be administered one hour before and up to one hour after the scheduled administration time. -If a medication was ordered to be administered with meals it should be administered right before a resident ate. -She did not know if Resident #6 usually ate breakfast or not, but the resident kept food in her	D 358		

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room and ate a lot.
-The MA should explain to Resident #6 that she needed to eat when taking her Metformin.
-Administering Metformin to Resident #6 without her eating could cause her to have an upset stomach or cause her blood sugar to drop.

Interview with the Administrator on 06/01/22 at 2:11pm revealed:
-If a medication was ordered to be administered with meals the resident should receive the medication at 7:00am, 12:00pm, or 5:00pm because that was when meals were served at the facility.
-She was not aware that Resident #6 did not usually eat breakfast.
-A MA should have made Resident #6's primary care provider (PCP) aware that the resident did not eat breakfast so the administration time for her Metformin could be adjusted.
-Resident #6's blood sugar could go too low if she received Metformin without eating.
-She was not aware of Resident #6 having any problems with nausea or low blood sugars.

Telephone interview with Resident #6's PCP on 06/02/22 at 2:55pm revealed:
-Metformin worked better if it was administered with food.
-Metformin was known to cause gastrointestinal (GI) distress and diarrhea so if Resident #6 took it without eating she could get sick.
-If Resident #6's blood sugar was low when she took Metformin without eating it could cause her blood sugar to go even lower.
-Resident #6 should eat before taking Metformin and she should have been informed by facility staff that Resident #6 did not usually eat breakfast.
-If she had been informed by facility staff that

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Resident #6 did not usually eat breakfast, she would have changed the dosage times for the Metformin.

d. Review of Resident #6's current FL-2 dated 03/15/22 revealed:
-Diagnosis included chronic obstructive pulmonary disease (COPD). (COPD is a lung disease that blocks airflow and makes it difficult to breath.)
-There was an order for Advair Diskus 500/50mcg inhale one puff twice a day, rinse mouth after each use. (Advair Diskus is a dry powder inhaler used to treat chronic obstructive pulmonary disease (COPD). The manufacturer recommends rinsing the mouth without swallowing after each dose to lessen the chance of getting a yeast infection (thrush) in the mouth or throat.)

Observation of the 9:00am medication pass on 06/01/22 revealed:
-The medication aide (MA) opened the cover lid to Resident #6's Advair Diskus inhaler.
-The MA slid the cover lid all the way to the bottom of the device until a click was heard and she handed the inhaler to the resident
-Resident #6 inhaled one deep puff of the Advair Diskus inhaler and exhaled slowly.
-Resident #6 did not rinse her mouth after using Advair Diskus and the MA did not offer the resident any water to rinse her mouth.
-The MA did not instruct Resident #6 to rinse her mouth.

Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Advair Diskus administer one inhalation by mouth twice a day, rinse mouth after each use.

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-The Advair Diskus was scheduled to be administered at 9:00am and 9:00pm and the 9:00am dose was documented as administered on 06/01/22.

Interview with Resident #6 on 06/01/22 at 10:33am revealed she knew that she was supposed to rinse out her mouth after using her Advair inhaler, but the MAs did not get her to do it.

Interview with the MA on 06/01/22 at 1:39pm revealed:
-She was not aware that residents should rinse out their mouth after using Advair Diskus.
-She had never noticed the instructions on the eMAR for Resident #6 to rinse out her mouth after each use of the Advair Diskus inhaler.

Interview with the Clinical Director (CD) on 06/02/22/ at 1:56pm revealed:
-The MAs should administer medications according to the instructions on the eMAR.
-The MAs were trained to have residents rinse out their mouth after administering Advair Diskus.
-Resident #6 could get a rash in her mouth if she did not rinse out her mouth after receiving Advair Diskus inhaler.

Interview with the Resident Care Coordinator (RCC) on 06/01/22 at 1:56pm revealed:
-She did not know that a resident should rinse their mouth after receiving Advair Diskus inhaler.
-MAs should administer medications as instructed on the eMAR and the MAs should check the eMAR and medication 3 times before administering a medication to a resident.
-Since it specifically instructed on the eMAR for the resident to rinse out her mouth after receiving Advair Diskus inhaler, the MA should ensure it

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was done.

Interview with the Administrator on 06/01/22 at 2:11pm revealed:
-Advair Diskus was a powder inhaler and a resident should rinse their mouth after inhalation because it could cause dry mouth or could interact with other medications.
-The MAs should administer medications as instructed on the eMAR.
-The MA should have offered Resident #6 water to rinse her mouth after receiving Advair Diskus.

Telephone interview with Resident #6's primary care provider (PCP) on 06/02/22 at 2:55pm revealed the resident should rinse out her mouth after receiving Advair Diskus to prevent her from getting thrush.

e. Review of Resident #6's current FL-2 dated 03/15/22 revealed there was an order for Miralax 1 capful in 8 ounces of water every day for constipation. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the cap.)

Observation of the 9:00am medication pass on 06/01/22 revealed:
-The medication aide (MA) poured Miralax powder out of the bottle and into a small clear medication cup labeled with cubic centimeters (cc) and milliliter (ml).
-The Miralax powder measured at 15ccs on the medication cup.
-The MA poured the Miralax powder into a 6-ounce cup and added water to the powder and mixed it with a spoon.
-The MA administered the Miralax to Resident #6

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at 9:32am.

Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Miralax powder mix 1 capful (17g) in 8 ounces of liquid of choice and drink by mouth daily for constipation.
-The Miralax was scheduled for administration at 8:00am and was documented as administered on 06/01/22.

Interview with Resident #6 on 06/01/22 at 10:33am revealed the Miralax gave her diarrhea.

Interview with the MA on 06/01/22 at 1:39pm revealed:
-She should have measured Resident #6's Miralax in the cap on the bottle using the line on the inside of the cap marking 17 grams.
-There was not a marking for grams on the small clear medication cups and mls and ccs were not the same as grams.

Second interview with the MA on 06/02/22 at 2:27pm revealed she used the 6 ounce cups on the medication cart to administer Miralax to Resident #6 because she did not have any other cups to put it in or any other way to measure the water.

Interview with the Resident Care Coordinator (RCC) on 06/01/22 at 1:56pm revealed:
-The correct dosage of Miralax should be measured by pouring it up to the white line on the cap on the bottle marking 17 grams.
-The MAs should not use small clear medication cups to measure Miralax powder because mls and ccs were not the same as grams.
-Not measuring the Miralax in the cap could

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cause Resident #6 to receive either too much or too little of the Miralax which could cause her to have diarrhea or constipation.

Interview with the Administrator on 06/01/22 at 2:11pm revealed:
-The MAs should be measuring the correct dose of Miralax by using the cap on the bottle.
-The MAs should not be using the clear medication cups to measure Miralax powder.
-She put a measuring cup on the medication carts and that was what the MAs should use to measure the water to mix the Miralax powder in.
-She put 10 ounce cups on the medication carts for the MAs to use to Miralax.

Telephone interview with Resident #6's primary care provider (PCP) on 06/02/22 at 2:55pm revealed:
-The MAs should be using the cap on the bottle to measure the Miralax powder.
-Using a medication cup to measure the Miralax powder could cause the MA to underdose the resident which could cause constipation, or it could cause them to overdose the resident which could cause diarrhea.
-Having diarrhea could cause the resident to lose electrolytes. (Electrolytes are essential minerals that are vital to many key functions in the body.)
-Miralax should be mixed in 8 ounces of water instead of 6 ounces.
-Mixing Miralax with 8 ounces of water helped the powder to dissolve completely and the resident was more likely to drink all of it if it was dissolved completely.

f. Review of Resident #7's current FL-2 dated 01/31/22 revealed:
-Diagnoses included diabetes mellitus and cognitive impairment.

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-There was an order for Incruse Ellipta 62.5mcg 1 inhalation daily. (Incruse Ellipta is a dry powder inhaler used to treat chronic obstructive pulmonary disease (COPD) and deliver medication deep into the lungs. COPD is a lung disease that blocks airflow and makes it difficult to breath. This type of inhaler is breath-activated requiring a deep, fast breath to release the medication from the device and into the lung. The manufacturer recommends to put the mouthpiece between the lips and take one long, steady deep breath in and hold it for about 3-4 seconds. Remove the inhaler from the mouth and breathe out slowly and gently.)

Observation of the 9:00am medication pass on 06/01/22 revealed:
-The medication aide (MA) opened the cover lid to Resident #7's Incruse Ellipta 62.5mcg inhaler.
-The MA slid the cover lid all the way to the bottom of the device until a click was heard and she handed the inhaler to the resident.
-The MA did not instruct the resident on how to use the inhaler.
-The MA did not instruct the resident to exhale prior to the resident putting her lips around the mouthpiece.
-At 9:47am, Resident #7 took one quick shallow breath in and did not inhale deeply or hold her breath.
-The MA did not instruct Resident #7 to breath in steady and deeply or hold her breath.
-Resident # 7 handed the inhaler back to the MA who closed the cover lid on the Incruse Ellipta inhaler.

Interview with the MA on 06/01/22 at 1:39pm revealed:
-Resident #7 never took a deep breath of her Incruse Ellipta inhaler.

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-She had instructed Resident #7 to take a deep breath of her Incruse Ellipta inhaler in the past but did not do it today.

Interview with the Resident Care Coordinator (RCC) on 06/01/22 at 1:56pm revealed:
-The MAs were trained to instruct residents to take a deep breath of their inhaler.
-The MA should remind Resident #7 to take a deep breath of the Incruse Ellipta inhaler.

Interview with the Administrator on 06/01/22 at 2:11pm revealed when the MAs were administering an inhaler, they should instruct residents to take a deep breath of the inhaler.

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

Attempted telephone interview with Resident #7's primary care provider on 06/03/22 at 3:50pm was unsuccessful.

2. Review of Resident #4's current FL-2 dated 09/07/21 revealed:
-Diagnosis included diabetes mellitus.
-There was an order for NovoLog inject 4 units before meals, hold for blood sugar less than 150. (NovoLog is a rapid-acting insulin used to lower blood sugar.)

Review of Resident #4's April 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for NovoLog inject 4 units before meals, hold for blood sugar less than 150.
-The NovoLog was scheduled to be administered at 6:50am, 11:50am, and 4:50pm.
-On 04/01/22 Resident #4's blood sugar was

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documented as 130 and it was documented that he was administered 4 units of NovoLog in his right abdomen at 6:50am.
-On 04/02/22 Resident #4's blood sugar was documented as 129 and it was documented that he was administered 4 units of NovoLog in his right arm at 4:50pm
-On 04/19/22 Resident #4's blood sugar was documented as 128 and it was documented that he was administered 4 units of NovoLog in his left abdomen at 11:50am.

Review of Resident #4's May 2022 eMAR revealed:
-There was an entry for NovoLog inject 4 units before meals, hold for blood sugar less than 150.
-The NovoLog was scheduled to be administered at 6:50am, 11:50am, and 4:50pm.
-On 05/02/22 Resident #4's blood sugar was documented as 117 and it was documented that he was administered 4 units of NovoLog in his left arm at 4:50pm.
-On 05/25/22 Resident #4's blood sugar was documented as 144 and it was documented that he was administered 4 units of NovoLog in his right arm at 6:50am.

Interview with the Clinical Director (CD) on 06/03/22 at 3:00pm revealed:
-If a medication was documented as administered on the eMAR that meant the medication was administered.
-She documented she administered 4 units of NovoLog to Resident #4 at 4:50pm on 04/02/22 when his blood sugar was 129 but did not think that she actually administered the NovoLog, because she knew not to administer insulin to Resident #4 if his blood sugar was below 150.
-She was probably rushing and documented that she administered the insulin when she did not

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because she was just clicking through on the eMAR.
-She did not know why she would document a site that she administered insulin if she did not administer the insulin to Resident #4.

Interview with the Resident Care Coordinator (RCC) on 06/03/22 at 12:19pm revealed if a resident had orders to hold insulin if their blood sugar was below a certain range the MA should not administer insulin if the blood sugar was below the range and it should be documented on the eMAR that the medication was not administered.

Second interview with the RCC on 06/03/22 at 3:00pm revealed:
-If a MA documented on the eMAR that a medication was administered it was assumed the resident was administered that medication.
-She documented that Resident #4's blood sugar was 130 at 6:50am on 04/01/22 and he was administered 4 units of NovoLog, but she did not think that she administered the NovoLog.
-She documented a site that she administered the NovoLog in because she was rushing.

Interview with the Administrator on 06/03/22 at 12:19pm revealed:
-The MAs should read the eMAR and the blood sugar parameters for residents and not administer insulin if the blood sugar was below the parameter.
-If the MA held the insulin it should be documented on the eMAR that it was not administered.

Attempted telephone interview with the MA on 06/03/22 at 3:32pm was unsuccessful.

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Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/03/22 at 3:50pm was unsuccessful.

3. Review of Resident #1's current FL-2 dated 02/09/22 revealed diagnoses included type 2 diabetes mellitus and muscle weakness.

Review of consultation notes for Resident #1 dated 05/12/22 revealed:
-The resident had cerumen debris on the tympanic membrane of the right ear. (Cerumen debris is ear wax. The tympanic membrane is the eardrum.)
-There was an order for Debrox 6.5% solution, 5 drops to the right ear twice a day for 4 days, then stop.

Review of Resident #1's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for ear drops 6.5% instill 5 drops to the right ear twice a day for 4 days, then stop.
-The ear drops were scheduled for administration at 9:00am and 9:00pm.
-There was a date written of 05/12/22 and a stop date on the eMAR of 05/17/22.
-The ear drops were documented as administered at 9:00am and 9:00pm on 05/16/22 and 05/17/22.
-Resident #1 was administered ear drops for 2 days instead of the 4 days that were ordered.

Interview with the Clinical Director (CD) on 06/02/22 at 1:56pm revealed:
-The facility's contracted pharmacy put start and stop dates for resident's medications on the eMAR.
-She was able to change the start and stop dates

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on the eMAR if needed.
-A MA should have noticed that Resident #1 was only administered 2 days of the ear drops and let the CD know.
-The MA or CD should have contacted Resident #1's primary care provider (PCP) for a new start and stop date for the medication and then the CD would have changed the dates on the eMAR so Resident #1 would be administered the full 4 days of ear drops.
-All medications should be administered as ordered.

Interview with the Resident Care Coordinator (RCC) on 06/02/22 at 1:22pm revealed:
-The facility's contracted pharmacy put the start and stop dates for medications on the eMAR but the CD could change the dates.
-Resident #1 not receiving her full dose of ear drops could cause her ear problems to become worse or come back.

Interview with the Administrator on 06/02/22 at 1:29pm revealed:
-Start and stop dates were put on the eMAR by the facility's contracted pharmacy but the dates could be changed by the CD.
-Resident #1 should have been administered her full course of ear drops because not receiving the full course could have caused her to need more care or to become sick.

Telephone interview with Resident #1's PCP on 06/02/22 at 2:55pm revealed:
-When she reexamined Resident #1's ear the week after she ordered the ear drops, the resident still had debris in her ear, and she was able to get some of the debris out of her ear but not all of it.
-She thought Resident #1 had been administered

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all 4 days of her ear drops as ordered so she was wondering why she still had so much cerebrum in her ear when she reexamined her.
-Resident #1 not receiving all 4 days of her ear drops could cause a cerebrum patch to form sooner than it would if her ear had been adequately cleaned out.

4. Review of Resident #2's current FL-2 dated 12/21/21 revealed:
-Diagnoses included muscle weakness, abnormal gait, and arthritis.
-He used a wheelchair to ambulate.
-There was an order for Oxycodone 10mg 1 tablet every 6 hours as needed for pain. (Oxycodone is narcotic used to treat moderate to severe pain.)

Review of Resident #2's physician's order dated 04/12/22 revealed the resident was prescribed Oxycodone 10mg tablets; take one tablet every 8 hours for pain.

Interview with Resident #2 on 06/01/22 at 1:34pm revealed:
-He suffered from back pain and had a difficult time sitting up straight in his wheelchair due to pain.
-He was frustrated that the facility ran out of his pain medication a few weeks ago.

Observation of Resident #2's medications on hand on 06/03/22 at 2:51pm revealed there was a supply of Oxycodone 10mg tablets dispensed on 05/16/22 with 11 of 30 tablets remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/03/22 at 10:20am revealed:
-Resident #2 was ordered Oxycodone 10mg; 1

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tablet every six hours as needed.
-They received a physician's order from the facility on 04/12/22 for Oxycodone 10mg; 1 tablet every 8 hours with a quantity of 90 tablets dispensed on 04/12/22.
-The facility sent a request to the physician for a refill of Oxycodone 10mg tablets every 8 hours on 05/09/22 at 2:26pm and 11:00pm and again on 05/15/22.
-There was a delay in the pharmacy receiving the order because the physician needed to write a hard script.
-Resident #2 missed his scheduled Oxycodone 10mg tablet on 05/13/22 at 3:00pm and 11:00pm, on 05/14/22 - 05/15/22 at 7:00am, 3:00pm, and 11:00pm and on 05/16/22 at 7:00am.

Review of Resident #2's April 2022 and May 2022 electronic medication administration records (eMARS) revealed:
-There was an entry on each eMAR for Oxycodone 10mg 1 tablet at 7:00am, 3:00pm, and 11:00pm.
-Oxycodone 10mg was documented as not administered on 05/13/22 at 3:00pm and 11:00pm, on 05/14/22 - 05/15/22 at 7:00am, 3:00pm, and 11:00pm and on 05/16/22 at 7:00am due to waiting on batch, awaiting an electronic prescription from the physician and awaiting pharmacy refill.

Interview with a medication aide on 06/03/22 at 10:58am revealed:
-The MAs were responsible for ordering medications and contacting the resident's primary care physician (PCP) if needed.
-The MAs were expected to notify the Resident Care Coordinator (RCC) if a resident was out of a medication.
-Residents should have at least a 6 day supply of

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medications available at the facility.
-She was not sure why Resident #2 was without his Oxycodone for 9 doses.

Interview with the RCC on 06/03/22 at 10:40am revealed:
-Resident #2 should not have missed 9 doses of Oxycodone 10mg.
-He had a difficult time with back pain and would become anxious and agitated if he did not get his pain medication as scheduled.
-The MA should have notified her when there was a delay in getting the resident his pain medication.
-The Clinical Director (CD) was responsible for auditing the medication charts to ensure residents were not without medications.
-She and the CD completed cart audits several times a month, but they should have contacted Resident #2's physician earlier to ensure he did not run out of his pain medication.

Interview with the Administrator on 06/02/22 at 2:06pm revealed:
-The MAs were expected to notify the facility's contracted pharmacy when a resident had five doses left of their medication.
-The MAs faxed the request to the pharmacy.
-If a medication had not arrived in time that had been ordered she expected the MA to contact the pharmacy to follow up.
-She was concerned that Resident #2 was without his scheduled Oxycodone for 9 consecutive doses due to his back pain; he became anxious and agitated when he was in pain.
-On the days that Resident #2 did not receive 9 doses of his Oxycodone, he could have had withdrawal symptoms and increased pain.

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Attempted telephone interview with Resident #2's family member on 06/02/22 at 11:19am and 06/03/22 at 10:17am were unsuccessful.

Attempted telephone interview with Resident #2's PCP on 06/02/22 at 2:23pm and 06/03/22 at 10:07am were unsuccessful.

5. Review of Resident #5's current FL-2 dated 01/04/22 revealed diagnoses included chronic obstructive pulmonary disease, atherosclerotic heart disease, acute on chronic diastolic heart failure, anxiety disorder, and gastroesophageal reflux disease.

a. Review of Resident #5's current FL-2 dated 01/04/22 revealed an order for Prednisone 1mg take 2 tablets at bedtime. (Prednisone is a corticosteroid used to treat inflammatory processes such as chronic obstructive lung disease.)

Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Prednisone 1mg take 2 tablets (2mg) at bedtime scheduled for 9:00pm.
-Prednisone 1mg was documented as not administered on 05/06/22 - 05/07/22 due to medication out of stock, not on cart.

Observation of Resident #5's medications on hand on 06/03/22 at 2:51pm revealed:
-There was a supply of Prednisone 1mg tablets with a start date of 05/09/22 with 4 of 56 tablets remaining.
-There were 2 tablets packaged in 2 unopened bubbles on the card.

Telephone interview with a pharmacist at the

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D 358	Continued From page 52 facility's contracted pharmacy on 06/03/22 at 3:20pm revealed: -There was a supply of 56 Prednisone 1mg tablets for Resident #5 dispensed on 04/04/22, delivered to the facility on 04/07/22, with a batch start date of 04/11/22. -There was a supply of 56 Prednisone 1mg tablets for Resident #5 dispensed on 05/02/22, delivered to the facility on 05/05/22, with a batch start date of 05/09/22. -Maintenance medications were sent in monthly cycle fills to the facility. -If a medication was not sent in the cycle fills, the facility should contact the pharmacy. Interview with Resident #5 on 06/03/22 at 4:11pm revealed: -She was unsure of all of the medications she was administered and she was not aware of running out of any medications. -She took Prednisone for her breathing problems and she needed it to help with her breathing. Interview with a medication aide (MA) on 06/03/22 at 3:05pm revealed: -Most medications came in monthly batch fills to the facility but sometimes the batch fills ran out early and she did not know why. -The MAs were responsible for ordering medications when the medication got to the colored strip on the bubble card (5 to 6 day supply) by either calling or faxing the pharmacy. -She was unsure why Resident #5 ran out of Prednisone. Interview with the Clinical Director on 06/03/22 at 4:00pm revealed: -The MAs were responsible for letting the Clinical Director know if a medication was out of refills when there was a 6 or 8-day supply remaining.	D 358		

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-She thought the issue with Resident #5's Prednisone running out may have been caused by needing refills or staff may have overlooked the supply on the medication cart.

Attempted telephone interview with Resident #5's primary care provider (PCP) on 06/03/22 at 3:50pm was unsuccessful.

b. Review of Resident #5's current FL-2 dated 01/04/22 revealed an order for Omeprazole 40mg 1 capsule once a day. (Omeprazole is used to treat acid reflux.)

Review of Resident #5's May 2022 and June 2022 electronic medication administration records (eMARs) revealed:
-There was an entry on each eMAR for Omeprazole 40mg 1 capsule every day scheduled at 7:00am.
-Omeprazole 40mg was documented as not administered from 05/28/22 - 05/30/22 and on 06/01/22 due to waiting for order, awaiting pharmacy.

Observation of Resident #5's medications on hand on 06/03/22 at 2:51pm revealed there was a supply of Omeprazole 40mg capsules dispensed on 05/31/22 with 4 of 6 capsules remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/03/22 at 3:20pm revealed:
-There was a supply of 28 Omeprazole 40mg capsules for Resident #5 dispensed on 04/04/22, delivered to the facility on 04/07/22, with a batch start date of 04/11/22.
-There was a supply of 28 Omeprazole 40mg capsules for Resident #5 dispensed on 05/02/22, delivered to the facility on 05/05/22, with a batch

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start date of 05/09/22.
-There was a supply of 6 Omeprazole 40mg capsules for Resident #5 dispensed on 05/31/22 and delivered to the facility on 06/01/22.
-Maintenance medications were sent in monthly cycle fills to the facility.
-If a medication was not sent in the cycle fills, the facility should contact the pharmacy.

Interview with Resident #5 on 06/03/22 at 4:11pm revealed:
-She was unsure of all of the medications she was administered and she was not aware of running out of any medications.
-She had indigestion or acid reflux symptoms "once in a while".

Interview with a medication aide (MA) on 06/03/22 at 3:05pm revealed:
-Most medications came in monthly batch fills to the facility but sometimes the batch fills ran out early and she did not know why.
-The MAs were responsible for ordering medications when the medication got to the colored strip on the bubble card (5 to 6 day supply) by either calling or faxing the pharmacy.
-She was unsure why Resident #5 ran out of Omeprazole.

Interview with the Clinical Director on 06/03/22 at 4:00pm revealed:
-The MAs were responsible for letting the Clinical Director know if a medication was out of refills when there was a 6 or 8-day supply remaining.
-She thought the issue with Resident #5's Omeprazole running out may have been caused by needing refills or staff may have overlooked the supply on the medication cart.

Attempted telephone interview with Resident #5's

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primary care provider (PCP) on 06/03/22 at 3:50pm was unsuccessful.

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The facility failed to administer medications as ordered for 4 of 4 residents observed during the medication pass resulting in a 24% medication error rate with 6 errors out of 25 opportunities. Resident #8 was administered rapid-acting insulin 57 minutes prior to receiving lunch putting the resident at risk for low blood sugar. Resident #4 was administered rapid-acting insulin 48 minutes prior to receiving lunch putting the resident at risk for low blood sugar. A medication used to lower blood sugar was not administered with a meal as ordered for Resident #6 putting the resident at risk of low blood sugar and stomach symptoms such as gastro-intestinal distress and diarrhea. Resident #6 received an inhaler without rinsing the mouth putting the resident at risk for thrush. Resident #6 did not receive the correct dosage of a laxative and complained of diarrhea. Resident #4 received a rapid-acting insulin on 5 occasions when his blood sugar was less than 150 putting him at risk for a low blood sugar. Resident #1 did not receive a full course of medication for ear wax removal resulting in the provider being unable to completely remove the wax buildup. Resident #2 missed 9 doses of a scheduled narcotic pain medication resulting in the resident experiencing pain. The failure of the facility to administer medications as ordered placed the residents at substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/02/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 3, 2022.

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D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

10A NCAC 13F .1004 Medication Administration

(i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure recording of the administration on the electronic medication administration record was by the medication aide who actually administered medications to 3 of 5 sampled residents (#2, #3, #4).

The findings are:

1. Review of Resident #4's current FL-2 dated 09/07/21 revealed diagnoses included femoral deep vein thrombosis, diabetes mellitus, thrombophlebitis left arm, tobacco dependency.

Review of Resident #4's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for NovoLog, a medication used to stabilize blood sugars, 4 units before meals, hold for fingerstick blood sugar (FSBS) less than 150.
-On 05/02/22 Resident #4's blood sugar was documented as 117 and it was documented that

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he was administered 4 units of NovoLog at 4:50pm.

Interview with the Clinical Director (CD) on 06/03/22 at 3:00pm revealed her initials were on Resident #4's eMAR as the one who administered NovoLog at 4:50pm on 05/02/22, but she was not working at the time and another medication aide (MA) was logged in under her name.

Second review of Resident #4's May 2022 eMAR revealed:
-A fingerstick blood sugar scheduled for 4:50pm and 10 medications scheduled for 4:50pm, 5:00pm, and 7:00pm were documented as administered to Resident #4 on the evening of 05/02/22: Aspercreme 4% (for mild pain), Aspirin 81mg (for mild pain or to thin the blood), Gabapentin 600mg (for seizures or to treat nerve pain), Vicodin 5-325mg (for moderate to severe pain), Levemir 22 units (for blood sugar), Melatonin 5mg (for sleep), Metformin 500mg (for blood sugar), NovoLog 4 units, Primidone 50mg (for seizures), and Simvastatin 10mg (for cholesterol).
-The initials of the CD who worked first shift on 05/02/22 was documented as performing the FSBS and administering those 10 medications instead of the MA who actually administered them.

Attempted telephone interview with the MA on 06/03/22 at 3:32pm was unsuccessful.

Refer to interview with the Clinical Director on 06/03/22 at 3:20pm.

Refer to interview with the Administrator on 06/03/22 at 3:20pm.

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2. Review of Resident #2's current FL-2 dated 12/21/21 revealed diagnoses included abnormal gait, esophageal reflux, anemia, anxiety, and arthritis.

Review of Resident #2's May 2022 electronic medication administration record (eMAR) revealed:
-Six medications scheduled for 6:00pm, 7:00pm, and 11:00pm were documented as administered to Resident #2 on the evening of 05/02/22: Albuterol HFA (for shortness of breath), Baclofen 10mg (for relaxing muscles), Dorzolamide-Timolol 22.3-6.8mg (for eye conditions), Latanoprost 0.005% (for high pressure in the eye), Oxycodone 10mg (for moderate to severe pain), and Restasis 0.05% (for dry eyes).
-The initials of the Clinical Director (CD) who worked first shift on 05/02/22 was documented as administering those 6 medications instead of the MA who actually administered them.

Attempted telephone interview with the MA on 06/03/22 at 3:32pm was unsuccessful.

Refer to interview with the CD on 06/03/22 at 3:20pm.

Refer to interview with the Administrator on 06/03/22 at 3:20pm.

3. Review of Resident #3's current FL-2 dated 11/30/21 revealed diagnoses included early stage dementia, Type 2 diabetes mellitus, schizoaffective disorder, and depression.

Review of Resident #3's May 2022 electronic medication administration record (eMAR)

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revealed:
-A fingerstick blood sugar (FSBS) scheduled at 7:00pm and 3 medications scheduled for 5:00pm and 7:00pm were documented as administered to Resident #3 on the evening of 05/02/22: Levemir 5 units (for blood sugar), Lorazepam 0.5mg (for anxiety), and Metformin 500mg (for blood sugar).
-The initials of the Clinical Director (CD) who worked first shift on 05/02/22 was documented as performing the FSBS and administering those 3 medications instead of the MA who actually administered them.

Attempted telephone interview with the MA on 06/03/22 at 3:32pm was unsuccessful.

Refer to interview with the CD on 06/03/22 at 3:20pm.

Refer to interview with the Administrator on 06/03/22 at 3:20pm.

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Interview with the Clinical Director (CD) on 06/03/22 at 3:20pm revealed:
-Medication aides (MA) counted off medication carts at the end and beginning of shifts.
-Once the MA counted off the medication carts the MA going off shift was to log out of the electronic medication administration record (eMAR).
-She worked first shift on 05/02/22.
-The MA who worked second shift on 05/02/22 counted the women's medication cart while the CD counted the men's medication cart and then they switched carts.
-When the CD finished counting the men's medication cart, she forgot to log out of the eMAR on that cart.
-It was not noticed that the CD had not logged out of the eMAR on the men's medication cart until

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the Administrator came in to work third shift on 05/02/22 and noticed it.
-When the Administrator came in for her shift she contacted the CD when she noticed that the CD was still logged into the eMAR on the men's medication cart and asked for her pass code to log her out of the eMAR before she started her shift.

Interview with the Administrator on 06/03/22 at 3:20pm revealed:
-MAs should log out of the eMAR when their shift ended.
-She noticed that the CD had not logged out of the eMAR on the men's medication cart when she came in to count the medication cart to start her shift on 05/02/22.

D912 G.S. 131D-21(2) Declaration of Residents' Rights (D912)

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, health care, and medication administration.

The findings are:

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D912	Continued From page 61 1. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#2) related toenails that were long, jagged, and curled; dry, flakey skin on his feet, dirt under his fingernails, hair that was growing over his ears and not clean shaven. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 5 sampled residents (#2, #3, #4) related to not obtaining podiatry care for a diabetic resident with long, thick toenails and open wounds on his feet, not notifying the primary care provider (PCP) of elevated blood sugars, and not notifying the mental health provider (MHP) of side effects of an antipsychotic medication (#3); not notifying the PCP of a resident's swollen legs and obtaining podiatry care for the resident's long, thick toenails (#2); and not obtaining an abdominal computed tomography (CT) scan for a resident (#4). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 4 of 4 residents (#4, #6, #7, #8) observed during the medication passes including errors with insulin (#4, #8), medication for diabetes and constipation (#6), inhaled medications used to treat asthma (#6, #7); and for 4 of 5 residents sampled (#1, #2, #4, #5) for record review including errors with a medication for ear wax removal (#1), a medication for moderate to severe pain (#2), insulin (#4), and medications for inflammation and acid reflux (#5).	D912		

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	[Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].			